TOAH-NNEST
Te Ohaakii a Hine - National Network Ending Sexual Violence Together

GOOD PRACTICE
Responding to Sexual Violence in Aotearoa

# Good Practice Responding to Sexual Violence

## Guidelines for 'mainstream' crisis support services for survivors

Round two

For the full project see **toahnnestgoodpractice.org**

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**Te Ohaaki a Hine National Network Ending Sexual Violence Together. New Zealand.**

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The word 'mainstream' appears in inverted commas to denote the way that its use is problematic due to the hegemonic assumptions which such a word can imply. It is used in spite of this due to lack of an alternative word able to accurately describe the services.

# CONTENT

# INTRODUCTION

Sexual violence support services developed out of responding to the needs of survivors in our communities. Decades of working from this client-centered orientation means that service providers have a high level of knowledge about what survivors want. The role of the specialist sexual assault crisis service is crucial for adult survivors. We are there to protect, promote and enhance the well-being of the survivor, including minimizing the psychological consequences of the trauma by attending to their emotional and psychological needs, both in and of themselves, and in relation to their journey through legal and medical processes. The Guidelines are intended to present the knowledge and skill of the sector, in relation to what we know works, responding to survivor needs and experiences, as well as add the research evidence-base. This is a living project, so ongoing consultation and research review will be conducted in order to keep it current.

# ABOUT THE PROJECT

The function of crisis support services responding to sexual violence perpetrated against adults and young people is to mitigate the psychological impacts of that sexual violence so that the survivor's psychological, social, physical, economic and spiritual well-being can be restored. While this has been done from a "grass roots" perspective for the last 30 years, advances in science mean that we can now link what we do to the expanding evidence base. It is in the interests of survivors that our work is informed by this evidence.

In addition, funding streams are increasingly requiring such links between evidence base and practice. The purpose of this project was to update existing Good Practice Guidelines, building upon the findings of the initial project conducted in 2009. The development of Good Practice Guidelines aims to support good practice across the country to a range of population groups and provide the opportunity for transparency and accountability with service partners, NZ Police and DSAC trained medical staff, with service funders and our community.

This project seeks to:

- Review the principles of good practice for provision of crisis support services to survivors of sexual violence and the Vision for services
- Update the evidence base for the principles
- Extend the guidelines to working with survivors from diverse communities.
- To achieve the latter, we formed research partnerships with people from a variety of communities, foremost among these being Māori/ tāngata whenua. Other communities or groups we partnered with to establish good practice when working with their members following sexual assault include: Pacific communities, Muslim women, people identifying as LGBTI, males, people with disabilities, and also people from Asian communities. While this is not an exhaustive list of those impacted by sexual violence, these groups have been chosen because of high numbers of survivors or the existence of particular challenges in service delivery.

# SECTOR FEEDBACK

In order to review and update the 2009 guidelines, our initial focus was on obtaining feedback and consultation with services, service partners and key stakeholders during the TOAH-NNEST annual hui 2015 (held in Whangarei). For this purpose, given the expertise of the sector, and the importance of capturing feedback, we presented a workshop at the hui to access a range of suggestions (via questionnaire and informal interviews) for the ongoing development of the guidelines.

- The general feedback obtained from the sector in regards to the 2009 Guidelines was that:
- The Guidelines were content rich and captured significant practices of crisis work well, while also

providing guidance for ongoing development.

- Some of the criticism included the limited availability of the guidelines to the sector (e.g. 50% of the questionnaire respondents were not able to access the Guidelines report and/or were unaware it existed). In addition, of those who had accessed the report, challenges finding specific information quickly (given the content load) were raised.
- Recommendations were made to provide improved dissemination of the guidelines information, in a way that was accessible to the sector (as a whole).

# WHO – RESEARCHERS, ADVISORY GROUP, FUNDERS

*Researchers:* In order to complete the requirements of this project, a Lead researcher with both research and sector/practitioner knowledge, was contracted to conduct the primary research tasks. The work of the Lead Researcher was overseen and supported by the Principle Project Supervisor.

**Lead Researcher: Dr Julie Wharewera-Mika (Ngāti Awa, Ngāi Tūhoe, Te Whānau ā Apanui)**

Julie is a Director, Clinical Psychologist and Researcher researcher and with The Flying Doctors –Ngā Manu Ārahi, Mobile Clinical Psychology Consultants. She has extensive experience as a researcher and practitioner supporting survivors in the mental health sector, with both adults and children, working in particular with acute and complex cases. Julie is passionate about improving service and support experiences for survivors, and her current mahi is focussed on enhancing access for Māori by providing a national mobile clinical psychology service. Julie has been a member of the National Standing Committee on Bicultural Issues for the New Zealand Psychological Society since 2006; and is currently one of two Bicultural Directors on the Executive of the Society.

**Principle Project Supervisor: Kathryn McPhillips - Clinical Psychologist.**

Kathryn is Executive Director at HELP, an Auckland agency serving survivors of sexual violence and their families and friends. She instigated this project as she is passionate about both good practice and collaborative working relationships in the sector so that we do the best we can for survivors and to end sexual violence. Kathryn contributed several research papers to the Task Force for Action on Sexual Violence (2007-2009), and has been part of the development of good practice guidelines for restorative justice with sexual violence. Kathryn is one of the founding members of Te Ohaakii a Hine - National Network Ending Sexual Violence Together and an executive committee member of the Tauiwi Caucus. She is a founding and executive committee member of Project Restore.

*Advisory Group:* An Advisory Group for the project was established to provide expertise and advice, to assist in ensuring it is useful to and for mainstream crisis support services and survivors of sexual violence who may want to use such services. This group was also established to support the involvement in the research of members of those groups which are partners in parts of the research – young people, Māori, Pacific Peoples, men, Muslim, LGBTI + people living with disability, and Asian.

**The following people were members of the project Advisory Group:**

- Andrea Black (Rape Crisis; Secondary Project Supervisor)
- Anjum Rahman (Trustee, Shama Hamilton Ethnic Women's Centre):

*"I have worked with and for ethnic minority communities in various volunteer roles for over a decade. This project is especially important to ensure accessible services for survivors of sexual violence from these communities, as they are very often reluctant to disclose sexual violence or to seek assistance."*

- Aych McArdle (previously of Rainbow Youth; LGBTI Human Rights Advocate):

*"I'm really proud that the needs of our rainbow whānau have been brought to the table in this project and it has been my honour to help facilitate that voice being woven throughout the document. Our rainbow communities are as diverse as our disability communities and I have been able to bring some intersectional weaving magic into this mahi."*

- Dr Christine Foley (Lead Clinician Pohutukawa SAATS Auckland. DSAC Board Member):

*"My aim was to represent the medical and forensic aspects of care for all those affected by Sexual Assault and ensure that medical and crisis support services are enabled to work together, to provide excellent services."*

- Detective Senior Sergeant Darrell Harpur (Police)
- Dawn Baxter (Youthline).

*"I wanted to be involved with this project as sexualviolence affects many of our young people in Aotearoa and the first response can be detrimental to healing. I have brought a youth perspective to the project and have learnt a great deal from all the other disciplines."*

- Ezekiel Robson (Disabled Person's Assembly)
- Hariata Riwhi (Rape Crisis)
- Hera Pierce (Nga Kaitiaki Mauri, TOAH-NNEST)
- Dr Jennifer Hauraki (Clinical Psychologist and Researcher, Asian representative)
- Joy Te Wiata (Nga Kaitaiki Mauri, TOAH-NNEST)

*Joy is a member of the Paetakawaenga of TOAH-NNEST and she represents the Māori whare, Nga Kaitiaki Mauri of TOAH-NNEST, in this Project. Alongside her colleagues in NKM, Joy has been an advocate for the elimination for sexual violence at national and regional levels for many years; particularly promoting the development and resourcing of Kaupapa Māori services in the sexual violence sector in order to more effectively address the issue of sexual violence in Māori communities. Joy represents NKM in this project to ensure the voices of Māori clinical practitioners and whanau are heard and enacted, in an endeavour to provide better access to appropriate healing pathways for Māori impacted by sexual violence in Aotearoa NZ.*

- Ken Clearwater (Manager, National Advocate, Male Survivors of Sexual Abuse Trust).

*"I have been working with and supporting male victim/survivors of sexual abuse since 1996. I am passionate about ensuring male survivors of sexual abuse have an effective voice as victims."*

- Louise Nicholas (Survivor Advocate, TOAH-NNEST)
- Melanie Calversbert (previously Team Leader Social Work and Crisis Response, Wellington Sexual Abuse HELP Foundation; current role Sexual Assault Prevention and Response Advisor at the New Zealand Defence Force);

*"Having worked in the sexual violence sector for over 20 years, I'm very aware of gaps that exist within agencies to work well with people in many diverse communities. I support this project because it ensures that the sector will have people's stories, information, research, and recommendations to better inform the work we do."*

- Michael McCarthy (Injury Prevention Portfolio Manager, Violence, ACC)
- Sarah Va'afusuaga McRobie (Registered Counsellor, Researcher and Supervisor, The University of Auckland's Health and Counselling Centre).

*"I bought a passion to capture the essence of our Pasifika heart and soul and the practical awareness of how to work with our Pasifika survivors of sexual violence and their families with respect, love and care. In working together with a small group of Pasifika Counsellors, Psychotherapists and Family Therapists from diverse cultural backgrounds and professional affiliations, we were able to update the previous Good Practice Guidelines used by mainstream crisis support services."*

- Wol (Wendy) Laird: (Violence Prevention Education Worker with SOS Kaipara/Ngā Whitiki Whānau Ahuru Mōwai ō Aotearoa - National Rape Crisis)

*"I wanted to be part of this advisory group because the time is right for these guidelines to get out into the field. Fabulous, caring and ethical people work in Sexual and Family Violence Crisis Support work and these guidelines will support and enhance the work of those people"*

**Community Researchers:**

The following researchers/practitioners were contracted to conduct community-based research, each representing a specific community, in the Inclusive Practice section of this project, with over-sight provided by the projects Lead researcher (Dr Julie Wharewera-Mika).

**Community researchers for this project included:**

Joy Te Wiata and Russell Smith (Korowai Tumanako), Sarah McRobie (Pacific), David Mitchell (MSSAT), Sandra Dickson (LGBTI+), Fariya Begum and Anjum Rahman (Shama), Ezekiel Robson (Salubrious), Dr Vivien Feng and Dr Jennifer Hauraki (Asian)

**Funders:**

- Lotteries Grants: Initial funding for the current Guidelines was successfully sought form the Lotteries Commission via a Lotteries Community Research Grant. This funding enabled the investigation of current literature and research, and the inclusive practice guidelines projects for Māori, Pacific, Men, LGBTI+, Muslim and Disability, and printed dissemination of the final report.
- ACC: As the project progressed it was decided, following sector feedback, that the report could be best disseminated via the development of a website and using other forms of media, including video interviews. In addition, including an inclusive practice project with the Asian community was seen as a priority. Therefore, additional funding was successfully sought from ACC to complete this phase of the Guidelines.

# GUIDELINES FOR CRISIS SUPPORT SERVICES FOR SURVIVORS (MAINSTREAM SERVICES) (ROUND TWO)

## BACKGROUND

Specialist sexual assault services providing crisis support have existed in New Zealand since the 1970s when a number of Rape Crisis collectives were established. Groups of women developed collectives to meet the needs of survivors of sexual violence as negative societal attitudes to survivors were not conducive to good treatment by services, communities or often even families. This was of particular concern given the high impacts of sexual violence and resulting vulnerability of many survivors thereafter. While societal attitudes have changed to a degree, a high incidence of sexual violence and high impacts on survivors have not changed. Quality of service responses has improved in line with changes in societal attitudes, but not sufficiently to ensure that survivors are not further harmed by contact with services.

In July 2007, in response to public pressure in the wake of what has come to be known as the Louise Nicholas trial (R v Rickards, Shipton and Schollum [2006]) the New Zealand Government established The Taskforce for Action on Sexual Violence to lead and coordinate efforts to address sexual violence, and advise Government on future actions. This Taskforce was somewhat unique in that it was established as a partnership between Government and a sector body Te Ohaaki a Hine - National Network Ending Sexual Violence Together (TOAH-NNEST), a bi- cultural umbrella group for those working in the sector, particularly the specialist community service providers. This group aims to promote social, political and institutional change so that all people can live free of sexual violence and its effects.

One of the six priority areas for the Taskforce to address was early intervention and crisis response to acute and chronic sexual abuse and assault, looking to an outcome of impact of sexual violence is reduced and survivors are supported. The sector believed that our grass roots practice was effective, but we needed to be able to demonstrate the evidence base for this. Negotiations with the Ministry of Social Development led to funding for a project to develop a framework for best practice by mainstream services in responding to acute needs of survivors of sexual assault, which resulted in the first good practice guidelines - Mainstream Crisis Support Services Responding to Sexual Violence Perpetrated Against Adults. Round 1. (Evidence Section)

We were well placed to undertake this project at the time due a number of factors:

- the development of Te Ohaaki a Hine National Network Ending Sexual Violence Together, a national organisation which includes both Nga Whiitiiki Whanau Ahuru Mowai o Aotearoa / The National Collective of Rape Crisis and Related Groups of Aotearoa Incorporated and other groups,
- the development of research and theory from the trauma field which was validating practices which were developed in this grass roots movement, such as, the importance of working at the client's pace,
- the importance of the relationship and the importance of honouring the adaptations a survivor made to living with experience of abuse
- the review Responding to Adult Survivors of Sexual Violence: A Review of Literature on Good Practice commissioned by the Ministry of Women's Affairs, and
- the 2009 stocktake and visioning process by specialist crisis support services which identified shared values in the work across the sector.

This all combined to provide us with a good opportunity to develop shared and multiply informed ideas about what best practice might be in the delivery of crisis support services.

# DEVELOPING GUIDELINES FOR GOOD PRACTICE

**The project set out to:**

- **Identify the knowledge that service providers held.** Validity of the resulting principles and practices were confirmed by a consultation round with survivors and service providers, asking for their feedback. The context of this service provision is the tri-partite response to sexual violence, so representative police and medical teams practising in this area of work were also consulted.
- **Link this knowledge with the research evidence about the effectiveness of various practices.** The highest level of scientific validation from a positivist point of view would have required the use of experimentally designed research producing statistically significant results, along with these results being replicated by further research and/or by delivery in different contexts. However, in their comprehensive review, Decker and Naugle (2009) were not able to identify any research relating to immediate intervention following sexual assault which met these parameters. This was not surprising given the multiple difficulties in applying rigorous research design, primarily due to ethical constraints such as the lack of ethics in randomly allocating survivors to a no treatment research control group. Therefore, we needed to look more broadly for research which could provide support for practices consistent with what that research might tell us, for example, survivor feedback, evaluations of service, and research about physiological and psychological impacts of trauma.

# GOOD PRACTICE

While it had been fashionable for some time to seek the supremacy of best practice, a number of limitations were identified with this concept.

- Use of best forecloses room for challenge and improvement.
- Any determination of what best practice is will be temporary, as it will be always changing as knowledge develops, and as survivor need changes along with changes in societal responses to sexual violence.
- What is best for one victim/survivor might not be for another due to differences in need based on variables such as rural/urban, gender, culture, age, sexual orientation, abilities, and resilience.

Therefore, this project sought to promote the multiple possibilities of good practice (Mossman et al, 2009), rather than the supremacy of best practice.

# THE 2009 GOOD PRACTICE PROJECT

**Three stages were used to develop the Guidelines, this included:**

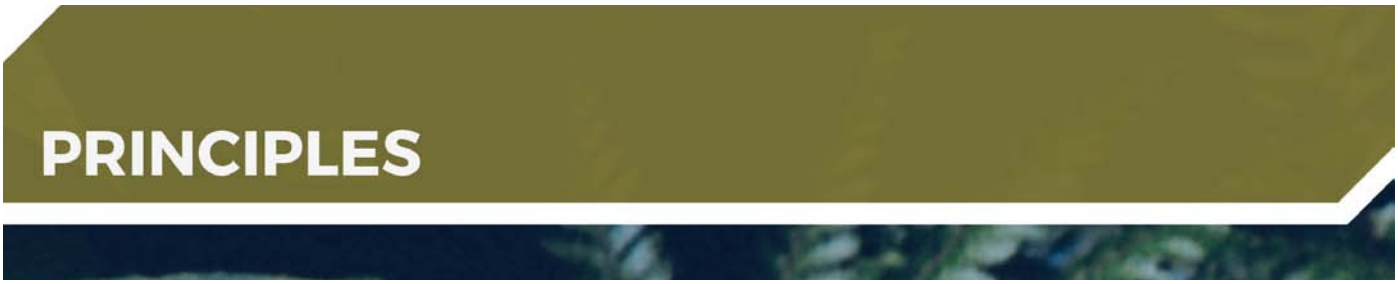
1. Interviews with specialist sexual assault services and key informants. The material from these interviews was considered alongside a number of other guidelines and practice documents from the field, and some initial guidelines were developed.
2. Sector consultation, survivor voices, and the review of literature, including the stocktake of mainstream services. During that project, services were asked what they valued about the services that they provided. When these values were clustered, they came to constitute most of the core principles that are espoused here.
3. Consultation with crisis support services and representative police and medical teams.

**The resulting Guidelines were then presented in 3 parts:**

- Good Practice Part 1 - Principles of Service Delivery (beginning with a 3 page summary of the principles)
- Good Practice Part 2 - Types of Service Delivery
- Good Practice Part 3 - Promising Practices

The Guidelines were intended to be used as a resource for the sector, to promote ongoing development of and reflection on good practice, including increasing access to research and identifying areas where research is needed; to bring to our relationships with others so that we can be accountable as we ask our partners to be; and to increase transparency in our relationships with our communities, at both local and national levels.

The guidelines were developed as a living project, in recognition of the changes which occur in practice and research over time. It had been intended to establish a vehicle for ongoing feedback into the guidelines, as well as regular review and updating of the research. This review and update is round two, in which we also expanded the guidelines to our work with survivors from diverse cultural and ethnic communities.




# PRINCIPLES OF GOOD PRACTICE

## INTRODUCTION

### The principles

The following crisis service 'Principles of Delivery' were developed utilizing the rich knowledge and experience of those working in the sexual violence sector. Information was originally gathered as part of a stock-take of services back in 2009, and then collated into statements of value. The principles have been updated on the basis of a survey of the sector early 2015, and the participation of people working in the sector on the advisory group for this project.

A fundamental premise of the work of sexual assault support services is that we work for victims/survivors, to have their needs heard and met. The inclusion of survivor voices alongside provider knowledge and research in this project reflects this orientation and the collaborative spirit of its development.

The evidence-base supporting the ways we work has developed over the past decade both internationally and locally. This literature has been integrated within each principle that follows. However there remains an ongoing need for further research, particularly within Aotearoa, regarding effective service interventions within the sexual violence sector.

### Practice examples

Within each Principle section, a section presenting the 'principle in practice' specific to various local services will be described. It is hoped this will provide some inspiration for the development of other services, and, also provide an opportunity for services to share 'good practice' with each other as this project becomes live.

# PRINCIPLE 1: WELFARE AND WELL-BEING OF THE VICTIM/SURVIVOR IS PARAMOUNT

Welfare and well-being of the victim/survivor is the reason for provision of crisis support services [1]

- Crisis support services work from the premise that the welfare and the well-being of the victim / survivor is the paramount concern
- Services focus on the provision of informed choice, control, safety, dignity and physical emotional and social well-being for survivors
- This involves direct support of the victim/survivor and systems advocacy in collaboration with them
- This may also involve direct support of the family or other social circle of the survivors

Without that consideration (paramountcy of victim need) as a guiding principle, the issue of "good practice" is little more than a discussion about the desirable practices identified by different groups in order to achieve their own particular imperatives. [2]

Sexual violence is one of the causes of greatest harm in our society, with impacts ranging through life-long anxiety and social withdrawal, disabling levels of shame and self-blame, suicide, alcohol and drug use, drop in socio-economic status, teen pregnancy and parenting, relationship and sexual difficulties, family violence and involvement in crime.[3] These impacts spread out around individuals to weaken families and social safety.

Survivors of sexual violence can have high impacts immediately, and significant proportions of survivors might still be impacted months and years later. These impacts include:

> Anxiety and fear, including "(a) fear of stimuli or items that were directly associated with the attack (e.g. a man's penis, tough-looking people); (b) fears of rape consequences (e.g. going to court, pregnancy, sexually transmitted diseases); and (c) fears of future attack (e.g. being alone, being in a strange place, having people behind you). [4]

The majority of survivors meet symptomatic criteria for PTSD soon after a sexual assault, and significant numbers still meet such criteria months and years later. Up to half of survivors develop a major depressive episode following sexual assault, with many survivors still reporting depression three years later.

Suicidal ideation following sexual assault has been reported for as many as 50% of survivors, with 19% having made a suicide attempt.

Several years after a sexual assault, half of one sample had difficulties in social functioning. This included a restricted social life and only going out with groups of friends; another study found that in the first year post-rape survivors showed impacts on economic, social, leisure and work functioning; and further studies have shown long-term impact in marital and family relationships. [5]

Negative community response can significantly elevate distress. [6] Victim blaming attitudes [7] and difficulties talking about sex and strong emotions means that victims/survivors can become isolated within their own relationships, families and communities. [8]

The legal system response to sexual violence can cause further harm to survivors [9] through conveying negative social attitudes, needing to prioritise rights of the alleged offender, and requiring the victim/survivor to do things at certain times which may well be at odds with their own healing needs. Following rape, victims/survivors can be further impacted by the ways that they are treated, to the degree that contact with medical and legal systems can lead victims/survivors to experience higher levels of post-traumatic stress. [10]

*"I knew that I could not survive it again.....My fear was that I'd actually have to kill myself, because I couldn't go through it again. That was scary."*
*- Shelley [11]*
*"The judicial process can and does re-victimize and re-traumatize victim/survivors. In most cases it is the victim/survivor's credibility that is put on trial which diminishes the need to seek the truth. Sadly social attitudes, myths surrounding sexual violence, lack of physical evidence and defense lawyers' theatrics in court play a huge part in a jury's decision to either acquit or convict."*
*- Louise Nicholas (Survivor Advocate)*

1. A fundamental premise of the work of sexual assault support services is that we work for victims/survivors, to have their needs heard and met. The inclusion of survivor voices alongside provider knowledge and research in this project reflects this orientation and the collaborative spirit of its development.
2. Mossman, E., Jordan, J., MacGibbon, L., Kingi, V., & Moore, L. (2009). Responding to adult survivors of sexual violence: A review of literature on good practice. Crime and Justice Research Centre. Report commissioned for the Ministry of Women's Affairs. p26.
3. Wall, L., & Quadara, A. (2014). Acknowledging complexity in the impacts of sexual victimisation trauma. Australian Centre for the Study of Sexual Assault. Australian Institute of Family Studies, Australian Government. Boyd, C. (2011). The impacts of sexual assault on women (ACSSA Response Sheet). Melbourne, Vic: Australian Institute of Family Studies.

Support from family and friends can be beneficial. Such support has been related to 'having someone to talk to' and 'being believed'. [12] This included receiving emotional support, being listened to, not being blamed, being encouraged to talk about the sexual assault and not being distracted by other things. [13]

Some responses from family, friends and significant others can be unhelpful. Specifically with regards to pressure to "get over it" (the sexual assault), [14] and suggestions that the survivor could have fought harder to prevent the crime. [15]

# PRACTICE EXAMPLES

1. Crisis support workers will honour and create space for the survivor's choices, even where this conflicts with the wishes of family, partner or police.
2. Crisis support workers will work with family and friends to assist in the development of positive social support for survivors, for example, through teaching family members about rape myths.
3. Crisis support workers work with which ever systems a survivor is involved with to facilitate "rape myth free" responses from those systems.
4. Crisis support workers will provide advocacy, defined by the Australian National Standards of Practice Manual as:

*Acting and working within systems and agencies on behalf of individuals to ensure that their rights are upheld and their needs met. Advocacy can be proactive in terms of seeking out the full potential that a system may offer, as well as reactive in terms of working against the potential for systems and agencies to further traumatise victim/survivors. [16]*

This advocacy is not generic, but rather seeks the optimum service response for each survivor.

4. Mossman, E., Jordan, J., MacGibbon, L., Kingi, V., & Moore, L. (2009). Responding to adult survivors of sexual violence: A review of literature on good practice. Crime and Justice Research Centre. Report commissioned for the Ministry of Women's Affairs. p31.
5. Petrak, J. (2002). The psychological impact of sexual assault. In Petrak, J., & Hedge, B. (Eds). The trauma of sexual assault: Treatment, prevention and practice (pp.19-44). UK: Wiley.
6. Classen, C., Palesh, O., & Aggarwal, R. (2005). Sexual revictimisation: A review of the empirical literature. Trauma, Violence and Abuse, 6(2), 103-129.
7. Ullma, S., Najdowski, C., & Filipas, H. (2009). Child sexual abuse, post-traumatic stress disorder and substance use: Predictors of revictimisation in adult sexual assault survivors. Journal of Child Sexual Abuse 18, 367-385.
8. Robertson, H. A., et al. (2016). Family violence and child sexual abuse among South Asians in the US. Journal of Immigrant and Minority Health 18 (4), 921-927.
9. Campbell, R., Wasco, S., Ahrens, C., Sefl, T., & Barnes, H. (2001). Preventing the 'second rape': Rape survivors experiences with community service providers. Journal of Interpersonal Violence 16(12), 1239-1259.
10. Campbell, R. (1998). The community response to rape: Victims' experiences with the legal, medical and mental health systems. American Journal of Community Psychology, 26, 355- 379.
11. Jordan, J. (2008). Serial survivors: Women's narratives of surviving rape. New South Wales: Federation Press. p.126
12. Campbell, R., Wasco, S., Ahrens, C., Sefl, T., & Barnes, H. (2001). Preventing the 'second rape': Rape survivors experiences with community service providers. Journal of Interpersonal Violence, 16(12), 1239-1259.
13. Filipas, H., & Ullman, S.E. (2001). Social reactions to sexual assault victims from various support sources. Violence and Victims, 16, 673-692.
14. Kingi, V., Jordan, J., Moeke-Maxwell, T., & Fairburn-Dunlop, P. (2009). Responding to sexual violence: pathways to recovery. Wellington: Ministry of Women's Affairs.
15. Baker, T., Skolnik, L., Davis, R., and Brickman, E. (1991). The social support of survivors of rape: The differences between rape survivors and survivors of other violent crimes and between husbands, boyfriends, and women friends. In A.Burgess (ed.) Rape and sexual assault III. New York: Garland Publishing.
16. Dean, C., Hardiman, A., & Draper, G. (1998). National Standards of Practice Manual for Services Against Sexual Violence. Melbourne: Centre Against Sexual Assault. p 49

# PRINCIPLE 2: CLIENT-CENTRED AND EMPOWERING PRACTICE

Engagement in treaty-based relationships with Tāngata Whenua is critical to support the capacity of Māori to restore mana to Māori victims/survivors as individuals and as a group, and is fundamental to meeting the terms of the Treaty of Waitangi.

*"At the heart of the Treaty is the notion of partnership, one that encourages cooperation, consultation, mutual benefit, compassion, compromise and good faith". [1]*

**The Treaty relationship:**

- Exists between whānau, hapū and iwi who have whakapapa to a shared Māori ancestry and Tauiwi who are all those people of other cultures who have chosen to make this land their home.
- Is based on a shared agreement that Te Tiriti o Waitangi is the founding document for relationships between Tangata Whenua within Aotearoa and Tauiwi who have entered New Zealand. Signed in 1840, the Treaty was understood by Māori to protect their rangatiratanga (chiefly autonomy) and resources, and to make for a peaceful and ordered society [2]
- "Treaty-based thinking instructs us to aspire to relationships that are: honest and genuine, where parties have integrity and are actively protective and allow room for growth to realise potentials and to respond to changing circumstances". [3]
- Acknowledges that Tāngata Whenua and Tauiwi are entitled to be guided by the values and practices which derive from their respective world views.
  - For Tāngata Whenua this includes the recognition of the unique customary and contemporary structures and practices of whānau, hapū and iwi, being provided for and fully engaged, the application of a holistic approach to well-being, rather than an individualistic approach, and Māori perspectives and holistic approaches to family violence prevention being recognised and given a high priority in policy and service development. [4]
  - In partnership Tauiwi can advocate for Kaupapa Māori and decolonising approaches to be more fully supported and engaged within the sexual violence sector, and support the development of a clearly developed research strategy that enables in-depth research to be undertaken from a Kaupapa Māori approach. [5]
  - Requires equitable and adequate access to resources and decision making so that both Tangata Whenua and Tauiwi may properly participate in responding to sexual violence and eliminating sexual violence from our communities.

Hoeata, C., Nikora, L.,W. Li, W., Young-Hauser, A., & Robertson, N. (2011). MAI Review 3, Māori women and intimate partner violence: Some socio-cultural influences. Page 1 of 12 http://review.mai.ac.nz, p.2.
Te Puni Kōkiri. (2010). Arotake Tūkino Whānau: Literature review on family violence. Wellington: Te Puni Kōkiri.
Hoeata, C., Nikora, L.,W. Li, W., Young-Hauser, A., & Robertson, N. (2011). MAI Review 3, Māori women and intimate partner violence: Some socio-cultural influences. Page 1 of 12 http://review.mai.ac.nz, p.2.
Ministry of Social Development. (2002). Te Rito NZ Family Violence Prevention Strategy. Wellington https://www.msd.govt.nz/documents/about-msd-

# PRACTICE EXAMPLES

1. The two house model of TOAH-NNEST is an example of a Treaty-based relationship. The separate groups of Nga Kaitiaki Mauri and Tauiwi caucus, while running their own houses, together form the relationship that is TOAH-NNEST.
2. The following clause from the constitution of SASH-Nelson (Sexual Abuse Support and Healing) demonstrates their commitment to tangata whenua and the Treaty of Waitangi.
   Objective 3.2 To provide services which are culturally inclusive and reflect Te Ao Maori me Te Ao Pakeha, and to support kaupapa Maori services and Maori aspirations for tino rangatiratanga, thereby upholding te Tiriti O Waitangi.
3. Wellington HELP puts this commitment into practice in the following ways:
   - Provision of Maori supervision.
   - An agenda item every team meeting (for all employed people) is to discuss an aspect of HELP's work given treaty based relationships so e.g. what are the ways we are responsive to the needs of whanau Maori right from when they first make contact with HELP, first enter the reception and are greeted and so on.
   - Maori are part of the interviewing team for prospective employees.
   - Representation at governance level.

and-our-work/publications-resources/planning-strategy/te-rito/te-rito.pdf
Pihama, L., Te Nana, R., Cameron, N., Smith, C., Reid, J., & Southey, K. (2016). Māori cultural definitions of sexual abuse. Sexual Abuse in Australia and New Zealand, June 2016, 7(1), 43-51.

# PRINCIPLE 3: VALUE BASED SERVICES

What we do and how we do it is informed by the nature of sexual violence and its cultural context, its impacts on victims/survivors and society, and what survivors need to heal. This informs our work with clients, the nature of our organisations and relationships, and our political advocacy and activism to get the needs of victims/survivors met and to end sexual violence.

Respect for service users involves an acknowledgement and articulation of the power dynamic inherent in a service delivery relationship. Sexual violence, being an abuse of power, is often associated with a loss of dignity, humiliation and intimidation of the victim/survivor.[1] The service delivery relationship has the potential to redress a sense of powerlessness by responding to victim/survivors as people with dignity and rights.[2]

**Tauiwi Constitution suggests that:**

- Sexual violence is an abuse of power. It occurs primarily due to the way society defines the roles of women and men and supports a patriarchal system that views others as property, while also rewarding those who exercise power and control over others with no regard for human rights or dignity. [3]
- Society has failed to make paramount the rights and needs of children and young people. As the degree of sexual violence perpetrated on children and young people has become apparent we have come to believe that society's failure to make paramount the rights and needs of children and young people allows adults to use their emotional, physical and social power to abuse children and young people and to fail to provide the nurturing and safe environments which would protect children and young people from abusive patterns of behaviour.
- Sexual violence predominantly victimises women[4] and is predominantly perpetrated by men, however both males and females perpetrate and are victimised by sexual violence. Gender differences can exist in the motivations and patterns of this violent behaviour. While some impacts of the violence are similar for males and females, some impacts are different due to the differences in patterns of perpetration and the societal context in which the victim makes sense of and lives with the consequences of the violence. [5]
- Sexual violence is most likely to be perpetrated on those perceived to be vulnerable, whether by age, gender, ethnicity, race, gender,[6] disability, a history of abuse, language, immigration, or the quality of social supports in a person's life.[7]
- In general, sexual violence is most likely to be perpetrated by those who are vulnerable to the messages of a rape supportive culture. For some this will be due to having been victims of violence themselves and living with the psychological and emotional consequences of this, though most victims of violence do not perpetrate sexual violence on others. Nor have all perpetrators been victims. Some perpetrators who find themselves in a position of power over others believe that they are entitled to take what they want due to the social and personal messages about power to which they have been exposed and which they have taken up, for example, rape perpetrated in war, or by groups of adult males. [8]

Our work with clients recognises the fundamental importance of not reflecting these dynamics if clients are to be safe and healing is to occur. This leads us to use principles of client-centred practice and empowerment through informed decision-making, to run our organisations in ways which minimise or take care with the use of institutional "power over" relationships, and to work in society to change individual, group and cultural attitudes and practices which support the factors which contribute to sexual violence. This latter point is a common stance for such services through the Western world. For example:

> Services against sexual violence aim to initiate, respond to and participate in proactive and preventative strategies, research, networking and media liaison designed to influence the attitudinal, behavioural and structural changes needed within society to end sexual violence and improve responses to victim/survivors of sexual violence [9]

RCNE best practice guidelines were developed from research with 14 members across Europe. The members'

1. Henderson, S. (2012). The pros and cons of providing dedicated sexual violence services: A literature review. Scotland: Rape Crisis Scotland.
2. Dean, C., Hardiman, A., & Draper, G. (1998). National Standards of Practice Manual for Services Against Sexual Violence. Melbourne: Centre Against Sexual Assault., p. 5.
3. Te Ohaaki a Hine -National Network: Ending Sexual Violence Together Tau Iwi Caucus Incorporated [TOAH-NNEST TC Inc], 2009, 4.1.6.
4. Thomas, A. (2013). Multi sectoral services and responses for women and girls subject to violence. Interactive Expert Panel: Making the Difference. New York: United Nations Commission on the Status of Women, Fifty-seventh session TOAH-NNEST TC Inc, 2009, 4.1.8.
5. Humphrey, J., & White, J. (2000). Women's vulnerability to sexual assault from adolescence to young adulthood. Journal of Adolescent Health 27 (6), 419-422.

ideological foundations also underpin the theoretical and practice frameworks, as professionalism, ethical positions and expertise are developed using inclusive and empowering methods of working. [10]

# PRACTICE EXAMPLES

- The two house model of TOAH-NNEST is an example of a Treaty-based relationship. The separate groups of Nga Kaitiaki Mauri and Tauiwi caucus, while running their own houses, together form the relationship that is TOAH-NNEST.
- The following clause from the constitution of SASH-Nelson (Sexual Abuse Support and Healing) demonstrates their commitment to tangata whenua and the Treaty of Waitangi.
- Objective 3.2 To provide services which are culturally inclusive and reflect Te Ao Maori me Te Ao Pakeha, and to support kaupapa Maori services and Maori aspirations for tino rangatiratanga, thereby upholding te Tiriti O Waitangi.
- Wellington HELP puts this commitment into practice in the following ways:
  - Provision of Maori supervision.
  - An agenda item every team meeting (for all employed people) is to discuss an aspect of HELP's work given treaty based relationships so e.g. what are the ways we are responsive to the needs of whanau Maori right from when they first make contact with HELP, first enter the reception and are greeted and so on.
  - Maori are part of the interviewing team for prospective employees.
- Representation at governance level.

6. TOAH-NNEST TC Inc, 2009, 4.1.9.
7. TOAH-NNEST TC Inc, 2009, 4.2.0.
8. Dean, C., Hardiman, A., & Draper, G. (1998). National Standards of Practice Manual for Services Against Sexual Violence. Melbourne: Centre Against Sexual Assault, p. 39.
9. Rape Crisis Network Europe (2003). Best practice guidelines for NGOS supporting women who have experienced sexual violence. Retrieved from www.rcne.com/downloads/RepsPubs/BstPrctce.pdf

# PRINCIPLE 4: CLIENT-CENTRED AND EMPOWERING PRACTICE

Fundamental premises arising from this values-based orientation to sexual violence and supported by knowledge of trauma, are client-centred and empowering practise:

- Begin from a place of respect for victims/survivors and their personal strengths and needs
- Develop relationship and rapport
- Sensitively ascertain what this victims/survivor's needs are, with regard to who they are as an individual and how they are responding to what they are experiencing. Assist victims/survivors through their decision-making process if need be.
- Assist victims/survivors through in getting their needs met.
- Advocate for respectful and informed treatment by others

The nature of sexual assault is that it is the imposition of the penultimate power of one person over another. Empowerment, or the restoration of power over self, is a counter to this significant, though often not complete, loss of power. Client-centred practice, whereby the client's needs are the most important determinant of what happens,[1] is a counter to the objectification and human dis-connection of the sexual assault. What victims/survivors feel, want, and need is of primary importance to this human working alongside and for them.

Client-centred practice is a long held foundation to work in this sector, and can seem straightforward. However, due to the impact of the assault and the demands of some of the ways that we respond to assault, it can be more complex to achieve than simply asking what victims/survivors want and helping them to get it.

For example, many women who are physiologically and emotionally in a state of traumatisation are not able to answer direct questions about their needs, as they are not necessarily able to access those parts of themselves that know what they need. They might more easily be able to identify what they don't want.

This approach to the work is further supported by what we are coming to know about the relationship between attachment patterns and PTSD,[2] that those with less secure patterns of attachment, whether that be avoidant or anxious, are more vulnerable to the development of PTSD. Being able to meet attachment needs arising from the event, that is, to be able to provide an appropriate and available human response, can mitigate the development of later trauma impacts.

### What constitutes client-centred and empowering practice:

- Begin from a place of respect for the survivor's feelings and needs,[3] such as, respect for their resilience, vulnerability, sense of shame, need to re-establish privacy and personal boundaries, need to regain control, need to believe that they are not vulnerable, need for dignity...whatever their individual needs are. Sexual violence can impact any aspect of self, so a survivor's needs can relate to any aspect of self. Working from an English based New Zealand culture, there are often not words or concepts to articulate all of the impacts that survivors experience from sexual violence so we recognise the need for holistic responses. [4]
- Develop relationship and rapport utilising verbal and non-verbal communications by which you let the survivor know that you are attuned to them and you are there for them. Attuning to a person who is traumatised requires one to "tune into" what the survivor is feeling and the depth of it, without being destabilised by this. In this you help the survivor to feel better, and are able to advocate effectively for them in the "world". Such attunement and presence alongside and for the victim/survivor can also assist them to move to feeling safe. While feeling safe can be a fundamental need and desire, it can also be a long journey. The sooner started, the less negative impact the experience of feeling unsafe will have.
- Sensitively ascertain what the survivor's needs are, with regard to who they are as an individual and how they are responding to what they have and are experiencing. Assist the survivor through their decision-making process if need be. In the aftermath of

1. Campbell, L. (2016). Sexual Assault Support Service for Canterbury: Research to inform service design. Aviva
2. Twaite, J., & Rodriguez-Srednicki, O. (2004). Childhood sexual and physical abuse and adult vulnerability to PTSD: The mediating effects of attachment and dissociation. Journal of Child Sexual Abuse, 13 (1), 17-38
3. Campbell, L. (2016). Sexual Assault Support Service for Canterbury: Research to inform service design. Aviva
4. Thomas, A. (2013). Multi sectoral services and responses for women and girls subject to violence. Interactive Expert Panel: Making the Difference. New York: United Nations Commission on the Status of Women, Fifty-seventh session. Campbell, L. (2016). Sexual Assault Support Service for Canterbury: Research to inform service design. Aviva

sexual violence, a survivor may not have the capacity to make all decisions unassisted. They may be feeling destabilised and unable to think or feel clearly if they experienced the assault as overwhelming.

- The context for this decision-making can be the midst of a legal system which has its own requirements, being mandated to protect the rights of the alleged offender and make a case. Therefore, our role is to create space around the survivor in this whereby they have the chance to exert some power for themself. The art of the work is to form good relationship with the survivor so they know their well-being is our number one concern, offer the survivor as much information as they are able to process, facilitate their decision-making capacities (e.g. slowing down the process, arranging privacy for them, reducing stress on them by making sure their physical needs are met as much as possible, and moving forward to take care of them when they need us to), with their consent.
- Advocate for respectful and informed treatment from other services - including victim/survivor rights to accurate information, informed consent and decision-making, choices and control, and to being treated with courtesy and compassion and with respect for their dignity and privacy - and from other groups, such as family and community.

Studies show that specialist sexual assault advocates increase victim's/survivor's information and knowledge and help them to understand options and make decisions. [5]

Many of the other services or people involved in responding to sexual violence have agendas other than, or in addition to, the welfare and well-being of the victim/survivor. Family and friends can themselves be secondarily traumatised by the event, or triggered into their own traumas. They may also be holding cultural beliefs and practices which lead to victim blaming or an inability to tolerate high levels of emotion or talk about sexual matters. Some families, friendships and/or communities are strong enough to hold this kind of event happening to one of their members, others not. Others fragment in the face of the impact of the trauma, and leave the survivor alone. Having a dedicated support worker means there is one person focused on the needs of victim/survivor, who doesn't have another agenda, is not personally involved and has support and supervision to deal with impacts on themselves .

The issue of whether there is a greater psychological benefit in reporting the sexual assault to the police remains unclear.

> Some studies have suggested involvement with the criminal justice system increases levels of fear [6] while others have suggested that those women who elected to proceed to prosecute their assailant reported higher self-esteem[7] "While clinically, it makes sense that attempting to take some kind of action towards increasing control over the event may be beneficial to the individual, the continued and not unfounded lack of faith in the criminal justice system to protect individuals remains high. It remains the task of the individual, and not the clinician, to decide whether or not to report their sexual assault to the police, proceed with examination, and legal proceedings". [8]
>
> Services would address a range of victim/survivor needs including physical and emotional safety, personal support needs (engaging with family), practical supports (access to money, transport, housing), forensic issues, medical needs, police reporting options, counselling options, and need to be delivered flexibly. [9]

# PRACTICE EXAMPLES

1. Client-centred practice and the concept of empowerment are cornerstones of the ways that sexual assault support services work due to our understanding that they are an effective response to sexual violence precisely because they undermine the dynamics of that violence.

The following excerpt from the Competency Guidelines of Whanau Ahuru Mowai/Rape Crisis demonstrates a commitment to client centred practice.

We see the counselling/support relationship being a partnership in which the Whanau Ahuru Mowai/Rape crisis worker facilitates a process of allowing the client to move at her

5. Blanch, A. (2008). Transcending violence: Emerging models for trauma healing in refugee communities. SAMHSA National Centre for Trauma-Informed Care. Retrieved from: http://www.vawnet.org/summary.php?doc_id=3479&find_type=web_sum_GC
6. Critelli, F. M. (2012). Voices of resistance: Seeking shelter services in Pakistan. Violence Against Women, 18(4): 437-458. Retrieved from: http://vaw.sagepub.com/content/18/4/437.full.pdf+html
7. Kulkarni, S., Bell, H., & McDaniel Rhodes, D. (2012). Back to basics: Essential qualities of services for survivors of intimate partner violence. Violence Against Women, 18(1): 85-101. Retrieved from: http://vaw.sagepub.com/content/18/1/85.full.pdf+html
8. Wasco, S., Campbell, R., Howard, A., Mason, G., Staggs, S., Schewe, P., & Riger, S. (2004). A statewide evaluation of services provided to rape

own pace, and, in the counselling situation, to structure her own healing journey. This differs from the traditional medical approach which sees the counsellor as the healthy expert who can fix or cure the client's sickness.

2. Arranging the service so that it meets the client's capacity, for example, getting other services to come to Wellington HELP to meet a client who is anxious about the meeting, or negotiating with police to meet at HELP and send a female officer if that is what the client needs to be able to consider reporting.

*"There are certain words or actions that can trigger bad memories of a rape. It was hugely beneficial to me when my counsellor asked if there was anything, words or actions that I didn't want to hear or see. Too easy, just ask first. It made the sessions easier to go through."*
*- Louise Nicholas (Survivor Advocate)*

*"I don't think he realises that he actually takes the inner you away from you, that you're only a shell, someone that's just fluffed the whole being out of you. Everyone struggles to get themselves back again."*
*- Connie (Jordan, 2008, p.163)*

*"For victim/survivors to be able to walk their journey safely, I have found through not only my own experiences, but that of others I have supported, that having one person to walk with you and help guide you through the maze of processes was immensely helpful. It helps gives back some control, it gives a sense of trust and empowerment. So much is taken away from you when you are raped, it's nice to know that people who are supporting you understand, realise your needs and are prepared to be patient allowing you to move through this journey at your own pace."*
*- Louise Nicholas (Survivor Advocate)*

survivors. Journal of Interpersonal Violence, 19, 252-263.
9. Kilpatrick, D., Saunders, B., Veronen, L., Best, C., and Von, J. (1987) Criminal victimization: Lifetime prevalence, reporting to police, and psychological impact. Crime and Delinquency, 33, 479–489.
10. Cluss PA, Boughton J, Frank LE, Stewart BD, West D. (1983). The rape victims: Psychological correlates of participation in the legal process. Criminal Justice and Behavior 10, 342–357.
11. Petrak, J. (2002). The psychological impact of sexual assault. In Petrak, J., & Hedge, B. (Eds). The trauma of sexual assault: Treatment, prevention and practice (pp.19-44). UK: Wiley.
12. 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

# PRINCIPLE 5: CULTURALLY INFORMED AND RESOURCED

Services provide inclusive supports that are responsive and culturally safe for diverse communities.

- The worldview of Tāngata Whenua is respected. The development of Tikanda or Kaupapa Māori services are supported, at the same time as mainstream services are as culturally safe for Tāngata Whenua as possible.
- The diverse ethnic and other cultural needs of survivors of sexual violence are acknowledged, and met as well as possible through cultural awareness developed through relationship and resourcing at both local and national levels.
- The development of ethnic-specific responses to sexual violence is supported.
- The particular needs of children and young people are catered to in the ways that we design and develop services.

Sexual violence can happen to anyone, but, due to the nature of perpetration, those who are not of the dominant social or cultural group, or are isolated, or are unable to tell are more likely to be perpetrated against. They may also face greater barriers to accessing services and justice. We aim to be able to provide as good a service as possible to everyone who needs and wants it.

- "Staff should be culturally responsive and respectful in all aspects of their practice" [1]
- Optimum service delivery would involve the choice to use culturally specific services, where survivors can be supported in their own language and through practices which reflected the beliefs and practices of their culture with regard to relationships, harm and healing. Such cultural resourcing is of particular importance in this field due to both the wide variations in the ways that societies respond to and manage sexual violence and its impacts, along with the degree of harm which can be caused by sexual violence.
- Current service availability means that there are actually few choices for such culture-specific service delivery. While supporting and advocating for the development of Kaupapa Māori services, mainstream services need to provide services, which meet the needs of our culturally diverse population as well as possible. [2]
- A focus of this second round of development was to expand the cultural reach of the guidelines through providing resources to increase the capability of services to respond appropriately to the cultural diversity of survivors, referred to as "inclusive practice guidelines". This refers to "responsiveness and cultural sensitivity to diversity". These guidelines provide crucial information and knowledge of appropriate and safe practices (for frontline staff and services) to improve the experiences of victims/survivors from the following communities and cultures:
  - Māori
  - People from Pacific communities
  - Men
  - People from the LGBTI+ community
  - Muslim women
  - People with Disability
  - People from Asian communities

1. Eckert, R. Good Practice Principles for working with refugee women experiencing domestic violence, In 'Improving responses to refugees with backgrounds of multiple trauma: pointers for practitioners in domestic violence sexual assault and settlement services'. www.adfvc.unsw.edu.au, p.12
2. Te Wiata, J., & Smith, R. (2016). Working with Maori survivors of sexual violence. A project to inform Good Practice Responding to Sexual Violence – Guidelines for mainstream crisis support services for survivors (round 2). TOAH-NNEST.

# PRINCIPLE 6: GENDER CHOICE

Client-centred practice dictates that clients needs with regard to service provider gender must predominate over other service delivery matters whenever possible

- This refers to offering: Gender choice
- And being aware of: Gender matching

Long term psychological harm from sexual violence is mitigated by the speed and consistency of the return to normal levels of arousal of the survivor's nervous system. In this context, it would be ideal for all survivors, regardless of sex, gender identity [link to gender identity heading in Doing our best for lgbtqi survivors report] or sexual orientation to be asked if they have a preferred gender of those who will support them.

If this level of flexibility is not available, then gender matching for cis straight women is likely to be the safest default if these women have been assaulted by a male. Factors supporting this position include:

- Women generally feel more able to talk about sexual matters with other women than with other men (excepting partner).
- Following sexual assault by a male, many women are scared of men and therefore find it difficult to engage with male providers. They can become distressed or frightened in response to male secondary sexual characteristics (such as smell or depth of voice) without necessarily even being aware of the source of their distress.
- In research looking at post-rape medical examinations, 82% of survivor/respondents said that it made a difference to them that the crisis support worker was female. This included the 1 male survivor/respondent involved in this part of the research. [1]
- Preferences for gender of staff providing forensic medical examinations and care has been investigated. Nearly 80% of respondents indicated that they would prefer a female to examine them and nearly ½ of the females and ¼ of the males indicated that they would not go ahead with the examination if there was no choice but to have a male examiner. [2]
- In an Australian study, while some survivors said that they wanted choice of the gender of staff, when choice was available, most chose a female provider[3]. In Jordan's NZ research, victims/survivors reported having a "woman present" made it easier for women to report rape and sexual assault [4]
- There can be an immediate rapport between women about rape, whereby the woman who has been raped expects understanding (and therefore emotional safety) from another woman in a way that she doesn't expect it from a man. This is both about the nature of rape and its perpetrators, but also that in our society women are generally expected to be those most able to respond to our emotional experience.
- However, if the offender was not male, and there is no choice available, then acknowledging the lack of choice and talking through with the survivor what her personal safety needs are in the process will be important.

For some cultures, it is not acceptable for cross gender talk about sexual matters, so gender matching for men would also be expected. However, in general for cis straight men, gender matching is less straightforward. While men need the same things that women do to be able to expect the emotional safety which comes from understanding and compassion, a number of studies have highlighted the significance of peer and group support as an effective therapeutic intervention for male victims/survivors[5]. One study highlighted the need for frontline services to have access to such supports, available following initial disclosure made by male victims/survivors.[6]

- Some men feel safer working with women, especially in the context of emotional repression and relationship struggles.
- Others need the opportunity to explore issues of sexuality, masculinity/vulnerability and sexual behaviour with men (some term this the "nuts 'n bolts" of the abuse experience). Many men have a number of therapists over time for different stages of their recovery.

Around 12% of New Zealand's population may identify under diverse sex, sexuality and gender umbrellas.[7] Research tells us that people of the LGBTIQ+ communities can face

1. Kelly, L., & Regan, L. (2003). Good practice in medical responses to recently reported rape, especially forensic examinations. Glasgow: Rape Crisis Network Europe. Lovett,J., Regan, L., & Kelly, L. (2004). Sexual Assault Referral Centres: Developing good practice and maximising potentials. (Home Office Research Study 285). UK: Home Office Research, Development and Statistics Directorate.
2. Chowdhury-Hawkins, R., Mclean, I., Winterholler, M., & Welch, J (2008). Preferred choice of gender of staff providing care to victims of sexual assault in Sexual Assault Referral Centres (SARCS). Journal of Forensic and Legal Medicine, 15, 363-367.
3. 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

high rates of sexual violence.[8] Gender choice is significant for these survivors as diverse sex, gender identity, and sexual orientation can heighten vulnerability following sexual assault. For example, if a gay identified male person was supported by a straight woman, he may experience high stress from not expecting to be understood by someone of an opposite gender AND sexuality to himself. A trans person will often be outed in the process and may anticipate negative reactions from others if genital examination is required in a medical process. If no choice is available, acknowledge the lack of choice and talk through with the survivor what their personal safety needs are in the process.

*The house seemed full of huge men (police officers). Among them, as they crowded in the doorway from the hall to the dining room, I could see a woman's face. I held on to her eyes and she on to mine. Someone asked if i was happy to talk to a male officer, and I said yes, assuming that the female officer would stay. She didn't; I felt sad and confused about that.*

*- Leefman, 2005 p. 25-26)*

# PRACTICE EXAMPLES

- Currently services in NZ mostly recruit women to support female survivors. The Human Rights Act 1993 (as at June 2016) makes provision for allowing employment which might otherwise be seen to be discriminatory, where it is for "a counsellor on highly personal matters such as sexual matters or the prevention of violence" Part 4, Section 27.
- In a situation where a number of boys and young men were identified as survivors by police following investigation of a man who had been abusing multiple boys over some years, the local crisis support service offered meetings for groups of survivors and their parents to meet local service providers, including male counsellors who worked with survivors.
- While Wellington HELP is not able to provide gender choice to males at point of contact, every man that contacts HELP is given info about MSSAT (Male Survivors of Sexual Abuse Trust) and Livingwell.
- Male Survivors of Sexual Abuse Trust is establishing itself as a national organisation so will be able to provide support for many more male survivors.
- If you are able to provide a practice example offering gender choice to survivors from LGBTIQ communities, please let us know so we can include it here: **toahnnestgoodpractice@gmail.com**

4. Jordan, J. (1998). Reporting rape: Women's experiences with the police, doctors and support agencies. Wellington: Institute of Criminology, p.30.
5. Fisher, A., Goodwin, R., & Patton, M. (2008). Men and healing: Theory, research and practice in working with male survivors. Toronto, Canada: Cornwall Public Enquiry.
6. Davis, M, (2002). Male sexual assault victims: A selective review of the literature and implications for support services. Aggression and Violence Behaviour 7 (3), 203-214.
7. Clark, T. C., Lucassen, M. F.G., Bullen, P., Denny, S. J., Fleming, T. M., Robinson, E. M., & Rossen, F. V. (2014). The health and well-being of transgender high school students: results from the New Zealand Adolescent Health Survey (Youth'12). Journal of Adolescent Health, 55(1), 93-99.
8. Lucassen, M. F. G., Clark, T. C., Moselen, E., Robinson, E. M., & Adolescent Health Research Group. (2014). Youth'12 the health and wellbeing of secondary school students in New Zealand: Results for young people attracted to the same sex or both sexes. Auckland: The University of Auckland.
9. Le Brun, C., Robinson, E., Warren, H. and Watson, P., (2005), Non-heterosexual Youth: A Profile of Their Health and Wellbeing; Data from Youth2000, The University of Auckland

# PRINCIPLE 7: SPECIALIST SEXUAL VIOLENCE RESPONSE

Victims / survivors and communities are best served by specialist services due to the particular dynamics and high level impacts from sexual violence.

The high levels of traumatization with which many survivors present, and the proliferation of rape myths mean that services can cause harm to survivors. Specialisation reduces the risk of this through a service's capacity to provide trauma-informed care and avoid both enactment of rape myth and replication of the dynamics of sexual violence. Fiscal and other trends and pressures may point to reducing specialization, but the following factors point to the need to maintain this principle.

There is potential for high negative impacts of sexual violence on quality of life, psychological functioning, and relationships. For example, the DSM V lists survivors of rape as having one of the highest prevalences of Post-traumatic Stress Disorder.

Early intervention is critical as the difficulties arising from sexual violence can have a deteriorating course due to both the physiological factors associated with trauma responses – the "kindling" effect whereby there is increasing hyper arousal at lower trigger thresholds – and the interplays of psychological and social factors e.g., social withdrawal due to lack of sense of safety in the world leads to less positive experiences of the world, which, along with emotional numbing, can lead to depression.

Informed and appropriate early intervention is essential[1] – ill-conceived early intervention, such as some models of Critical Stress Debriefing, has been shown to have the potential to cause further harm following trauma.

Many survivors seek sexual violence specific responses. In one evaluation, the most common reasons survivors gave for contacting the sexual assault centre were psychological symptoms and needs, most commonly anxiety or depression 66.4%, wanting to talk with someone who understood 32.8%, and flashbacks or nightmares 16.8%. [2]

Survivor feedback about services supports specialization: In an Australian study, survivors rated the services provided by specialist services highly for both the specialist knowledge brought and the way that it was offered with an emphasis on emotional care and support. [3]

In a US study, victims/survivors reported all aspects of the sexual violence support services to be positive. Particular aspects mentioned were the staff, the counsellors, staff being non- judgmental, believing victims, promoting recovery and/or coping skills and feelings of safety and comfort. Respondents reported that the biggest difficulties that they had faced were emotional issues and talking about the experience.[4] Much of this feedback suggested the need for specialisation.

Trauma-informed services are designed to be responsive and respectful to the needs of victims/survivors, and to avoid trauma-related dynamics that may be re-traumatising for those seeking help.

One study presented a tool which aims to provide guidance on creating an organisational culture of trauma-informed care. It suggested this can be achieved by incorporating an understanding of the prevalence and impact of trauma and the complex paths to healing and recovery in all aspects of service delivery. Five key principles were identified, which included: safety, trustworthiness, choice, collaboration, and empowerment[5].

In addition to providing trauma-informed care, services need to be able to provide sexual violence specific care as cultural ambivalence about sexual violence can easily play out in the responses of service providers. When such responses occur at this time of high vulnerability, a person may have little resilience and so be easily harmed by such ambivalence.

For example, the service provider who idly wonders "what were you doing there anyway?" or "why didn't

1. Hawkins, S., & Taylor, K. (2015). The changing landscape of domestic and sexual violence services: All-Party Parliamentary Group on Domestic and Sexual Violence Inquiry. Bristol: Women's Aid Federation of England.
2. Monroe, L.M., Kinney, L., Weist, M., Dafeamekpor, D., & Reynolds, M. (2005). The experience of sexual assault: Findings from a statewide victim needs assessment. Journal of Interpersonal Violence, 20, 767- 776.
3. Lievore, D. (2005). No longer silent: a study of women's help-seeking decisions and service responses to sexual assault. Canberra, Australian Institute of Criminology.
4. Monroe, L.M., Kinney, L., Weist, M., Dafeamekpor, D., & Reynolds, M. (2005). The experience of sexual assault: Findings from a statewide victim

you leave when he first began to pressure you?" can inadvertently reinforce a process of self-blame. The service provider who thinks that many complaints of sexual violence are false brings this filter to their normal processes of selective attention when listening to the survivor's disclosure. Negative responses to disclosures can have a range of consequences, including increasing the severity of the impacts, leaving the survivor isolated and unwilling to risk seeking other support, and delaying any further disclosures – for days, months, years or decades.

It might be expected that general social services or mental health services could provide a specialist response to sexual violence, however, wide prevalence of cultural ambivalence and a historical lack of recognition of the role of trauma in the etiology of mental health difficulties, mean that much work has needed to be invested in teaching clinicians how to ask about sexual violence in a way that assists people to feel safe enough to disclose[6].

Cultural ambivalence also plays out in families so it is helpful to have specialist guidance available for them as well.

There are specific legal and court procedures which relate to sexual violence so it is in the interests of survivors and their supporters to receive accurate information.[7]

Specialist sexual violence services tend to provide a range of services, being almost a one-stop shop for sexual violence (excluding police and most medical responses). This is helpful not only for survivors and their families, but also for communities. When the local school teacher or youth group leader suspects sexual violence but needs to consult, there is a place to go.

*"If I had available to me in 1993, someone advocating on my behalf when I first disclosed to the police about historic rapes, I know I would not have lost 14 years of my life going through 2 deposition hearings and 5 trials."*

*- Louise Nicholas (Survivor Advocate)*

# PRACTICE EXAMPLES

Most centres around the country were established as specialist centres and remain so. Some have begun to provide other services in response to funding possibilities (often family violence services) or in response to needs identified in their communities or by survivors.[8]

needs assessment. Journal of Interpersonal Violence, 20, 767- 776.
5. Fallot, R. D., & Harris, M. (2009). Creating Cultures of Trauma-Informed Care (CCTIC): A self-assessment and planning tool. Retrieved from the University of Iowa http://www.healthcare.uiowa.edu/icmh/documents/CCTICSelf-AssessmentandPlanningProtocol10709.pdf
6. Read, J., Hammersley, P., & Rudegair, T. (2007). Why, when and how to ask about childhood abuse.
7. Advances in Psychiatric Treatment, 13, 101-110.
8. Henderson, S. (2012). The pros and cons of providing dedicated sexual violence services: A literature review. Scotland: Rape Crisis Scotland.

# PRINCIPLE 8: QUALITY

- Services provided are of the highest quality given the state of knowledge and resources. This is achieved through ongoing evaluation of service delivery with assessment based on feedback from victims/survivors, staff and service delivery partners, practice guidelines and research evidence.
- Staff are supported through appropriate training, leave, resources and supervision

It is important that services are of high quality as the potential for crisis support workers to cause harm is as great as it is for anyone else in the aftermath of sexual violence. There are high costs to survivors (and therefore to society) if we fail to ameliorate harm when we had the opportunity to do so.

However, research validation is difficult to achieve due to ethical challenges of engaging survivors in evaluative research.

> "The nature of sexual assault services presents challenges for evaluation. Most sexual assault agencies provide crisis intervention services, typically free of charge and brief in duration, to clients who may be in crisis and/or in danger. The context in which rape crisis services are delivered raises practical concerns for evaluators who must take care to protect the safety, confidentiality of survivors, and design their evaluations in ways that respect recovery from sexual assault. For example, contacting a survivor in her home to evaluate the sexual assault services she previously received may violate her privacy, interfere with her recovery process, or place her in danger (if she lives with her assailant)."[1]

Innovation is called for, as in spite of these challenges, research is needed. To demonstrate quality we need evaluation and documentation testing effective models of care, victim/survivor feedback and outcome measures, understanding of sexual assault and abuse recovery in different cultures, and development and evaluation of interventions (including alternative therapies) to highlight Good Practice in crisis services and to enhance service delivery.[2]

A further barrier might be to the achievement of quality itself. Decades of under-resourcing to the sector is likely to have constrained the capacity of services to support workers well and to always meet the needs of survivors. However, informal reports from services of client feedback are that this is good. A move to collecting this information on a national basis would take us one step closer to being able to achieve and assert quality.

## PRACTICE EXAMPLES

1. Client feedback - in light of how difficult this is to get formally in the crisis situation, one service records spontaneous evaluative comments made by victims/survivors during support at police interviews and medical examinations.
2. Service feedback – informal feedback gathered in tri-partite meetings, and regular feedback surveys to gather qualitative information from all of those involved in partnered service provision.
3. SASH-Nelson (Sexual Abuse Support and Healing) allocates a training fund for each worker and sets a resources budget to purchase the latest books and video resources.
4. At Wellington HELP's Crisis Response Team, if there is a phone call that stands out in some way – it is taken to the monthly meeting (as opposed to supervision) to be discussed as a team so that all can benefit from the learning. This requires a level of trust for it to be done well.

1. Wasco, S., Campbell, R., Howard, A., Mason, G., Staggs, S., Schewe, P., & Riger, S. (2004). A statewide evaluation of services provided to rape survivors. Journal of Interpersonal Violence, 19, 252-263, p.253.
2. Callender, T., & Dartnall, L. (2001). Mental health responses for victims of sexual violence and rape in resource-poor settings: Briefing paper. Sexual Violence Research Initiative. Columbia University Press.

# PRINCIPLE 9: ACCESSIBLE SUPPORTS

**The nature of sexual violence requires an immediate 24/7 response.**

- Accessible to all victims/survivors:
- At no cost to the victim/survivor.
- Via routes that survivors can use - 0800, face to face, phone, e-mail, web-sites, texts, video-conferencing for rural clients.

**Crisis services need to be available 24/7, 365 days per year because:**

- Sexual abuse and assault may occur at any time, including weekends and holidays.
- There is anecdotal evidence that sexual abuse and assault occur more often at night, as context and opportunities for sexual abuse and assault are greater during those times.
- Flashbacks and nightmares following sexual assault can happen anytime, but often happen at night.
- Disabling terror following sexual assault can happen anytime, but mostly happens at night.
- Privacy to talk on the phone about something that you feel ashamed and distressed about when you do talk about it can happen anytime, but often happens at night.
- Crisis services need to be immediately available, with sufficient specialist staff able to respond to victims/survivors needs.
    - Research has indicated that a long delay between attack and seeking assistance contributes to the scale of psychological difficulties people present with. Recommendations from survivors were that there be more services and that they be more widely advertised.[1]
- Crisis support services should be contacted immediately following a sexual assault disclosure to police so that supports are available as early in the process as possible. This helps to ensure client emotional safety in waiting times and waiting areas.
    - Crisis support workers need time to develop the relationship which they will use to perform support functions through the medical or police interview.
    - Accessing an immediate response following sexual assault can be challenging for victims/survivors who reside in rural communities, as services in such locations often operate with limited resource (funding) and capacity[2]. To ensure specialist sexual violence supports are accessible to victims/survivors in rural communities, it is essential for the sector to advocate for the funding of community-based services.
- Services need to be accessible to all victims/survivors. To ensure accessibility of supports, there is a need for:
- Access to free services.
    - Free services are essential, in particular as low income groups are highly represented among survivors of sexual violence. In one US study, 63% of the sample reported an annual household income of $30,000 or less.[3]
    - In an evaluation of rape crisis services in New York, survivors reported that lack of accessibility and cost were factors that led to them not accessing services.[4]
    - Ensuring access to free support services can alleviate distress for victims/survivors. One study reported a relationship between financial hardship and sexual violence. This was firstly in relation to the psychological impact of sexual assault impacting on capacity to maintain employment, and secondly income and asset poverty increase risk for sexual violence and can inhibit recovery.[5]
- Sufficient numbers of services to cover geographic spread of the population.
- Sufficient service capacity to meet increasing levels of demand.
- Sufficient service capacity to support the diverse needs of victims/survivors. This includes providing physically accessible services for people with disability
- Multiple options for victims/survivors to access support, which can include: Face to face contact, freephone 0800 telephone support, online (email,

1. Monroe, L.M., Kinney, L., Weist, M., Dafeamekpor, D., & Reynolds, M. (2005). The experience of sexual assault: Findings from a statewide victim needs assessment. Journal of Interpersonal Violence, 20, 767- 776.
2. Annan, S. (2011). It's not just a job. This is where we live. This is our backyard: The experience of expert legal and advocate providers with sexually assaulted women in rural areas. Journal of the American Psychiatric Nurses Association 17(2), 139-147.
3. Valentiner, D., Foa, E., Riggs, D., & Gershuny, B., (1996). Coping strategies and posttraumatic stress disorder in female victims of sexual and non-sexual assault. Journal of Abnormal Psychology, 105, 455- 458.
4. Fry, D. (2007). A room of our own: Sexual assault survivors evaluate services. New York: New York City Alliance Against Sexual Assault.

live contact through service websites), text, video-conferencing.
    - A US study investigated 24/7 crisis service access and found most callers (68.6%) to the sexual assault service hotline called as "in crisis" so needed immediate service.[6]
- Services need to be linked into local communities so appropriate referrals are made.
    - Where a certain population cannot be well served by a particular service, for example, where a service does not work with a group such as men or young people, that service would be a part of making arrangements or highlighting the need for that population to be served.
- Services need to be advertised in ways that all sectors of the population know that they are available and how to access them in their locality.
    - Advertising needs to be targeted particularly at demographic groups that are known to be most likely to be victimised (e.g. people with mental health difficulties; people with disabilities; children and young people; sex workers; known victims of abuse).
    - Service promotion needs to 'out' sexual abuse and assault as a critical social issue and requires on-going national promotion, including strategic media coverage (e.g. television, radio, magazines, internet).

# PRACTICE EXAMPLES

1. Being accessible to young people: Working with local school counsellors to offer a service in high schools. www.dearem.nz web-site offers information to young people about how to support peers.
2. Improving access through having offices in several areas of a region as does Wellington HELP with their offices in Wellington, Porirua and Kapiti, and Rape Crisis groups in Dunedin who provide outreach support sessions in Oamaru, and Hamilton who provide counselling sessions in Raglan.
3. Offering a mobile service – going to the clients if they can't get to the office.

5. Loya, R. M. (2014). The role of sexual violence in creating and maintaining economic insecurity among asset-poor women of color. Violence against women 20 (11), 1299-1320.
6. Wasco, S., Campbell, R., Howard, A., Mason, G., Staggs, S., Schewe, P., & Riger, S. (2004). A statewide evaluation of services provided to rape survivors. Journal of Interpersonal Violence, 19, 252-263.

# PRINCIPLE 10: THERAPEUTIC ENVIRONMENTS

Services should be provided in environments which promote victim/survivor well-being and welfare

Providing appropriate environments for survivors of sexual violence has a direct impact on their well- being.

The environment has the capacity to prolong or exacerbate anxiety, or to assist in the development or maintenance of feelings of safety and calmness, both of which impact on the potential for recovery of the nervous system. This applies to both the physical environment itself, and the environment created by the tone of human interaction. Survivors often describe a sense of 'being exposed', that they feel as though everyone around them knows exactly what has happened to them, and this can trigger feelings of shame.

These issues apply to all environments in which the victim/survivor is required to be, whether that be an interview room, a waiting room, a police car, or a medical environment.

Following sexual assault, victims/survivors can be further impacted by the ways that they are treated, to the degree that contact with medical and legal systems can lead victims/survivors to experience higher levels of post-traumatic stress.[1]

- Qualities of the physical environment:
- Calm and smooth – avoid others coming in to the environment, loud or otherwise intrusive noises, sounds of anger or discord; temperature and lighting are appropriate for survivor comfort.
- Survivor perceptions of control – e.g. not sitting with their back to the door.

This enhances a sense of feeling 'protected' – not left alone, particularly in a public environment such as a waiting room or toilet area with partial walls; not exposed to offenders or reminders of them - their belongings, smells, sounds; not exposed to the scrutiny of uninvolved others.

- The absence of misogyny or objectification – no signs of the denigration of women or the sexual objectification of women or men.
- Young people have been found to prefer physical environments to be light, warm, inviting, home-like and welcoming.[2] Male victims/survivors have indicated creating a 'male friendly entrance and waiting room using posters and relevant information' such as newspapers and inclusive service information for men and families[3]. For the LBGTI+ community, 'communicate that your service celebrates, not just tolerates, LGBTI+ individuals and communities from all cultural backgrounds through positive images, posters and signs in public spaces', and 'create an environment which celebrates gender and sexuality diversity'. [4]
- Qualities of engagement and human interaction:
- Have a genuine understanding of the seriousness of sexual assault and abuse.
- Are sensitive to the survivor's needs.
- Do not minimise the trauma or stigma experienced by the survivor.
- Do not stereotype the survivor.
- Genuinely care for the safety and well-being of the survivor.
- Behave with courtesy and compassion, and respect for survivor's dignity and privacy.
- Focussed – no discussion of other matters such as other cases or interagency issues.
- Young people have been found to be looking for staff that are patient, trustworthy, young, caring, understanding and non-judgemental.[5]

1. Campbell, R. (1998). The community response to rape: Victims' experiences with the legal, medical and mental health systems. American Journal of Community Psychology, 26, 355- 379.
2. Woodley, A., Davis, R., & Metzger, N. (2013). Breaking the silence but keeping secrets : what young people want to address sexual violence. Tu Wahine Trust; HELP (Auckland Sexual Abuse HELP Foundation). Auckland, NZ.
3. Crisis Support Services for Survivors, (2016). Inclusive Practice – Supporting men. TOAH-NNEST.

# PRACTICE EXAMPLES

1. Some crisis support services have no street signs so that survivors visiting them do not inadvertently disclose by being seen to enter the building.
2. Some services provide two waiting rooms, with one being "woman only" for those survivors feeling too vulnerable to be in more public environments.

*From Mel, recently ex Wellington HELP: "One of the things I most love that happened is that a survivor suggested we have an art space in the waiting room - so we did one up and it transformed the waiting area and gets such a positive response from people when they come in the first time - survivors' own art is put up. It simultaneously makes the waiting area more beautiful and welcoming as well as meant that we took down the majority of the education type posters."*

3. Nga Whiitiiki Whanau Ahuru Mowai o Aotearoa/ National Collective of Rape Crisis and Related Groups of Aotearoa Inc groups provide separate spaces for womyn only, whanau spaces and spaces where womyn are able to be supported by male supports or whanau e.g. Whangarei Rape Crisis have premises that provide one floor for womyn and one for whanau and have hours in the day where whanau are welcome and the rest of the day is for womyn only.

4. Crisis Support Services for Survivors. (2016). Inclusive Practice – Supporting people in the LGBTI+ community. TOAH-NNEST.
5. Woodley, A., Davis, R., & Metzger, N. (2013). Breaking the silence but keeping secrets: What young people want to address sexual violence. Tu Wahine Trust; HELP (Auckland Sexual Abuse HELP Foundation). Auckland, NZ

# PRINCIPLE 11: INDEPENDENT SERVICES

Services should be provided in environments which proServices are independent from statutory or legal responses to sexual violence in order to preserve their capacity to work in a client-centred way.

Frontline staff within independent stand-alone sexual violence services have the ability to focus solely on the needs of victims/survivors, provide more inclusive sexual assault community outreach, and may be in a better position to establish well-balanced partnerships.[1]

For example, research has indicated that Rape Crisis Centers were more responsive to the needs of survivors and more able to engage in social change efforts in comparison to government led social service organisations.[2] In the UK, one of the major challenges faced by independent sexual violence services was the extra effort and work required to establish and maintain relationships with other agencies, however maintaining independence was perceived as more of a strength in improving access for victims and maintaining their confidence.[3]

Due to the nature of their roles, many of the other services or people involved in responding to sexual violence have agendas other than, or in addition to, the welfare and well-being of the victim. It can be a result of these other pressures or requirements that these services can inadvertently cause harm to the survivor.

As an example of how another agenda can cause harm to a survivor, is the nature of the process to get justice. Often crime of this nature lacks independent witnesses and corroborative evidence such as DNA evidence. As a result, a common response to an allegation of sexual violation can be victim-blaming[4] 'she wanted it' and victims can feel 'fobbed off' or that they were wasting police and doctors' time[5]. Along with the evidential standard of reasonable belief the victim's credibility is most often made the issue in court[6]. The following quote is from a woman sexually assaulted in her own bedroom by a man who broke into her home:

*The doctor explained that the blood sample would also be used to detect the presence of alcohol: if no alcohol was present, then the rapist couldn't say I'd been drunk. Was the doctor suggesting that if I had been drinking there could be some confusion as to whether or not I'd consented to intercourse? Taking the blood sample seemed an unnecessary and almost abusive intrusion into my body. But I had no option: I was to undergo an invasive procedure to defend myself against possible accusations from the perpetrator of this crime. [7]*

The harm caused by such experiences can lead to significant distress for victims. A UK based study found that neither individual variables, nor rape-related variables alone predicted high scores on a measure of post-traumatic stress, but secondary victimisation by medical or legal personnel did so. The more re-victimising actions or comments there had been, the higher the level of post-traumatic symptomatology. This effect was ameliorated where the survivor had high levels of mental health support.[8] This study was published in 1999. It is not clear what degree of change has occurred over time as we were not able to find any recent replication.

One of the roles of the crisis support service is to ameliorate harm through providing a concurrent person who is focused on the needs of the survivor.[9] This includes providing full information about the reasons for the action of the other role, assisting the victim/survivor to move away from the harm causing issue if this is what they want, and negotiating with other services to alter what they are doing or how they are doing it if harm is being caused.

Advocates provide a significant role supporting victims/survivors so they do not have to deal with different agencies in different locations.[10]

Victims who access the support of an advocate are less likely to experience negative outcomes (such as self-blame and depression) and less distress. Victims are also less reluctant to seek further support.[11] Advocate support can reduce common barriers to victim participation in the criminal justice process.[12]

1. O'Sullivan, E., & Carlton, A. (2001). Victim services, community outreach, and contemporary rape crisis centres: a comparison of independent and multi-service centres. Journal of Interpersonal Violence, 16, 343-360.
2. Patterson, D., & Laskey, S.J. (2009). The effectiveness of sexual assault services in multi-service agencies. Retreived from VAWnet: the National Online Resource Centre on Violence Against Women: http://www.vawnet.org/Assoc_Files_VAWnet/AR_DualPrograms.pdf
3. Robinson, H., & Hudson, K. (2011). Different yet complementary: Two approaches to supporting victims of sexual violence in the UK. Criminology and Criminal Justice 11(5), 515-533.
4. Campbell, R., Wasco, S., Ahrens, C., Sefl, T., & Barnes, H. (2001). Preventing the "Second Rape": Rape survivors' experiences with community

A study in the UK found that higher levels of advocacy had been required to assist victims to get their needs met where factors of the assault and factors of the victim did not fit the mold of: stranger rape with a weapon causing injury to a victim who shows distress, was not using alcohol at the time of the assault and who seems receptive to help. It is important to note that scenarios fitting this “mold, are not the majority [13]

# PRACTICE EXAMPLES

Current NZ specialist crisis support services are independent community organisations. While many are in relationship with statutory legal and medical responses, these relationships do not accord any institutional “power over“, other than that in play by their statutory or social status.

service providers. Journal of Interpersonal Violence, 16, 1239 – 1259.
5. Lievore, D. (2005). No longer silent: a study of women’s help-seeking decisions and service responses to sexual assault. Canberra, Australian Institute of Criminology.
6. Leefman, Charlotte (2005). To be alive: An attack and afterwards. Nelson: Craig Potton & Auckland: Auckland Sexual Abuse HELP Foundation.
7. Leefman, Charlotte (2005). To be alive: An attack and afterwards. Nelson: Craig Potton & Auckland: Auckland Sexual Abuse HELP Foundation, p.33.
8. Campbell,R., Sefl, T., Barnes, H., Ahrens, C., Wasco, S., & Zaragoza-Diesfeld, Y. (1999). Community services for rape survivors: Enhancing psychological well-being or increasing trauma? Journal of Consulting and Clinical Psychology, 67, 847-858.
9. Wall, L., & Quadara, A. (2014). Acknowledging complexity in the impacts of sexual victimization trauma. Australian Centre for the Study of Sexual Assault. Australian Institute of Family Studies, Australian Government.
10. Kingi, V., Jordan, J., Moeke-Maxwell, T., & Fairburn-Dunlop, P. (2009). Responding to sexual violence: pathways to recovery. Wellington: Ministry of Women’s Affairs.
11. Campbell, R. (2006). Rape survivors’ experiences with the legal and medical systems: Do rape victim advocates make a difference? Violence Against Women 12, 30-45
12. Patterson, D., & Tringalia, B. (2014). Understanding how advocates can affect sexual assault victim engagement in the criminal justice process. Journal of Interpersonal Violence, 6, pp 1987-97.
13. Campbell, R. (1998). The community response to rape: Victims’ experiences with the legal, medical and mental health systems. American Journal of Community Psychology, 26, 355- 379.

# PRINCIPLE 12: SUSTAINABLE

- Services need to be secure with sufficient resources so that they can meet the current and increasing demand for service in ways which meet victim/survivor needs
- Income sources need to be adequate, long-term and negotiated in a timely fashion, to enable services to avoid the constant distraction of endeavouring to ensure sufficient resources for continuing service delivery.
- The nature of the work can have a high cost on those doing it if staff support systems are not in place.

Most New Zealand services are operating on insufficient income to provide full services and/or to pay the staff for all they do. This leads to victims/survivors having insufficient access to service, and to staff recruitment and retention difficulties, which can lead to compromises in service quality.

> A stocktake of NZ crisis support services in 2009 found that services believe that they are under-resourced, and that they manage this by reducing hours of service, not paying staff for some or all of their work, or paying staff low wages.[1]

The need for services is increasing, as sexual violence increasingly "comes out", both through intentional efforts to reach victims/survivors and changes in society in general, more survivors are seeking services.

This work impacts workers in multiple ways. Working so closely with traumatized people in their hours of need (and at all hours of the day and night) can lead to vicarious traumatisation and emotional fatigue. In addition, the work brings people face to face with the realities of both the perpetration of sexual violence in our society and our society's response to it – somewhat lonely things to know given general levels of denial and victim-blaming in society.

Research has found that there are a number of variables which are protective in terms of the development of vicarious traumatisation and/or secondary traumatisation, including level of education.[2]

Organisations can also become overwhelmed by the nature of crisis work - this has been called "organisational trauma"[3]. In response to this, the 'Organisational Resiliency Model' focusses on developing both individual and organisational characteristics of resiliency. The model suggests identifying symptoms (such as a lack of recognition that the very nature of the work affects the culture of the organization), and signs of what to watch out for (such as detachment from meetings and learning opportunities, personality conflicts, and feelings of resentment). Strategies for building strong and healthy organisations include regularly revisiting the service's mission, vision and core values, and considering the ways that everyday stressors can be made more challenging by trauma exposure and finding ways to mitigate this to increase resiliency.[4]

## PRACTICE EXAMPLES

1. Services attempt to provide appropriate levels of training, supervision and support to staff to enable their work to be sustainable. One service encapsulates this with a "building resilience" policy.
2. Developing guidelines to assist staff in the work – from Mel recently ex Wellington HELP:

*"When I started at HELP again in 2008, there was nothing at all in writing to assist me support a woman at court. I felt strongly about that being detrimental to the agency and in particular people we were supporting. So, I set up a meeting with Louise Nicholas and other service agencies in the area, consulted with someone with considerable experience in the work (Jennifer Annan), and from there guidelines were developed which assist people new to the supporting work as well as the survivor giving evidence."*

1. Te Ohaaki a Hine: National Network Ending Sexual Violence Together – Tauiwi Caucus. (2009). Tauiwi Response to Sexual Violence: Mainstream Crisis Support and Recovery and Support Services and Pacific Services. NZ: Report to Ministry of Social Development.
2. Baird, S. & Jenkins, S. R. (2003). Vicarious traumatization, secondary traumatic stress, and burnout in sexual assault and domestic violence agency staff. Violence and Victims, 18, 71-86.
3. Vivian, O., & Hormann, S. (2013). Organisational trauma and healing. North Charleston, S. C, Create Space.
4. Lord, J. H., & O'Brien, K. (2007). Developing resilience. National victim Assistance Academy, Track 1: Participants Text (Chapter 10, 1-40). Retrieved from the Vermont Centre for Crime Victim Services: http://tinyurl.com?Developing-Resilience

# PRINCIPLE 13: MULTIPLE SUPPORTS WITHIN SERVICES

Crisis sexual assault support services are integrated with other psychosocial services to give survivors a "wrap around service", best meeting the needs of the clients and the community.

To best meet the needs of survivors, services are most often integrated – crisis and non-crisis support services, court support, advocacy, on-going counselling, and prevention education. This enables provision of a "wrap-around service" with smooth transitions "connectedness of services"[1], to be able to meet multiple of the client's needs at this and other points in their journey.

Integrated service provides longer term counselling and therapy for the needs of survivors. While studies vary on the proportions, all studies find that some sexual assault survivors will recover from the psychological impacts over a period of months, but that for many survivors, recovery time is measured in years. [2]

> In an evaluation of New York rape crisis centres, survivors said that they needed long-term counselling, and group therapy.[13]
>
> US services have tended to provide short term counselling only as a part of their services. In an evaluation across 19 sexual assault centers in Maryland, about 20% of those survivors who recommended service improvements wanted more therapy, more time for therapy sessions, and/or group therapy.[14]

A survivor's recovery journey may have many points of acute and varying need. Integration of crisis, counselling and support and advocacy services allows for these needs to be met by a service with which the client feels comfortable, and a service which can reasonably be expected to understand the victims journey of recovery and needs.[5]

Such integration also means that we do not separate service delivery from lobbying, enabling a direct path from survivors, through services, to public voice. We become a channel for those voices rather than a dead end. This integrated response builds morale through keeping services involved as a part of the solutions on wider levels than only working with the individual survivors. We are not helpless in the face of this serious social problem with which we work every day.

Integration also serves our communities, providing consultation and education to our communities, along with keeping the addressing of sexual violence on the community agenda.

## PRACTICE EXAMPLES

1. SASH-Nelson (Sexual Abuse Support and Healing) describes such integration as follows:
2. Crisis support services might work alongside on-going counselling by providing support while the client is waiting to see a counsellor, or during times of acute need. Both aspects of service can be matched to the client's needs through in-house co-operation and consultation.
3. Wellington HELP offers integrated social work and counselling services – a social worker might come into a counselling session to talk about reporting to police or other CYF or justice processes, or might work alongside the counselling providing psycho-education to family members about sexual violence, the survivor's needs and the process of secondary traumatization which can occur for family members.
4. Many services provide telephone support to clients who are in counselling.

1. Wall, L., & Quadara, A. (2014). Acknowledging complexity in the impacts of sexual victimization trauma. Australian Centre for the Study of Sexual Assault. Australian Institute of Family Studies, Australian Government.
2. For a summary see Petrak, J. (2002). The psychological impact of sexual assault. In Petrak, J., & Hedge, B. (Eds). The trauma of sexual assault: Treatment, prevention and practice (pp.19-44). UK: Wiley.
3. Fry, D. (2007). A room of our own: Sexual assault survivors evaluate services. New York: New York City Alliance Against Sexual Assault.
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5. Patterson, D., & Laskey, S. (2011). The effectiveness of sexual assault services in multi-service agencies. National Research Centre on Domestic Violence VAWnet.org http://www.vawnet.org/applied-research-papers/print-document.php?doc_id=2078

# PRINCIPLE 14: WORKING COLLABORATIVELY BOTH NATIONALLY AND IN OUR LOCAL COMMUNITIES

## A. WORK IN TRI-PARTITE RELATIONSHIP

This is about ensuring that services are all working collaboratively both nationally and in our local communities.

A coordinated psycho-social, medical and legal response is that which is most likely to best meet the needs of survivors of sexual violence.

This means that Crisis Support, Medical Forensic services and Police work together to ensure that all those affected are able to access all aspects of a coordinated response.

Such an approach offers multiple points of entry, and maximizes access to justice, medical care and support for well-being. It also supports provision of consistent and quality services through providing a vehicle for collaboration and specialisation among service providers.

This is achieved principally by two main initiatives

1. The National Tripartite Forum on Sexual Violence
2. Local Level Agreements (LLA) in all local areas of New Zealand

The National Tripartite Forum on Sexual Violence

This forum was set up in 2009 by agreement between Te Ohaaki a Hine – National Network Ending Sexual Violence Together (TOAH-NNEST), Rape Crisis, Doctors for Sexual Abuse Care DSAC, and the then Police Commissioner Howard Broad. It reflects the collaborative tri-partite response to sexual violence, being a medical response, a criminal justice response and a crisis support response to maximise psychological and emotional well-being of the survivor. In 2013, Victim Support joined the national forum.

It's main purpose is to be representative at a National Level

The Representatives are from

- Police National,
- TOAH-NNEST – Tauiwi Caucus, Nga Kaitiaki Mauri
- National Collective of Rape Crisis – Maori and non-Maori representation
- DSAC
- Victim Support

### Local Level Agreements LLA

An LLA is the local area working model of the Tripartite approach to service delivery.

All areas of New Zealand should now have an LLA in place and those providing Police, Medical or Crisis Support services should be using the LLA to ensure there is a good working relationship....

### An effective tripartite relationship-LLA:

*Is based on:*

- Agreement that victim/survivor needs are paramount drivers of service and response
- Partnership – whereby the functions of each role are considered different but equal, and where the parties hold respect for and understanding about each of the different roles
- Local and national formal infrastructures and agreements addressing:
- Prioritisation of victim/survivor safety and well-being, and right to informed decision-making
- Identification of the roles and responsibilities of each party, and the tools and routes for accountability for these

1. Maier, S. (2012). Sexual assault nurse examiners' perceptions of their relationship with doctors, rape victim advocates, police and prosecutors. Journal of Interpersonal Violence 27(7), 1314-1340.
2. Beckett, L. L. (2007). Care in collaboration: Preventing secondary victimization through a holistic approach to pre-court sexual violence interventions. Unpublished doctoral dissertation, Victoria, University of Wellington. Wellington, NZ.
3. Beckett, L. L. (2007). Care in collaboration: Preventing secondary victimization through a holistic approach to pre-court sexual violence interventions. Unpublished doctoral dissertation, Victoria, University of Wellington. Wellington, NZ.
4. Beckett, L. L. (2007). Care in collaboration: Preventing secondary victimization through a holistic approach to pre-court sexual violence interven-

  - One study investigated sexual assault nurse examiners' perceptions of their relationships with other professionals who treat and interact with victims/survivors. Positive relationships were marked by open communications and respect shown towards the health professionals as well as victims/survivors. On the contrary, negative relationships were the result of medical practitioners perceiving the treatment of victims/survivors by other professionals (such as the police) to be poor, when advocates overstep boundaries and question medical practitioners about evidence collection or the exam, and when prosecutors fail to properly prepare them to testify during trial.[1]
- Agreed protocols and procedures for referral and other services required by the victim
- Transparency about possible conflicts in roles, responsibilities and accountabilities, and protocols for mitigating those conflicts and resolving disputes safely and quickly in the interests of minimising impact on service provision to victim/survivors

*Protocols for ensuring good communication, including:*

- Sharing of critical information: Meetings enable effective case co-ordination and management, information sharing and mechanisms for resolving inter-agency difficulties. Enhancing practice through sharing of ideas, clarifying role responsibilities, agreeing on basic standards for research and practice, and mitigating impacts of staff turnover can be achieved.[2]
  - Confidentiality agreements
  - Protocols for informing one another of relevant communications or initiatives being undertaken (e.g. media statements), so that each agency can respond appropriately
  - Sharing information and resources
- Clarity and transparency regarding all decision points and potential consequences
- Compliance with all relevant legislation and regulations
- Agreement to advise and consult re all service initiatives or changes which could impact survivors of sexual violence and/or the tri-partite relationships.
- Designated representatives from each party
- Protocols to ensure information about the agreement is understood by all personnel involved in each service
  - Theory suggests multiple values in the development of protocols, such as ensuring inter-agency liaisons are professional, effective and victim-focused; reducing the likelihood of one agency being subsumed by another; and providing a written basis for monitoring service provision. An evaluation showed that existence of protocols correlated with effective relationships between law enforcement agencies and Rape Crisis advocates, but that existence of protocols did not ensure that police followed them.[3]
- All parties agree to undertake training and create learning opportunities for each organisation to develop professionally
  - Training gains include co-ordination between organisations; collegiality; giving each organisation a stake in the others; accuracy of information, insight into the expertise and operations of other groups; common knowledge, philosophy, concern and a spirit of cooperation; development of skill, understanding, support and enthusiasm; and the development of new policies and procedures.[4]
- Regular local and national meetings to discuss specific content of the work, and the relationship – issues arising and changes in the roles or circumstances of one party which might impact on the others
  - On-going evaluation is also theorised to have much value, in part through the collaboration to develop the evaluation procedures. Research has suggested the need for combined goal setting, agreed standards and official sanctions to encourage compliance.[5]
- Specialisation – supporting good service provision and development of trust and confidence between the parties.
  - Specialist police sexual assault teams have impacted on competence and confidence, development of professional and integrated services, facilitated involvement of support agencies at early stage, and have been associated with a paradigm shift to redefining policing as "protecting victims from the impacts of crime".[6]

tions. Unpublished doctoral dissertation, Victoria, University of Wellington. Wellington, NZ.

5. Beckett, L. L. (2007). Care in collaboration: Preventing secondary victimization through a holistic approach to pre-court sexual violence interventions. Unpublished doctoral dissertation, Victoria, University of Wellington. Wellington, NZ.
6. Beckett, L. L. (2007). Care in collaboration: Preventing secondary victimization through a holistic approach to pre-court sexual violence interventions. Unpublished doctoral dissertation, Victoria, University of Wellington. Wellington, NZ, p.29.
7. Beckett, L. L. (2007). Care in collaboration: Preventing secondary victimization through a holistic approach to pre-court sexual violence interventions. Unpublished doctoral dissertation, Victoria, University of Wellington. Wellington, NZ, p.40

*Is nurtured by relationship developed through:*

- Small teams, the members of which can come to know each other personally through regular work, meetings and training
- Mutual training practices at local level (police, medical teams and support services all involved in each other's training).

*An effective tripartite relationship is nurtured by relationship developed through:*

- Small teams, the members of which can come to know each other personally through regular work, meetings and training.
- Mutual training practices at local level (police, medical teams and support services all involved in each other's training).
- There remains debate about the value of a move to physically integrated services. Referring to the evaluations of Britain's SARCs, Beckett suggests sharing premises as "an important step". However, she also points out that these were developed at the exclusion of Rape Crisis centres and that this is a concern as "the therapeutic necessity for victim empowerment is more likely to be understood, integral, and lasting if underpinned by a feminist perspective".[7] [8]

**Research supports the tri-partite approach.**

In the US, the collaboration of legal, medical and mental health resources using an ecological conception of person-environment fit as the criteria for a "good" outcome was investigated. The question explored "Did the system respond in a manner consistent with victims' needs?" (p.360). Survivors who lived in areas with co-ordinated approaches were more likely to have positive experiences with the systems involved, and to be able to obtain services which were considered to be consistent with their needs. [9]

In another study, communities considered to be highly co-ordinated regarding services for sexual violence were compared with communities considered to have low co-ordination. In communities considered to be highly co-ordinated, three types of multi-agency programmes existed: co-ordinated service programmes, interagency training programmes and community-level reform groups. Common features of multi-agency service programmes, whether co-ordination was formal or informal, were that they involved staff from multiple agencies, and focused on improving service delivery for victims. In contrast, in communities with low co-ordination, interagency training was the only kind of multi-agency programme. There were also differences between the nature of the training between communities with high service co-ordination and those with low service co-ordination. For the former, training was short but frequent, had goals of both relationship building and on-going learning, and was reciprocal. For the latter, training tended to be mandated, infrequent, long, and restricted to established service providers only. [10]

In a review of four communities, a number of factors were identified as practices that enhanced the provision of care to survivors of sexual assault, and led to increased successful prosecution of sexual assault cases. These included:

- Inter-agency task forces and networks
- Joint interviewing with victims
- Cross-training between agencies
- Referral services [11]

# B. LOCAL CONFIGURATIONS FOR LOCAL NEED

The natures of our communities vary widely in ethnic make-up, socio-demographic profile, and availability of other resources. Therefore, services need to be tailored to take into account local contexts, needs and service constraints. A one-size-fits-all approach to crisis support services provision is unlikely to be effective for victim/survivors.

8. Such exclusion has also occurred in New Zealand's first attempt to develop an integrated service, Puawaitahi in Auckland. In spite of full participation throughout the initial years of service planning and development, community crisis support services were excluded from the final set up.
9. Campbell, R. (1998). The community response to rape: Victims' experiences with the legal, medical and mental health systems. American Journal of Community Psychology, 26, 355- 379.
10. Campbell,R., Sefl, T., Barnes, H., Ahrens, C., Wasco, S., & Zaragoza-Diesfeld, Y. (1999). Community services for rape survivors: Enhancing psychological well-being or increasing trauma? Journal of Consulting and Clinical Psychology, 67, 847-858.
11. Epstein & Langenbahn (1994), cited in Decker, S.E., & Naugle, A. F. (2009). Immediate intervention for sexual assault: A review with recommenda-

# PRACTICE EXAMPLES

1. Mid North Women's Support and Youth Services - in response to the local needs of the Kerikeri community, this group have at times provided extra services such as budgeting and youth services.
2. In the Kaipara area, following a drop in funding for the women's centre, Rape Crisis picked up the function of providing emergency housing and associated advocacy to women and children in situations of violence.

# C. GOOD RELATIONSHIPS WITH OTHER LOCAL SERVICES (NON-TRI-PARTITE)

Sexual violence happens to a person in the context of the rest of their life and their other needs. Any pre-existing difficulties can hamper recovery, and the period of disorganisation which can occur following sexual assault can mean that survivors might need assistance with issues that they previously managed well themselves. Therefore, crisis support workers might need to engage a number of other services for a victim/survivor to be optimally supported following an assault.

> For example, one study found hotline and advocacy workers linked survivors (on average) to at least two additional community resources.[12]

Stigma attached to sexual assault also attaches to those agencies which work with survivors of sexual assault. This can contribute - along with shame, doubt, lack of trust, and a belief that they can manage on their own - to many survivors not seeking help directly from sexual assault services.

Good community relationships mean that other services who receive disclosures of sexual violence are able to assist survivors to access sexual assault services.

> For example, in a review of four communities, it was found that coordination between sexual assault victim advocates and organisations assisting underserved populations, led to better provision of translation, technical assistance, training and funding by and for some advocacy groups.[13]

Sexual violence can seem like society's 'dirty secret', as if there is an alternate reality that only survivors, you, and your colleagues are aware of. This can feel isolating. To be widely active in community relationships and talking about sexual violence exposes the secret and the isolation it engenders. This is both good for the mental health of service providers and assists communities to alter their attitudes to sexual violence and its victims.

> The 'Blowing the secret' study, based in the USA, found that agencies in communities which were co-ordinated in their responses to sexual violence, were involved in community-level reform, such as interagency task forces, women's action groups e.g. court watch, t-shirts carrying survivor voices.[14]

# PRACTICE EXAMPLES

1. Collaborative work with school counselors can lead to provision of specialist counseling and crisis support services to youth in schools. This both improves young people's access to service and improves awareness of sexual violence and its effects in the school community.
2. While some survivors wish to control the use of their personal and health information, others are happy for mental health services and crisis support services to work together to develop complementary plans for counselling and support.
3. Dunedin has a good relationship with Shakti for the benefit of clients of both services.

tions and implications for practitioners. Journal of Aggression, Maltreatment and Trauma, 18, 419-441.

12. Wasco, S., Campbell, R., Howard, A., Mason, G., Staggs, S., Schewe, P., & Riger, S. (2004). A statewide evaluation of services provided to rape survivors. Journal of Interpersonal Violence, 19, 252-263.
13. Epstein & Langenbahn (1994), cited in Decker, S.E., & Naugle, A. F. (2009). Immediate intervention for sexual assault: A review with recommendations and implications for practitioners. Journal of Aggression, Maltreatment and Trauma, 18, 419-441.

# D. NATIONAL CO-ORDINATION

As a network of predominantly small organisations, working collaboratively can achieve sharing of resources and development of strategic planning and relationships, in order to achieve the goals of provision of appropriate services and ending sexual violence.

# PRACTICE EXAMPLES

Both of the following networks support agencies providing specialist services in response to sexual violence:

1. Nga Whiitiiki Whanau  Ahuru Mowai o Aotearoa/ National Collective of Rape Crisis and Related Groups of Aotearoa Inc.
   - Te Ohaaki a Hine – National Network Ending Sexual Violence Together.
   - Co-ordination by Nga Whiitiiki Whanau  Ahuru Mowai o Aotearoa/ National Collective of Rape Crisis and Related Groups of Aotearoa Inc for Rape Awareness Week allows a national theme which increases the power to bring public attention to the issue.
2. Nga Whiitiiki Whanau  Ahuru Mowai o Aotearoa/ National Collective of Rape Crisis and Related Groups of Aotearoa Inc also coordinate standardised education resources and standardised worker training for volunteers and staff on a national level to reduce the duplication by local agencies.  This process enhances the National Resources by gaining multiple women's input.

14. Campbell,R., Sefl, T., Barnes, H., Ahrens, C., Wasco, S., & Zaragoza-Diesfeld, Y. (1999). Community services for rape survivors: Enhancing psychological well-being or increasing trauma? Journal of Consulting and Clinical Psychology, 67, 847-858.

# PRINCIPLE 15: COMMUNITIES WORKING TOGETHER TO PREVENT AND ADDRESS SEXUAL VIOLENCE

Everybody has the right to live free of sexual violence. Survivors do not cause the sexual violence which is perpetrated on them, and nor is it up to them to prevent it. Those who offend must stop doing so. Responsibility for prevention sits with the whole community. Specialist services contribute to community change through provision of services, education, advocacy and statistical and other information about the nature of sexual violence.

Perpetration of sexual violence is supported by the "cultural scaffolding" of misogyny, rape myths, and wide acceptance of public sexual objectification of women, so responsibility for prevention sits with the whole community.

Safety education and messages not informed by those with specialist knowledge, often look only at how people can keep themselves safe to avoid sexual violence. This approach implies that following a set of clearly defined rules (further to the precautions women and others take consciously and unconsciously daily to try and keep safe) will mean you avoid sexual violence. This not only places all responsibility on women and other people who are targets for sexual violence, it sets them up. If sexual violence does occur and they have not followed the "rules", that is, out late, lost your friend, ran out of money for a taxi, accepted a drink from stranger, then they can be blamed for not following the rules. This feeds in to and upholds common myths about rape that blame survivors for their experience of sexual violence.

The tendency to approach sexual violence prevention by only telling victims/survivors how to be safe is prevalent and dangerous. This has immense implications for all survivors.

Negative responses to disclosure of sexual assault and abuse (such as victim-blaming) have a detrimental impact on the wellbeing of victims/survivors. Studies have found this increased distress results in delayed recovery, and heightened symptoms related to Posttraumatic Stress.[1]

Young people also appear vulnerable in internalizing the ways in which sexual violence is framed by their community.

> In a NZ study many young people really struggled to envisage a situation in which the victim would not have been responsible for what had happened. At a time in their lives that they are seeking independence and taking risks, they have been warned by the adults in their lives 'to be careful'. 'They weren't' and thus 'they have brought it upon themselves'. Indications are that young people who experience sexual abuse are deeply affected, not only by the violence, but by feelings of shame. Young people need good prevention information that takes account of adolescent 'risk taking behaviour' to reduce the likelihood of self-blame, and also information that reduces the threshold of what is considered 'abuse or assault' and will help them reframe what has happened to them or their friends.[2]

## PRACTICE EXAMPLES

Sexual Abuse Prevention Network (SAPN), which was formerly known as Wellington Sexual Abuse Network (WSAN), has developed and is continuing to develop, strategies that recognise that the responsibility to prevent sexual violence rests with the whole community. This includes:

1. Collaboration

   Sexual Abuse Prevention Network is a standalone charitable trust, governed by Wellington Rape Crisis, Wellington Sexual Abuse HELP Foundation and WellStop. The four agencies work closely together sharing their expertise in each of their specialist areas. The agencies also collaborate with organisations outside the sector and participate in community collaborations that address sexual violence specifically, as well as those with a more general focus such as safety, alcohol and youth.

Sexual Abuse Prevention Network is a key partner in the Who are You? collaboration, which developed the Who are You? film and toolkit. The project focuses on ethical bystander intervention in bars, and is widely used in New Zealand and internationally.

2. Training and Education

**Sexual violence prevention training that focuses on:**

- changing attitudes and behaviours that support sexual violence and create an environment in which it can happen
- training a wide range of groups
- using the ethical bystander intervention model in training. This is a method that trains people to identify unsafe situations and to intervene before sexual assault occurs. It aims to empower the community.

SAPN trains a wide range of groups – including government departments, businesses, youth workers, hospitality staff, school teachers.

In particular SAPN trains local hospitality staff to identify sexual assault and to intervene. SAPN is working on making this training a mandatory part of the Duty Manager curriculum and to establish a network of bars who have done the training and can achieve "Safer Bar" status.

Workshops with young people to encourage healthy relationships and consent – with the aim of making these the norm in sexual relationships. This includes the Who are You? Programme and Mates and Dates. (http://www.acc.co.nz/preventing-injuries/at-school/mates-dates/index.htm)

Educating young and older adults with intellectual and learning disabilities about healthy relationships and consent. SAPN recognizes that this is a group that often misses out on any education about sex and sexuality.

3. Consultation and Advice

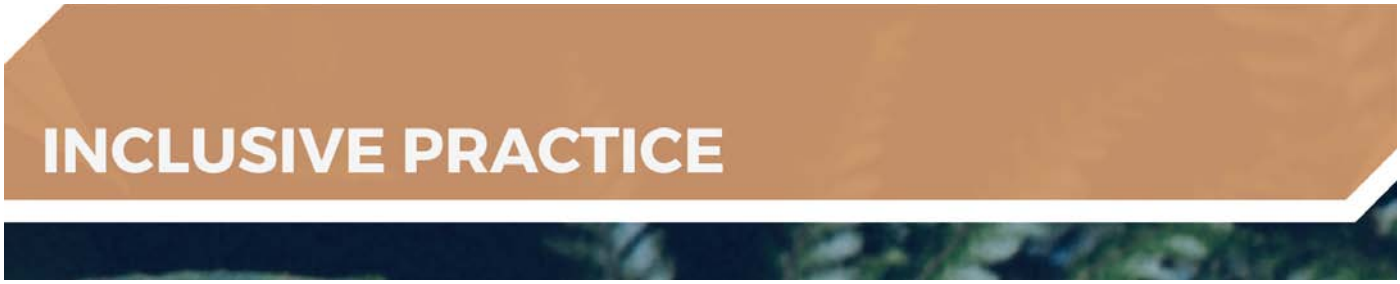
The Network provides consultation and advice to range of organisations, including businesses, government departments, community groups and secondary and tertiary education institutions, about responding to incidents of sexual violence and on their own prevention initiatives. This includes policy development, strategic planning, and advice such as how to respond to a disclosure of sexual violence as well as train-the-trainer programmes.

4. Advocacy and public awareness

SAPN advocates to change the widespread attitudes, beliefs and behaviours that support sexual violence. SAPN does this by:

- Speaking at events
- Supporting community advocacy
- Providing a specialist sexual violence perspective in the media
- Sharing commentary and new initiatives on social media.

1. Campbell, R., Wasco, S. M., Ahrens, C. E. Sefl, T., & Barnes, H. E. (2001). Preventing the second rape: Rape survivors' experiences with community service providers. Journal of Interpersonal Violence, 16, 1239-1259.
2. Woodley, A., Davis, R., & Metzger, N. (2013). Breaking the silence but keeping secrets: what young people want to address sexual violence. Tu Wahine Trust; HELP (Auckland Sexual Abuse HELP Foundation). Auckland, NZ.



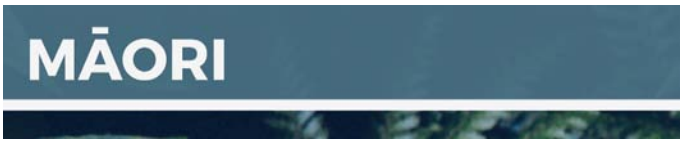

# RESPONSIVENESS AND CULTURAL SENSITIVITY TO DIVERSITY IN THE CONTEXT OF SEXUAL VIOLENCE CRISIS SUPPORT SERVICES

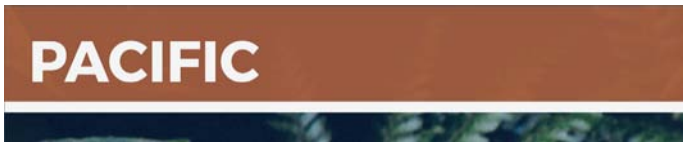
## INTRODUCTION

A focus of this second round of development was to expand the cultural reach of the guidelines through providing resources to increase the capability of services to respond appropriately to the cultural diversity of survivors using the services. While there is much general information available about the cultural competence needed to work with people from diverse cultures, there is little information available about working specifically with survivors of sexual violence.

Over the course of the project, we have come to think of this as inclusive practice, where this refers to responsiveness and cultural sensitivity to diversity.

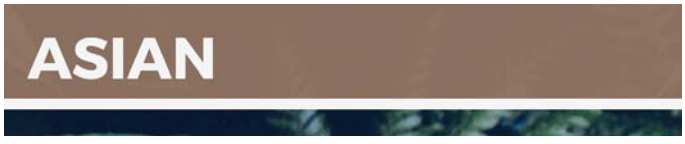
These guidelines provide crucial information and knowledge of appropriate and safe practices (for frontline staff and services) to improve the experiences of victims/survivors from the following communities and cultures:







# HOW TO USE THE INCLUSIVE PRACTICE GUIDELINES

Each Inclusive Practice guidelines section, representing a diverse community or cultural group, will be presented using the following format:

- **Background Information** - What we used to develop the guidelines
- **Essential Knowledge** - What we need to know
- **Essential Practice** - What we need to do
  - On the frontline
  - Crisis support services
  - Sector and community development
- **Relevant references**
  - Enhancing cultural competence
  - Other related research

We offer a mix of information to support the development of your knowledge. While the guidelines and video interviews might draw your attention first, reading the report which sits behind the guidelines, in the Background Information section, will give you more complete information.

# INTERSECTIONALITY

The guidelines are to provide background information, but do not detract from the principle of client centred practice. Any person you are working with will bring their own unique needs – some people are well embedded in a particular culture, while others may live across multiple cultures depending on their circumstances – a Muslim woman with a disability, a gay male whose family is Māori and Asian. You still need to listen to the person in front of you, but increased knowledge of culture/s might help you to better understand what they say. Cultural competence does not suggest treating all members of a cultural group in the same way. Rather, it presumes that difference and diversity between and within groups are valued, and acknowledges a positive integration of diversity, difference and multiculturalism within a system of care.

# INCLUSIVE PRACTICES

Selecting the community groups: This process was driven primarily by the desire to provide better support to groups who were already presenting for service, or who were conspicuous by their relative absence from services. This was with the exception of Māori who were prioritized as tāngata whenua. Asian communities were not identified in the initial groups, however other funding was sought to enable the research to be extended to this community.

1. **Advisory Group:** The initial phase of this research project involved community engagement and relationship building. A research Advisory Group was established through consulting with existing service relationships and reaching out to communities to develop new ones, as well as ensuring a diverse group of sexual violence specialists were engaged in the project. The group held face-to-face and teleconference meetings over the duration of the project, with regular updates also provided via email.
2. **Community researchers:** The Advisory Group representative from each community group identified potential community researchers, drawing on their connections to the community and research experience. Potential community researchers were then approached to conduct the research, and were selected based on their availability to complete the project within the specified time-frame. For several communities, the advisory group member became part of the research team.
3. **Consultation:** The Guidelines were derived from these reports and other relevant research, with consultation between the Advisory Group, community researcher and research team during the development process.
4. **Future research:** The research process was designed to also directly benefit the communities involved, with communities being free to use the research for their own purposes.


# SUPPORTING MĀORI SURVIVORS

Good Practice Guidelines for 'mainstream' sexual violence crisis support services - Working with Maori survivors of sexual violence (Te Wiata & Smith, 2016)

## ESSENTIAL LEARNING - WHAT WE NEED TO KNOW

- Sexual violence against Māori affects not just Māori individuals, but also the wellbeing of whānau, hapū and iwi.
- Healing is a priority and relates to 'whānau ora' (whole of whānau wellbeing). Taking a 'whānau ora' approach to working with Māori centralizes whānau involvement and whānau healing.
- There can be obstacles to whānau healing; these can be overcome, and alternative positive pathways forward can be forged when strong abilities in Māori cultural competence are present.
- Engagement with kaumātua brings significant benefits for Māori, particularly in providing wisdom for healing and oversight of processes. Kaumātua can also facilitate safe relationships, networking, and connections with mana whenua (the 'home people'/ guardians of a particular area). The term kaumātua refers to both male and female elders, however female elders are also sometimes referred to as 'kuia'.
- Services will be enhanced by having an understanding of, and respect for Māori processes such as powhiri (a process of meeting in a way which acknowledges each person's mana and tapu), whakawhanaungatanga (connecting in a meaningful way), and 'hohourongo' (a conflict resolution process). Understanding the value of positive reconnection to whānau, hāpu and iwi for Māori is also important.
- Quality service delivery for Māori includes all of the above, relying heavily on a workforce that is culturally competent with Māori and, in the case of Tauiwi services, is also committed to working in true partnership with Māori.

RELEVANT REFERENCES - OTHER RELATED RESEARCH
Enhancing cultural competence - Milne, M. (2010). He rongoa kei te korero. Talking therapies for Maori: Wise practice guide for mental health and addiction services. Auckland: Te Pou o Te Whakaaro Nui.
OTHER RELATED RESEARCH
Aldridge, Nuki. (2012). Through maori eyes. In Ngapuhi Speaks: He Wakaputanga o te Rangatiratanga o Nu
Tireni and Te Tiriti o Waitangi Independent Report on Ngapuhi Nui Tonu Claim (pp xi-xii). Te Kawariki & Network Waitangi Whangarei (Inc).
Durie, M. (1994). Whaiora: Maori health development. Auckland: Oxford.
Durie, M. (2003). Nga kahui pou: Launching Maori futures. Wellington: Huia.
Durie, M. (2005, May). Indigenous health reforms: Best health outcomes for Maori in New Zealand. Paper presented at the Alberta Symposium on


# ESSENTIAL PRACTICE - WHAT WE NEED TO DO

### On the frontline

- Cultural support and engagement:
  - Engagement with individuals (kaumatua, Māori clinicians), groups (Nga Kaitiaki Mauri, TOAH-NNEST) and Kaupapa Maori services who can support the delivery of culturally appropriate and relevant services for Māori will enhance all services.
- Cultural competence for non-Māori practitioners includes:
  - Acknowledging the limitations as non-Māori to work with Māori which can result from operating from a different worldview and having different lived experiences. For example, it is important for non-Māori to develop understanding and skills for working with the ongoing realities of the impacts of colonisation on Māori as tangata whenua.
  - Accepting the validity of differing worldviews and the validity of differing therapeutic approaches and practices that arise from Te Ao Māori (a Māori worldview), recognising that cultural practices can be valid clinical interventions.
  - Understanding the importance of accessing kaumātua/tohunga as healers and sources of wisdom for service guidance roles (for example, Board/Clinical Direction), and cultural supervision with Māori.

### Crisis support services

- Inter-service relationship development:

Ongoing development of Te Tiriti partnership and relationship between mainstream and Māori services is a priority. Te Tiriti partnership with Māori would be demonstrated by:

- All requests for services by Māori that are received by mainstream services will in the first instance be referred to local Kaupapa Māori sexual violence services. Support will be provided for Māori to access these services.
- Where there are no Kaupapa Māori services available, or there is limited capacity, it may be possible to refer Māori to another Māori therapist in the community who is confident and capable of working with survivors of sexual violence. The reality of limited Māori capacity is also a prompt for mainstream services to advocate for more funding for Kaupapa Māori sexual violence services.
  - Respectful working relationships will be developed with local hapū/iwi services and Kaupapa Māori services to ensure appropriate access to kaumātua and encourage genuine participation at all levels of service delivery.
  - Continued development in cultural competency will be promoted. This is particularly relevant at present while the capacity of Kaupapa Māori services is still limited (and needing to increase). Developments in cultural competency can be facilitated by regular cultural supervision, for example meeting monthly to identify the work with Māori survivors and obtaining specialist cultural input.
  - Policies and funding contracts would reflect that when working with Māori whānau, whānau ora is promoted above other bodies of thought such as feminist ideals that exclude tāne within survivor services. For example, tāne would be included in healing pathways for whānau.

Health, Unleashing Innovation in Health Care, Alberta, Canada. Retrieved from http://www.massey.ac.nz/massey/fms/Te%20Mata%20O%20Te%20Tau/ Publications%20%20Mason/M%20Durie%20Indigenous%20Health%20reforms%20Best%20Health%20outcomes%20for%20Maori%20in%20New%20Zealand.pdf?8D669ABBF3E26A2D11D67B8D01C9AE4C
Fanslow, J.L., Robinson, E.M., Crengle, S., & Perese, L. (2007). Prevalence of child sexual abuse reported by a cross-sectional sample of New Zealand women. Child Abuse & Neglect, 31(9), 935-945. Retrieved from www.sciencedirect.com/science/article/pii/S0145213407002050
Fanslow, J.L. & Robinson, E.M. (2004). Violence against women in New Zealand: Prevalence and health consequences. New Zealand Medical Journal, 117(1206). Retrieved from https://researchspace.auckland.ac.nz/2292/4673

# MĀORI

- Accessing Māori expertise:

Engaging with Kaumatua and local iwi must be a priority, with guidance in this process sought from local kaupapa Māori sexual violence support services. Developing a Tiriti partnership could facilitate the development of a 'Contact List' which would provide information about who could be accessed by Tauiwi services to support the process of ensuring suitable tautoko (support) for, and treatment of, Māori seeking support:

- The list would be developed in partnership with local Kaupapa Māori sexual violence support services or other Māori/iwi services where Kaupapa Māori sexual violence services do not currently exist.
- Kaumātua should not be consulted in isolation but should have the support of the expertise of Kaupapa Māori sexual violence service practitioners to support them in their roles; advice from these kaumātua should be respected.
- Kaumatua should be recompensed, such as through payment or koha that is commensurate with the highly specialised knowledge and experience they bring to their roles.

### Workforce development

- The overall priority for workforce development should be to support Kaupapa Māori Service development. The workforce development priority within mainstream services should be on continual development of cultural competence.
- Upskilling Māori practitioners to increase capacity and capability to work with Māori by:
- Increasing proficiency in te reo Māori me ona tikanga
- Accessing and developing proficiency/training in culturally specific resources, such as those developed by 'Te Whānau o Te Kakano' and other kaupapa Māori services
- Where mainstream intervention models are used, actively seek cultural supervision to increase proficiency in blending these with Māori approaches and delivering them within a framework based on tikanga and values that fit with Te Ao Māori.
- Accessing supervision with other Māori in the field (including kaumātua) who can support continuing development.
- Promoting the involvement of tāne in service delivery by inviting and encouraging Māori men to train to work in this area (having a workforce development plan for tāne specifically).
- Funding for mobile services to assist with service delivery as well as to provide training/workforce development.

### Sector Development

The Report of the Taskforce for Action on Sexual Violence (2009) recommendation 11c (p.4), supported by TOAH-NNEST, supports the investment in Māori/whānau-led solutions informed by Te Ohaakii a Hine as a prevention model for tangata whenua.

This includes actively advocating for:

- Better resourcing for Kaupapa Māori Services. There is currently a dearth of Kaupapa Māori sexual violence services throughout Aotearoa NZ. This is largely due to funding constraints across the whole of the sexual violence sector and also supported by Government policy to rationalise funding streams.
- Promoting support for Māori by Māori who are cognisant with Māori tikanga and values to assist them to navigate a pathway forward with Police, the Courts, statutory and medical organisations, and any other support services.
- Ensuring Kaupapa Māori processes such as hohourongo (Māori conflict resolution process) can be accessed and recognised, as opposed to only Tauiwi restorative justice processes.
- Relationship building with Māori services and the

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Jansen, P., Bacal, K. and Crengle, S. (2009). He Ritenga Whakaaro: Maori experiences of health services. Auckland: Mauri Ora Associates.
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Māori community that is genuine and meaningful to both parties. Relationship building must not be dependent on current service delivery to Māori clients. Confining pro-active relationship building with the Māori community to times of crisis would be akin to tokenism.

- Supporting the development of a separate set of Good Practice Guidelines for Kaupapa Māori Sexual Violence services providing crisis support.
- Ensuring that Good Practice Guidelines for mainstream services working with Māori are consistent with these Good Practice Guidelines for Kaupapa Māori Sexual Violence services providing crisis support.

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# SUPPORTING SURVIVORS IN PACIFIC COMMUNITES

- **Good Practice Guidelines for 'Mainstream' Sexual Violence Crisis Services - Working with Pacific (Va'afusuaga McRobie, 2016).**
  (The examples drawn from this report that follow, are primarily in relation to the Samoan community. In this instance, while the examples are Samoan, many are transferable and relate to other Pacific cultures. The examples used are supported by the group of participants made up of multiple Pacific identities).
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# ESSENTIAL LEARNING - WHAT WE NEED TO KNOW

- The diversity and multicultural vibrance of Pacific ethnic groups enriches New Zealand's population. The 2013 census revealed that 7.4% of New Zealand's population is Pacific people. People identified themselves with one or more Pacific ethnic groups: Tongan, Samoan, Cook Islands Maori, Niuean, Tokelauan and Fijian. Pacific people are not evenly spread across the country, with most living in the north. At the time of the census, around 200,000 Pacific people were living in the Auckland region (66%), around 36,000 in the Wellington region (12%), and around 12,700 in Canterbury (7%).
- Pacific women and children living in New Zealand are at risk of sexual violence.
- A NZ study found that Pacific women had the second highest rates of child sexual abuse and intimate partner violence.
- A survey of young people found that almost 3 out of 10 Pasifika females reported having experi-

RESOURCES FOR DEVELOPING CULTURAL COMPETENCE:
http://www.tepou.co.nz/resources/talking-therapies-for-pasifika-peoples/152
This page contains a pdf file of the booklet "Talking Therapies for Pasifika Peoples". It is intended for those working in the fields of mental health and addiction, but also contains much general information.
http://www.leva.co.nz/training-careers/engaging-pasifika
Nga vaka o kaigatapu - A Pacific Conceptual Framework to address family violence in New Zealand.
https://www.familyservices.govt.nz/documents/about-programmes/pacific-framework-fa2.pdf
OTHER RELATED RESEARCH:

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enced unwanted sexual contact, as did 1 in 6 Pasifika males. 76% of the females described the experience as "terrible" or "very bad". 43% of females and 37% of males had told someone. They were most likely to have told friends, followed by other family members, parents, teachers and school counsellors.

- In the same survey, it was found that the Pasifika young people (55%) were more likely than NZ Europeans (46%), to identify barriers to accessing healthcare services.
- A study of Pasifika victims of crime, including sexual crimes, found that most preferred to access informal support systems such as family, friends and church ministers and friends, but that they also wanted more information on formal support services, access to formal Pasifika services, and people in services who could speak their language.

- Pacific cultures value a "collectivist philosophy of life that emphasises cooperation and closeness between people and groups". Fonofale(Pulotu-Endemann, 2001)uses the metaphor of a Samoan fale(house) to capture a Pacific model of what is important:
- **The Foundation** - represents family, whether it be nuclear, extended, kinship ties through marriage or titles that forms the central basis of social organisation for Pasifika. The gafa (genealogy) is foundational in a family which connects them to their titles, lands, island, sea, spirituality and other cultures.
- **The Posts:**
- **Spiritual:** Relates to the sense of wellbeing, whether it be Christianity or traditional spirituality relating to nature, spirits, language, beliefs, ancestors and history, or a combination of both.
- **Physical:** Relates to biological or physical wellbeing. It is the relationship of the body which comprises anatomy and physiology as well as physical or organic and inorganic substances such as food, water, air and medications that can have either positive or negative impacts on the physical wellbeing.
- ***Mental:*** Relates to the wellbeing or the health of the mind which involves thinking and emotions, as well as behaviour.
- **Other:** Relates to sexuality, gender, age, and socio-economic status.
- **The Roof:** Cultural values and beliefs provide a roof covering that gives shelter from the elements of life. Culture is evolving and there are differences between New Zealand-born and Pacific-born families, in that traditional Pasifika cultural values and beliefs maybe influenced by Pālagi (European) worldviews.
- The circular movements in the Samoan house metaphor capture the way in which the foundations, floor, posts and roof interact with each other and endorse holistic approaches and ongoing continuity (Pulotu-Endemann, 2001).
- All of the above characteristics of health occur within the environment, context and time period pertinent to that individual.
- The collectivist nature of the culture means that relationship is of primary importance. The Samoan worldview and the Samoan relational self cannot be separated from the va or relational collective space between individual and parents, siblings, grandparents and community members.
  - Vafealoaloa'I recognises that people are sacred beings and that "there are obligations and duties to ensure that the primacy of the other is meaningfully valued" (p.106). Teu le va is the obligation to maintain this as sacred space, to tend and care for it and keep it clear so that real meeting, connection and healing can take place. Sexual violence fundamentally breaches this obligation.
  - Also important is Feagaiga, a binding and sacred covenant (Tuimaleali'ifano, as cited in Huffer&-So'o, 2000, p. 172) which refers to the status of

ACC's Sexual Abuse and Mental Injury: Practice Guidelines for Aotearoa New Zealand (2008). ACC Wellington, New Zealand.
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Agee, M. N., McIntosh, T., Culbertson, P., & 'OfaMakasiale, C. (Eds.). (2013). Pacific identities and well-being. cross-cultural perspectives. New York, NY: Routledge.
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the sister and to the covenant between sister and brother. This relationship has as its focus the treasured and protected status of sisters, and by extension, of women generally (AumuaMata'itusiSimanu, 2002; Huntsman & Hooper, 1996). The respect inherent in the relationship includes a prohibition on sexual talk, jokes or sexual content in media such as films where brothers and sisters are present (AumuaMata'itusiSimanu, 2002). In Samoa this forms the basis of gender relationships.

  - Working with a Pacific survivor/family/community means honouring the va, the sacred space between you. It draws on talanoa (talking story). This involves being respectful of the va and vafeloloa'i (relational sacred space) providing a platform of reverence ensuring a survivor's experiences can be told with dignity, pride and strength. Talanoa will begin with the survivor, but move to include others from his or world when the survivor is ready.

- Forgiveness is important to many Pacific people. One principle is that of Ifoga, a Samoan principle of forgiveness in which an offender and survivor's family and/or church are involved in a restorative justice process. The challenge for many non-Pacific people is to be aware of bringing to the work a cultural ideology of working with the individual which is different to working collectively or systemically with Pacific families, people and groups. Part of the indigenous healing process is the possibility of exploring restorative justice from a Pacific perspective. This Ifoga process may not be used right from the start particularly where there is acute trauma involved and facing the offender would be too traumatic. For some Pacific survivors it can be a timing issue, waiting for the right time in which they would be strong enough (with their appropriate support people) to confront the offender.
- Sexual abuse is a complex health issue that traumatically impacts the foundational fabrics of family and spiritual values for Pacific people. It can be shrouded in secrecy, shame and silence in order to maintain traditional values of peace, respect, solidarity and resilience within families and the wider community. This means that it is often not reported, and services are not accessed.
- Multi-systemic approaches areneeded to understand the wider traumatic impact sexual violence has not only on the survivor's traditional indigenous values such as spiritual, respect, and solidarity but also on their families, Church and community of support people.
- The profile of Pacific identity is complex and research has highlighted issues of cultural conflicts and considerable difference between the needs of younger Pacific people in comparison to their elders.
  - One cultural conflict is that between New Zealand-born and Island-born Pasifika people. In addition, there is a growing population of multi-ethnic young people. Pacific values and principles may not consistently apply, as cultural, social, and environmental factors may vary for each family. Therefore, a Pacific survivor may range on a spectrum from being culturally well connected to family and church to not being connected at all.
  - There can be considerable difference between the beliefs and needs of older people and those of younger people. An aspect of this which has been identified by young people is that they prefer to seek support from a sister, close cousin or friend as they don't expect their parents to understand their experiences of sexual violence - that they will not exactly blame them, but will associate the sexual violence with a failure to have followed traditional ways. This also led them to want formal support from other young people, such as a peer mentor, someone who had been through it and understood. If they were to access a formal support service, they wanted to be able

ies, University of Auckland Pacific Scholars Postgraduate Seminar Series.
Anae, M., Fuamatu, N., Lima, I., Mariner, K., Park, J., &Suaalii-Sauni, T. (2000). The Roles and Responsibilities of Some Samoan Men in Reproduction. Auckland:Pacific Health Research Centre; The University of Auckland.
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to take a friend with them.

- A key concern was that agencies would not understand the impact on their family, and the young person would be left alone to deal with the family's response. To not make matters worse, a counsellor would need to understand that while family, church and community are great supports for young people, it is not easy to raise or deal with sexual abuse in any of those settings. They would also need to understand the "intergenerational cultural sensitivities and the difference between 'the old and new worlds' that the young people are moving in." (p 35).
- Young people are also very concerned about confidentiality – they are concerned about the stigma for themselves of others knowing, the stigma for their mothers that they had not kept them safe, and the potential for male family members to punish the offender. While they wanted a Pacific counsellor, they wanted the person to be of a different ethnicity to preserve confidentiality. They also wanted the right to determine whether or not the matter would be reported to an authority.
    - Young Pacific people wanted support services to be available to them in schools, universities or youth centre's, that is, places they are allowed to be. They were also interested in on-line support services, though internet use was monitored by family for some.
- Responses to sexual abuse need to be understood in the context for Pacific people in New Zealand. Pacific people's health issues include socio-economic and cultural factors such as income, poverty, employment, occupation, education, housing, and ethnicity (Ministry of Health, 2014).
    - On average there are relatively more Pacific people experiencing hardship than other groups, and living in overcrowded homes, as they are less likely to own their homes. In addition, the unemployment rate for Pacific people is nearly twice the national unemployment rate (Ministry of Health 2014).

**On the frontline**

## ESSENTIAL PRACTICE - WHAT WE NEED TO DO

- Assess not assume as each case is different. Conduct a cultural assessment right from the start. Ask your Pacific survivor about the correct pronunciation of their name (if you are unsure) and their Pacific ethnic identity.
    - Practitioners should gain an awareness of any stereotypes they might hold about the Pacific community and their identity.
    - It is important to understand that, when dealing with Pacific communities, there is diversity of Pacific ethnic identities which can highlight issues of cultural conflicts, particularly if they are New Zealand or Island born.
- A Pacific survivor led process is essential. This includes informing a Pacific survivor of their medical and legal rights and obligations. It is crucial that they are informed of their choices right from the start, that they understand the information given before

Bowden, R. (2013). Cultural counseling: Beyond method and modality. In M. N. Agee, T. McIntosh, P. Culbertson, & C. 'OfaMakasiale (Eds.) Pacific identities and well-being (pp. 142–52). New York, NY: Routledge
Culbertson, P., Agee, M. N., & 'OfaMakasiale, C. (Eds.) (2007). Peninauliuli: Contemporary challenges in mental health for Pacific peoples. Honolulu: University of Hawai`i Press.
Efi, T. (2009). O le e lava I tiga, ole ivi, le toto, ma le aano/He who rallies in my hour of need is my kin. Paper presented to New Zealand Families Commission at the Pasifika Families Fono, Manukau, NZ.
Fanslow, J., and Robinson, E. (2004) 'Violence against women in New Zealand: prevalence and health consequences.' The New Zealand Medical

# PACIFIC

consent is sought. This is important as the survivor decides who is 'part of their process' as there can be safety issues involved and there are always ongoing consequences of these decisions.

  - The survivor will identify their community of care/ key support people (particularly when there is a young person involved). In this process it is important to support the survivor (and family) in understanding their choice of whether to report the sexual violence to the Police or not.
  - If a medical examination is required, it is important that the survivor has a support person who is there to take care of them after the procedure.

- Language barriers: Pacific families who have migrated may not have strong English language skills and struggle to understand, therefore cultural interpreters and/or cultural advisors can be needed.
- Gendered approaches: As the work inherently involves sexual matters, gender matching is important - males work with males and females with females. Seek guidance from the client if gender is unclear or the client identifies as other.
- Pacific survivors may be guarded, protective and fearful when accessing mainstream services due to negative experiences associated with stereotyping and a lack of cultural understanding and competency. Acknowledge experiences of discrimination and stigma and check in with the survivor about what this means for them and offer care and support.
- Key Samoan values have been identified as fa'amafafa'ina (empathy), pa utonu (compassion) and faipe e fa'aliafa'atasi ma le malosi (respect) (Ma'ia'I 2010, p. 639). These align well with the value base of most counselling and support work with survivors of sexual violence.
- Honour the sacred space of the relationship between you – va. This is essential to allow real meeting, connection and healing to take place in the wake of the trampling of the relational boundary which has taken place in sexual abuse. Provide a platform of reverence to ensure that the survivor can tell of their experiences with dignity, pride and strength. It is also important to allow time for the survivor to talk about their connections, their support people and community of care (church or other) around them.
- Talanoa is key in firstly acknowledging the survivor has had the courage to tell and to break her/his silence. Counselling with the survivor takes time as counselling needs to be at their pace. When relational connections have been formed and the Pacific survivor is willing to step into the va'a/vaka/paopao (meaning indigenous outrigger), the journey begins. The therapist role has been described as one of navigation, requiring confidence and skills to "fish for what is important in a round-about or indirect way" p. 24, TePou o TeWhakaaro Nui, 2010). This process involves seeking information and allowing the Pacific survivor to tell their story which may take time. Direct questioning related to self-exposure or self-assertion can be perceived as rude and intrusive by Pacificpeople (Waldegrave, 1990).
- It is when the survivor is ready with their appropriate support person/s that talanoa begins with their family members. Talanoa enables the family to talk and make a safety plan together to deal with the issue, and with the shame and disgrace of what has happened, to develop a way forward together.
  - Those involved in the talanoa process could be representatives from families, church or community members.
  - Be aware that many young Pacific people will not want their parents to know what has happened, instead seeking support from family members nearer their own age.

### Guidelines for Crisis Service delivery:

- Cultural awareness: Appropriate cultural workshops must be provided by Pacific people who have the

Journal, 117(1206), 1173-1184. Retrieved from http://women.govt.nz/our-work/increased-safety-violence/what-violence-against-women#sthash.lBeBz66Y.dpuf
Farrelly, T., &Nabobo-Baba, U. (2012, December 3–5). Talanoa as empathetic research. Paper presented at the International Development Conference, Auckland, NZ.
Foliaki, S. A., Kokaua, J., Schaaf, D., &Tukuitonga, C. (2006). Pacific people. In M. A. Oakley-Browne, J. E. Wells, & K. M. Scott (Eds.), Terauhingengaro: The New Zealand Mental Health Survey (pp. 178–208). Wellington, NZ: Ministry of Health.
Garcia-Moreno C, HeiseL, Jansen HAFM, Ellsberg M, Watts C. (2005). WHO multi-country study on women's health and domestic violence against

# PACIFIC

required competency and skills. These may be community and church leaders aware of the impact of sexual violence, professional Pacific counsellors, psychotherapists and psychologists, or those experienced in working with Pacific people.

- Content needs to include cultural sensitivity to Pacific values relating to the significance of including family early in the process, spirituality, the role of Church, and Christian values about forgiveness and gender.
- There needs to be improved access to appropriate support people and services with both cultural and sexual violence professionals.
    - Employ young Pacific counsellors or support workers to work with young survivors, and more mature Pacific staff who can work with families.
    - Some experienced Pacific practitioners have chosen not to apply for ACC registration due to language based requirements for the application and reports – so there may be experienced people in your area that you need to find other routes to.
- Engaging a Pacific supervisor who is bilingual helps to provide an environment for clinical discussion, analysis, and theological dialogue. Taking case studies of work with Pacific survivors to cross-cultural study group settings enables knowledge of other cultural therapeutic tools to further sculpt one's own learnings and discoveries.

### Guidelines for Sector and community development:

- Education for Pacific families is crucial. Family can blame, dismiss a survivor or hide sexual violence from the church. Therefore, parents need to know how to emotionally support their child/adolescent, to believe them, to check in on their safety, and any suicidal ideation or behaviour.
    - Pacific families also need to know about. Child Youth and Family services for children/adolescents, High School policies on sexual abuse disclosures at the health centre/counselling room, Police, Medical forensics, Evidential video units, ACC Counsellors and specialist cultural Pacific advisors.
- Shame could be lifted and access improved through the development and advertising of an online directory of crisis support services for Pacific people.
    - Digital links and click for online access is needed for Pacific survivors and families to access relevant Pacific support services and non-Pacific mainstream services who work with sexual violence. Social media, radio, television, networking and development of pamphlets could assist with increasing access to crisis support services.
- Support for the ongoing development of the 'Pasifika Counsellors, Psychotherapists, and Family Therapist network' which was initiated as a result of the Good Practice Guidelines research project. This informal group consists of Pacific professionals who could be called in on sexual violence cases and provide clinical/supervision/consultation.
- Nurture the Pacific workforce: Encourage Pacific practitioners to write about their sexual violence practice, engage in research that demonstrates the cultural, spiritual creativity and effectiveness of their approaches, and disseminate information about their work. This would enrich the work of others and benefit the Pacific community.
- Engage Pacific Church communities - Churches can provide a vehicle for sexual violence community education, psycho-education on how to deal with disclosures and abuse and also the possibility of incorporating sexual violence prevention in their theological curriculums. This idea is not supported by all as some perceive the church as a potential barrier to prevention of sexual violence due to the way that some leaders in positions of power have sexually abused. However, others see the opportu-

women: initial results on prevalence, health outcomes and women's responses. Geneva: World Health Organization.
Helu-Thaman, K. H. (1997). Kakala: A Pacific concept of teaching and learning. Keynote address, Australian College of Education National Conference, Cairns, Australia.
Ma'ia'i, S. (2010). Tusiupu Samoa. The Samoan dictionary of PapaaliʻiDrSemisiMa'ia'i. Auckland, NZ: Island Press.
'OfaMakasiale, C. (2007). The use of symbol and metaphor in Pacific counselling. In P. Culbertson, M. N. Agee, & C. 'OfaMakasiale (Eds.). Peninauliuli: Contemporary challenges in mental health for Pacific peoples (pp. 109–121). Honolulu: University of Hawai`i Press.
Makasiale, C., Silipa, N., &Va'afusuaga McRobie, S. (2011). Stress through Pasifika eyes. New Zealand Tertiary Counsellors Hui, Auckland: University of

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nities of a contextualised Christian theology to help address attitudes and silence from the church on issues relating to sexual violence (Ministry of Pacific Island Affairs, 2010). Ways the Church could assist include:

- Encouraging Church Reverends, Pastors, Priests, and youth leaders into training/formal training to learn about responding well to initial disclosures of sexual violence and developing a community of care/support plan for the survivor.
- Provision of workshops for parents to help them understand sexual violence. Practitioners could be invited to sit on panels to present information about: legal and medical processes, Child Youth and Family services for children/adolescents, high school policies on sexual abuse disclosures at the health centre/counselling room, the role of Police, the criminal justice system and restorative justice, ACC funded counselling for survivors, treatment for those who cause harm, and specialist Pacific cultural advisors.
- The centrality of the church in pacific communities means that it could be helpful for survivor agencies to be visible within religious organisations. However, there is also an issue of privacy/confidentiality, in that a survivor may not want to be seen to be associated with such an agency within their church until the church lifts shame from survivors.

- More opportunities for talanoa and dialogue across perceived cultural differences would be valuable for all—Pacific, Maori, palagi and others including those who themselves are multi-ethnic This could assist in reducing the misunderstandings and limited knowledge among practitioners across different ethnicities and cultures about the diversity of modalities and approaches being used in mainstream crisis support services, and about others' world views.

Auckland.
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# SUPPORTING SURVIVORS IN THE LBGTI+ COMMUNITY

**Good Practice Guidelines for 'Mainstream' Sexual Violence Crisis Services - Doing our best for LGBTIQ Survivors (Dickson, 2016)**

- Te Hohou Te Rongo Kahukura – Outing Violence report (Dickson, 2016) http://www.kahukura.co.nz/
- Building Rainbow Communities Free of Partner and Sexual Violence (Dickson, 2016)
- Queering Sexual Violence: Radical Voices from Within the Anti-Violence Movement (Patterson, 2016)

## ESSENTIAL LEARNING - WHAT WE NEED TO KNOW

Assess your agency's capacity to respond healthily to LGBTI+ survivors prior to reaching out to LGBTI+ communities. Remember that the first response a LGBTI+ survivor receives will have a significant impact on whether they will continue to engage, and on how that survivor recovers over time. Be aware that many LGBTI+ people will have little trust of the Police or healthcare agencies, and this may impact on their willingness to engage. Be aware that people's ethnicity and cultural identity will be critical to their understanding and lived experience of being part of the LGBTI+ community.

LGBTI+ cultural competence is:

- An ongoing commitment to understanding and relationship with LGBTI+ communities and individuals, including those from Māori, Pacifica and Asian communities.
- Not a checklist but a process, that will change over time as LGBTI+ culture changes. It's important not to over-promise.
- Be clear and honest about who can access your service. If you only serve lesbians and bisexual women but not trans women, gender non-conforming people or male survivors of any kind, say that, rather than describing yourself as LGBTI+ friendly.
- All staff understanding their assumptions about LGBTI+ people, and engaging in ongoing reflection about homophobia, biphobia and transphobia.
- Assessment not assumption, an understanding that everyone who comes to your service has the right to self-define their own gender identity and sexuality.
- Staff training in using language which does not assume gender, gender roles, sexual preferences or that there is anything called 'normal'.

ENHANCING CULTURAL COMPETENCE
Assessment: How Inclusive is your agency to LGBTQ survivors?, The Network/La Red, www.tnlr.org
Creating a Trans-Welcoming Environment: Tips Sheet for Sexual Assault Service Providers, FORGE, USA.
Creating Inclusive Agencies: Sexual Violence and Individuals who Identify as LGBTQ, (2012), National Sexual Violence Resource Center and Pennsylvania Coalition Against Rape, USA.
Culturally Competent Service Provision to Lesbian, Gay, Bisexual and Transgender Survivors of Sexual Violence, (2009), National Online Resource Center on Violence Against Women, USA.
'I am local' (Rainbow Youth) http://www.imlocal.co.nz/
Queer and Trans 101 (Rainbow Youth) http://www.ry.org.nz/wp-content/uploads/2011/09/RY-Queer101-long-8pages.pdf
Takatāpui: Part of the Whānau https://www.mentalhealth.org.nz/assets/ResourceFinder/takatapui.pdf
Strengthening Solutions for Pasefika Rainbow http://www.leva.co.nz/library/leva/strengthening-solutions-for-pasefika-rainbow
Patterson, J (ed) (2016). Queering Sexual Violence: Radical voices from within the anti-violence movement. NY: Riverdale Ave Books.


# ESSENTIAL PRACTICE - WHAT WE NEED TO DO

### On the frontline

Confidentiality and language – Survivors are the experts of their own experience.

- Ask and mirror the language LGBTI+ survivors use for their bodies and body parts - trans people will often use non-traditional language for their genitals and other sex-linked body parts. Mirroring this language is particularly important to respect gender identities which may have been undermined by sexual violence.
- Ask and mirror the following:
  - The language LGBTI+ survivors use for their bodies
  - The language LGBTI+ survivors use for their partners and relationships
  - The names, pronouns and identities. Do not assume partner's gender and avoid heteronormative language or pronouns. Do not assume someone with a same sex partner is lesbian or gay, ask them how they identify to avoid biphobia. In reference to relationships, do not assume that the survivor operates within a monogamous framework as they may have multiple partners/ relationships. Judgements around polyamory will not be useful to the survivor.
- Ask and mirror the names and pronouns LGBTI+ survivors wish to use, whether they are present or not.
- Do not make assumptions about the gender of the perpetrator – ask open questions if the information is needed.
- Explain confidentiality policies and respect LGBTI+ survivor's rights to direct who knows about their sexuality and gender identity – inside and outside your service. Disclosing someone's sexuality or gender without their consent mirrors patterns of power which may have been part of sexual abuse.

### Respect

- Use the resources listed here, and:
  - Talk to people you work with about their knowledge
  - Avoid asking a lot of questions. While the survivor may seem ok, they may not be and as you're in a position of power, they may not feel comfortable to say so.
- Do not make assumptions about, or pathologise LGBTI+ identities. Do not assume sexual violence caused someone's sexuality or gender identity.
- Do not make assumptions about homophobia, biphobia or transphobia being more common in some cultures – listen to survivors' experience of their families and communities.
- Recognise that trans people have unique relationships with mental health services as they have to navigate these in order to access transition related healthcare, which may create lack of trust. Recognise fears around disclosing sexual violence and the impact this may have on accessing transition related healthcare.
- Acknowledge experiences of discrimination and stigma, and check in about what this means for resilience. Be aware that if someone discloses their sexuality or gender identity to you, it is a sign of trust.
- If you get someone's pronoun or sexuality wrong, apologise and move on. Don't make it a big deal, just try and get it right next time.
- Explain why you are asking questions about bodies

OTHER RESEARCH:
Clark, T. C., Lucassen, M. F.G., Bullen, P., Denny, S. J., Fleming, T. M., Robinson, E. M., & Rossen, F. V. (2014). The health and well-being of transgender high school students: results from the New Zealand Adolescent Health Survey (Youth'12). Journal of Adolescent Health, 55(1), 93-99.
Fenaughty, J., Braun, V., Gavey, N., Aspin, C., Reynolds, P. & Schmidt, J. (2006). Sexual coercion among gay men, bisexual men and takatāpui tāne in Aotearoa/New Zealand, Department of Psychology, The University of Auckland.
Fileborn, B., (2012), Sexual violence and gay, lesbian, bisexual, trans, intersex and queer communities, Australian Center for the Study of Sexual Assault.

# LGBTI+

or sexual contact as LGBTI+ people, especially trans people, may have experienced being asked invasive questions to satisfy curiosity.

- Take care and time when supporting LGBTI+ people with forensic examinations after sexual violence, as sexual violence may have involved parts of their bodies people would rather not think about which may create additional trauma. It may also "out" people as trans, so survivors will need you to demonstrate respect for their preferred gender identity. Explain what is going to happen and why, and ask for permission at every stage. Use the words the trans person uses for their bodies.

Using the language LGBTI+ survivors use for themselves, their bodies, partners, names and pronouns is validating and will help LGBTI+ survivors feel safe in your service. This is important after the trauma of sexual violence.

Offer a range of more and less gendered clothing and underwear, allowing people to select for themselves.

### Crisis support services

- Relationships with LGBTI+ Community
- Develop relationships with local LGBTI+ services to increase cultural competency and find out how your service is perceived in your community – do LGBTI+ survivors know what you do?
- Collaborate on creating resources for your websites, posters and pamphlets which are LGBTI+ appropriate and name specific ways sexual violence happens for LGBTI+ people.
- Create websites, posters and promotional material which feature diverse images of LGBTI+ people, including similar gender couples.
- Attend LGBTI+ events, advertise in LGBTI+ media and ensure outreach reaches LGBTI+ individuals.
- Consider partnerships or supervision with gender diversity experts to inform relationships with and services for the transgender community.
- Name not just homophobia but transphobia and biphobia too in your websites, posters and promotional material to send a message that your service is open to LGBTI+ survivors, not just gay and lesbian survivors.
- Use Māori identity terms like takatāpui and Pacifica identity terms like Fa'afafine (Samoa, America Samoa and Tokelau), Fakaleiti or Leiti (Tonga), Fakafifine (Niue), Aka'vaine (Cook Islands), Mahu (Tahiti and Hawaii), Vakasalewalewa (Fiji)

### Staff and Volunteers

- Advertise paid and voluntary roles in LGBTI+ media.
- Include sexuality and gender identity in discrimination policies which protect staff and survivors.
- Train all staff and volunteers in sexuality and gender diversity and update regularly, as the language is fluid and evolving, and ensure this training includes non-Pākehā identities.
- Include LGBTI+ issues as a regular item on staff meeting agendas and peer supervision sessions.
- Ensure all staff follow discrimination policies which interrupt and address LGBTI+ phobias with other agencies, staff members or survivors.

### Physical Environment

- Because help-seeking for LGBTI+ survivors may be more difficult, make sure they feel welcome in your agency. First impressions count.
- Communicate that your service celebrates, not just tolerates, LGBTI+ individuals and communities from all cultural backgrounds through positive images, posters and signs in your public spaces.
- Create an environment which celebrates gender and sexuality diversity and also understand that this may still not feel safe enough for some survivors to disclose in.

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, The University of Auckland.
Hohou Te Rongo Kahukura – Outing Violence (2015), Statistics: Partner and Sexual Violence is a Rainbow Problem, Aotearoa New Zealand.
Hohou Te Rongo Kahukura – Outing Violence (2015), Hooking up, having fun, asking for and giving consent, Aotearoa New Zealand.
Hohou Te Rongo Kahukura – Outing Violence (2015), Bisexual Survivors, Aotearoa New Zealand.
Hohou Te Rongo Kahukura – Outing Violence (2015), Gay Survivors, Aotearoa New Zealand.
Hohou Te Rongo Kahukura – Outing Violence (2015), Lesbian Survivors, Aotearoa New Zealand.

# LGBTI+

- Ensure at least one bathroom is private and gender neutral, to allow all survivors somewhere safe to change and go to the toilet.

### Intake Forms and Processes

- If your service is sex-segregated, stated identity should be enough to access – if someone identifies as a woman, they should be able to access your service. If this is not the case, make it explicit in your outreach materials, so trans women (or trans men) survivors do not face the humiliation of not having their gender identity respected when they try to get help after sexual violence.
- Do not ask gate-keeping questions about people's body, genitals, hormones or surgery or require extra "proof" for trans people as this is discrimination.
- Create inclusive intake forms, client history forms and body maps which allow people to self-identify their sexuality and gender and are appropriate for LGBTI+ people.
- Be aware that coming out for LGBTI+ people may take time, as survivors test whether this is a safe space in which to talk about themselves. This is not a sign of dishonesty.

Hohou Te Rongo Kahukura – Outing Violence (2015), Trans and Intersex Survivors, Aotearoa New Zealand.
Intersex Fact Sheet, Free and Equal United Nations for LGBT Equality.
Is your "T" Written in Disappearing Ink? A Checklist for Transgender Inclusion, FORGE, USA.
Lavender Islands: The New Zealand Study, (2007), Journal of Homosexuality.
Le Brun, C., Robinson, E., Warren, H. and Watson, P., (2005), Non-heterosexual Youth: A Profile of Their Health and Wellbeing; Data from Youth2000, The University of Auckland.
Lesbian, Gay, Bisexual, Transgender, Queer and HIV Affected Hate Violence in 2014, (2015), National Coalition of Anti-Violence Programs, USA.
Let's Talk About It! A transgender survivor's guide to accessing therapy, (2015), FORGE, USA.
Lucassen, M. F. G., Clark, T. C., Moselen, E., Robinson, E. M., & Adolescent Health Research Group. (2014). Youth'12 the health and wellbeing of secondary school students in New Zealand: Results for young people attracted to the same sex or both sexes. Auckland: The University of Auckland.
National Intimate Partner and Sexual Violence Survey: 2010 Findings on Victimisation by Sexual Orientation, (2010), Center for Disease Control, USA.
Practical Tips for Working with Transgender Survivors of Sexual Violence, (2008), FORGE, USA.
Private Lives 2: The second national survey of the health and wellbeing of GLBT Australians, (2012), La Trobe University, Australia.
Pronouns and Trans People: Victim Service Providers Fact Sheet #1, (2012), FORGE, USA.
Quick Organizational Audit: LGBT Visibility and Inclusion, (2001), The Northwest Network of Bisexual, Trans, Lesbian and Gay Survivors of Abuse.
Quick Tips: Trans Inclusion – A guide for LGB(T) organizations and businesses, FORGE, USA.
Quick Tips: Trans Inclusion – A guide for service providers, FORGE, USA.
Responding to Transgender Victims of Sexual Assault, (2014), Office for Victims of Crime, USA.
Roberts, A., Rosario, M., Corliss, H., Koenen, K., and Bryn Austin, S., (2012), Childhood Gender Nonconformity: A Risk Indicator for Childhood Abuse and Posttraumatic Stress in Youth, Pediatrics, USA.
Setting the Stage: Strategies for Supporting LGBTIQ Survivors, (2010), Connections Volume XIII, Washington Coalition of Sexual Assault Programs, USA.
Sheltering Transgender Women: Providing Welcoming Services, (2014), National Resource Center on Domestic Violence and FORGE, USA.
Some Do's and Don'ts for working with GLBT Folks, The Network/La Red www.tnlr.org
Takatāpui: Part of the Whanau, (2015), Tiwhanawhana Trust and Mental Health Foundation.
Terms Paradox: Victim Service Providers Fact Sheet #2, (2012), FORGE, USA.
The Impact on Individuals and Communities: Sexual Violence and Individuals who Identify as LGBTQ, (2012), National Sexual Violence Resource Center and Pennsylvania Coalition Against Rape, USA.
Thinking About the Unthinkable: Transgender in an Immutable Binary World, (2010), FORGE, USA.
To Be Who I Am: Report of the Inquiry into Discrimination Experienced by Transgender People, (2008), Human Rights Commission, New Zealand.
Tranzform: What we wish our GPs, Nurses and Specialists knew, (2015), www.tranzform.org.nz
Transgender Rates of Violence: Victim Service Providers Fact Sheet #8, (2012), FORGE, USA.
Why It Matters: Rethinking Victim Assistance for Lesbian, Gay, Bisexual, Transgender, and Queer Victims of Hate Violence and Intimate Partner Violence, (2010), National Center of Victims of Crime and the National Coalition of Anti-Violence Programs, USA.
Working therapeutically with LGBTI clients: a practice wisdom resource (2014), National LGBTI Health Alliance, Australia.


# SUPPORTING MALE SURVIVORS

**Good Practice Guidelines for 'Mainstream' Sexual Violence Crisis Services - Doing our best for LGBTIQ Survivors (Dickson, 2016)**

- Good Practice Guidelines for Mainstream Sexual Violence Crisis Services - Working with Men (David Mitchell, 2015)
- Foster, G., Boyd, C., & O'Leary, P. (2012). Improving policy and practice responses for men sexually abused in childhood. ACSSA Wrap, 12. 1-20
- Sullivan, M (2010 - 2011). An Exploration of Service Delivery to Male Survivors of Sexual Abuse. Mankind, UK http://www.wcmt.org.uk/sites/default/filesmigrated-reports/840_1.pdf

## ESSENTIAL LEARNING - WHAT WE NEED TO KNOW

Specialist workforce development should start with debunking the myths and stereotypes surrounding male victims/survivors.

*"Unless this area is addressed by professionals in their professional development their ability to both engage with and otherwise support male victims of CSA will be severely compromised."*

### Myths and stereotypes

- Societal beliefs about males being self-reliant and dominant, relatively immune to expressions of vulnerability or helplessness are commonly understood and believed. For many survivors seeking help is almost unimaginable, almost a worse outcome than non-disclosure (Barnett et al, 2011; Romano & De Luca, 2001). Situations where the abuser is female can considerably worsen the contradiction between societal expectations, self-image and the experience of abuse (Davies, 2002).
- The belief that survivors move on to perpetrate abuse on others, creating a cycle of abuse. That is, the victim moves on to become a perpetrator. Olgoff et al (2012) report that this assumption is incorrect. They cite research that found 95% of survivors do not move on to become perpetrators (Olgoff et al, 2012). Regardless of the accuracy of this belief, that it actually exists contributes to male survivors not disclosing their experience of CSA (Nicholls, 2014).
- The lack of belief that males are sexually abused and the belief that sexual abuse has little effect on males or at least that abuse is not as severe for males as it is for females.
- One specific gender stereotype is the view commonly held which sees males as seeking and appreciating early sexual experiences regardless of the nature of these experiences (Stemple & Meyer, 2014). The isolation, anxiety, depression and self blame resulting from this myth can lead to a loss of hope and subsequent suicidality.
- Questions or self examination about sexual orientation, particularly for heterosexual males. This is

Davies, M. (2002). Male sexual assault victims: A selective review of the literature and implications for support services. Aggression and violent behavior, 7(3). 203-214.
Fisher, A., Goodwin, R., & Patton, M. (2008). Men and healing: Theory, research and practice in working with male survivors. Toronto, Canada: Cornwall Public Enquiry.
Jacob, C., & Veach, P. (2005). Intrapersonal and familial effects of child sexual abuse on female partners of male survivors. Journal of Counselling Psychology, 52(3), 284- 297. doi:org/10.1037/0022- 0167.52.3.284
Kia-Keating, M., Sorsoli, L., & Grossman, F. (2010). Relational challenges and recovery processes in male survivors of childhood sexual abuse. Journal


especially common if the victim sustained an erection during anal penetration (Stemple & Meyer, 2014). This can also involve doubts about sexual orientation if a heterosexual man was not a willing partner to a woman who wanted sex (Davies, 2002).

- The refusal of society to believe that female offenders exist (Saradjian & Cortoni, 2010), or to believe that female offending is in some way less traumatic than male perpetration.

### Understanding male victims/survivors

- There is a huge need for further research into understanding the impacts on males and what the best approaches are when supporting male victim/survivors (Sullivan 2011).
- What we do know from male victims/survivors is the significance and impact of fear, shame, guilt and humiliation. Often men present with intense anger, and beneath this is deep sadness.

*"The first thing to understand is the anger, even rage that invariably underpins male victim's response to CSA. Victims are acutely aware of this anger as well as the fear it creates in them. Professionals need to be aware that anger is an emotion that is common in male victims of CSA and such negative emotions should be validated and not discounted. Further this anger should be an expected response underpinning engagement with male victims. Professionals need to be comfortable and empathic with the expression of anger and not immediately equate this with a potential for violence. The expression of anger should certainly not be inhibited by professionals. Anger must be seen as part of the process of the victim coming to understand and link the complexity of their lives with the original abuse"*

*-Mitchell, 2015, p. 5*

### Understanding the complex issues associated with sexuality.

- Sexuality is about complete awareness of self acceptance.

  "Heterosexual males questioning their sexual orientation following abuse by a male perpetrator is common and causes considerable ongoing distress in victims. This distress presents in differing ways, for example men moving on to despise male homosexuals. Alternatively if the perpetrator is female this also impacts on the victim's questioning of "normal" relationships and sexual behaviour. Difficulties in future relationships with a female are a common occurrence. If the male victim is homosexual the impact the abuse has on the victim's understanding and experience of future relationships with male partners is similarly affected" (Mitchell, 2016, p. 12)

### Understanding barriers to engaging with support services

A sense of mistrust in relation to professional services and government agencies is often reported by male survivors in relation to accessing support. Many of the men we work with have had negative responses from the Police over the years, especially when first disclosing and it can be more difficult if the offender was a female...many are completely reluctant to put in a complaint (Ken Clearwater, 2016).

*Another difficulty is for the men who have been in care (as children) and have been sexually, physically and emotionally abused by those who were supposed to look after them so their trust of any one to do with the system was the enemy. Remembering in many cases it was the Police and white social workers who took them from their homes -Ken Clearwater, 2016*

of Interpersonal Violence, 25(4). 666-683.
Mitchell, D., & Chapman, P. (2014). Where's Harry? A client centered approach to supporting men who have been sexually abused as children. Nelson, New Zealand: Male Room
Monk-Turner, E., & Light, D. (2010). Male sexual assaults and rape: who seeks counselling? Sexual Abuse: A Journal of research and Treatment, 22(3). 255-265.
Nicholls, N. (2014). Engaging Men, An Exploration of the Help-Seeking Experiences of Male Survivors of Childhood Sexual Abuse. Unpublished Doctoral thesis. London, England. City University London.

# MEN

There is a contrast between the rules of masculinity and what it takes to engage in therapeutic services: Psychotherapy versus Masculinity

**Psychotherapy**

- Disclosing private experience
- Relinquishing control
- Nonsexual intimacy
- Showing weakness
- Experiencing shame
- Acting vulnerable
- Seeking help
- Expressing feelings
- Being introspective
- Addressing relationship conflict
- Confronting pain
- Acknowledging failure
- Admitting ignorance

**Masculinity**

- Hiding private experiences
- Maintaining control
- Sexualisation of intimacy
- Showing strength
- Expressing pride
- Acting invincible
- Being self-reliant
- Being stoic
- Taking action
- Avoiding conflict
- Denying pain
- Endlessly persisting
- Feigning omniscience

## ESSENTIAL PRACTICE - WHAT WE NEED TO DO

**On the frontline**

- Believe: If a male approaches you the most important thing is to believe the disclosure and ensure that they are in a safe place. One of the biggest struggles most have is when people say allegations when in reality the abuse is a fact (Ken Clearwater, 2016).
- The survivor's need for genuine and honest information: Provide comprehensive information. Be honest and transparent about processes. This will not only aid in reducing anxiety and fear associated with the unknown but will also reduce (in part) barriers related to mistrust.

*Let them know how difficult the process is of (going to court). Avoid making any promises...What seemed most important was that the client understood the process and had some degree of control in how it was managed... There is no mistrust with DSAC once men know and understand their role.*
*-Ken Clearwater, 2016*

- Provide a variety of support options with flexibility:
- This may include offering a range of counselling and support face-to-face, telephone, email, live chat and/or group programs
  - Flexible appointment times: Offering evening appointments in particular for full-time working

O'Leary, P. (2009). Men who were sexually abused in childhood: Coping strategies and comparisons in psychological functioning. Child Abuse & Neglect, 33(7). 471-479.
O'Leary, P., & Gould, N. (2009). Exploring coping factors amongst men who were sexually abused in childhood and subsequent suicidal ideation. Community comparison, explanations and practice implications. British Journal of Social Work, 39(5). 950-968.
Ouellette, M. (2009). Some things are better left unsaid: Discourses of the sexual abuse of boys. Jeunesse: Young people. Texts. Cultures.1(1). 67-93.
Romano, E., & De Luca, R. (2001). Male sexual abuse: A review of the effects, abuse characteristics, and links to later psychological functioning. Aggression and Violent Behavior, 6(1). 55-78.


men can enhance access to support services for male survivors
- Offer a choice of service provider, in particular prioritising an option of gender choice for male survivors
- Provide structure during the session, use a professional competent approach balanced with a laid back friendly manner being proactive and sensitive.

### Crisis support services

- Training for all staff into the particular needs of male survivors.
- The physical environment
  - Create a more male friendly entrance and waiting room using posters and relevant information. This does not mean stereotypical car or sports magazines, more a newspaper and inclusive service information for men and families, and avoiding material which portrays men as perpetrators.
- Strengthen interagency processes and communication
  - Develop genuine partnerships with local service providers that support referrals and avoid unnecessary repetition of personal information.

### Sector Development

- A commitment to workforce development and expansion of services to support the unique needs of male survivors (designing, developing and marketing services specifically to men).

Evidence suggests that in order to support healing and recovery it is necessary to create gender appropriate services and interventions that:

- Reach out and engage men. An informative male focused website can be key to acknowledging their experience, emotions, and informing clients of support services available. Likewise online e-counselling, telephone support and helplines are also considered important, especially for those living in remote areas.
- Address barriers to men's help seeking.
- Assist men and their families to build supportive relationships.
- Provide opportunities for group support.
- Develop public discussions that offer hope for an improved future.
- Service developments should consider diversity: acknowledging and adapting services to meet the differences in men's cultural and sexual identities. Male victims/survivors of sexual victimization are a diverse group with diverse needs, especially given that the men who are most likely to have experienced child sexual abuse and to face difficulties in accessing support are men who are socially disadvantaged. That is, indigenous men, men with disability, mental illness, same-sex attracted, from culturally and linguistically diverse communities, men in prison, in military, rural and regional, young, and male sex workers.

Stemple, L; & Meyer, I. (2014). The Sexual Victimization of Men in America: New Data Challenge Old Assumptions. American Journal of Public Health, 104 (6), 19-26.
Yarrow, C. & Churchill, S. (2009). Counsellors and psychologists experience of working with male survivors of sexual trauma: a pilot study. Counselling Psychology Quarterly, 22(2). 267-277. doi: 10.1080/09515070903171926


# SUPPORTING MUSLIM WOMEN

**Good Practice Guidelines for 'Mainstream' Sexual Violence Crisis Services - Doing our best for LGBTIQ Survivors (Dickson, 2016)**

Good Practice Guidelines for 'Mainstream' Sexual Violence Crisis Services - Working with Muslim Women

(F. Begum, & A. Rahman 2016)

## ESSENTIAL LEARNING - WHAT WE NEED TO KNOW

- You need to know any stereotypes that you hold about the Muslim community and have a readiness to address these by accessing further education about the Muslim faith.
- Muslims in NZ come from 80 or more different cultures/nationalities. You need to know Islamic teachings and realise that they are not always applied uniformly as they are intertwined with culture. You will need to develop an awareness of the victim's level of assimilation into the different cultures that they bring with them. For example a Muslim from India may have a different worldview than a Muslim woman from a Middle Eastern country.
- Religion (Islam) is not only a part of Muslim identity, it defines the way Muslims live - it is a system. Remember this alongside other ethnic cultural competence training you may have.
- Have an understanding of the Muslim ethos (underpinnings) that support women's rights and do not accept sexual abuse and violence against women. Prophet Mohammed (PBUH), regarded by Muslims as their leader and the last Prophet of God, has himself condemned men hitting their wives and there is no account of him hitting any woman or child in his lifetime. In the last sermon by Prophet, he emphasised to men that "they must be kind to their women" and further stressed that "wives have rights over their husbands in addition to husbands having rights over wives; that wives are to be treated well, for they are their husbands' partners and committed helpers" (Faizi, 2001).
- Thus any form of domestic violence or 'zulm' (torture, injustice, tyranny, cruelty, deprivation) in marriage is a "clear violation of Islamic law". Women have the right to equity, freedom and kindness and they also should have freedom from "fear of any human being, freedom from all oppression, the right to justice, freedom from defamation, and the right to peacefulness even during divorce" (Faizi, 2001). However, the interpretation and translation of Arabic words by many scholars has resulted in giving power to men to exercise violence in the name of religion. Aspects of obedience and "qawwamun" (protection, maintenance and safeguarding) have been misinterpreted leading to demands for women to be submissive, overpowered and to be put in a degraded category by abusive men (Faizi, 2001).
- Understand that many Muslim women can not easily leave an abusive partner. She is likely to greatly fear loss of the children and inability to provide for them. Many would not have managed or ever paid bills. There would be a need for significant upskilling in

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# MUSLIM WOMEN

their care for their own lives.

- Understand the broader impact of sexual violence on not only the victim/survivor but also her wider whanau and community (related to shame and judgement).
- Immigration may also be an issue. For example, the wife may be a dependent of the principal applicant (mostly men in cases of families coming from other countries) which gives power into the man's hand to decide the woman's fate.
- Modesty about her body could make disclosure and medical examination very difficult.
- Muslim women are cautious of accessing mainstream services due to negative experiences associated with stereotyping and a lack of cultural understanding. There is a need for professionals working with Muslim women to understand the cultural context of the victim/survivor "knowing where we come from".
- Low rates of disclosure of sexual violence – brings dishonour on them, their family and the Muslim community.
- Barriers to accessing health services include:
  - "Insensitivity" to the modesty of many Muslim women, such as the hospital gown and the procedures that a woman has to go through (particularly following sexual abuse).
  - "Lack of education, intimidation, and lack of exposure to the world"- Women hesitate to enquire and question consultants (as it is seen as questioning their capability) about the process and also may not take part in making informed decisions about their treatment, as they are unaware of their rights.
  - Religious beliefs - Muslim women may believe that issues of abuse are from God and may accept the situation they are in. They may also believe that patience and enduring pain is the way to gain forgiveness.

## On the frontline

- Assess the extent the Muslim woman has assimilated into the western culture. Gauge her present situation - her education, employment, relationship, culture, ethnicity, amount of time she has stayed in New Zealand, to what extent are Islamic values important for her and so on.
- Do not engage with survivors or families about their religious beliefs, but prioritise connecting the survivor with other Muslim specific supports.
- Client choice and consent is essential before engaging with family.
- Assist new migrants and family of victims to stay in close relationship with the community as this may provide some cultural support.
- Many immigrant Muslim families don't understand English and they don't understand the context of the situation they are in, so there has to be people of their own language who can explain to them. Arrange interpreters if needed.
- Understand and validate the immense pressures she might be under to not make a complaint, whether the perpetrator is family or not – potential for escalating violence, shame and dishonour, perceived religious pressures, immigration pressures, potential loss of children and livelihood, lack of social support.
- Understand her need for modesty, and support her in negotiating ways to accommodate this in the process.

## Crisis support services

- Workforce development should be a priority to address the needs of Muslim victims/survivors. This should include a focus on recruiting young Muslim crisis support workers. Support from peers who the survivor can identify with are the best support. The focus on recruiting a skilled workforce who possess dual competency, that is, cultural and religious knowledge and specialist knowledge of sexual

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violence, is also highly recommended.

- Prioritise staff training and education: Provide workshops in aspects of sensitivity training in cultural and religious needs, and cultural competency workshops provided by Muslims that are competent or have the skills to work with people - leaders who are aware of the social issues, social workers, or people who work with minorities and immigrants.

### Sector and Community Development

- Development of Muslim for Muslim services:
  - An organisation with competencies of both the New Zealand legal system and Islamic knowledge to act on behalf of the victim/survivor.
  - Requires a lawyer who is informed of both the Shariah and New Zealand law.
  - Counselling is very important- Muslim counsellors who know both the religion and the legal system.
  - An ability to engage in 'Mushwarah' (consultation) in a way that is culturally appropriate.
  - Knowing the 'shariah' (theology and jurisdprudence) of Islam and providing services like counselling.
- Need for an organisation which deals with the statutory organisations straight away, in a way which is informed by Islamic ethics and in which advocacy and support are provided by qualified professionals from the Muslim community. The organisation would provide support to the woman/girl and family and liaise with:
  - CYF
  - Police
  - Medical personnel
  - WINZ
  - Community leaders
  - School and other relevant organisations.
- The development of consultative (panels) groups that can provide their cultural expertise on such matters. A need to develop panels in this country from various ethnic/religious groups who are given a short course on social work/counselling issues and who can be called on in cases of family violence or sexual violence or for consultation by Department of Corrections, where the panel can provide expertise in the specific cultural or religious aspects that need to be taken into account. Membership of such a panel would be a paid position, and could work at a national level servicing practitioners throughout the country, in a variety of fields – maybe even health and mental health.
- Development of appropriate resources, such as a database of contact people such as Imams or community leaders who can provide for spiritual needs.
- Workshops for new settlers (both refugees and migrants) as they may experience culture shock which can lead to them being more possessive and sceptical about the surroundings that their children are growing in. Help parents understand that their culture and religion is a part of their new identity of being a New Zealander, and that there are rights and benefits which can assist.
  - Provide good understanding on the topic of sexual abuse. Create an appropriate workshop that will be beneficial both for children and parents for building open relationships. It becomes necessary that parents attend workshops to be able to have a conversation with their children on sexual abuse and be approachable when necessary. This helps in breaking the barrier of lack of communication and alienating their children.
- Cultural supports – Imams (Shariah) are seen as leaders in the Muslim community, and beacons of support for some. However there is a sense of mistrust of such people (in power) as there can be a lack of understanding of how to respond to someone who has experienced sexual violence and a lack of knowledge regarding appropriate supports

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and healing pathways for victims/survivors. It is seen that this is an area of potential support in the future that should be progressed with caution. That is, the willingness of Imams to engage in relevant education with regard to responding to sexual violence is vital.

- Address the need for emergency housing.

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# SUPPORTING SURVIVORS WITH DISABILITY

**Good Practice Guidelines for 'Mainstream' Sexual Violence Crisis Services - Doing our best for LGBTIQ Survivors (Dickson, 2016)**

Good Practice Guidelines for 'Mainstream' Sexual Violence Crisis Services - Everything with us: Report on working with people with disability (Robson, 2016)

## ESSENTIAL LEARNING - WHAT WE NEED TO KNOW

People with disabilities who experience sexual violence have the same needs as other survivors. In addition they may have specific needs that are related to their disabilities.

- Of critical importance is...
  - knowing that they can contact crisis support services and get help.
  - knowing that policies and practices of those organisations won't impede gaining access to support.
  - having access in appropriate ways to all necessary information while using services, and to help them make informed decisions on appropriate referral options.
  - having safe, accessible routes into and within service facilities.
  - having appropriately trained staff who understand and can meet their needs.
- Services should understand the strategic, philosophical, legal contexts of providing accessible support for disabled people
  - Services need to be familiar with the UNCRPD, the dynamics of social model, medical model, and rights-based approaches to disability. Services must recognise the links between government actions in health and disability services, sexual violence services, and meeting the needs of disabled victims/survivors on an equal basis with others. Services should be orientated to implement actions around concepts of universal design, reasonable accommodation and supported decision-making.

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# ESSENTIAL PRACTICE - WHAT WE NEED TO DO

### On the frontline

- Communication with disabled people should meet their different access needs
  - Effective communication can be a significant barrier to disabled people accessing services. Successful communication can only be achieved when adaptations are readily available and easily achieved. If disabled people are unable to tell their story, ask questions, and learn about services, they will not be able to benefit from valuable and needed support available.
  - Services need to be flexible and knowledgeable about ways to meet the different needs of disabled people. Services must become familiar with and practiced in how to share all necessary information in ways which are appropriate to their needs, and accessible to them. A particular focus is needed on access for Deaf people, and availability of crisis support service staff with at least basic understanding of NZ Sign Language.
  - Staff should provide supports grounded in the will and preferences of the disabled person and not organised solely based on the 'specialist' views and experiences of the non-disabled professionals.
  - For example
    - Working with NZ Sign Language Interpreters, the NZ Relay Service, client interaction primarily by email, SMS or telephone typewriter (TTY)
    - Opportunities for staff to receive training on using communication boards and other assistive devices
- Service staff should have adequate awareness and skills
  - Services need to address the general lack of disability awareness and/or attitudinal barriers or misunderstandings staff have about disability, and ensure staff have skills to adapt their support to the needs of people with disabilities.
  - Job descriptions and recruitment processes should include seeking disability awareness, knowledge and skills, or willingness to acquire it.
  - Staff training should address the specific situations of disabled people, the different manifestations of violence perpetrated against them, and social model and human rights understandings of disability.
  - For example
    - Services must not re-enforce myths/beliefs of dependence, helplessness, disabled people as perpetual passive recipients of care, and avoid negative frames of 'vulnerability', instead recognising the complex interactions between protective factors and risk factors, in context for that particular disabled person.

### Crisis support services

- Services need to be prepared and willing to support disabled people in practice
  - Services need to define people with disabilities as a target group and organise their services in order to reflect that. Services should assess their operations to identify any barriers for disabled people and find ways to promote accessible and effective support. Services must be willing to undertake any necessary changes to provide accessible and effective support to disabled peo-

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# DISABILITY

ple. Services should be designed and operated in ways that ensure they are accessible for people with disabilities. Services need to approach accessibility enhancement as a process, not a one-time task.

- Service information should be accessible to disabled people
  - Services need to make information about their services readily available in appropriate formats and promote themselves directly to people with disabilities. Services must ensure disabled people can obtain information about services' accessibility features and know if facilities are appropriate to their needs.
  - Services should distribute information to areas where it is likely to reach people with disabilities (such as appropriate disability services and other locations) to support informed choice. Telephone contacts or referral pathway information is especially important for services which maintain a confidential address for security reasons.
  - For example
    - Provision of information in plain language, Braille, large print and accessible electronic formats, captioned/audio-described video clips, information in NZ Sign Language.
    - Provision of information on accessible websites or via social media platforms (and at the next time of upgrading a website, ensuring that the new design conforms to international web content accessibility guidelines).
    - Use of international symbols for wheelchair access etc. to indicate the accessibility of facilities.
- The physical environments where crisis support is offered should be appropriate and accessible for people with disabilities
  - There can be an assumption that 'physical access' relates only to people using wheelchairs, whereas services should provide access for all disabilities – physical, mobility, visual, hearing, or cognitive. Travel routes to services and building entrances should be safe and accessible.
  - Services should be laid out to allow people with disabilities to be as independent as possible in all common areas. Accommodation services must also ensure accessibility modifications extend to bathrooms, kitchens and laundries, outdoor areas, and any other standard components of the service used by all clients.
  - Services must ensure equal access to emergency equipment and notifications of emergencies, and that evacuation plans are inclusive of people with disabilities.
  - For example
    - Mobility Parking spaces, proximity to public transport routes, good clear signage, Braille markings on doors, audio announcements in lifts
    - Ramps and step-free entry/exit and within internal spaces, high contrast markings on edges of steps, adequate lighting, grassed areas to toilet guide dogs
    - Bathrooms with non-slip surfaces, equipped with hand rails, easy to reach and turn/control taps
    - Doors easy to push open, wide doorways, door handles, telephones and light switches in easy reach
    - Hearing loops, visual fire alarms, telephones with adjustable volume and large keypads
- Service policies and procedures should be inclusive of and appropriate for disabled people
  - Services need to recognise that disabled people are experts in their own lives and experiences and promote support service options that are valued by them. Simple screening and assessment procedures to enable early identification of a self

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disclosed disability are the beginning of provision of tailored support.

- Services must ensure policies and practices do not unfairly exclude or create delays in service provision, or make that service more difficult to obtain for disabled people. Services should adapt more flexible policies where required, or create new policies to accommodate the needs of people with disabilities.
- While staff may well adapt their approach as they work with a client, without inclusion of relevant instructions in formal procedures there is a risk that new or inexperienced staff may not be aware of what approaches have been agreed upon by the organisation. These policies should be integrated within existing documents so that they are not overlooked or allowed to become out of date.
- To access a safe environment, people with disabilities who have experienced violence may lose access to personal support (either funded services, or practical support in real terms), so policies and procedures need to recognise that access often depends on availability of personal assistance if required.

- For example:
- Service planning takes an individualised approach to assimilate with people's use of mobility aids or service animals, use of medication or portable medical equipment, need for information in alternate formats, or support of a professional carer.
- Providing reader/writer assistance to complete forms, providing services in more accessible locations, allowing for longer times in interviews.
- Discretion for people with cognitive or psychiatric disabilities who might not be able to understand or consistently conform to following service rules.

- Partnerships should be developed with the disability sector
  - Services need to build trust with disabled people by networking through relevant organisations such as Disabled People's Organisations, and improving their service responses through collaboration with disability support service agencies.
  - Services must invest in creating links between agencies for development and better co-ordination and referrals between supportive environments which meet the needs of people with disabilities.
  - Services should establish good networks to draw on the expertise and resources of disabled people, and to increase disabled people's awareness of violence and crisis services available.
  - These partnerships need to extend to all crisis services supporting all people who experience violence, e.g. sexual assault services, police, judicial systems, and health services.
  - Services (and particularly women's organisations) should acknowledge oppressive processes of social structures that work against disabled people, and participate in projects that increase awareness among the general public and specific professional groups.
  - Services should aim for all cross-sector training and integrated service models to be co-designed and co-delivered with disabled people.
- Disability data should be collected, and used to improve services
  - Services should keep statistics on the number of people with disabilities accessing their services, gain an understanding of how many disabled people live in the community the service covers, and collect feedback from disabled people about their experience of accessing services, and ideas for improvement.

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# DISABILITY

- Services should document any limitations and challenges faced by their service in their attempts to assist people with disabilities, and the strategies they have successfully utilised to overcome any challenges faced in providing a service to people with disabilities. All of this information should be used for service planning.
- Services need to adopt performance indicators to track progress in serving people with disabilities, in terms of both commitment and capacity.

- Leadership and management practices should show a commitment to accessibility, and planning that meets the needs of disabled people
  - Services need to emphasise the participation of people with disabilities in the management of services to ensure that they are involved in decision-making regarding policies and practices. Services should have a strategy to employ disabled people in a variety of roles (not necessarily specific to directly serving disabled clients). This helps to ensure that support provided to disabled people, especially women, is grounded in their experiences.
  - People with disabilities should be represented in service consultations, and disability accessibility issues included in any submissions on government policy/legislation being prepared.
  - Service budgets and funding proposals need to be prepared so that appropriate plans and allocations can be made to incorporate disability accessibility issues, including costs for translation and updating of materials, providing interpreters, and/or provision of training and support for staff.
  - For example
    - Strategic and operational documents incorporating formal disability action plans
    - Disabled people with expertise as Board members, and/or as an external disability advisory group providing input into design, delivery, evaluation and improvement of services
    - Using networks within disability organisations to disseminate job advertisements and providing job advertisements, job descriptions, and contracts in accessible formats

### Sector Development

Actively raise awareness of violence against disabled people

- acknowledge oppressive processes of social structures that work against disabled people.
- publicly take a stance alongside disabled women and take part in awareness-raising about violence against them.
- participate in awareness raising and projects that increase awareness among general public and specific professional groups and that address violence and stereotypes.

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## ESSENTIAL LEARNING - WHAT WE NEED TO KNOW

1. **Asian** is a broad term used to refer to individuals who originate from a plethora of countries and cultures on the Asian continent. Asians now account for 12% of the entire New Zealand population according to the 2013 census, with the eight largest Asian ethnic groups in New Zealand being Chinese, Indian, Korean, Filipino, Japanese, Sri Lankan, Cambodian and Thai.
2. **Tackling the 'model minority' myth.** Professionals need to recognise that the often purported label of a 'model minority' and low sexual violence statistics in Asian communities, perhaps due to underreporting, does not mean that sexual violence is not occurring in Asian communities (Allnock, Radford et. al, 2012; Kanukollu & Mahalingham, 2011; Sue, S., Nakamura, Chung & Yee-Bradbury, 1992; Takeuchi, Zane et. al, 2007; Yoshioka & Dang, 2000).
3. **Rates of unwanted sexual touching or forced sexual behaviour experienced by high schools students in New Zealand are similar for Asian and NZ European students.** Chinese students – 10% reported sexual abuse in their lifetimes with 67% of these never having told anyone. Five % reported having been abused more than once in the previous 12 months with 43% of these describing the abuse as severe. Indian students, 12% reported sexual abuse with 71% not having told anyone. Seven % had been abused more than once in the previous 12 months, with 51% describing this as severe. Other Asian students – 9% reported sexual abuse, with 66% not having told anyone. 4% had experienced more than one episode in the past 12 months, with 43% describing this as severe.
4. **Conservative attitudes towards sex and a lack of knowledge around sexual violence.** There is a lack of necessary space for discussion and education around sex and sexual violence due to the taboo nature of the topic within Asian communities (Futa,

RELEVANT REFERENCES: Improving cultural competence http://www.tepou.co.nz/uploads/files/resource-assets/Talking-Therapies-for-Asian-People.pdf (This very useful booklet is intended for those working in the fields of mental health and addiction, but also contains much general information about Asian cultures and the use of counselling and other therapies.)
OTHER RELATED RESEARCH: Allnock, D., et al. (2012). "In demand: Therapeutic services for children and young people who have experienced sexual abuse." Child Abuse Review 21(5): 318-334.
Cowburn, M., et al. (2015). Speaking about sexual abuse in British South Asian communities: offenders, victims and the challenges of shame and reintegration. Journal of Sexual Aggression 21(1): 4-15.

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Hsu et al. 2001; Ohio Alliance to end sexual violence 2014; Robertson, Chaudhary et al. 2016).

- There is often a lack of terminology or concepts pertaining to sexual violence (e.g., unwanted and unacceptable sexual behaviour), and if present, the meanings attributed may differ for different individuals and cultural groups within Asian communities.
- Within Asian communities, there is limited knowledge around the rights of an individual, the potential difficulties that one may face in the aftermath of sexual violence, as well as the services available to support survivors and how to access these.

5. **Shame and stigma.** Asian survivors often fear bringing shame on oneself and one's immediate and extended family due to the emphasis placed on family duty and harmony, and the far-reaching effects of shame and stigma attached to being a survivor of sexual violence (Kanukollu & Mahalingham, 2011; Rastogi, Khushalani et al. 2014; Robertson, Chaudhary et al. 2016; Yoshioka & Dang, 2000).
   - Prioritising the reputation of family is important. Asian survivors can remain silent due to this fear, and the focus is often on denial or minimisation.
   - The shame and stigma is further augmented due to the ethnic minority status and consequent smaller Asian communities in New Zealand.
6. **Somatisation.** There may be a tendency for Asian survivors to somatise and present under the guise of other issues (e.g., stress, sleep difficulties, asking a question for a friend) and professionals need to be aware of these "tell-tale" signs.
7. **Cultural dynamics and patriarchal norms.** The dynamics surrounding the topic of sex and sexual violence in Asian communities often reinforces patriarchal norms and values where male rights, dominance and authority is championed (Cowburn, Gill et. al., 2015; Kanukollu & Mahalingham, 2011).

This, coupled with the formal and hierarchical nature of families in Asian families (Futa, Hsu et. al. 2001), can mean:

- An Asian survivor's experiences of sexual violence may not be recognised as such within their families and community.
- The decision of whether an Asian survivor seeks help and where this help comes from may rest with individuals (usually male) within a survivor's family and even wider community (e.g., religious group or organisation).
- Informal sources of support (e.g., talking with relatives or friends) are often the first-port-of-call.
- There can be a greater endorsement of rape myths in Asian communities meaning the survivor is blamed, and they may be questioned about their role in precipitating the sexual violence.

8. **The role of acculturation**. An individual's level of acculturation to and internalisation of Western culture and values is important since it can mediate the level to which an Asian survivor (and their family) is affected by issues such as conservatism and a lack of knowledge pertaining to sexual violence, stigma, shame and adherence to patriarchal norms, and consequently their decision to disclose and seek help (Futa, Hsu et al. 2001; Kanukollu & Mahalingam, 2011; Kim & Ingrid, 2015; Te Pou, 2010).
9. **Vulnerable populations within Asian communities.** International students, visitors/tourists, refugees and recent migrants may be more vulnerable due to more idealised perceptions of New Zealand (e.g., "New Zealand is no crime, clean and green"), less understanding around individual rights and boundaries regarding acceptable/unacceptable behaviour (e.g., "New Zealanders are friendlier, it's normal to hug and kiss, even if it makes me feel uncomfortable"), as well as a lack of established support networks from family, friends and individuals within their communities.

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Kanukollu, S. (2010). Model minority myth and perceptions of child sexual abuse among South Asian immigrants. Michigan, University of Michigan. Doctoral dissertation.
Kanukollu, S. and R. Mahalingam (2011). The idealized cultural identities model on help-seeking and child sexual abuse: A conceptual model of contextualizing perceptions and experiences of South Asian Americans. Journal of Child Sexual Abuse 20: 218-243.
Kim, E. and H. Ingrid (2015). Intimate partner violence among Asian Indian women in the United States: Recognition of abuse and help-seeking atti-


# ESSENTIAL PRACTICE - WHAT WE NEED TO DO

## On the frontline

1. "One size does not fit all". It is important to take an individualised approach in working with Asian survivors due to the vast diversity amongst the different communities.
   - Take into account the issues, beliefs and values that are important to the survivor's culture and country of origin, and examine how these intertwine with the survivor's own experiences as an individual within their own culture and community, as well as in New Zealand, especially acculturation to and internalisation of Western concepts and values.
   - For some, having a professional who matches their gender, age, culture and language is really important. For others, having such a culture match may be a deterrent due to the shame and stigma and consequent fear of exposure with having someone from their comparatively small community (when contrasted to countries of origin).
   - Do not assume that widely held beliefs, values and ways of working associated with a particular Asian culture may apply to an Asian survivor from that culture.
   - It is important to have a service that is able to match the gender, age, culture and language of a survivor AND have professionals (who are not from a survivor's culture) be able to "pick and choose" from a culturally appropriate and sensitive "toolbox" of knowledge and skills in order to individualise their approach.
2. **The importance of rapport building and confidentiality.** Time should be spent on rapport building and ensuring confidentiality in order to address the significant effects of stigma and shame attached to being a survivor of sexual violence and speaking about such experiences. This is particularly important for young people who want to protect themselves from the views and reactions of parents and others, and to protect their families from feeling shame and guilt and being criticised by others.
3. **The importance of normalisation and education.** It is important to normalise an Asian survivor's experiences and fears (particularly with regards to disclosure and help seeking) in order to combat the stigma attached to sexual violence. Due to the lack of discussions and education around sex and sexual violence in Asian communities, it is valuable to:
   - Provide some information around boundaries of behaviour and individual rights, particularly in helping the survivor label their experiences.
   - Provide some education about sexual violence, the common experiences of other survivors in the aftermath of such trauma and the supports and services available in the community.

## Crisis support services

1. Where possible, employ staff from the Asian communities in the service area.
2. Young Asian students prefer that a qualified and same gender person provide them with assistance, who is preferably Asian but not from their particular community, and who is young enough to understand the particular issues that they face in their families

tudes. International Journal of Mental Health 44(3): 200-214.
MacPherson, L. (2015). National Ethnic Population Projections: 2013(base)–2038. Retrieved 02/08/2016, 2016.
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Rastogi, P., et al. (2014). Understanding clinician perception of common presentations in South Asians seeking mental health treatment and determining barriers and facilitators to treatment. Asian Journal Of Psychiatry 7(1): 15-21.

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and communities.

3. Ensure all frontline staff have training in working with Asian survivors so that they have sufficient skills and knowledge to meet the needs of the individual client.
4. Provision of cultural consultation will enhance those skills and knowledge and allow for continued recognition and discussion of the issues pertinent to the culture of the survivor (e.g., shame and stigma, patriarchal norms, acculturation) and is vital to tailoring an individualised approach to each survivor.
5. Young Chinese and Korean students have expressed a preference for on-line services. They would look here for help, and would prefer skype or internet based counselling through on-line messaging to avoid being identified seeking help. Young Indian and South Asian students might look on-line, but their internet use was monitored so they would prefer face to face assistance.

### Sector and Community Development

1. Provide education to the wider Asian community. This will not only educate and empower Asian survivors to recognise the need to seek help and the appropriate services, but also provide the platform to increase knowledge and reduce stigma in their communities, paving the way for greater recognition and support amongst family and friends, who are often the first-port-of-call for Asian survivors. Providing language-appropriate resources is a good way to promote education, including written materials about what is acceptable and unacceptable, when to seek help, the services available and how to access these. Other forms of resources can include audio or video recordings of Asians talking about sexual violence, to further provide education, reduce shame and stigma, and normalise help seeking.
2. Young people are most likely to disclose to a friend, so education targeted to assisting friends could have great value. It could also inform survivors without directly addressing them as such.
3. Young women wanted to hear more stories from young people who were sexually abused and got through it. They also believed that such stories could assist their parents to consider their own reactions

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Sue, S., Nakamura, C. Y., Chung, R. C. Y., & Yee-Bradbury, C. (1992). Mental Health Research on Asian Americans. Journal of Community Psychology, 22, 61-67.
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# VISION FOR MAINSTREAM EARLY INTERVENTION AND CRISIS SUPPORT SERVICES

Nation-wide coverage of specialist sexual violence support services which are able to provide 24/7 early intervention following recent sexual assault and on-going acute interventions when needed to maintain or assist in establishing emotional and psychological well-being of survivors.

The vision above has not changed since the 2009 guidelines project, and many of the components remain the same. However, there is also significant difference resulting from the engagement with a number of groups in the "inclusion" projects and developments in services overseas. For this reason, the critical components of service are presented as "proposed", as full consultation about the changes needs to occur within the sector.

## PROPOSED CRITICAL COMPONENTS OF SERVICE

**1. Partnership with a kaupapa Maori service provider responding to sexual violence.**

Maori are at higher than average risk of sexual violence, and can present with complex difficulties related to the impacts of colonization and cultural identity. Currently, there are few kaupapa Maori services specialising in sexual violence left across the country, and none with 24/7 capacity, so the ways that the partnerships would operate in terms of service delivery would change over time with the development of further kaupapa Maori services.

**2. Capacity to provide inclusive services.**

This will include national and/or local relationships with groups who serve or are advocates for populations with particular cultural or other needs. These will vary depending on local need and capacity. All of the groups involved in this research recommend that relationships are built and cultural knowledge is developed to enable services to provide inclusive services. Further recommendations from many groups are that staff is recruited from the specific cultural group.

**3. 24/7 telephone and internet communication service**

- Information
- Referral
- Support
- Acute counselling interventions e.g. safety assessments
- For survivors and their support networks
- Consultations for other service providers
- Liaise with police and medical teams re call-outs
- Co-ordinated data collection

**Rationale:**
Provides access to specialist services for much of the population. Easy to access – doesn't require travel, can often be accessed without needing to explain to someone else where you are going. Can respond to acute need, and work with the caller to resolution or make emergency referrals. Internet capacity meets the needs of young people – it meets them where they are and in a manner which is comfortable for them.

**Research:**

- USA - Monroe et al (2005). In a state wide evaluation of services provided by specialist sexual assault centres in Maryland, USA – 89.9% of respondents said they were satisfied or very satisfied with hotline service.

- USA - Wasco et al (2004). In a state wide evaluation of sexual assault services in Illinois, of those service users who agreed to participate in the evaluation, more than 80% of hotline callers said that they gained somewhat or a lot more information, around 90% said that they felt some or a lot of support had been provided to them.

- NZ – Woodley at al (2013). In this research with young people of different ethnic groups, most said that an online service would help them to access information and assistance. Barriers remained for those who said that their internet use was monitored.

**4. 24/7 Call-out service for advocacy and support**

(ideally 2 staff available for each call-out, 1 for survivor, 1 for whanau)

- Police interviews – from preliminary interview to closure of case
- Forensic medical examinations
- Therapeutic medical examinations
- Follow-up medical examinations when requested

**Rationale:**
Police and medical processes can cause further traumatisation through replication of dynamics of the abuse or triggers into fear endured during the abuse. Police and medical staff have other roles to perform so cannot always maintain focus on the psychological well-being of the survivor. Support can offset the development of PTSD and other adverse impacts.

*The police inquiries were beginning to come together, and providing them with the help they needed was traumatic in itself, especially when they asked for specific details of the attack. Sessions with the counsellor gave me the space to off- load the added emotional stress.*
(Leefman, 2005, p. 52).

- **Importance of someone to advocate for survivor well-being:**

Kylie was "raped at knifepoint by a stranger in an attack which included her being forced to drink alcohol and being beaten around the head". She was accused of making a false complaint due to inconsistencies in her story. From her point of view, this arose from being pushed to provide information when she was "past it", no longer able to think straight.

*I did feel they were calling the shots. I was too tired and distressed to think that I had a right to say, "This is enough".... It didn't really occur to me that I could say I was too tired and wanted to go home.* (Jordan, 1998, p. 42)

- **Importance of assistance from some one who understands the process:**

*Then an officer came in to say that they were trying to find a woman doctor to examine me. He had assumed that I would prefer a woman. I didn't tell him that I really didn't care; I thought his sensitivity was too nice to throw away. And when I finally had the medical examination later that day, I was pleased I hadn't said anything. The examination was far more extensive than I would ever have imagined; I could not have coped if the doctor had been male.*
(Leefman, 2005, p. 31).

*I was beginning to understand that this thing – rape – was far more taxing, far more demanding, than I had ever imagined. I thought I was strong enough to overcome its effects. I thought I could keep living the way I'd always lived..... At first I had refused to allow the attack to change my life, but now I realised that it was a greater force than I'd reckoned with.* (Leefman, 2005, p.53)

- **Ideally need two staff to work with family:**

Telling mother: *Immediately she was in tears. I put my arms around her to comfort her, knowing that I didn't have the strength for this. Fortunately she had a good neighbour who came in to take care of her. My trauma was different from hers, and each of us needed support.*
(Leefman, 2005, p. 49).

**Research:**

· NZ – Jordan (1998) - Identified four themes of what women need to be satisfied with police performance in their experiences in the reporting process:
  - To be believed
  - To be treated with respect and under standing
  - To be allowed to retain some degree of control over proceedings; and
  - To be provided with adequate information. (p.70)

These themes form the basis of much of the advocacy work crisis support workers do in police and medical processes.

· USA – Campbell (1998) – Contact with medical and legal systems can lead to higher levels of post-traumatic stress following rape. This effect can be ameliorated with mental health support.

· USA – Campbell (2006). Rape advocates assist victims/survivors to get a better deal in medical and legal systems and to feel less distressed by them.

· USA- Wasco et al (2004) State wide evaluation of Illinois sexual assault advocacy services (what we would consider call-outs to police interviews, medical exams and court support). Of those who participated in the evaluation, 87.2 % reported that they got somewhat or a lot more information, 96.5% some or a lot of support, and 84.7% reported somewhat or a lot of help in making decisions.

· UK- Lovett, Regan & Kelly (2004) – 93% of survivor/respondents were satisfied with crisis worker role at medical examinations. This was the highest score for any of the services provided by the Sexual Assault Referral Centre. Both survivors and police supported the role of the support worker at the police interview. Survivors said that she helped them to feel safe and relaxed, and police commented that it assisted the survivor to stay the distance through a difficult process, and it allowed them to concentrate on their own role. Statistics also showed a relationship between the crisis support worker being involved and survivors withdrawing from the legal process – of those who did not have a crisis support worker, 53% withdrew, of those who did, only 20% withdrew.

· Petrak (2002) identifies a number of factors indicating need for assessment in the acute post-rape period:
  - a history of suicidal behaviour is associated with the presence of suicidal ideation post-rape (Petrak & Campbell, 1999, cited in Petrak).
  - a prior history of sexual assault leads to more severe signs of traumatisation post-rape (Ruch, Amedeo, Leon, & Gartrell, 1991, cited in Petrak).
  - Alcohol and drug abuse relates to in creased PTSD symptomatology (Ruch & Leon, 1983, cited in Petrak).
  - Stressful life events in previous 12 months may increase post-rape symptomology, though this hasn't been confirmed by all studies – (Ruch & Leon, cited in Petrak).

· Zoellner, Foa, & Brigidi (1999, cited in Petrak) Found that positive social support might offset the development of PTSD following rape.

**5. Emergency face to face sessions – day-time**

- To assist clients with emotional and functional stabilisation, assessing and arranging safety, and decision-making.

- Acute counselling interventions
- Support
- Referral
- Assistance with decision-making
- Arranging access to resources
- For survivors and their support networks

**Rationale:**

Most clients presenting for this service feel that they are in "crisis". They need to be responded to as soon as possible so that distress can be contained, time-dependant decisions made, and plans for safety put in place, Responding appropriately to acute need reduces long-term impacts. Many situations can lead to acute need arising, for example, a recent trigger to memories of sexual assault, recent life stressors combining to render useless prior strategies of ignoring the impacts of the sexual assault, imminent change in possible exposure to the offender (e.g. up for probation), birth of a child, another family disclosure, or an upcoming court case. One of the most common causes of acute need is a recent sexual assault. Symptom levels tend to be high in the first weeks after the assault and many survivors need assistance to redevelop psychological stability, and/or have a need for supportive contact. Such sessions need to be offered as a separate aspect of service as even if counsellors were available on short notice to pick up new clients, it could be inappropriate and unethical whilst containing the crisis to open up the narrative of the abuse to get sufficient information to begin a claim for ACC cover.

> *In all this, you're dealing with so many people, yet they expect you to be able to – like the police expect you to be able to ring up and make phone calls.*
>
> *You're not in a position to make phone calls, you're not in a position to speak to all these different people, you're at your lowest point, and your most vulnerable... you don't want to be the one to chase people, you need it all there for you... I think the problem is, although it's available, they don't realise how easy it needs to be... not 'cause people aren't determined to get support, but because everything's hard work, when something like that 's happened... I needed them to ring me. I can't emphasise enough that you're not in a position to do things for yourself. You can't go and find the help you need, you can't.*
> (St Mary's service user, Interview 11, Undetected Offender, p. 54).

### 6. Follow-up service

- Co-ordinated follow-up including telephone, e-mail, text or face to face communications and liaison with other support agencies
- Depending on client need, arrangements with clients and course of case, this service might operate for anything from 1 month to multiple years.

**Rationale:**

For many survivors, sexual abuse or assault continues to impact their lives for some time. There is a personal journey of adapting to the fact that this has happened and what it means for you, and we live in a world in which portrayals of people being sexually objectified are everywhere, and sexual violence is most often encountered as prime time TV entertainment. Some survivors need on-going professional assistance, while for others they need someone they can talk to about it as appropriate social support is often not forthcoming from friends and family as people don't want to talk about it or don't know what to say.

**Research:**

- US - Rape has a high impact. Research invariably shows that rape has high psychological consequences in the first few weeks and months with up to 95% of survivors meeting criteria for PTSD. Further, while many survivors do improve significantly by three to four months after the event, many do not. Significant proportions of survivors continue to report anxiety and depression many years after the rape. E.g. Rothbaum, Foa, Riggs, Murdock & Walsh (1992).

- Bryant (2003). We don't yet fully understand predictors of PTSD e.g. one review suggests that of those who meet criteria for ASD, approximately ≤ go on to PTSD. However, also approximately half of people who develop PTSD did not experience ASD in the initial month, and 5% experience delayed onset (more than 6 months after the event).

· UK – Lovett, Regan & Kelly (2004) – While in this sector there has often been debate about whether services should call survivors, or wait for survivors to call them to be less intrusive and more client-centred, in this study 78% of survivor/respondents supported the idea of proactive follow-up, though with a range of opinion on optimum timeframe for first contact – within a few days 37%, after a week 33% and after a couple of weeks 30%. Pro-active follow-up also had an impact on withdrawal, with 30% of those contacted only once withdrawing, reducing to 20% of those contacted 2-10 times.

### 7. Case Tracker

This role is to work alongside the survivor to provide support through and information about police, prosecution, courts, and corrections re progress of case and to communicate this to the survivor regularly and appropriately. In addition, to arrange other services the client might need (e.g. court preparation) and appropriate return of property held as evidence.

**Rationale:**
Many survivors want information about what is happening in legal processes so that they know whether they are physically safe or not, when they are going to need to think about the assault again, and in general to maintain some sense of control.

**Research:**
· UK – Lovett, Regan & Kelly (2004) – When there was not a "case tracker" 64% of respondents thought that they had not been well informed about the case. Of those who had a "case tracker" service, 75% praised the accurate information that they had been given and almost all respondents were satisfied with the service.

> *In the end I initiated it and said, "you've got to send us more letters, tell us what the hell is going on", because there were times when they'd say, "look, the trial's here", but then you didn't hear and then you're waiting to go to trial and then someone phones and says, "oh no, it's not happening for another six months". You're going in like a roller coaster here, there was no communication to say, "no, it's not actually going to be happening". That was really hard, I actually suffered every time that happened.*
>
> *Emotionally you do, trying to prepare yourself for it I said, "I know this is only another job to you." For some of them it wasn't, they were really involved, but I said, "I'm thinking about this every day. You've got three that you're thinking about. Every single day"....They probably felt that they were doing enough, but when you live with something day by day, it's not enough.*
>
> *You need to know this guy is going to be put away or whatever you're feeling, and he's not going to be out there. Just those little silly things: are you making sure he can't get out? He can't get bail, can he? Because you don't know...It would have been nice if there was someone to answer those questions and not feel silly about it.* Helen (Jordan 2008 pp67-68)

### 8. Court Services

- Court preparation
- Advocacy and liaison through court
- processes when possible and appropriate
- Court support – trial, verdict, sentencing, restorative justice referral, parole applications, release
- Emotional Harm and Victim Impact
- Reports

**Rationale:**
The nature of the adversarial system can be very hard on the survivor (and their family/supporters) - they are a witness only so have no legal representation in this process other than what the Prosecutor can provide alongside their duties for the State; their credibility is questioned; they see the offender, and must tolerate him seeing them; and they have to tell intimate details of their experience and feeling to a public room where not everyone is even sympathetic. It is described by some survivors as the hardest thing they have ever had to do. Further, court processes are offender focussed, and police and prosecution have clear roles to perform regardless of how empathic they are towards the survivor.

Because re-traumatisation as a result of a Court process is so common, it is essential that survivors are offered the option of an independent support worker to assist them through these processes, both during the trial and in the preceding weeks to become familiar with what will be required of them and the environment in which it will occur, to assist with ensuring that appropriate court applications are made and to develop strategies for managing the emotions associated with this often difficult process.

It is important that the person providing support in court is someone who is able to "focus on what the victim/survivor needs rather than venting their own emotions" (Jordan, 2008, p.90), as can be the case when a family member or friend is the designated support person. It is hard to see people we love go through these experiences and be maligned. While family and friends can still attend and be supportive, the survivor is allowed to keep just one person with her (or him) through all processes.

> *Because all of a sudden I saw myself as being tied up, naked, gagged and being left on the bed by this man, and that was why court was so traumatic, because all of a sudden you saw what had really happened. That this person got off on seeing you, that was and that was really horrible, that was really damaging to see that perspective.* Gabriel (Jordan, 2008, p. 124).

**Note : Independent Sexual Violence Advocates**

Over recent years, it has been recommended and proposed that New Zealand adopt the UK model of having Independent Sexual Violence Advocates who advise survivors on legal options and procedures, and are the communication bridge for the survivor with police and prosecutors. They perform parts of the call-out roles, case tracker roles, court support roles and Specialist Victim Advisor(MOJ) roles We support the clear addition of the communication and legal information functions to the roles of sexual assault support services, but note that this configuration is often reported without the emotional and psychological support currently provided by specialist crisis

support workers in New Zealand. We understand this as crucial to the reduction of post-traumatic mental injury, and note that Rape Crisis groups in the UK include emotional support in their definitions of the role. In terms of whether all of these functions are best performed in one role or multiple roles, we suggest that this is best decided at a local level depending on need and resources – the functions might all be able to be covered in one role in areas of low demand but in larger areas might be split to accommodate high demand and to promote specialization.

**Research:**

- The role was recommended by McDonald and Tinsley (2011) following their research into current practice in New Zealand, and the ways that the criminal justice system works for survivors of sexual violence in various parts of Europe. They recommend that the role also encompasses the current role of Specialist Court Advisors. An evaluation of the role published in 2009 found the service provided to be of great value to survivors. McDonald and Tinsley note that this value was also seen by The Government Response to the Stern Review - " ISVAs are so crucial to the way that 'the State fulfils its obligations to victims of violence [that] funding should be available in all areas where the demand makes a post viable".

**9. Information bank**

- Knowledge of great app and internet resources such as Living Well – Supporting Men, and www.dearem.nz
- Specialist libraries – books, DVDs, tapes.
- Pamphlets.
- Web information – regularly updated.
- For survivors and their support networks

**Rationale**:

- Sexual violence remains relatively "secret" in our society so resources are not easily available through usual means such as the local library or DVD store.
- Many survivors are not able to "take in" much information if they are significantly impacted by the assault. Giving pamphlets means that they are able to access the information when they are ready.
- Much misinformation exists in our communities which can harm survivors. Giving accurate

information to friends and family can offset this.

**Research:**

· Bryant (2003). In terms of understanding the pathways of the development of PTSD: "It is apparent that the appraisals of the symptom, rather than the symptom itself, may be critical in determining the influence it will have on subsequent adaptation" (p 793). Information about common responses to sexual violence can give context for people making these symptom appraisals.

**10. Resource bank – acute practical need**

- Clothing, transport.
- Safety – alternative accommodation, respite care, alert systems, changing locks.
- Cleaning
- Funds.

**Rationale:**

· Clothing is often necessary when it has been destroyed in the assault, is triggering to the assault, or is taken as evidence.

· Transport can become an issue for survivors who develop high levels of anxiety – some feel that they can no longer travel on public transport and others can no longer drive in situations they find stressful.

· Emergency housing is needed in many instances of sexual assault, because the victims are not safe to return home, or because they do not wish to return to the place where the assault occurred. For some "homeless" people, a previous sense of safety which meant they felt safe enough to live this way can be undermined by the sexual assault.

· Feeling safe is an important step in recovering from the anxiety often caused by sexual assault. Many survivors can't get this staying alone, or without adding extra fortifications to their homes.

· When an assault has taken place in a home or a car, to return to that place with detritus from the assault and the police investigation still visible can be further retraumatising. Funding for services to contract cleaners would assist with returning home and to functioning in life.

· Money can be important following assault – a person may not be able to work, may need to replace broken clothes or other items, need to catch taxis instead of buses, need a holiday or to treat themselves well, and may need to reduce other stressors to be able to cope with the impact of the assault.

**Research:**

· UK – Lovett, Regan, & Kelly (2004) – in the acute aftermath of a sexual assault, many survivors needed assistance with practical matters.

**11. Social work support** e.g. assistance with Work and Income and accommodation, as well as consultations and liaisons re child safety, and crisis support work.

**Rationale:**

Whether due to the impacts of repeat victimisation, or other factors, services see many survivors who are not well resourced in the world, whether that be financially, socially or other. Sexual violence can also cause massive disruption to individuals and to family functioning. The safety of adults and the safety of children are often issues to be attended to.

**12. The above to be integrated with recovery and support services including:**

- Counselling
- Psychotherapy
- Support
- Support groups
- Services for those supporting survivors – family and friends.

**Rationale:**

Service integration enables both acute and longer term needs of survivors to be met by a provider with whom they can develop a trusting relationship. This maximises survivor access over time to services which are designed with their needs in mind.

**Research:**

· USA - Wasco (2004) – took pre-counselling and post-counselling measures: a posttraumatic stress index PSI and a scale called Counselling Outcome Index (COI) containing items relating to support, trust of self, attribution of blame for the assault, capacity to

talk about thoughts and feelings about the assault. This scale was developed collaboratively between the researchers and service providers. Results showed significant differences on all items following counselling. Half of respondents had ten or more sessions.

### 13. Prevention and education services

**Rationale:**
The prevalence and negative impacts of sexual violence are such that if it was an infectious disease, it would be called a pandemic and massive efforts would be in place to prevent it. The fact that it is a social ill rather than a medical ill should not matter in terms of the energy and resources our communities devote to ending it. Funding is required to provide prevention and education initiatives in a population approach, but also for small local programmes responding to local need and opportunity.

### 14. Advocacy – to end sexual violence, to improve conditions for survivors

**Rationale:**
We must end sexual violence. As with prevention, specialist services are those in our communities who are aware of the real face of this violence. To be true to every survivor we support, we must advocate to improve the systems that they deal with, resources available to them, their access to real justice and to stop sexual violence.

### 15. Other services as locally determined

**Rationale:**
Services work to serve survivors within their local communities as fully as possible. This might mean that they offer a wider array of services than those usually considered associated with sexual violence so that survivors in their area can get that service. Conversely, resources available in a particular community might provide the opportunity for development of innovative services for survivors.

# Working with Māori survivors of sexual violence

**Joy Te Wiata and Russell Smith**

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A project to inform Good Practice Responding to Sexual Violence – Guidelines for mainstream crisis support services for survivors. Round Two. TOAH-NNEST 2016.

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This document has been prepared by Joy Te Wiata (Ngati Raukawa) and Russell Smith (Ngatikahu, Ngapuhinui tonu), co-directors of Korowai Tumanako. This kaupapa Māori Sexual Violence Prevention and Intervention Specialist service is designed to support Māori utilising unique Maori clinical practices to meet the needs of Maori.

Together Joy and Russell have a combined 28 years experience within the sexual violence sector. They have been involved in several significant research projects, particularly for Māori, within the sector.

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## Literature Review

This section examines the literature pertaining to sexual violence in Aotearoa. More specifically it provides an exploration of sexual violence within an indigenous Māori context and identifies prevalence rates, impact, and a background of services and interventions including kaupapa Māori, as well as service limitations.

Sexual violence in Aotearoa has a significant impact on many thousands of people, sometimes spanning from generation to generation. Some of these effects range from loss of potential to achieve, to loss of life. Amidst these are issues of mental and physical health, alcohol abuse and both medical and illegal drug use. Research on sexual violence suggests that in Aotearoa, up to one in three girls will be subject to an unwanted sexual experience by the age of 16 years. The majority of those incidents would be considered serious, with over 70% involving genital contact (Fanslow, Robinson & Crengle, 2007) and up to one in five women will experience sexual assault as an adult (Fanslow & Robinson, 2004).

Of grave concern are the high rates of Māori as victims/survivors of sexual abuse and assault, with Māori females (both kōtiro and wāhine) almost twice as likely to suffer sexual assault in comparison to the general population (Mayhew & Reilly, 2007). This overrepresentation of Māori was also found by Fanslow and colleagues (Fanslow, Robinson & Crengle, 2007).

Also important to the following discussion is the acknowledgement of sexual abuse of boys and other males. The statistics for the abuse of boys and other males vary significantly and to quote them here may be to do a disservice to the numbers of males who have experienced sexual assault in their lifetime. Suffice to say, all sexual abuse is believed to be underreported and it is likely that the reporting of sexual abuse for males is exacerbated by societal constructs that can adversely impact on males: e.g. "boys are socialized not to be victims… Guys are expected still, to tough things out and not ask for help", and in a largely, "homophobic society, the issue of sexual identity comes into play" (paras 1-3, Mc Bride, 2011).

Whilst the research for New Zealand statistics focuses specifically on the abuse of Māori females in comparison to other non-Māori groups collectively, and to a lesser degree males, it is important to state that the guideline recommendations we are considering are intended to positively embrace all Māori who experience sexual violence including: wāhine, tāne, tamariki, rangatahi, kaumātua, kuia and koroua, takatāpui tāne, takatāpui wāhine, whakawahine and tangata ira tāne, etc. The preceding list is not exhaustive and is intended to demonstrate the inclusion of all current and future articulations of gender and sexual orientation, of people who identify as Māori. Also this paper wishes to acknowledge those who continue to struggle with the articulation of gender identity and/or sexual orientation.

Reporting of sexual assaults and abuse in Aotearoa is extremely minimal, with only 9% of incidents ever reported to Police (Ministry of Women's Affairs, 2012). This may be related to the low conviction rates in this country, with only 13% of cases recorded by the Police resulting in conviction (Triggs et al, 2009).

Survivors with a history of victimisation are particularly vulnerable to repeated sexual violence resulting in an increase in complexity of their health and psychological needs. Repeat sexual violence, referred to as 'revictimisation', is a serious issue with at least 50% of girls and women who have been abused likely to be sexually revictimised. Women experiencing childhood sexual abuse are at higher risk of revictimisation in adulthood co-occurring with other forms of violence (Ministry of Women's Affairs, 2012).

Multiple social, political, cultural and economic factors cause substantial inequalities and disadvantages for indigenous people (Jansen, Bacal & Crengle, 2009; Leitner & Holzner, 2008), and in the local context, for Māori. Given the high rates of Māori victims/survivors (as above, Matthew & Reilly, 2007; Fanslow, et al., 2007) and the impacts of revictimisation on vulnerable groups (Ministry of Women's Affairs, 2012), it is reasonable to determine that Māori whānau and communities are likely to be at greater risk of experiencing long-term negative outcomes than the general population.

### *Impacts of sexual violence*

Research shows that sexual violence is one of the leading causes of trauma amongst kōtiro and wāhine Māori (Te Puni Kōkiri, 2008). Drawing on studies by the Ministry of Women's Affairs, TOAH-NNEST (n.d) states the impacts of sexual violence can result in a range of issues including disruptions to sleep, changes in personal and social wellbeing, diminished mental and emotional health, difficulties with intimacy and relationships and impacts on a multitude of areas of life functioning. According to the Ministry of Women's Affairs study, the impacts of sexual violence may include higher levels of unemployment/lower socio-economic status and 'significantly poorer long-term psychological and health outcomes', (2012, p.11). Additionally, support people of those who have experienced sexual violence, may experience emotional, physical and psychological distress that creates disruptions to their lives and families (TOAH-NNEST, n.d). Therefore, it is reasonable to conclude that Māori victim/survivors, their whānau and communities are likely to experience a range of these impacts.

Viewing sexual violence from a Māori worldview highlights other significant impacts for Māori. From a Māori perspective all forms of violence are considered a violation of mana and tapu (Peri, Tate, Puku, 1997). Te Puni Kōkiri (2009) also states that an impact of sexual violence is that it 'negatively affects the sense of 'mana' experienced by individuals and their whānau. Violations of mana and tapu are not congruent with Māori values such as *wairuatanga, whānaungatanga, manaakitanga*, and

*kaitiakitanga* (TOAH-NNEST, n.d). Over time the violation of values can result in the development of cultural distortions (Smith & Te Wiata, 2009). They offer an example of this where a perpetrator of harm may continue to be referred to as 'Kaumātua' which denotes a role of mana, as opposed to simply being called a 'koroua', meaning an older male. They continue, that referring to a perpetrator as a Kaumātua erroneously links the principles and values inherent in the Kaumātua role to abusive behaviour. Smith & Te Wiata state that cultural distortions are also reinforced by dominant discourses that have traditionally endorsed Western values, social sites and practices as safe, and tikanga Māori values and practices, for example marae and communal sleeping practices, as unsafe. The corollary of negative articulations of tikanga Māori is that some Māori internalise diminished articulations of identity and become further disconnected from te Ao Māori. Experiences of sexual violence, especially where the perpetrator of the violence is whānau or a member of standing within their communities, can serve to further consolidate these views of identity and disconnection (Smith & Te Wiata, 2009).

The importance of secure identity and connection to te Ao Māori for Māori well-being, and conversely the absence of these, due to the experience of sexual violence on Māori are asserted in Te Puāwaitanga o Te Kākano – A Background Paper Report, which was commissioned by Te Puni Kōkiri (2009a), to explore understandings of sexual violence for Māori (p. 176). One of the key conclusions of the report is that:

> "the over-representation of sexual violence experienced by Māori can be contextualised as a result of the suppression of tikanga and mātauranga Māori through a range of influences. …these influences include the distortion and misrepresentation of tikanga due to a variety of factors such as Christianity, colonisation, urbanisation, alienation to whenua, and the denial of mātauranga Māori. Each of these influences has contributed to the marginalisation of te reo and tikanga Māori for many people and, as such, has contributed significantly to the breakdown of intergenerational transmission of whakapapa and knowledge of what it means to be Māori." (p. 176)

Referring to the work of Denise Wilson (n.d), Te Puni Kōkiri (2009a) also describes sexual violation as a violation of 'te whare tangata' which:

> "has the potential to create distress amongst Māori women. This distress is not only physical or psychological in origin, but also spiritual and has multiple dimensions to it. Not only is this a violation of the woman herself, but also a violation of her tipuna and her future generations. Spiritual distress is often a dimension that is neither recognised nor acknowledged, but one that impedes recovery and healing." (p.14)

This demonstrates and is consistent with the views of all the contributors to the project which conclude that critical to the discussion of sexual violence is understanding that sexual violence has "been perpetrated upon whakapapa" (p. 15).

## *Sexual Violence Services and Interventions for Māori*

### *Mainstream/Bicultural Services and Interventions*

For the purpose of this review we are considering Mainstream and Bi-cultural services together as claims to being 'mainstream' or 'bi-cultural' may be contested due to varying understandings and articulations of what distinguishes a 'bi-cultural' service from a 'mainstream' service. Therefore, for clarity, we are discussing in this section services/organisations providing services, interventions or programmes for Māori, with some greater or lesser Kaupapa Māori content, and which sit within larger non-Māori services or organisations.

For many years mainstream/bi-cultural services and interventions have dominated the social services landscape (Ministry of Justice, 2009). Kaupapa Māori services and interventions are scarce in comparison to mainstream/bi-cultural services. For example, all statutory services such as Corrections, Health (including District Health Boards), Child Youth and Family and Education are mainstream/bicultural establishments. The non-government organisation (NGO) sector is also dominated by mainstream/bi-cultural services such as Salvation Army, Rape Crisis, Barnardos and Youth Horizons Trust which are a few amongst a plethora of national mainstream/bi-cultural entities. In general, mainstream/bi-cultural services are guided by Western practices which are informed by Western philosophical ideologies. There are rigid pathways to accessing these services such as the way referral and assessment information is collected. For example, consumers are required to attend assessments and ongoing appointments at centralised, often difficult to access locations and which are unfamiliar to Māori whereas meeting in a home or having some cultural references in an environment can support engagement and healing processes (Te Puni Kōkiri, 2009).

Western cultural approaches that place the individual at the centre of healing, often with the exclusion of Kaumātua, whānau and community (where Māori identity is understood, taught and transferred) in any form of intervention or restoration, are not compatible with Māori values that prioritise iwi, hapū and whānau and which Durie and others draw on to construct various Māori models of practice (Durie 1994, 2003; Pere, 2014).

The majority of counselling practices in mainstream/bi-cultural interventions draw heavily on various Western models of practice. Moe Milne (2010), refers to various models of practice as 'talking therapies'

and concludes that 'It does not really matter which model of talking therapy is being used, as long as what underpins the application of the model are practices and principles consistent with Te Ao Māori and an understanding of the social and cultural context of the individual and their whānau.' (p. 37).

Approaches utilised in responses to sexual violence events are generally described as Client-centred and Trauma-focused and such crisis responses often have their foundations in bodies of thought based on models such as those described. An example of this is trauma-focused CBT:

> Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is a components-based psychosocial treatment model that incorporates elements of cognitive-behavioral, attachment, humanistic, empowerment, and family therapy models. It includes several core treatment components designed to be provided in a flexible manner to address the unique needs of each child and family. There is strong scientific evidence that this therapy works in treating trauma symptoms in children, adolescents, and their parents. This model was initially developed to address trauma associated with child sexual abuse and has more recently been adapted for use with children who have experienced a wide array of traumatic experiences, including multiple traumas.
> (Child Sexual Abuse Task Force and Research & Practice Core, 2004)

The Good Practice Guidelines (MSD, 2009) offer fifteen 'Principles of Delivery' for 'Mainstream Crisis Support Services Responding to Sexual Violence Perpetrated Against Adults' (p.11) which have some similarities to Kaupapa Māori service delivery concerns such as: the welfare and well-being of the victim/survivor being paramount; requiring a specialist sexual violence response; provision of quality services; integrated services such as working with other services to provide a thorough wrap around response to meet the needs of clients; and working collaboratively nationally and locally, etc. Accessibility to Kaupapa Māori services is also a particular concern as is being culturally competent and resourced; which are discussed further in this report.

Principle 3 speaks of the importance of a values-based approach to sexual violence and that 'client-centred practice and the concept of empowerment are cornerstones of the ways that sexual assault support services work due to our understanding that they are an effective response to sexual violence precisely because they undermine the dynamics of that violence' (p.21) and that these as values, inform thinking on what survivors need to heal, 'the nature of our organisations and relationships, and our political advocacy and activism to get the needs of victims/survivors met and to end sexual violence' (p.21).

Values-based practice is important to Māori and working with Māori. However, differences in values and concepts such as what constitutes empowerment when drawn from differing cultural worldviews,

whilst at some levels may appear similar, can lead to significant differences in interpretation and practice. A simple example of this may be differences in understanding what is required for the welfare and well-being of the victim/survivor and healing; and therefore how that is achieved (Principle 1). Principles that inform a Māori worldview are discussed further in this report.

Within the Mainstream Good Practice Guidelines (Ministry of Social Development, 2009) there is an acknowledgement and good intention to respond to Treaty obligations, and reference to Māori approaches to working with people in crisis. Again, it is important to note that mainstream responses are drawn primarily from Western philosophical perspectives which vary considerably from a Māori worldview. The inequity in valuing Māori approaches to crisis and ongoing trauma within the wider support system is evident. For example, a therapist (non-Māori) reports that where she has described treatment for trauma based on Paiheretia (Durie, 2003) and Whare Tapa Wha (Durie, 1994) she has been advised by some ACC assessors that it is not an acceptable form of treatment, that it is not evidenced-based and therefore there is no justification for use. Alternatively, the response has been that (Māori models) are only an appropriate therapy for Māori. However, it is contended that trauma-focused psychotherapeutic approaches fit conceptually with Te Whare Tapa Wha and other holistic Māori models utilised to address sexual violence (Anonymous, personal communication, 2016).

Western philosophical perspectives are often screened/disguised in what we might describe as a new world, feminist, integrated approach which can lull us into thinking we are closer to a Māori worldview.

### *Limitations for Māori Within Mainstream/Bi-cultural Services*

When reviewing mainstream/bicultural services in relation to service delivery for Māori, it is important to consider the concept of 'dualism', "A critical element here in the way in which early writers represented Māori is the issue of dualisms. Dualisms are constructed that position the colonised and coloniser relationship", (Te Puni Kōkiri, 2009a, p.17). For example:

> …colonised being unknown, savage, heathen, in the dark, immoral and inferior to name a few. Whereas the coloniser is well known, discoverer, civilised, Christian, enlightened, moral and literate. Each of these binaries locates colonised peoples as inferior to their colonisers and provides justification for ongoing oppression. (Te Puni Kōkiri, 2009a, p18)

When viewing dualism in current times and positioning Western clinical practice alongside Māori clinical practice there are still strong echoes of the historical positioning, where Western ideology and psychology is endorsed above Māori clinical and psychological practices (Te Puni Kōkiri, 2009a). This is reinforced by statutory agency policies on practice delivery.

All services within the sexual violence sector utilise Western models of practice which are primarily imported from outside of Aotearoa. Kaupapa Māori organisations on the other hand utilise approaches to practice that are derived from a local, indigenous worldview. All approaches to practice are required to meet statutory standards which are informed by Western clinical practice standards. Māori clinical practices which are drawn from te Ao Māori principles, values and practices and which have been used for centuries, are screened and monitored utilising a Western psychological framework.

Feedback to Māori service providers from Māori accessing support through essential services such as Police, judicial and other statutory agencies was, "…that there was an enforcement of other world view criteria to access services and enforcement of other world views to provide service in a meaningful way for Māori," (Reid for Ngā Kaitiaki Mauri ,Te Ōhākī a Hine- National Network for Ending Sexual Violence Together, 2010, p.71) and continues,

> Mainstream services compound the issues of loss of cultural identity and heritage while placing their clients within a Pākehā thinking framework. In most accounts, clients who have been through a mainstream/Pākehā framework have had to undergo a decolonisation process in order for cultural healing to begin. In some instances the whakapapa of the client and the values of the organisation does not always support in the healing process. Bi-cultural services are offered by mainstream services but these values may not always align with kaupapa Māori values. (p.74)

Returning to the paradigm of dualism, it is pertinent to discuss the imperceptibility and invisibility of culture in relation to practice. When culture is mentioned in relation to practice it is commonly understood as indigenous culture or other minority culture. Culture is relatively unacknowledged when referring to Western interventions (Smith & Te Wiata, 2009). Jones and colleagues (1999) refer to lack of acknowledgement of specific cultural contributions to healing other than those that derive from dominant culture, within mainstream services (cited in Nathan, Wilson & Hillman, 2003). They comment that the lack of acknowledgement is apparent in treatment delivery and impacts on measuring outcomes effectively for minority groups such as Māori. He argues that groups are rarely identified by ethnicity and overall statistics, that are largely measuring the outcomes of acknowledged, Western practices, may be masking poor outcomes for Māori and other minorities:

> The lack of acknowledgement of "culture" as a variable relevant to treatment efficacy represents a gap in the literature in this field. Jones and colleagues (1999) note that, despite a large body of research and theory surrounding aetiology, treatment and prevention of child sexual abuse, there has been meagre attention paid to culture-specific contributions to the problem. Programmes

> described in published articles generally exclude minority groups, fail to provide details of the ethnicity of subjects, and, if treatment outcomes are described, they are rarely (if ever) distinguished by ethnicity. When minority groups participate in treatment, professionals working with them may assume that treatment has worked. It may be however, that those positive outcomes for non-minorities simply mask poor outcomes for minorities (Nathan, Wilson & Hillman, 2003).

Whilst the masking of 'poor outcomes for minorities' continues, it will result in methods of delivery in mainstream/bi-cultural services remaining unchanged for minorities such as Māori and the outcomes for those groups will continue to be the same.

The Ministry of Health and the Accident Compensation Corporation (ACC) commissioned research into Māori accessing mainstream health services with the intention to review how their services were, or were not meeting the needs of Māori consumers. The research paper, He Ritenga Whakaaro: Māori experiences of Health Services (Jansen, Bacal & Crengle, 2009) found there were barriers for Māori to access services at a number of levels, including organisational, human resource, individual and community:

> At the organisational level barriers include: the timing and availability of services, the universal, Western approach to health care, the under-representation of Māori in the health professions, appointment systems, and the lack of appropriate educational and promotional material. At the human resource level barriers include: the characteristics of non-Māori health staff, including their perceptions of and attitudes about Māori patients; and appropriate provider-patient communication, or lack thereof. At the individual or community level barriers include: the socio-economic position of many Māori which makes healthcare unaffordable; and patient attitudes, beliefs and preferences which may make healthcare inappropriate, feared and/or not a priority. (Jansen, et al., 2009, p.8)

Durie (2005), argues that Māori should be able to expect treatment that draws on principles and practices drawn from their own culture that are known to be effective for Māori wellbeing:

> Māori as much as other New Zealanders expect the best possible treatment using tried and true methods. They also hope they will not be subjected to unnecessary interventions and will have access to new technologies and developments benchmarked against the best in the world. There are also expectations that health care workers will be competent at the interface between their own culture and the culture of others. Language barriers, differing codes for social interaction, variable community expectations and a willingness to involve friends or families in

> assessment, treatment and rehabilitation make important differences to the way care is experienced (Durie, 2005, p.8).

There is evidence to suggest that tikanga Māori principles have been effective when integrated into mainstream services and programmes. These integrated approaches are usually referred to as 'bi-cultural': a combination of Western (mainstream) and traditional (indigenous) mātauranga (knowledge). An example of such an intervention is the Te Piriti child sex offending treatment programme based at Paremoremo Prison, Auckland. The mainstream correctional programme integrated some tikanga Māori principles in their approach which resulted in positive outcomes as demonstrated in the reduction of recidivism:

> Mäori men who completed the Te Piriti treatment programme that combined a tikanga focus and Cognitive Behaviour Therapy (CBT) had a lower sexual recidivism rate (4.41%) than Mäori who completed Kia Märama with only CBT (13.58%) over time(Nathan, Wilson & Hillman, 2003, p.39).

Applying tikanga Māori practices and principles has been effective in improving outcomes:

> When tikanga Mäori processes are applied to Mäori individuals certain things happen to their wairua, hinengaro and tinana. What happens has never really been acknowledged within a Päkehä paradigm as a scientifically credible intervention in the psychology of human behaviour…This important piece of work shines a light for others to follow in finding a place for our tikanga, to achieve what Pākehā science could not on its own (Nathan et. al., 2003, p.3).

In this instance, tikanga Māori was carefully introduced into the programme by Māori who are knowledgeable and respected members of their respective iwi and hapū as well as experienced practitioners in both Western and Māori approaches to practice, and was supported by Tauiwi practitioners within that organisation.

However, a strong caution in respect of Māori programmes within mainstream/bi-cultural services emerges in Milne's (2005) report, Māori Perspectives on Kaupapa Māori and Psychology. Milne states that "Kaupapa Māori mental health services associated with mainstream institutions such as DHBs were criticised for providing mainstream, Western-based services, albeit with a Māori veneer." (p. 16). She continues that, overall there was agreement amongst her participants that:

> for those trained in Western philosophies and practices of psychology and mental health, assessment and diagnosis was done from a different point of view, with different values and

> different perceptions (from Kaupapa Māori perspectives), and hence different conclusions (Milne, 2005, p.16).

### *Kaupapa Māori Services and Interventions*

Numbers of Māori models of practice for health and well-being have been developed partly due to the inadequacy of recognition afforded Māori culture and cultural knowledges as contributors to change (Durie, 2003). Significantly, both a traditional and a contemporary Māori view honour connections to geographical origins, to iwi, hapū and whānau, before the individual.

There is very little literature specifically pertaining to sexual violence and Māori either as victims/survivors or perpetrators. There is even less literature that is written or acknowledged by Māori authors on this topic of addressing sexual violence from a Māori worldview. Having said this, the models and applications of Māori principles in practice and Māori clinical practices are being applied in a number of areas, particularly in mental health.

There are many Māori health frameworks that guide Kaupapa Māori service delivery and interventions. Moana Jackson highlights this in his comments:

> Within pre-European times Māori had clear processes that defined ways of interacting and which provided norms of control. He notes that "a complex set of customs and lore" existed that provided the mechanism for regulating behaviour. These mechanisms included both preventions and interventions and provided systems of social control and resolution processes(Te Puni Kōkiri, 2009a, p.22).

Customs and lores, understood as Tikanga or Kaupapa Māori, continue to be applied by Māori practitioners in our contemporary context, often despite the lack of acknowledgement and genuine validation by Western practitioners that they are effective clinical interventions.

There are many Māori clinical practice methodologies and frameworks available and for the purpose of this review we offer brief detail on three of these models which are commonly utilised within the sexual violence sector:

#### Te Whare Tapa Wha

Te Whare Tapa Wha was developed by Durie (1994) in consultation with Kaumātua from Iwi around the motu:

> With its strong foundations and four equal sides, the symbol of the wharenui illustrates the four dimensions of Māori well-being. Should one of the four dimensions be missing or in some way damaged, a person, or a collective may become 'unbalanced' and subsequently unwell. For many Māori modern health services lack recognition of taha wairua (the spiritual dimension). In a traditional Māori approach, the inclusion of the wairua, the role of the whānau (family) and the balance of the hinengaro (mind) are as important as the physical manifestations of illness
> (Ministry of Health, 2015).

## Te Wheke Kamaatu

The model, Te Wheke Kamātu, or the 'Octopus of Great Wisdom' was developed by Dr Rangimarie Turuki Rose Pere, CBE:

> There is a mergence of the "8" tentacles of the Octopus… 1) Wairua / Spiritual Dimension)… 2) TahaTinana /The Physical World… 3) He Taonga Tukuiho / Treasures That Have Come Down… 4) Mana/Divine Vested Authority… 5)Whānaungatanga /Kinship Ties that move in the Four Directions across the Universe… 6) Hinengaro/"The Hidden Mother" who is the Intellectual and Mental dimension… 7) Ranga Whatumanawa /Relating to the Emotions and Senses… 8) Mauri /Life Principle, Ethos, Psyche (Pere, 2014).

## Tihei-wa Mauri Ora

Tihei-wa Mauri Ora was developed by Teina Piripi and Vivienne Body:

> The construct is based on concepts of the realms of creation according to the Māori worldview: Te Korekore, Te Pö, Te Whei-Ao Ki Te Ao Märama, Tihei-wa Mauri Ora! Te Korekore: The realm of potential being, Te Pö: The world of becoming, Te Whei-Ao Ki Te Ao Mārama: the state between the world of darkness and the world of light, but is much closer to the unfolding of the world of light, Te Ao Mārama: The realm of being. In many ways this körero is the birthing story of an idea to use our own cultural knowledge as a means of assessment, a framework to gauge a particular place or stage, Te Wā, in the whole of one's life story. There is a growth and emergence through the darkness and towards light as the idea grows to take form in our hearts and minds (Piripi & Body, 2010 p.34-42).

There are a multitude of Māori models of practice that draw on Te Ao Māori and further frameworks continue to be generated as Māori practitioners return to Māori values and principles to inform practice, and this includes practice specific to responding to the crisis and ongoing trauma related to sexual violence.

### *Kaupapa Māori Service Development*

The Māori Social and Economic Advancement Act 1945 was,

> Established, within the Native Affairs Department, the means by which a welfare system could operate… The Māori Social and Economic Advancement Act acknowledged the severity of the social problems facing Māoridom and laid the foundation for a welfare system that would strive to tackle those difficulties (Szazy, Rogers & Simpson, 1993, p. xiii).

Significant initiatives have been developed to address some of the difficulties that were recognised in the Act (1945) including the national movement known as the Māori Women's Welfare League which was a Māori response to the broader issues, including violence. Māori continued to grapple with the impacts of sexual violence and a significant step to specifically address sexual violence from a Kaupapa Māori world view resulted in the formation of Te Kakano o Te Whānau. A number of Kaupapa Māori sexual violence prevention and intervention services have been established over subsequent decades (Te Puni Kōkiri, 2009), and in recent years, Ngā Kaitiaki Mauri (NKM) the Māori representative rōpū of Te Ōhākī a Hine- National Network Ending Sexual Violence Together (TOAH-NNEST). Most of the Māori services that are available today can trace their genesis back to the foundational and ground-breaking work achieved by Te Kākano o Te Whānau. These organisations are discussed briefly here:

Te Roopu Wāhine Māori Toko I te Ora ( Māori Women's Welfare League):

In September 1951 the Māori Women Welfare League (MWWL) was founded to "carry out its huge and important kaupapa – the promotion of all activities that would improve the position of Māori, particularly women and children, in fields of health, education and welfare" (Szazy, Rogers, & Simpson, 1993, p.xiii). The Māori Women's Welfare League also dealt with issues of concern to combat domestic violence. It was within the domestic violence kaupapa that they addressed the issue of sexual violence. For 64 years the MWWL has dealt with the burgeoning social issues within Māori whānau and communities.

**Te Kākano o Te Whānau** (in Te Puāwaitanga o Te Kākano, Te Puni Kōkiri, 2009a)

Some of those who were involved in the establishment of Te Kākano o Te Whānau remain in the sector and from their historical perspective the development of Te Kakano o Te Whānau is:

> "a critical event in the (sexual violence) sector and was a development that brought a wide range of Māori women into working with whānau and who also began a movement towards bringing Kaupapa Māori approaches to the fore in dealing with sexual violence" (p54).

Thirty-nine Māori Women's Centres were established 'under the umbrella of Te Whānau o Te Kākano' (p.55) and as a collective they accessed funding and resources, including from Government. As well as direct delivery to whānau, a training arm was developed to prepare Māori to work in the sector utilising a Kaupapa Māori informed delivery. Of particular note is the key focus on understanding the whare tangata, known as the womb in te Ao Pākehā, but understood as 'Houses of Humanity' (p.33) in mātauranga Māori where: 'Whare tangata is rooted in the creation of the world and in the overriding tapu of whakapapa' (p.33). Acts of sexual violence are a violation of the tapu of the whare tangata and of whakapapa and 'were not acceptable within Te Ao Māori' (p.53). A training package was developed to support workers in their delivery and to ensure that whānau healing was central to practice.

The first Māori Women's Refuge Centre was also started during this period when a Māori Women's Centre found it 'too difficult within the context of (their relationship with) a Pākehā organisation' 'to implement Māori strategies' and that 'it was soon evident that there was need for Māori services'. This led to the establishment of Te Whakaruruhau in Hamilton.

### Ngā Kaitiaki Mauri : Te Ōhākī a Hine – National Network Ending Sexual Violence Together (TOAH-NNEST)

TOAH-NNEST was founded in 2005 with the vision of a sexual violence-free Aotearoa (TOAH-NNEST, n.d). Governed by the Paetakawaenga, TOAH-NNEST comprises two groups, the Tauiwi caucus and the Kaupapa Māori rōpū, Ngā Kaitiaki Mauri (NKM).

NKM's principles/takepu are designed specifically to address sexual violence from a kaupapa Māori worldview. Referred to as nine guiding kaupapa in Ngā Kaitiaki Mauri Strategic Plan, they are:

> MĀTAURANGA MĀORI - the maintenance and acknowledgement of Māori knowledge, WAIRUATANGA – the acknowledgement of Māori spirituality, HAUORATANGA – the well-being of our people, WHĀNAUNGATANGA –whakapapa ties with an emphasis on the importance of knowing the connections of those with whom you interact. Creating a collective responsibility and obligation towards the elimination of sexual violence,

> PUKENGATANGA - Knowledge development and retention and that expertise of Kaupapa and Tikanga Māori practitioners are integral to the elimination of sexual violence, MANAAKITANGA – the expression of mana enhancing behaviour, RANGATIRATANGA – the attributes of leadership. Successful leadership responds to the specific needs of the people, UKAIPOTANGA – the place of sustenance and these recognised places of sustenance provide the best environment for positive change, KAITIAKITANGA – the guardianship of well-being. The pathway to healing incorporates the application of and respect for taonga Māori.
> (TOAH-NNEST, n.d., p.1-16)

Ngā Kaitiaki Mauri developments: Te Puāwaitanga o Te Kākano Background Paper Report

In 2009 a working group was formed from within Ngā Kaitiaki Mauri (NKM, TOAH–NNEST) alongside Te Puni Kōkiri to develop a background paper to provide, "an exploration in understanding sexual violence for Māori. The background paper explores traditional and contemporary knowledge related to healthy relationships for Māori and also Māori views of sexual violence" (Te Puni Kōkiri, 2009a, p.6).

Te Puāwaitanga o Te Kākano (Te Puāwaitanga) uses a Māori research methodology framework with three key methods which were literature review, key informant interviews and four case studies. Three of the case studies were taken from Kaupapa Māori agencies and the fourth from a Māori rōpū within a mainstream agency. All agencies were selected as they dealt primarily with sexual violence within their communities. This was unique research in that it was the first time an insight into responses to sexual violence from a Māori worldview, was obtained. The research found a collection of Māori practitioners were effectively applying Māori principles in their practice: "Kaupapa Māori providers of sexual violence services use tikanga Māori concepts and practices in their work with whānau", (Te Puni Kōkiri, 2009a, p.182). It continues:

> Service users noted that there was a distinctive difference between Māori providers and non-Māori providers that they have been involved with. Their involvement with Māori providers was seen as making a significant change in their lives through the process of understanding more about themselves as Māori, their status and their place within whānau and whakapapa… the change element was also clearly attributed to the access of mātauranga Māori (Te Puni Kōkiri, 2009a, p.88).

The breadth and depth Māori principles were clearly evident in the literature and therefore, for example, the practitioner would need to know more than how to pronounce te reo Māori, but also importantly, to learn the etymology of the words and how to use them to effect positive change.

## Kaupapa Māori Services

There now remain a very small number of Kaupapa Māori services whose primary focus is to provide sexual violence crisis and ongoing support to victim/survivors. Likewise, there has been great difficulty in establishing services more specifically focussed on those who have perpetrated sexual violence. A constant struggle for resources and equity with mainstream services in general and the need to meet delivery criteria specific to a Western worldview to achieve funding, have contributed to the eventual closure of many Kaupapa Māori services. Healing for the whānau as a central tenet for Kauapapa Māori delivery can be misunderstood, misinterpreted and made extremely difficult by practices informed by policies established within structures based on Western philosophical understandings.

### Kaupapa Māori Victim Survivor Services

In Te Puāwaitanga o Te Kākano (2009), three Kaupapa Māori services working with victim/survivors, and their whānau, were interviewed. Each of their founders can trace their early history in the sexual violence sector back to Te Kakano o Te Whānau.

Provided here is a brief overview of their services as described in Te Puāwaitanga o Te Kākano (Te Puni Kōkiri, 2009a):

#### Service 1

A Kaupapa Māori service in the Eastern Bay of Plenty identifies themselves as one of a very few offering sexual violence services in the entire region saying, "In the Eastern Bay of Plenty, (we) were bereft of any services in terms of tiaki Whānau and the issues around domestic violence and the issues around sexual violation." (p.123). The service has te Ao Māori as the foundation for their approach to service provision utilising tikanga Māori in their work with people who have been sexually harmed and their whānau. The provider notes that although there are some alternate service providers, whānau have reported that those providers' lack of Māori knowledge had negatively impacted on the experience of victim/survivors of sexual abuse. The service describes their approach to healing as utilising:

> "Māori models as a form of intervention with Māori whānau. The Whānau are at the forefront of any intervention, keeping the whānau intact, maintaining the Whānau integrity… utilising

> whakapapa and Māori elements as a healing process. Working with te reo Māori as opposed to the English language." (TPOTK in Te Puni Kōkiri, 2009a, p.123)

### Service 2

The service is:

> Based within Waitakere City and is operating as a Kaupapa Māori service since 1987. (The Provider) provides support for individual whānau members who have been sexually violated and their Whānau…. (the service's) philosophical view on well-being holds that the role of the wāhine is central to the well-being of Whānau. Believing that if the wahine is well then the ripple effects will benefit community as a whole… programmes and procedures are based on a number of underlying Māori core values. They are Mauri Ora, Mana Wāhine, Whānau Ora, Tu Tāngata, and Tutahi Te Iwi Māori (TPOTK in Te Puni Kōkiri, 2009a, p.134).

### Service 3

A Kaupapa Māori service was established in Christchurch in 1986 'to enable wāhine Māori and their whānau to overcome the effects of abuse' (p.147).

> The overall mission of (the Kaupapa Māori Provider) is about the restoration of the whānau in terms of their mana, dignity and pride as a Māori person and as a Māori whānau through a journey of healing that incorporates:
>
> - Te Taha Wairua (Spiritual)
> - Te Taha Hinengaro (Mental)
> - Te Taha Whānau (Family)
> - Te Taha Tinana (Physical Wellbeing) (p.149)

People who accessed the service chose to do so for the following reasons:

> - (It) is a Kaupapa Māori organisation working with survivors of Sexual Abuse in Otautahi and surrounding districts
> - All of the kaimahi in the organisation are Māori
> - Being in a safe environment where whānau cared (TPOTK in Te Puni Kōkiri, 2009a, p153-154).

All of these services have successfully developed their own models of practice drawing on kōrero tāwhito and there is a strong consistency of approach, that is ensuring that he whare tangata and ensuing whakapapa and whānau principles remain central to their practice. Whānau healing is held as critical for safety and wellbeing of the individual, whānau, hapū and iwi.

A more indepth outline of their services is available in Te Puāwaitanga o Te Kākano (Te Puni Kōkiri, 2009a).

People who have experienced sexual harm are referred to these services together with their whānau who themselves may be victims of historical sexual abuse. The perpetrator of sexual harm may also be within the whānau or wider whānau or hapū group. Consequently, where sexual abuse has been identified, kaimahi must be skilled to recognise and manage the presenting crises and trauma at multiple levels.

### Māori Rōpū within a Mainstream Service – Harmful Sexual Behaviour

#### Service 4

A service delivery programme within a mainstream service primarily for people who had perpetrated sexual abuse was the fourth service examined within Te Puāwaitanga o Te Kākano. The service was established in 2002 within a mainstream/bi-cultural organisation that was:

> 'specifically targeted for Māori and utilises a tikanga Māori approach' (p.100). The service was 'aspiring to live within the principle of being Māori within a non-Māori organisation… it is often quite difficult to provide this type of distinctive service within a non-Māori organisation and this can prove to be a barrier… specific programmes for Māori clients and whānau were begun in recognition both of the needs of those clients, and to demonstrate (the organisation's) commitment to developing indigenous models of treatment… (kaimahi) work with groups, whānau, individuals, and of recent have started working informally with victims of the perpetrators where appropriate.'

Key points from stakeholders and whānau included the importance of Kaupapa and Tikanga Māori and the need for kaupapa Māori services to be available in other parts of the country (TPOTK, 2009). Key developers of this programme felt unable to maintain the integrity of Kaupapa Māori service delivery within the constraints of a non-Māori organisation and Western clinical priorities.

#### A Kaupapa Māori Harmful Sexual Behaviour Service

This service was established in recognition of the need for an independent Kaupapa Māori service within the Harmful Sexual Behaviour sector in order to maintain Māori cultural/clinical integrity in its service delivery.

Whilst there are a very small number of Māori practitioners in the Harmful Sexual Behaviour sector, there is currently only one Kaupapa Māori service whose primary focus is therapeutic rehabilitation of people with harmful or concerning sexual behaviour and its prevention:

> "(the service comprises) Māori clinical practitioners (who) offer a unique Māori clinical approach to their work with whānau. Māori clinical practice refers to the application of both Māori cultural and clinical knowledge and applied specifically within the sexual violence sector. Practice is informed by Māori values and principles and utilises knowledge and experience from the fields of sexual violence prevention education, survivor services and sexual offender treatment" (Korowai Tūmanako, n.d.).

The primary standards and principles of practice are used by the service in the treatment of people with Harmful Sexual Behaviour (HSB). These are, but not limited to, Whānaungatanga – Connecting together, Kotahitanga – Standing together, Manākitanga – Urging together towards integrity, Kaitiakitanga – Guarding and protecting each other, Rangatiratanga – Stepping into responsibility. Wairuatanga – Spirituality is the cohesive binding principle, which weaves through all the others and draws them together.

Consistent with the three Kaupapa Māori services described as working with survivors, discussed here, the service has successfully developed its own approach to practice drawing on kōrero tawhito and ensuring that he whare tāngata and ensuing whakapapa and whānau principles remain central to their practice.

The two services within the harmful sexual behaviour sector, whose primary focus is to address the perpetration of sexual harm, are discussed in this report that is victim/survivor focused, as people who are referred for harmful sexual behaviour, together with their whānau, are frequently also victims of historical sexual abuse. As discussed above in survivor services, members of their support whānau may have experienced sexual abuse; and the primary victim is often a whānau member and may present at some of the hui. Consequently, where sexual abuse has been identified, kaimahi must be skilled to recognise and manage the presenting crises and trauma at multiple levels.

### *Barriers to Kaupapa Māori Service Delivery*

Any exploration of barriers to Kaupapa Māori service delivery must firstly consider the privileging of a Western worldview above a Māori worldview and therefore respective healing practices that are derived from each. For example, a fundamental difficulty is that Kauapapa Māori services must align with

specific service delivery requirements in order to access funding which can create a 'siloing off' of whānau members whether it be due to gender or role in the incident of harm. This is in contradiction to the central notion of whānau healing informed by kōrero tāwhito.

There are also few mainstream/bicultural services that prioritise effective cultural and associated clinical competency, to ensure staff are adequately equipped to support Māori in their healing; whilst in comparison, all practitioners are required to complete comprehensive study and qualifications in Western psychological and psychotherapeutic practice. It is a common observation that in Aotearoa society, Tikanga Māori practices are embraced for openings and closings of events, yet very little is understood or recognised regarding the contribution that the values and principles that underpin these processes, can make to people's healing processes (Smith & Te Wiata, 2009). There appears to be little value placed in achieving competence in mātauranga Māori and understanding the Māori psyche from a te Ao Māori perspective. Nikora (2007) asserts:

> "Māori have their own approaches to health and well-being, which stem from a world view that values balance, continuity, unity and purpose. The world view is not typically thought of as 'psychology', yet it is a foundation for shared understandings and intelligible action among Māori. Māori behaviours, values, ways of doing things and understandings are often not visible nor valued" (p. 8).

Likewise, when Milne (2005) met with Māori participants active in their Māori communities from a range of backgrounds including Kaumātua, tohunga, consumers, whānau members, young people, mental health professionals, educationalists, social services workers and psychologists to discuss "Māori Perspectives on Kaupapa Māori and Psychology" (p. 21), she found, "There was considerable discussion of the dangers of Māori centred psychology training being viewed as lesser than, secondary to or less robust than Western centred psychology training" (p. 21). She also noted that, "a number of participants pointed out that Māori communities often had kaupapa Māori psychologists in their midst, who were widely recognised within their communities but not recognised or acknowledged outside of them" (p. 25).

Disparities in utilising Western methodology rather than Māori worldview approaches to practice appears to have some resonance in the 'simplicity of intent' for all, alluded to by Sir Hugh Kāwharu in his discussion of the Treaty of Waitangi. He says, "There is both strength and weakness in the Treaty of Waitangi: a paradox that might well lie in its very simplicity", (Kawharu, 1989, p. x). The apparent 'simplicity of intent' behind the Treaty of Waitangi (Te Tiriti) may support the application of 'universal' practices drawn from dominant culture, since the 'intention' is to do well for all. For example, many mainstream services use Western methodologies with well-meaning 'intent' to a greater or lesser extent with all, including Māori clients.

Over the past 176 years, since the signing of Te Tiriti, colonisation has contributed to the breakdown of the traditional Māori way of life, beliefs, values and philosophy, social structures and systems of discipline and justice, as well as loss of identity. These have all profoundly impacted negatively on social, cultural, economic and health facets for Māori (Durie, 1994, 2003; Pihama, Jenkins & Middleton, 2003; Te Puni Kōkiri, 1997). These eroding factors significantly limit Māori access to their maatauranga and reduce the effectiveness of treatment in reducing harm from sexual violence.

Further barriers to Kaupapa Māori service delivery are outlined by Hamilton-Kātene (Te Puni Kōkiri, 2009a):

- lack of specific funding to develop service provision
- diversity of Māori population
- workforce development issues
- referrals
- working with other agencies (p. 27-31)

Hamilton-Kātene concludes that the greatest barrier is that "funding allocations are not evenly spread amongst all service providers which has resulted in the under-representation of Kaupapa and Tikanga Māori service providers within Aotearoa" (p. 31).

SUMMARY

In summary, Māori have significantly higher rates of victim/survivors (Mayhew & Reilly, 2007). The psychological and emotional complexity that Māori experience increases their vulnerability to harm and results in a high rate of revictimisation.

The erosion of Māori values and increasing cultural distortions have a direct link to colonisation (Durie, 1998, 2004; Pihama, Jenkins & Middleton, 2003; Te Puni Kōkiri, 1997) which continues to negatively affect Māori today. Negative effects are endorsed through the privileging of Western knowledge supported by the wealth of research, resources and publications both historically and currently which validate Western knowledge and approaches to practice (Aldridge, 2012).

The majority of government and non-government social services deliver mainstream care, which primarily draws on Western models of practice in an endeavour to meet the needs of Māori. There are significant barriers to Māori accessing services due to the characteristics of mainstream services that do not meet the needs of Māori (Jansen, Bacal & Crengle, 2009).

Some literature refers to gaps of cultural knowledge masking poor outcomes for Māori (Nathan et al., 2003), and that there is no requirement for practitioners or services to attain any significant learning in Te Ao Māori clinical practice such as a Bachelor, Master or PhD equivalents despite Māori literature strongly indicating that practitioners must have an in-depth knowledge of Māori applications (Te Puni Kōkiri, 2009a).

Māori models of practice offer unique insights to health and wellbeing. There are many empowering Māori paradigms and practices yet very few are known outside those practising from a Kaupapa Māori worldview. Without a sound understanding of the kaupapa Māori principles on which the models and approaches are based, they are not understood or applied effectively. Māori expect best possible treatment using tried and true methods and should not be subjected to unnecessary interventions (Durie, 2005).

The literature discussed demonstrates that there remains a cavernous gap between relative ease of access to services providing Western practice compared to poor access to Kaupapa Māori services providing Kaupapa Māori practices to address sexual violence. The following sentiments by Nuki Aldridge a Rangatira and Kaumātua of Ngāpuhi Nui Tonu, summarise the ongoing issues of disparity that are experienced by Māori, tāngata whenua, in Aotearoa:

> "We as Māori have yet to be credited with human intelligence that has the capacity to think and make decisions. The history of a people is their culture and a culture has expectations that those selected to transfer their history are guided by the rules of engagement determined by that culture. When will Tāngata Whenua get the opportunity to be part of the decision making process? In a Treaty debate, you would think it reasonable that the rules of engagement are promulgated in equity by both parties. But it is inequitable where one party to a treaty (Tauiwi/Pākehā) makes the rules and has access to wealth to prosecute their evidence" (Aldridge, 2012, p.xi).

In this case the wealth of validation, research, resources, written publications on practice have been prioritised, "while the other party (Māori) is directed on how and when the resources are available. The availability or the lack of resources then controls the outcome" (Aldridge, 2012, p.xi). One may perceive this to be the current situation where Māori currently sit in comparison to their Tauiwi and Pākehā peers.

## *METHODOLOGY*

This particular study is positioned within a larger research project that is designed using Western research methodology. Given the focus of this specific study was on engaging a Māori perspective, a Kaupapa Māori approach was adopted undertaking research that draws on a number of influences including tikanga Māori values and practices, and Māori knowledge and perspectives about the world (Moewaka Barnes, 2000).

> "Kaupapa Māori has been regarded as theory and analysis that involves research approaches developed by and for Māori" (Mead, 1996 cited in Te Puni Kōkiri, 2009a).

Qualitative methods were utilised enabling us to 'give a voice' and provide an opportunity to explain phenomenon from our own perspective. This was to ensure a Māori perspective would be heard, and allow for more equal empowerment of the participants.

Working with a Māori Project Research Manager who is experienced in Kaupapa Māori research approaches, ensured the Researchers were supported to draw on Kaupapa Māori principles in designing the research approach. In addition, the Researchers for the project hold considerable experience in the sexual violence sector and position themselves within a Māori worldview. Therefore, it was also important to find a way of conducting the research that would acknowledge their interactions within the groups and to provide space for their contribution to the gathering of lived experiences (Jan Fook, 2002) of Māori practitioners within the sexual violence sector and to the ongoing generation of knowledge. Their co-participation in the research is congruent with Kaupapa Māori philosophy and principles.

The intention was to meet with Māori representatives from as many sexual violence response services as possible and with Kaumātua, key community figures who hold Māori knowledge and carry responsibility for the wellbeing of whānau, hapū and iwi.

A one day hui was designed to gather a range of Māori perspectives for good practice guidelines for mainstream sexual violence crisis support services working with Māori. To ensure a wider range of views, several individual hui were held with Kaumātua in Te Ika a Māui and an additional smaller hui was held in Te Wai Pounamu. The hui were facilitated by the Co-Researchers; the Research Project Manager also participated in facilitating at the larger hui.

## *Participants:*

The study included 18 participants in the Hui (1) in Te Ika a Māui; six individual interviews in Te Tai Tokerau; and six participants in the Hui (2) in Te Wai Pounamu. In addition, the Co-Researchers and the

Research Project Manager contributed to discussions. In total, 33 participants were involved in the conversations.

To provide opportunity for a range of views to be heard in Hui (1), equal numbers of invitations were sent to the following three groups: Kaupapa Māori services; Mainstream or Bi-Cultural services; and Kaumātua. Some services were unable to release staff to attend and one mainstream service was unable to provide a Māori staff member who was willing to participate. Six participants from each of these groups attended. The group comprised social practitioners and Kaumātua who are also actively involved in the sexual violence sector and related health fields.

Hui (2) was attended by eight participants from a Kaupapa Māori service and the age range of participants was from early twenties to mid-fifties.

Overall, the approximate ages of participants ranged between early twenties and early eighties. Those participating included social work students, social practitioners and community leaders.

Participants were given full details of the scope and purpose of the research.

### *Interview Procedures:*

Hui (1) was held at a local marae (Wai Tākere Oranga) located at Waitakere Hospital. Participants attended from as far south as Hamilton, south-east from Opōtiki and as far north as Whangārei. At the conclusion of the hui each participant was offered a koha as an acknowledgement of their involvement.

Hui (2) took place at a Te Puna Oranga, a Kaupapa Māori Social Service in Otautahi. Other individual Kaumātua interviews took place in homes and at Māori Trust Board offices in Te Tai Tokerau.

Initial processes for each of the hui were conducted by the Manawhenua, the local hosts. For the marae-based Hui (1) this was in the form of formal pōwhiri processes which were led by local Kaumātua. Hui (2) followed a similar less formal process of whakatau which was also led by Manawhenua. In both cases a process of whakawhānaungatanga including identifying self in respect of whakapapa and sharing kai was an important part of the process. These processes create a safe space for Māori within which conversations of importance, of mana and tapu, can ensue.

The group interviews and the individual interviews were focused on the needs of Māori who were experiencing the trauma of sexual violence and seeking crisis support from mainstream services.

In Hui (1) each of the three participant groups: Kaupapa Māori; Mainstream; Kaumātua; were separated to promote freer, less inhibited discussion and each group was facilitated by a Co-Researcher or Research Project Manager. Following the separate group discussions all participants were gathered together to share key points generated from the smaller group discussions.

Hui (2) was co-facilitated by the Co-Researchers and the individual interviews were facilitated by one or other of the Co-Researchers.

A series of Probing Questions (see appendix) was prepared to initiate discussion to elicit perspectives and ideas in respect of Good Practice Guidelines to support Māori who had experienced sexual violence. The questions proposed discussion around: Māori needs and expectations of crisis services; Crisis supports for Māori; Recommendations for improving the experiences of Māori with crisis services.

The individual interviews with Kaumātua were less structured so that participants had opportunity to share traditional knowledge that may not have otherwise been elicited within the scope of the prepared guidelines.

Integral to participants' discussions was the seeking of help by Māori from a mainstream service; whether Māori could be well served within mainstream services; how Good Practice Guidelines could support non-Māori practitioners whose services were sought by Māori; and appropriate support services for Māori experiencing a sexual violence crisis.

The group interviews were recorded and transcribed with the participants' consent. Some of the individual Kaumātua interviews were audio-recorded and transcribed with consent and written notes were recorded for the remainder, with appropriate consent. A transcriber of Māori descent who possessed a sound understanding of te reo Māori and knowledge of the sexual violence sector was contracted to complete this work, with the parameters of confidentiality required for this project upheld.

The hui data was reviewed by the Co-Researchers and Research Project Manager and coded to identify common themes.

## *RESULTS*

Information pertaining to Māori and sexual violence crises and services, was gathered from hui and individual interviews from two main participant groups: Kaumātua, and kaimahi Māori from kaupapa Māori and mainstream services. From this data three main themes were identified which included:

Māori needs and expectations of crisis services, Crisis supports for Māori, and Recommendations for improving the experiences of Māori with crisis services. Within each theme subthemes were also identified which are displayed in the table below:

| Māori needs and expectations of crisis services |
|---|
| Embracing a holistic framework<br>Engagement<br>Choice |

| Crisis supports for Māori |
|---|
| Kaupapa Māori services<br>Mainstream and bi-cultural services |

| Recommendations for improving the experiences of Māori with crisis services |
|---|
| Workforce development<br>Cultural support and engagement<br>Enhancing inter-service relationships<br>- Kaupapa Māori service development |

## *Māori needs and expectations of crisis services:*

- Embracing a holistic framework:

Participants across all groups, irrespective of whether they work within a Kaupapa Māori or Tauiwi/Bi-cultural service, were consistent in asserting a Holistic Framework for working with Māori in crisis. Most particularly a holistic approach that stems from a Māori worldview was considered a priority and that:

> *"…anything to do with Māori is written from a Kaupapa Māori worldview"*

> *"We draw on our ways of healing from a te Ao Māori (Māori worldview)""*

*Wairuatanga:*

There are several aspects of a Māori worldview that emerged as critical to a holistic Māori worldview. In particular, wairua is considered central to any discussion of Te Ao Māori. Wairuatanga is considered to be critical in addressing sexual violence. Participants spoke of the impact of sexual violence on wairua:

> *"In particular, at the point of crisis, you know their wairua has been all damaged"*

In Te Ao Māori, familial and sexual relationships are maintained through whakapapa and the responsibilities that are inherent through whakapapa (Te Puni Kōkiri, 2009). Disconnection can result in isolation and for Māori.

> "*isolation can be life-threatening".*

Whakapapa and reconnection with whānau was discussed as a wairua process integral to addressing the isolation and disconnection that may be experienced by Māori who have been sexually abused:

> *"We do whakapapa… to link their wairua up so that's their whānau, hapū, iwi; so that's on the wairua side"*

> *"the (Wairua) kōrero … we've taken it not just out of our office and (our agency) but we've taken it into the police, the courts, XXX district council, the hospital - where we physically go out there and make contact with them and it is structured on the Wairua, we come from Wairua so when the Wairua is talking we acknowledge it"*

*Whānau Ora: Whānau as healers:*

Participants stressed the need for acknowledgement of whānau as able to actively contribute to whānau ora, that is, their own healing and wellbeing. Whānau ora includes the recognition of the mana and ability of individuals and the whānau to provide positive contexts for living that can generate solutions to support healing and the prevention of further harm:

> *"The key point for me…. (is) the importance of whānau having the power to do their own healing"*

> *"When the whānau take it back on themselves they own it back to where it should be and the healing is greater"*

Healing is evidenced by practitioners when clients are encouraged to draw on their past, positive whānau and tupuna experiences:

> *"They recall a vision in and there's an emotion attached to it: 'I was walking down the beach with my nanny …'"*

Rather than overlaying external concepts, the view being expressed is that the reconnection to Māori values and practices supports the whānau and the victim/survivors to move forward in healing. Kaupapa Māori practices seek to return Māori people 'home' to traditional, age-old whānau and hapū values that will support them on a pathway to wellbeing.

> *"that's what we need to focus on as (victim/survivors) to let go of stuff. You need to fill the gap up and you fill the gap up with their mana and the strength that they already have"*

*Māori as healers:*

Māori practices and processes (tikanga) that are rooted within Te Ao Māori have provided healing for Māori whānau for aeons:

> *"We've been doing (traditional Māori healing) way back and even back in the time of our tupuna"*

> *"I think it is simple… that (Tauiwi need to) understand that Māori have been their own healers and practitioners (for many generations)"*

*Whānau ora and feminism conflict:*

Whānau ora or wellbeing is established through strengthening the whānau relationships. Specifically, this includes tāne alongside wāhine. Some practitioners working within organisations that adhere strictly to feminist priorities, discussed experiencing difficulty in practising tikanga Māori and meeting contractual obligations within constraints that rigidly separate wāhine who are seeking their help, from tāne. Tāne are excluded from service or become invisible in accounts of practice under contracts that are understood to be based on feminist principles of 'best' practice:

> *"we work in a feminist organization. There's been a bit of a (conflict); because we're Māori we work with Māori … whānau, hapū, iwi (inclusive of tāne)"*

> *"we do work with male survivors or the partners of the survivors … not with just the survivors. We work with (survivors') parents because it does impact on the whole whānau… I do wonder how the whānau ora approach, which is very acceptable for us as Māori, … fits in a feminist organization.*

*We've got a whānau whare that we took years to get and we've established it and bring (whānau) through there … We're not supposed to work with males but I know that we do because it's kaupapa Māori. I can tell when (the wahine) is going flip out because she gets this glass look in her eyes and so we do need to support him in how to meet her needs…"*

- Engagement:

At all levels, effective engagement with support services for Māori seeking sexual violence crisis support is required. Effective engagement with Māori seeking help in a system that is constructed on a mainstream worldview is compromised through lack of cultural knowledge and understanding of **Māori**, which impacts on the way services are delivered.

*Māori victims and survivors:*

There can be an internalised diminished view of Māori identity or concerns regarding confidentiality when Māori are seeking to access services. It is critical that practitioners are able to engage with these conflicts in order to support the restoration of whānau ora which will result in healing for the individual.

Engagement and commitment with whānau within Te Ao Māori is grounded in values such as wairuatanga, whakapapa and whānaungatanga. Māori practitioners draw on such values to establish mutual responsibility and commitment:

*"we've had (Māori) people turn around and say I don't want to work with Māori and I say you know, no matter what, whether you look in the mirror upside down or inside out you will always be Māori and whenever somebody does something wrong you're not hurting yourself or your whānau you're hurting me because I'm Māori and so for me it's about working in a relationship together to heal together because you when you hurt you, you hurt me because I'm Māori; your pain is my pain; healing together"*

*Inter-Service Relationships:*

Partnership and importantly, relationship, between Kaupapa Māori and Tauiwi/Bi-Cultural sexual violence crisis support services based on Te Tiriti o Waitangi is essential for meaningful engagement between Tauiwi and Māori to occur:

*"I want (Tauiwi services/practitioners) to understand the Treaty of Waitangi. We're a partnership. We're not you or I, and a lot of them don't understand the kaupapa the Te Tiriti and I think the Te Tiriti plays a big part in the kind of support and choices (available to Māori)"*

Consistently there is an acknowledgement that relationship building between Māori and mainstream services is critical in order for Māori to receive appropriate support:

*"there is a collaboration and partnership that goes on between us and them but … what the collaboration is all about is supporting any Māori that may need us… we want better than (how that is working currently)… we've been working on getting a partnership between us so that we can be there so if a call comes in you know they can actually direct those people to the (Kaupapa Māori) services- now whether that works or not has to be actually up to us, to actually engage with each other and make it work and so we haven't done that"*

*"I think about building relationships within my local area with all the Pākehā services around sexual violence stuff and all the Māori services and build this relationship so that we are all on the same page"*

In general participants felt there was a lack of support services that are adequate to meet the needs of many Māori who are in crisis. This includes interactions with the Courts, Police and/or Child Youth and Family and Victim Support and also Housing Corporation and WINZ who often need to be accessed at various points of crisis:

*"Child, Youth & Family, they do not practice wairua"*

"*…people make an assumption that because they are Victim Support they know how to support anybody but it's actually really a (sexual violence) specialists' area."*

*"Housing Corp's got nothing in there to meet Māori needs; … none of them Kōrero Te Reo there"*

*"There is no cultural support in court processes"*

*"My wahine has done restorative justice kaupapa Māori style and I tried to explain to the court advisor and she shut me down and she just said this is my whare …this is how it goes when you're on my whare. She said I will talk about (Tauiwi) restorative justice. But there is Māori kaupapa restorative justice"*

Notions of tapu are not sufficiently understood and attended to. Lack of understanding and acknowledgement of tapu by support networks and knowing how to work with tapu, can result in ongoing violations for the Māori victim/survivor:

> *"…they disclose to the police and they come out of there and then they've got to disclose to support networks. You know then they are being traumatized over and over and over and for me it's 'where do we stop?'"*

Kaumātua (K) outlined how further violation can occur by repeat and/or premature questioning:

> *K: "There's a boundary there (that is what we call tapu, and Māori) understood the boundaries … you don't violate that tapu; …if (the victim/survivor) wants to be safe … wants to be alone or even (says) I can't talk to you now I've got something on my mind – there's a tapu and that's understood. But now (the response is) 'what's wrong with you? Why can't I talk to you … it goes on and on and comes back aggravated"*
>
> Q… "*that can happen when a person is in crisis … and you're being asked to give an account … Are we are violating tapu again?"*
>
> K: "*(yes) without realizing it because we don't understand that environment of tapu anymore for what it is because somebody has come along with another language and said this is what tapu is Māori and you better believe it but it isn't. I mean you can understand if it went back there you know from the old Māori world"*

- Choice:

The issue of offering a choice of services was controversial and important to all participants. The choice being referred to was whether Māori clients should be offered the choice of working with Kaupapa Māori services or with Tauiwi services. Currently all crisis telephone counselling services are operated by Tauiwi or Bi-cultural services. The only service available in the larger Auckland area at the time of the interviews had no Māori practitioners operating the crisis call lines therefore the conversation in respect of choice between Tauiwi or Kaupapa Māori services at that early point of contact would be offered by Tauiwi practitioners.

The outstandingly predominant view was captured in comments such as "*it's not a real choice for whanau*" because "*it's not level playing field to make a choice"*. This is in part reference to the impact of

colonisation which is considered to be a primary factor in weighting the whānau's decision towards Tauiwi services:

> *"a few times (Māori) have said to us, 'no we want to go upstairs to the Tauiwi (programme) and work with them because they know they what they're doing… but in the end just by doing whakawhānaungatanga with them they change their minds"*

Further a Tauiwi worldview as experienced by Kaupapa Māori practitioners appears to privilege choice above a secure cultural identity which is understood from a Māori worldview to be critical to wellbeing. The disparity between the two is more distinct when taking into account the notion of limited choice:

> *"(Tauiwi) actually think they have this moral obligation … that they've given a choice to our people. They haven't taken into consideration that our people are colonized and have been impacted. We have been oppressed. We are not on an even playing field. It would be tied if we were all on that same even playing field - if we had the same understandings, values and beliefs - we don't"*

> *"(Tauiwi) have this obligation to offer choice. Now if they really knew what it was like for us as Māori - if we give them that full awareness of the impact it has (on Māori).. it's not about you and the goodwill that you must (offer) people it's really about what is best for that person… what it means to be Māori'; to really (have) that full awareness of the impact (of colonisation), versus obligation to offer choice"*

The kind of choice on offer, how choice is presented and who offers choice, are further potential collision points between Tauiwi and Māori worldviews:

> *"Tauiwi worldview privileges for example at the first point of contact, this idea of choice. So when Māori speak with a Tauiwi person they are given a choice to either stay with the Tauiwi service or access a Māori service… what we were saying is, in the first instance Māori be referred to Māori services for a conversation. A conversation around whether they would like to access a Tauiwi service can occur within a Māori service rather than at first point of contact with a Tauiwi service"*

> *"You're right, they do have a right to make a choice but do you give them the choice and do you, are your people expert enough to take them through that healing process? … at the end of the day they come back around years later, to me"*

We compare the choice of Tauiwi/Māori to the following choices which stem from a Kaupapa Māori perspective. The meaning of choice is held firmly within Te Ao Māori and relies on the ability of practitioners to be able to work within the complexities of a Māori worldview.

> *"…if we believe we know what's best for our people why are we saying we have a choice? You know my nannies never gave me a choice. Why? Because they knew what was best for me. Did they say, 'moko, you choose? Do you want the kawakawa or do you want this or that? What would I know? But what they did was, they said. So this whole misconception about choice is actually a (myth)"*

> *"… the choice is about knowing our Kuia and our Kaumātua who are out there and we can ring and let them know. I have this Kaumātua and I have this kōrero ki ia: 'e mātau, tēnā koe e hoa, haere mai ki te tautoko ki ahau', and he goes, 'ae ka pai'. And he'll come no matter what…"*

> *(K)…"if I was referred to as Kaumātua, it's (for) the person that I can deal with my way. But the Kaumātua next to me might be able to deal with a person that is deeply religious. He goes to him and can't come to me because I have a wairua thing. But it's in the Māori world and this one might be the religious world and of course they might be in that world; so it can't be answered by one elder…"*

Impacts of colonisation are complex and in some cases Māori victim/survivors do request to work with Tauiwi services:

> *"They are too whakamā and they want to go to a Pākehā service. That way they can just deal with it. Do it the Pākehā way and get it over and done with in their eyes and I want them to have that choice. That's a choice"*

> *"...we do have Māori that come in and want to work with Tauiwi only because … Māori have been their abusers. So they've shifted to Tauiwi… if they say… (they) want to choose to go with Māori again, to lift up and enhance the Māori wahine in them and help bring healing to them (they can return)"*

Since this request occurs most often within a Tauiwi/Bicultural context, the importance of decolonisation conversations as a pathway to restoration of wellbeing is diminished. It appears that the Tauiwi/Māori choice for Māori is proportional to the impact of colonisation and inversely proportional to the understanding of cultural identity:

> *"we've all been through this cookie cutter of Western culture … but that's the reality for some of our people. They hold that, so for them it's important to have an idea of choice. So that's why we are saying the choice conversation should be with Māori in the first instance and then they can choose to go back after they have done whakawhānautanga with us"*

The prevalent view is that choices should be made available to Māori but not necessarily focused on the Tauiwi/Māori choice of service. Also, that choice for Māori is socially-negotiated. Kaumātua, tohunga and other healers and practitioners are all valid possibilities for healing and well-being and knowledge about these options may not necessarily rest with the client. In the final analysis, how and where the conversations about choices are conducted is critical to the outcome:

> *"we don't disagree with our people having a choice but who has the conversation about that choice with them (is critical), so what we are saying is in the first instance that a (Kaupapa) Māori service should have the conversation"*

### *Crisis support for Māori:*

- Kaupapa Māori services:

Of utmost concern to all participants was the dearth of Kaupapa Māori sexual violence crisis support services across the country. The availability of Kaupapa Māori services is extremely limited and access to those services is often difficult. Participants reported limited or no access to specialist crisis services that meet the needs of Māori.

> *"We don't have a (Kaupapa Māori service) providing that, we don't have an (Iwi service), you have a mainstream Kaupapa. You have a (mainstream service) providing crisis services mainstream kaupapa… that's what concerns me, same with our area no Māori in crisis support services."*

There were recollections by one participant from a Kaupapa Māori service of Māori whānau not being referred to their service or having difficulty locating their service, they had accessed a mainstream service, not knowing a Kaupapa Māori service existed next door. This was not a singular occurrence:

> *"I can tell (again and again) the same story around whānau who have gone down stairs (to a mainstream service in same vicinity) and they've come (to us) like 15 years later and cried and said I'm home. Isn't that amazing (that) someone can come and say I've been looking for you?"*

The sense of "*I'm home*" implies returning to a place that is known, common and safely familiar. Safe and familiar environments for Māori were being reproduced by Māori within the services they worked. These are philosophies from Te Ao Māori that Māori practitioners were practising in order for clients to experience a greater degree of safety. One participant working within a mainstream service shared the following:

> *"What we found is the background (of Māori with mental health), a lot of it was sexual abuse, so what we did, we actually created and developed a team of clinicians and a team of cultural Kaumātua here in Waitematā and we moulded the two together. We worked and developed these two streams to deal with one Kaumātua, with their cultural identity and, two when they needed the doctors, nurses and the counsellors they needed them because, well they had been institutionalized."*

This way of working with Māori, as pointed out, was a way of de-institutionalising clients through Kaupapa Māori practices. They went on to talk about how Māori narratives and understandings are transferred from practitioner to client and vice versa:

> *"Only Māori can tell it how it is to Māori"*

While this appeared very direct, the reality and outcome was that a space was created where both Māori practitioner and client were able to find a safe place of working. Kaupapa Māori practices were exercised in a physical environment that was conducive in supporting the wellbeing of not only the individual but of the whole whānau. It is usual when working from Te Ao Māori to work with the whānau and others that are part of the person's support network:

> *"This marae here is a healing marae, it's here for a reason, it's not only here to take on groups and bring groups on it's actually here for people to heal."*

Marae and other significant spaces for Māori call forward other paradigms that sit within a Kaupapa Māori world such as the wisdom and presence of a Kuia. One participant commented:

> *"I would have preferred to have talked to a nanny figure. A nanny who can offer you that, that Manaakitanga, you know that she (brings); that aroha and it would have to be female. That's just my personal experience that I wanted a nanny to talk to. Yep a kuia, a kuia that can, you know, not going to make it right, but that stillness about just being quiet in the moment."*

> *"Yeah and that's definitely kaupapa Māori. Some of the clients just want to sing, or they want you to sing for them. So yeah that's a part of their healing as well, and to sing songs, they want to*

*hear they've heard when they were little. Like you said there's not enough kuia, koroua and koro out there for our tamaariki."*

Some participants were very familiar with Tikanga and Te Reo Māori while others were not so familiar, however, all participants acknowledged how important Māori practices and a space for te reo Māori to occur, were in creating an environment that is safe for whānau Māori:

*"We may not all have Te Reo. We may not have the articulation of the Karakia that go with (certain areas) but we have access to that, and we know why that's important."*

Having noted the above, what was evident from the conversations regarding Kaupapa Māori was that when crisis occurred, there needed to be Kaupapa Māori services present at the first point of contact.

*"Kaupapa Māori at first point of contact at crisis – referral immediate"*

*"The first thing I think is to offer Kaupapa Māori with a Māori service. That's what I would say."*

It was clear that the limited availability and poor access to Kaupapa Māori services is of grave concern to all participants and the **development of Kaupapa Māori services** is critical if the needs of Māori impacted by sexual violence are to be addressed.

- Mainstream and Bi-Cultural services

A number of participants shared personal experiences of significant limitations for Māori working in Mainstream and Bi Cultural services.

Participants argued that Kaupapa Māori interventions that are informed by articulations of a Māori worldview, which is intrinsically holistic, are in the main regarded by mainstream services as less relevant than Western clinical interventions in achieving healing/wellbeing and rather that *"priority is given to Western clinical practice"*. It was acknowledged that within Tauiwi services there may be *"Māori working in there and they have it in their hearts to (work in a holistic/Māori worldview) but it is not possible."*

*"The integrity and mana of tikanga Māori practices are consistent with the principles of positive change that Western practitioners endeavour to attain. Mainstream practice requires us to focus on tangible, measurable evidence. Privileging the tangible to this extent, limits the ability to*

*measure the principles and effects of wairuatanga, because it sits within a realm that Western practice is unable to measure."*

There were consistent messages of Māori practices either being limited or disallowed within the service.

Of significant concern to some working within some Tauiwi services, and reinforced by their experiences with statutory services, were conduct guidelines restricting initiating or participating in conversations about wairua:

*"Under the policy that I work with (in) Kaupapa Tauiwi and bi-cultural we are not allowed to talk about Wairua, the spirit, and yet our whole office is filled with Wairua and spirit."*

While this conversation was about the wairua and its application for Māori practitioners in the workplace they went on to specifically bring to the attention of the group that the mauri and essence of Wāhine is dismissed because their wairua is not acknowledged through practice of wairua kōrero.

*"(wairua conversation) is shut down when we go to CYPS training. They don't acknowledge the wairua and I only work in the wairua. It's not acknowledged and that's what's coming through with the Māori wāhine is that their Wairua is not being acknowledged"*

This is significant when reviewing service delivery within the sexual violence sector given the high rates of wāhine(women) as victims/survivors of sexual crimes. There was an indication from some participants that mainstream crisis services should develop Māori services alongside to meet these critical and important needs.

*"So, what we need is that mainstream services providing 24 hour crisis (support) must develop Māori services alongside, or they must support the development of (Māori) cultural services alongside, because they cannot service our people."*

Another limitation was identified within mainstream services which was the inability to work in an all-inclusive way with whānau as some agencies were not allowed to include men in the therapeutic work required to bring about safety for the whānau. Māori practitioners from -one mainstream (bi-cultural) service described the conflict with the service's feminist philosophy when trying to deliver a whānau ora approach:

*"I was told not to claim for them (men) MSD goes 'don't you put them on your books'. I go what? You don't put those males on your books."*

*"We are not allowed to. They (mainstream service) have taken our whānau away, and we just have to have females and they're not allowed to have children. They brought in this thing where we can't claim it's just getting harder and harder."*

*"I think that's why the significant difference is about Tauiwi and Māori, around mainstream organisations and Māori organisations. It's a bit of a hara and a mamae to hear that you have to bring the men in outside of the kaupapa or policy of the agency."*

*"I guess this is some of the things that we are trying to address with this particular conversation. Why is it that we have to step out of their (mainstream) policy and into our Tikanga? "*

*"The fact of the matter is it was similar for us is when we were there (in mainstream), it was a similar process. There were things we couldn't practice as Māori within mainstream organisations and we had to take it outside of the organisation. So what are we saying, are we saying that we continue to do that? Or are we saying, well actually it should be a part of the policy within the mainstream organisation? Because this is what the conversation is about."*

A number of participants who have experienced working in mainstream or bi-cultural services spoke about feeling 'burnt-out' and 'undervalued'. They agreed that 'Māori kaimahi are vulnerable in mainstream services' as they are often overloaded with complex Māori cases as non-Māori within the service are not able to provide cultural, competent interventions.

Some practitioners had developed Kaupapa Māori initiatives that had been successful in working with Māori and non-Māori whānau yet with little acknowledgement, such as one remaining as an unpaid volunteer for many years:

*"I develop Kaupapa Māori initiatives which they take and use and I receive no acknowledgement"*

For others, the Kaupapa Māori practices they developed were re-presented under a Tauiwi framework:

*"…call it Māori practice; don't colonise the knowledge with a Pākehā name"*

Some participants linked the requirement to reframe Kaupapa Māori practices under Tauiwi practices frameworks to demonstrate they are meeting the requirement of Western clinical interventions in their practice, to the difficulty in accessing funding for their services:

> *"…while we might practice Kaupapa Māori over here we are ticking off the CBT box; or even with domestic violence you're ticking off the Duluth model. But the reality is we are practising (Kaupapa) Māori …so the reason that we don't get the pūtea and some of the issues (we experience within mainstream/bi-culturalservices) is because we are having to acknowledge these other models of practice."*

Meanwhile, some kaimahi felt that the mainstream/bi-cultural services were continuing to benefit from Kaupapa Māori interventions.

Many of the aspects that participants mentioned related to the lack of expertise and knowledge of non-Māori practitioners to work therapeutically with Māori within the world of taha Māori:

> *"A part of that therapeutic healing is Te Reo Māori, that taha wairua part which they (mainstream) are not experts."*

Māori kaimahi expressed grave concern that Māori accessing mainstream services may not be receiving the full service that they deserve to support them to move them toward greater whānau ora, that Māori practitioners are able to offer. The counter argument from one of the Kaumātua rōpū was that Kaupapa Māori knowledge is available to all, asserting tupuna kōrero encourages: *'aroha ki te tangata'* not *'ki te tangata Māori'*.

However, the majority of participants felt strongly that the health and wellbeing of the whānau Māori would not be met if Kaupapa Māori practitioners were not directly involved in the therapeutic process:

> *"How do they get to healthy and well if we're (Māori practitioners) not there to make it happen?"*

As whakapapa relational practices are important to Māori for the wellbeing of Māori, there was a lack of confidence that this could be adequately attended to, consistent with the above aspects and agreed with by most participants who stated:

> *"Whakapapa is a critical tool for working with Māori… it's tapu … there is a problem with giving it to Tauiwi … a problem with being to asked to write it down … you don't give it away; it comes to you in its own time"*

Whakapapa conversations are articulated in a way that is seamless, for example:

> *"Awwww, kia ora kare, or else you will hear a name, you will start connecting those names like it's so (matter of fact). I don't know what mainstream does, and I don't want to know, but I suspect they don't do what we do."*

In contrast a participant shared the following experience:

> *"I actually went to a counsellor (mainstream) and actually tried to cope with this … I walked in there, sat down, and she goes, 'good morning my name is 'blah blah blah', look I have some paper work I need you to fill out.'. Then handed me this Whakapapa paper they had, and (said) 'I want to know your relationships and blah blah.'. You don't even know who I am!"*

Overall, most participants experienced significant limitations to their ability to practice from a Kaupapa Māori worldview within mainstream services, endorsing the need for *workforce development* and ongoing *Kaupapa Māori service development* to meet the need for Māori in a way that is congruent with a Māori identity and with the whānau who are seeking help.

### Government organisations and NGOs

Participants working in in one particular region spoke of the need for a stronger tripartite agreement throughout that region. Narratives were shared of Māori whānau being re-traumatised when engaging with crisis support services, such as with the Police, or medical assessments following an incident of sexual violence. The main concerns were the lack of Kaumātua at critical points of crisis and generalist workers within Victim Support who are engaged by the Police, who *"do not practise wairua healing and are not skilled to work with survivors (of sexual violence) in crisis."*

> *"where it gets hard for me is we don't have a lot of Māori doctors so sometimes we have to accept that, but we don't have to accept (the absence of Māori) … I would like to see that doctors have Kaumātua (Kuia) beside them… I would like to know that DSAC doctors are trained to know some of this stuff, that is you know Tikanga for us, like for our wāhine. You know they pull your underwear down; you know you've got to pull your hair up when they're doing that, so without any thought! You know we used to be a part of the (examination) yeah you know we use to be a part of that…"*

Tikanga may vary in different areas but the same concerns were widespread amongst the participants. In general, participants also felt that Māori whānau may be reluctant to contact external services such as NZ Police and other Government agencies due to prior negative experiences that have been perceived to have threatened their livelihood or their whānau in some way:

> *"We need to change the process because, the process for whether it's a child or an adult their first point of call is with government agencies and we know that our people don't have a relationship with government agencies because it threatens the livelihood of that whanau."*

Most participants believed that it was not enough to rely on relationships with Tauiwi/Bi-Cultural services to refer Māori to Kaupapa Māori services. While such relationships are critical, to ensure consistent practice and accountability, any and all Good Practice Guidelines and internal mainstream/bi-cultural services' policies should require that the first conversation in respect to Māori whānau, including choice of service should sit with Kaupapa Māori services:

> *"(in respect of any) good practice guidelines … anything to do with Māori is written from a Kaupapa Māori worldview."*

Several participants spoke of the need to continue to work with local and central Governments to achieve equity of and access to resources in the sexual violence sector for the ***ongoing development of Kaupapa Māori services*:**

> *"that has to be Government; that has to be policies; that (ability to practise Kaupapa Māori) was out of our hands*
> *…at a National level we need to actually start (the change process) and making plans that we create space for a safe space for kaupapa, Kaupapa Māori."*

## ***Recommendations** for Improving the Experiences of Māori with Crisis Services:*

### *Four key areas of recommendation for change that have been identified throughout this report are summarised here:*

- Enhancing inter-service relationships

Participants considered strengthening relationships between Mainstream and Kaupapa Māori services as critical for the well-being of Māori clients. Relationship development between the services would be

occurring consistently over time rather than only at the point of crisis for a client. If this was occurring participants generally felt that Tauiwi services would be more likely to know when to refer to Kaupapa Māori services and there was a greater likelihood of whānau receiving the appropriate support. Also the reciprocal sharing of knowledge would be able to occur more readily. Strong inter-service relationships, that is between Tauiwi, Bi-cultural and Kaupapa Māori services is critical in order to achieve these outcomes.

> *"(for example) the kōrero we need to have with mainstream is that (Kaupapa Māori providers) are here and this is how you access them… my advice to mainstream is that they have a working relationship with a Kaupapa Māori service"*

> *"there is a collaboration and partnership that goes on between us (Kaupapa Māori providers) and them (Tauiwi/Bi-cultural providers) but … what the collaboration is all about is supporting any Māori that may need us… we want better than (how that is working currently) …"*

> *"I think about building relationships within my local area with all the Pākehā services around sexual violence stuff and all the Māori services and build this relationship so that we are all on the same page"*

- Workforce development

Workforce development requires at least dual foci. Firstly, increasing awareness and understanding for Tauiwi practitioners of the issues, both historical and current that impact on Māori needs to be addressed. Secondly, increasing the capability and capacity of Kaupapa Māori providers to meet the demand for services, requires the support of Tauiwi services and Government resources.

> *"(Tauiwi) haven't taken into consideration that our people are colonised. We have been impacted. We have*
>
> *been oppressed. We are not on an even playing field. It would be tied if we were all on that same even playing field,*
>
> *we (would) have the same understanding, values and beliefs. We don't. So for me I think that it's a major issue*
>
> *when it comes to a competency that Pākehā have to have. Some have had training; some (need) in-depth training*
>
> *about looking at themselves and looking at us through a value base that's of our making not theirs*

*…mainstream services … those who are working in this field, need training around what it means for Māori to be Māori"*

*"so what we need is for mainstream services providing the 24 hour crisis, they must develop Māori services alongside …they must support the development of cultural services alongside because they cannot service our people like we can do"*

- Cultural support and engagement

In order for Māori needs to be met effectively, it is critical that effective cultural support across the whole of the support system is available so that safe and meaningful engagement with Māori victim/survivors, their whānau and their communities, can occur in order to achieve acceptable outcomes for Māori whānau.

*"...need to get some whakaaro Māori going on that will give (non-Māori) enough information to know that they can't work with Māori in a way that's holistic… bring Pākehā in to learn and do the Treaty of Waitangi training … that's a compulsory thing… after that they need to do a competency"*

- Kaupapa Māori service development

One Kaumātua stressed that Māori are "*trying to put the Māori world back into some balance and someone (Tauiwi worldview) is deviating you from it".*

In order for whānau to have access to crisis support that is Kaupapa Māori, that offers hope to achieve such balance which is critical to Māori well-being, support from mainstream services and the wider system is required to support Kaupapa Māori service development.

*"Māori must have the opportunity to develop right alongside and be equally visible and their services equally valid and mainstream because they're sitting there (they have a) responsibility to support…"*

## SUMMARY

Although this document speaks largely in terms of wāhine and tāne, we also firmly reiterate our intention to include in the following recommendations, all people who articulate their gender identity or sexual

orientation inside or outside the parameters of wāhine/tāne or homosexual/heterosexual orientation. We affirm their right of access to Kaupapa Māori services and their right to appropriate, sensitive and timely support to access those services.

The imbalance of access to Kaupapa Māori services is maintained and supported by mainstream services; including by competing for resources to provide services for Māori rather than supporting the development of relevant Kaupapa Māori services. This highlights the need for services to reconsider their relationship to Māori and Māori practices and to support the autonomy of Kaupapa Māori services by referring clients to Māori services; sharing resources; and supporting funding and resourcing for these services.

Te Puāwaitanga o Te Kākano (Te Puni Kōkiri, 2009) strongly affirms and supports Kaupapa Māori approaches and concludes that issues which require:

> "further development to support current and future Providers include: further developing Kaupapa Māori service delivery; improving funding models; workforce development and training; enhancing support systems and networks within the sector; supporting organisational infrastructure sustainability; informed public policy development; and the development of a research programme… "(p.175-176).

Te Tiriti o Waitangi together with He Whakaputanga O Te Rangatiratanga and the United Nations Declaration on the Rights of Indigenous Peoples, create a strong foundation and convincing reasons for addressing the concerns raised by Māori in respect of addressing the needs of Māori who have been impacted by sexual violence.

There is a strong impetus from Māori to develop and provide Kaupapa Māori services; that Māori practices become rightfully acknowledged alongside mainstream services and that Māori clinical practices have equity of validation through research, resources, publications and practice delivery. The contributions Māori have made to culture and identity in Aotearoa are ubiquitous and a compelling reason for Kaupapa Māori services to be available to Māori and others, yet to a large extent remains barely acknowledged throughout the sexual violence sector.

## GOOD PRACTICE GUIDELINES

Supported by the research discussed and foundational documents: Te Tiriti o Waitangi, He Whakaputanga O Te Rangatiratanga and the United Nations Declaration on the Rights of Indigenous Peoples, we offer the following Good Practice Guideline recommendations as a beginning point for informing Good Practice Guidelines for Mainstream Support Services. These are intended as interim measures whilst supporting the development and resourcing of Kaupapa Māori services, to ensure Māori have ease of access to Kaupapa Māori services, congruent with various articulations of Māori identity.

### 1. INTER-SERVICE RELATIONSHIP DEVELOPMENT

Ongoing development of Te Tiriti partnership and relationship between mainstream and Māori services is a priority. Te Tiriti partnership with Māori would be demonstrated by the following:

- All requests for service by Māori that are received by mainstream services will in the first instance be referred to local Kaupapa Māori sexual violence services.
- Working relationships will be developed with local hapū and iwi services and Kaupapa Māori services to ensure appropriate access to Kaumātua and ensuring genuine participation at all levels.
- Evidence that healing is a priority above mandatory guidelines e.g. tāne would be included in healing pathways.
- Support for Māori to access Kaupapa Māori hohourongo/restorative justice services.
- Policies and funding contracts would reflect that when working with Māori whānau, whānau ora is promoted above other bodies of thought such as feminist principles that exclude tāne within survivor services.

### 2. WORKFORCE DEVELOPMENT

The priority for workforce development should be to support Kaupapa Māori Service development (see no. 4).

The workforce development priority within Mainstream Services should be on developing cultural competence. Cultural competence includes:

- Upskilling Māori practitioners to increase capacity and capability to work with Māori by:

- Participating in cultural identity exploration and training.
- Accessing and developing proficiency in culturally specific resources e.g. those developed by 'Te Whānau o Te Kākano'.
- Increasing proficiency in 'te reo Māori me ona Tikanga'. A minimum standard for te reo Māori is bi-lingual awareness and a service commitment to upskilling staff in correct pronunciation with a strategy to achieve proficiency in basic conversation.

Cultural competence training for non-Māori practitioners begins with:

- The acknowledgement of the limitations as non-Māori to work with Māori including:
    - Understanding and working with the ongoing realities of the impacts of colonisation on Māori;
    - The validity of differing worldviews and validity of differing therapeutic approaches and practices that arise from those worldviews;
    - The importance of accessing Kaumātua/tohunga etc. as healers and/or for service guidance roles (e.g. Board/Clinical Direction).

This is consistent with TOAH-NNEST'S Taskforce Report recommendation 11c (MOJ, 2009, p.4): "supporting and investing in Māori/whānau-led solutions informed by Te Ohaakii a Hine as a prevention model for tangata whenua".

3. CULTURAL SUPPORT AND ENGAGEMENT

- Access to a list of Kaumātua who could be accessed by Tauiwi services to support the process of ensuring suitable tautoko for Māori seeking support.

- The list would be developed and recommendations made in partnership with local Kaupapa Māori sexual violence services or other Māori or iwi services where Kaupapa Māori sexual violence services do not currently exist.
- Relationship building with Māori services and the Māori community will not be dependent on current service delivery to Māori clients. Confining pro-active relationship building with the Māori community to times of crisis would be akin to tokenism.
- Kaumātua should not be consulted in isolation but should have the support of the expertise of Kaupapa Māori sexual violence service practitioners to support them in their roles and their advice should be respected.
- Kaumātua should be recompensed, such as through payment or koha that is commensurate with the highly specialised knowledge and experience they bring to their roles.

- Advocacy

- Support for Māori by Māori who are cognisant with Māori tikanga and values to support them to navigate a pathway forward with Police, the Courts, statutory organisations; medical; and any other support services.
- To ensure Kaupapa Māori processes such as Hohourongo can be accessed and recognised, as opposed to Tauiwi restorative justice processes.

## 4. KAUPAPA MĀORI SERVICE DEVELOPMENT

There is currently a dearth of Kaupapa Māori sexual violence services throughout Aotearoa. This is largely due to:

- Funding constraints across the whole of the sexual violence sector and also supported by Government policy to rationalise funding streams.
- Whānau often struggle to access services due to constraints such as transport, whānau obligations or budget.

The following recommendations are made to support Kaupapa Māori Service Development:

- Better resourcing for Kaupapa Māori Services.
- Funding for mobile services to provide training/workforce development.
- A separate set of Good Practice Guidelines for Kaupapa Māori Sexual Violence services providing crisis support, and funding for this development.
- Mainstream Service Good Practice Guidelines for Māori should be consistent with Good Practice Guidelines for Kaupapa Māori Sexual Violence services providing crisis support.

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Appendix

# Good Practice Guidelines

## Working with Māori

### *Interview domains:*

| What kinds of supports are needed, specifically for Māori, when in crisis following sexual assault/abuse? |
|---|
| Probing questions:<br>- **Te taha Māori: Access to cultural supports (te reo speaker, Kaumātua, tikanga Māori)**<br>- **Te taha wairua: Spiritual support (access to karakia, tohunga, rongoa Māori)**<br>- **Te taha tinana: Physical support (support with the medical process)**<br>- **Te taha hinengaro: Emotional support: specific therapeutic interventions (counselling)**<br>- **Te taha whānau: Support for whānau, social support (financial, housing/accommodation)**<br>- **Te Ao Pākehā: Legal/police process, information to make an informed choice (service options, to make a police report or not)** |

| Support options and choices for Māori |
|---|
| Probing questions:<br>- **Kaupapa Māori services**<br>- **Tauiwi services** |

| How do these needs translate into recommendations/guidelines for those working with Māori survivors seeking crisis services? |
|---|
| Probing questions: |

- **What do you recommend to Tauiwi services and/or people working with Māori in crisis?**

## *Good Practice Guidelines for Mainstream Crisis Support Services - Round 2*

## *Working with Māori*

### *Hui:*

The hui will be at the Waitakere Hospital marae, Wednesday 15th July 2015

Please find below the hui itinerary.

| | |
|---|---|
| 9am Preparation | |
| 10am Pōwhiri | |
| 10.30am Cup of tea | |
| 10.45am Introduction to the project | |
| 11am Group discussions (Kaumātua, Kaupapa Māori, Mainstream/Bi-cultural) | |
| 12.30pm Kai | |
| 1pm Wrap up discussion (all groups together) | |
| | |

# Doing our best for LGBTIQ survivors

**Sandra Dickson**

A project to inform Good Practice Responding to Sexual Violence – Guidelines for mainstream crisis support services for survivors. Round Two. TOAH-NNEST 2016.

Funded by Lottery Community Sector Research Fund.

This document has been prepared by Sandra Dickson, a bisexual, queer, cis feminist woman who has been working as an activist, volunteer and paid staff member in the gendered violence sectors for more than twenty years. She has had an interest in preventing and responding to sexual violence towards LGBTIQ people for at least a decade and set up the first LGBTIQ specific project responding to partner and sexual violence in 2015, Hohou Te Rongo Kahukura – Outing Violence.

Many thanks to all who have contributed to this document, particularly to the LGBTIQ survivors who shared their stories of experiencing sexual violence and help-seeking in Aotearoa New Zealand. Some survivors from the Rainbow community who gave feedback on these recommendations would like to remain anonymous. The people/organisations who would like to be named are:

Kassie Hartendorp (Evolve Youth Health Services)
Miriam Sessa and Rachel Harrison (CAPS Hauraki)
OUTline NZ
Rape Crisis Dunedin
Anne Nicholson (Qtopia and MSSAT)
Ellie Lim (Auckland Women's Centre)
Rainbow Youth
Daniel McGrath (Rape Prevention Education)
Siaosi Mulipola (Village Collective)

And also Hohou Te Rongo Kahukura – Outing Violence as a whole

**LGBTIQ** stands for lesbian, gay, bisexual, transgender, intersex and queer or questioning. LGBTIQ, like Rainbow, is an umbrella term for people with diverse sexes, gender identities and sexualities. There are many other terms used to describe people from these communities in Aotearoa New Zealand including akava'ine, asexual, fa'afafine, fakaleiti, FtM, gender fluid, gender-neutral, gender nonconforming, genderqueer, gender variant, hinehi, hinehua, mahu, MtF, non-binary, palopa, pansexual, polysexual, rae rae, tangata ira tane, takatāpui, tóngzhì, trans man, trans woman, transfeminine, transgender, transmasculine, transsexual, vaka sa lewa lewa and whakawahine. Knowing every term is less important than respecting the words an LGBTIQ survivor uses to describe themselves, their bodies and their relationships, and mirroring this language when supporting them.

**Sex –** biological make-up (body and chromosomes). Everyone has a sex. Although there are infinite possibilities of bodies, people are usually assigned either "male" or "female" at birth. Sex is usually determined by a variety of things including chromosomes, reproductive organs and secondary sex characteristics. For example, intersex is the term used to apply to a wide range of natural bodily variations, and is much more common than typically thought. Some intersex traits are visible at birth while others become apparent in puberty. Some chromosomal intersex variations may not be physically apparent at all.[1]

**Sexuality** – who someone is sexually, emotionally, physically and/or romantically attracted to. Everyone has a sexuality. Sexuality can change over time, for example, someone may be usually attracted to people with similar genders to them, but sometimes also be attracted to people with different genders to them. There are infinite possibilities. For example, takatāpui is a traditional term meaning 'intimate companion of the same sex.' It has been reclaimed to embrace all Māori who identify with diverse genders and sexualities.[2]

**Gender identity –** how someone identifies their own gender internally – there are an infinite number of possibilities including male, female, both, neither or somewhere in between. Everyone has a gender identity. Gender identity is independent of sexuality. For example, people assigned female at birth, who are now living as men may describe themselves as FtM, transmasculine or trans men. People assigned male at birth, now living as women, may describe themselves as MtF, transfeminine or trans women. People who view themselves as neither male or female, both male and female or different combinations at different times may describe themselves as gender non-conforming, genderfluid or genderqueer.[3]

In this document, when research findings are specific to one part of the LGBTIQ community, this will be signified. For example, although there is little research for all LGBTIQ people in comparison to sexual violence research overall (which is itself a challenging area requiring more attention), research specifically into trans, gender diverse and sex diverse survivors is even more sparse.

It is difficult to estimate the numbers of people who identify as LGBTIQ in Aotearoa New Zealand, since questions about sex, sexuality and gender identity are not routinely asked as part of information gathering,

[1] Intersex Fact Sheet.
[2] Takatāpui: Part of the Whānau, (2015).
[3] Thinking About the Unthinkable: Transgender in an Immutable Binary World (2010).

and fear of discrimination and stigma is still likely to create undercounting in situations where questions are asked. The best estimates for sexuality and gender identity come from the nationally representative Youth 2000 data series, based on secondary school students.[4] In Youth '12, 8% of secondary school students identified as same, both or neither sex attracted or unsure. Four percent identified as trans (a girl who feels like she should have been a boy, or a boy who feels like he should have been a girl) or unsure about their gender identity. These figures indicate that around 12% of New Zealand's population may identify under sex, sexuality and gender diverse umbrellas.[5]

## Methodology

This project has drawn on just completed original research through Hohou Te Rongo Kahukura – Outing Violence. The full report is available here. http://www.kahukura.co.nz/wp-content/uploads/2015/07/Building-Rainbow-Communities-Free-of-Partner-and-Sexual-Violence-20161.pdf

In addition, the researcher completed a literature review of published material, hosted two community workshops and held assorted key informant conversations via email and in person with LGBTIQ people working in the specialist sexual violence sector or inside LGBTIQ community groups to inform this work.

**Hohou Te Rongo Kahukura – Outing Violence**[6] is a project dedicated to building Rainbow communities in Aotearoa New Zealand free of partner and sexual violence. Established in 2015, the first year involved creating a website with Rainbow-specific partner and sexual violence content, holding 20 community hui around the country to raise awareness of partner and sexual violence and establish what Rainbow communities wanted to address this violence; and running an online survey asking in depth questions about experiences inside intimate partner relationships; sexual violence both inside and outside intimate relationships; and experiences of help-seeking for Rainbow survivors.[7] Results from both the community hui and the survey, which received responses from 407 people, have informed this document.

The literature review of research and guidelines relevant to good practice for LGBTIQ survivors utilised the Hohou Te Rongo Kahukura – Outing Violence resource library; contacted the New Zealand Family Violence Clearinghouse with a generic research request; and followed up research recommendations from key informants. All references are noted. There was a high degree of agreement in identified texts regarding kinds of sexual violence experienced by people in LGBTIQ communities; challenges in responding well to LGBTIQ survivors; and LGBTIQ cultural competencies for survivor services. Most research was not focused only on crisis response services, but on holistic responses to sexual violence for LGBTIQ communities. Some resources were aimed at some groups in the LGBTIQ community, in particular trans and gender diverse people.

In January 2016, an email requesting nominations for workshops in Auckland and Wellington in February to discuss developing good practice guidelines for LGBTIQ survivors was circulated through the TOAH-NNEST

[4] Clark et al (2014) and Lucassen et al (2014).

[5] This simplified definition for trans was used by the Youth 2012 research team to ensure the question was understood by all secondary students. No questions were asked about intersex status.

[6] www.kahukura.co.nz

[7] Hohou Te Rongo Kahukura – Outing Violence uses "Rainbow" to refer to people identifying under sex, sexuality and gender diversity umbrellas, in much the same way as this project is using "LGBTIQ".

Tauiwi Caucus network. The email invited LGBTIQ identified people working in mainstream crisis response agencies to participate. Both workshops were also open to advisory group members from Hohou Te Rongo Kahukura – Outing Violence. The original response to this email inside the sexual violence sector was limited to two nominations from specialist agencies, one from a survivor agency, and one from a harmful sexual behavior agency. To increase participation, the researcher contacted a number of specialist groups around the country with staff or volunteers meeting the criteria identified. This resulted in more attendees, and some individuals and organisations participating via email/telephone. In addition, members of the Hohou Te Rongo Kahukura – Outing Violence advisory group unable to attend either hui were all offered the opportunity to participate via email, telephone or in person meeting. Several additional key informants from LGBTIQ communities were also identified, and contacted directly. The end result was participation of some form by nine individuals working in the specialist sexual violence sector for seven agencies, and eleven individuals working in the LGBTIQ community sector for ten agencies.

The community workshops included a presentation on the Hohou Te Rongo Kahukura – Outing Violence survey results, before moving to address four key questions:

1. How does homophobia, biphobia and transphobia – or the fear of these phobias – stop help seeking?
2. How do LGBTIQ+ norms affect how sexual violence happens?
3. What are the never do's for practitioners working with LGBTIQ+ survivors?
4. What do we want for LGBTIQ+ sexual violence survivors from services – what does it look like?

These questions were also answered by those answering via email or in person meetings. Information from all these sources has been integrated into the following document.

## Why focus on LGBTIQ survivors?

Mainstream crisis support services in Aotearoa New Zealand were first established in the 1980s by the second wave feminist movement, predominantly to respond to men's violence towards women. In the 1990s, the beginnings of a male survivors' support network began. This history means that LGBTIQ survivors do not always perceive existing mainstream crisis services as being for them. In the 20 community hui held by Hohou Te Rongo Kahukura – Outing Violence in 2015, LGBTIQ people attending often did not know where they could go for help if they experienced sexual violence. While all survivor agencies were not well-known, male survivor services and kaupapa Māori services were almost completely invisible in LGBTIQ communities.

In addition, LGBTIQ community groups are often dealing with disclosures of sexual violence internally, and struggle to identify appropriate services for LGBTIQ survivors.

### Ethical imperative to have a comprehensive response

Mainstream crisis support services recognise and attempt to respond to the ethical imperative to respond to all experiences of sexual violence and harm because of the impacts of trauma on survivors, family/whānau and communities. In addition, the location of sexual violence within relations of power and control is well recognised by the survivor sector. LGBTIQ people are vulnerable to being targeted for sexual violence because they break gender and sexuality norms. For example, boys and men who present as 'feminine,' trans people who do not conform to gender expectations, and women who have relationships with women all challenge

and can be targeted by systems which support male privilege and sexist oppression. Therefore, responding to LGBTIQ survivors is part of having a comprehensive response to sexual violence.[8]

**Scale of the problem**

There has for many years been a lack of research into LGBTIQ populations in terms of experiencing sexual violence. In recent years however there has been a surge in limited, small scale studies in the United Kingdom, Australia and the USA, often driven by the LGBTIQ community themselves.[9] While most of these studies cannot be used to deduce population scale rates of sexual violence, they consistently demonstrate sexual violence is a significant issue for the LGBTIQ community in terms of high rates of lifetime prevalence.[10] There are indications across these surveys that lifetime sexual violence experience for trans people may reach 50%, and that trans women of colour are most likely to be victimised.[11]

In 2010, the Centers for Disease Control released results of their large scale population based study which measured experiences of sexual violence and compared across sexualities. With a data set of more than sixteen thousand people, this research is able to demonstrate statistically significant differences in lifetime experiences of sexual violence across sexualities.

**Table One: Data from the National Intimate Partner and Sexual Violence Survey, Center for Disease Control[12]**

| Sexuality and Gender | Lifetime experience of rape | Lifetime experience of sexual violence other than rape including being made to penetrate, sexual coercion, unwanted sexual contact and non-contact unwanted experiences |
|---|---|---|
| Lesbians | 13% | 46% |
| Bisexual women | 46% | 75% |
| Heterosexual women | 17% | 43% |
| Gay men | | 40% |
| Bisexual men | | 47% |
| Heterosexual men | 1% | 21% |

In the USA it appears bisexual people are significantly more likely to experience sexual violence than other sexualities, for both genders (the survey did not ask questions about gender identity); but also that gay men and lesbians are also more likely than heterosexual men and women respectively to experience sexual

[8] Culturally Competent Service Provision to Lesbian, Gay, Bisexual and Transgender Survivors of Sexual Violence, (2009).
[9] See for example Private Lives 2: The second national survey of the health and wellbeing of GLBT Australians, (2012).
[10] Fileborn, B. (2012).
[11] Culturally Competent Service Provision to Lesbian, Gay, Bisexual and Transgender Survivors of Sexual Violence, (2009); Transgender Rates of Violence (2012); Responding to Transgender Victims of Sexual Assault (2014) and Lesbian, Gay, Bisexual, Transgender, Queer and HIV-Affected Hate Violence in 2014 (2015).
[12] National Intimate Partner and Sexual Violence Survey: 2010 Findings on Victimisation by Sexual Orientation, (2010). Rape is defined by unwanted oral, anal or vaginal penetration. The numbers for gay and bisexual men were too small to measure due to the sample size.

violence other than rape. Bisexual women are also significantly more likely to be raped in their lifetime than women of other sexualities.

In Aotearoa New Zealand, the only population-based indicator available for sexuality and experiences of sexual violence comes from Youth 2000 data. Same and both sex attracted students are more likely to have been touched in sexual ways or made to do sexual things they didn't want to do (32%) than either female students of all sexualities (26%) or male students of all sexualities (14%).[13]

The Hohou Te Rongo Kahukura – Outing Violence research in Aotearoa New Zealand in 2015/6 cannot estimate population rates as the research utilised a snowball online survey technique rather than random sampling. This technique has proven effectiveness with hard to reach populations, including the LGBTIQ community,[14] and involved promoting the survey through LGBTIQ online, print, radio and social media, and using the advisory group members as 'champions' to ensure various groups in the LGBTIQ community were aware of the survey.[15] It was also promoted through the community hui road trip. However, snowballing means it is unclear whether people responded to this survey because they were more likely to have experienced partner or sexual violence than the average person in the LGBTIQ community. The survey was available online from 8 September 2015 until 8 January 2016 (four months). During that time it was answered by 407 respondents. Not all respondents answered every question.

The survey[16] asked general information about age, identity, ethnicity and disability status, and respondents were diverse in all these areas. The survey moved on to ask about experiences in intimate relationships; unwanted sexual experiences; the effects of any abuse; and what any help-seeking experiences were like.

The sexual violence questions were introduced as "sexual things you did not want to happen, whether it was from a partner, a family member, someone you knew, or a stranger." The survey then asked specific questions about different kinds of unwanted sexual experiences, based on international surveys investigating prevalence rates, surveys specifically targeting LGBTIQ populations, and discussions and feedback from the Hohou Te Rongo Kahukura – Outing Violence advisory group about community experiences. Respondents were asked to identify for each experience how many people had done this to them. For each block of questions, respondents were reminded to focus only on unwanted sexual experiences.

The data from this survey is consistent with similar small-scale research elsewhere in terms of indicating significant issues with sexual violence for LGBTIQ communities. More than two thirds of people responding to that question had experienced unwanted touching of sexual body parts; more than half had experienced unwanted flashing or masturbation, unwanted kissing, or been pressured into sexual acts or touching they did not want during otherwise consensual sexual encounters. Nearly half of the respondents to that question had been made to touch someone else's body parts, and around a third had been made to show sexual body parts

[13] Le Brun et al (2005) and Fleming et al (2007).
[14] Lavender Islands: The New Zealand Study, (2007).
[15] The launch of the survey was covered by GayNZ, Lesbian Radio, Lesbian Net Aotearoa, Manawatu Standard, Newswire.co.nz and Diversity Promotion Through Social Networking. It was also featured on many social media LGBTIQ sites including Facebook and the Human Rights Commission online newsletter. It's uncertain quite how widely promoted it was due to the "snowball" effect.
[16] See Appendix One.

to someone when they didn't want to, or received threats they would be sexually assaulted. One in five people who answered that question had been made to look at or participate in sexual photos or videos.

**Table 2: Hohou Te Rongo Kahukura – Outing Violence – Sexual violence questions.**
**How many people have ever…**

| Answer Options (n=330) | % one or more | % three or more |
|---|---|---|
| Exposed their sexual body parts to you, flashed you, or masturbated in front of you? | 52 | 15 |
| Made you touch their sexual body parts? | 44 | 15 |
| Made you show your sexual body parts to them? | 39 | 12 |
| Made you look at or participate in sexual photos or videos? | 20 | 4 |
| Threatened to sexually assault you? | 30 | 10 |
| Kissed you in a sexual way? | 60 | 32 |
| Touched your sexual body parts? | 69 | 37 |
| Touched parts of your body you did not want touched during sex? | 50 | 19 |
| During a consenting sexual encounter, pressured you to have sex in ways you didn't want to? | 53 | 12 |

Table 3 responses were to more specific questions regarding being made to perform or receive unwanted oral, vaginal or anal sex. A reminder that responses should be limited to unwanted acts was stated at the top of this page.

As with the responses in Table 2, there are clear indications of concerning levels of sexual violence. Around half of people responding to these questions indicate experiencing coercion or being incapacitated due to drugs, alcohol or otherwise unconscious when unwanted oral, vaginal or anal sex took place. A third experienced pressure and one in four experienced physical force or threats. Just under one in five people had unwanted oral, vaginal or anal sex due to being pressured by someone with authority over them, and slightly more than one in ten were pressured by being expected to 'prove' their sexual or gender identity.

**Table 3: Hohou Te Rongo Kahukura – Outing Violence – Sexual violence questions.**
**How many people have ever made you perform or receive oral, vaginal or anal sex:**

| Answer Options (n=329) | % one or more | % three or more |
|---|---|---|
| When you were drunk, high, drugged, asleep, or passed out | 47 | 12 |
| By using their authority over you, for example, your b**oss, teacher, or someone else in a position of power?** | 18 | 2 |
| By pressuring you by e.g. telling you lies, making promises about the **future they knew were untrue, threatening to end your relationship, or threatening to spread rumours about you?** | 33 | 5 |
| By wearing you down by repeatedly asking for sex, or showing they **were unhappy if you refused?** | 50 | 8 |
| By telling you if you didn**'t have sex with them, you were not 'really' your sexuality/gender identity** | 12 | 2 |
| By using physical force or threats? | 26 | 6 |

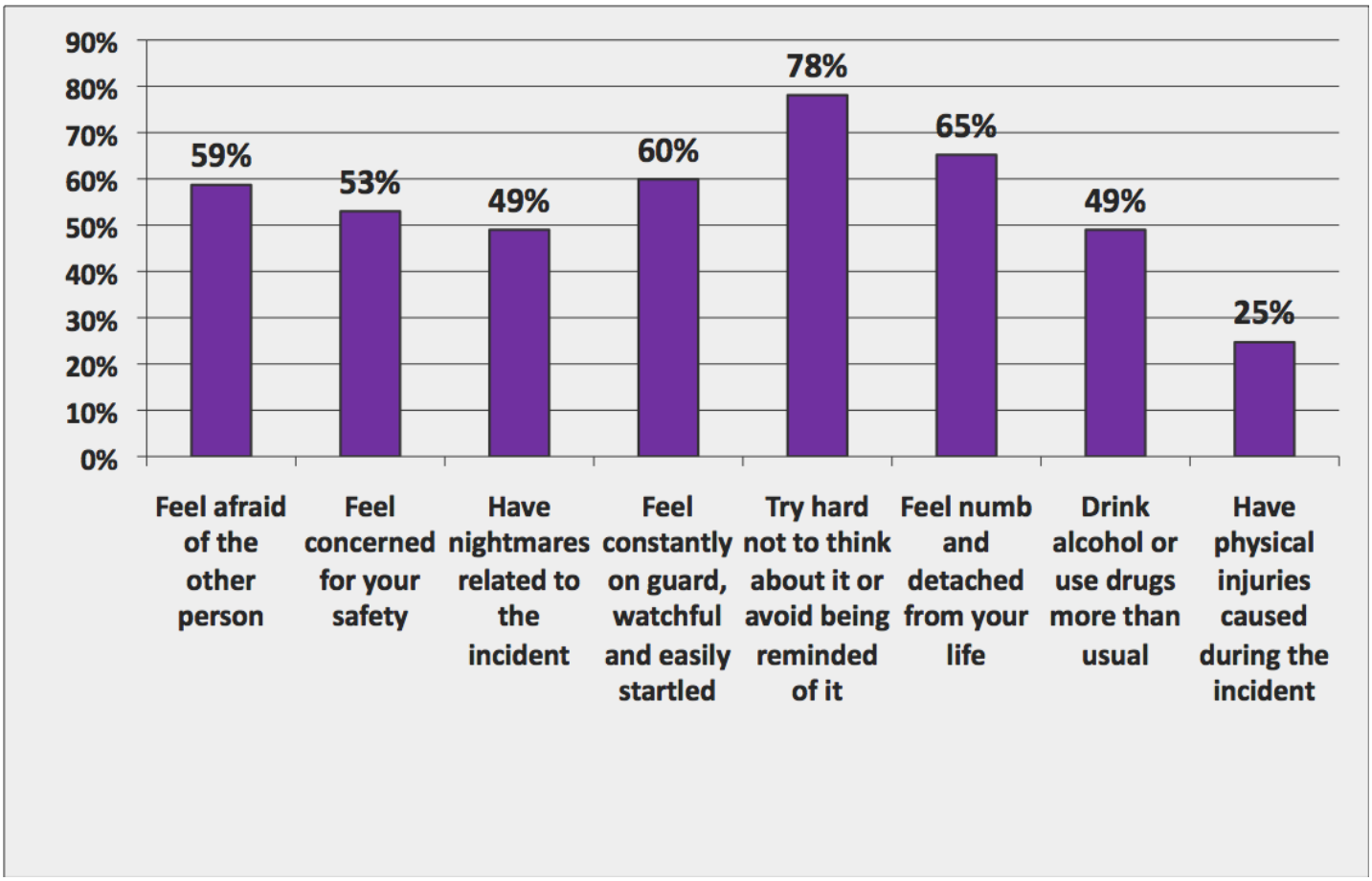
There is a growing research consensus, which the Hohou Te Rongo Kahukura – Outing Violence project adds to, that sexual violence is a significant issue inside LGBTIQ communities.

## Focus on LGBTIQ Survivors – Types of Sexual Violence

People from the LGBTIQ community experience sexual violence in many of the same ways as other survivors, experience some common forms of sexual violence in different ways and experience distinct forms of sexual violence. All research suggests, as with other survivors, that the impacts of sexual violence on LGBTIQ survivors can be severe, complex and recurring over time as well as unique and individual.

The Hohou Te Rongo Kahukura – Outing Violence survey asked respondents about the impact of the worst incident of sexual violence they had experienced/described in the preceding survey questions. Chart 1 shows the responses, with percentages given for the respondents that answered this question. These percentages indicate that sexual violence experienced by respondents had severe impacts, with three quarters of respondents trying to forget the incident(s); approximately two thirds feeling numb, detached or constantly on-guard and easily startled; more than half reporting fear of the perpetrator; half feeling concerned for their safety or using alcohol and drugs more than usual, and one in four having physical injuries as a result of the sexual violence.

**Figure 1: Hohou Te Rongo Kahukura – Outing Violence: Impacts of Sexual Violence (n=247)**




**Child Sexual Abuse**

Few studies have compared rates of child sexual abuse across sexuality or gender identity, and this area is particularly sensitive to LGBTIQ communities, as homophobia, biphobia and transphobia mean people who do not conform to sexuality or gender norms have traditionally been (and often still are) pathologised. This means medical professions, in particular mental health professions, have sought to find a 'reason' for people being sex, sexuality or gender diverse, and frequently child sexual abuse has been suggested as a 'cause' of being LGBTIQ.[17] This fear of being pathologised is a major barrier to LGBTIQ people seeking help for sexual violence, and will be discussed later in this document.

However, studies that have compared child sexual abuse rates across sexuality consistently find higher rates of child sexual abuse for LGBT people.[18] Being a child who does not conform to gender norms and is perceived to be different appears to increase the risks of being targeted for child sexual abuse. In studies which have examined this correlation more closely, the majority of childhood sexual abuse survivors identifying as lesbian,

[17] Let's Talk About It: A Transgender Survivors Guide to Accessing Therapy, (2015).

[18] Culturally Competent Service Provision to Lesbian, Gay, Bisexual and Transgender Survivors of Sexual Violence, (2009); The Impact on Individuals and Communities: Sexual Violence and Individuals who Identify as LGBTQ, (2012); Roberts et al (2012) and Responding to Transgender Victims of Sexual Assault (2014).

gay or bisexual had some sense of their sexuality before the child sexual abuse, making researchers conclude that LGBTIQ status is not a pathological response to childhood sexual abuse.

In addition to higher rates, evidence suggests that child sexual abuse for gay and bisexual male survivors may involve higher levels of forced penetration, physical force, instances of multiple perpetrators and happen over extended periods of time in comparison to other male survivors.[19]

Nineteen percent of respondents to the Hohou Te Rongo Kahukura – Outing Violence survey who responded to this question indicated at least one of their perpetrators had been a family member (see Table 4).

**Hate Motivated Sexual Violence – Punishment for Breaking Sex, Gender and Sexuality Norms**

A range of studies in different countries indicate that LGBTIQ people experience sexual violence including verbal threats, contact sexual harassment and rape from people to punish their perceived sexuality, gender identity or gender expression. These types of sexual violence tend to be less likely to be reported to the Police and more likely to involve multiple perpetrators.[20] 'Corrective rape' is one term that has been used for one type of hate motivated sexual violence, when women believed to be lesbians are raped to 'make them heterosexual'.

In the Hohou Te Rongo Kahukura – Outing Violence survey, 25% of people who answered that question said they had experienced physical injuries as a result of sexual violence. Hate motivated sexual violence may include attempts to cause physical damage including cutting of genitals and sexual body parts or bruising to people's faces as well as homophobic, biphobic or transphobic verbal abuse and slurs about people's identities or bodies.[21] Hate motivated sexual violence towards trans and gender diverse people may also include perpetrators targeting body parts, especially sexual body parts, to oppose, deny or try to destroy gender identity or self-esteem (e.g. vaginal penetration of trans men).[22]

Hate motivated sexual violence sits in a context of significant discrimination, harassment and violence experienced by LGBTIQ people (particularly those who are most marginalised such as trans and gender diverse people and Māori, Pacifica and other groups who experience racism as well as/intertwined with homophobia, biphobia and transphobia).[23] For example, same and both sex attracted students and trans students in New Zealand report significantly higher levels of fear of bullying, experiences of bullying and experiences of violence in school than do other students.[24]

[19] Culturally Competent Service Provision to Lesbian, Gay, Bisexual and Transgender Survivors of Sexual Violence, (2009) and The Impact on Individuals and Communities: Sexual Violence and Individuals who Identify as LGBTQ, (2012).
[20] Practical Tips for Working with Trans Survivors of Sexual Violence (2008); Culturally Competent Service Provision to Lesbian, Gay, Bisexual and Transgender Survivors of Sexual Violence, (2009); Fileborn, B. (2012) and Impact on Individuals and Communities: Sexual Violence and Individuals who Identify as LGBTQ, (2012) and Responding to Transgender Victims of Sexual Assault (2014).
[21] Responding to Transgender Victims of Sexual Assault (2014).
[22] Let's Talk About It: A Transgender Survivors Guide to Accessing Therapy, (2015).
[23] Why It Matters: Rethinking Victim Assistance for Lesbian, Gay, Bisexual, Transgender and Queer Victims of Hate Violence and Intimate Partner Violence, (2010); Sheltering Transgender Women: Providing Welcoming Services (2014) and Responding to Transgender Victims of Sexual Assault, (2014).
[24] Le Brun et al (2005) and Fleming et al (2007).

**Sexual Violence as Part of Intimate Partner Violence**

While likely to vary between specific groups within the LGBTIQ community, reported rates of sexual violence as part of intimate partner violence for LGBTIQ survivors appear similar to rates non-transgender women report in relationships with men, and also appear to involve a similar continuum of behaviours including coercion, social pressure and the use of physical violence.[25] The forms of coercion may also involve patterns specific to LGBTIQ people, such as ideas about how gay men/lesbians have sex; pressures on bisexual women to have threesomes; or ideas about how 'real' women or men have sex.[26] Masculinity norms which suggest men should always want sex also provide the context for sexual coercion towards gay and bisexual men, and takatāpui tāne.[27]

Normative ideas about masculinity and femininity can also operate to make it difficult for LGBTIQ survivors to recognise sexual victimization inside intimate relationships. This includes misconceptions that women cannot sexually abuse other women; that men cannot be victims of sexual violence because they always want sex; and that trans women cannot be victims of sexual abuse from non-trans women, because they are really men.[28]

In the Hohou Te Rongo Kahukura – Outing Violence survey, respondents were asked to indicate who perpetrated sexual violence they had identified earlier in the survey. The results appear in Table 4. Sexual violence from intimate partners was the most common, with 63% of people who responded to this question indicating at least one partner had perpetrated sexual violence towards them.

[25] Fileborn, B., (2012) and The Impact on Individuals and Communities: Sexual Violence and Individuals who Identify as LGBTQ, (2012).

[26] Hohou Te Rongo Kahukura – Outing Violence (2015) – Bisexual Survivors, Gay Survivors, Lesbian Survivors and Trans and Intersex Survivors.

[27] Fenaughty et al (2006).

[28] Setting the Stage: Strategies for Supporting LGBTIQ Survivors, (2010); Why It Matters: Rethinking Victim Assistance for Lesbian, Gay, Bisexual, Transgender and Queer Victims of Hate Violence and Intimate Partner Violence, (2010); Fileborn, B., (2012); The Impact on Individuals and Communities: Sexual Violence and Individuals who Identify as LGBTQ, (2012); Responding to Transgender Victims of Sexual Assault, (2014); Hohou Te Rongo Kahukura – Outing Violence (2015) – Bisexual Survivors, Gay Survivors, Lesbian Survivors and Trans and Intersex Survivors; Let's Talk About It: A Transgender Survivors Guide to Accessing Therapy, (2015).

**Table 4: Hohou Te Rongo Kahukura – Outing Violence – Relationship to Perpetrator**

| For each person who did these things to you, please describe their relationship to you when **the incident(s) occurred (n=314)** | | | | |
|---|---|---|---|---|
| Options | **One** | **Two** | **Three or more** | **% with at least one of this perpetrator** |
| Partner, boyfriend or girlfriend | 134 | 43 | 20 | 63% |
| Friend | 72 | 12 | 10 | 30% |
| Work colleague | 13 | 6 | 3 | 7% |
| Someone I'**d just met** | 64 | 10 | 26 | 32% |
| Family member | 39 | 12 | 9 | 19% |
| Stranger | 49 | 21 | 36 | 34% |

**Adult Sexual Violence from Other Perpetrators**

The published literature makes little comment on sexual violence towards LGBTIQ adults which is not within an intimate relationship or defined as hate motivated. However, emerging evidence in the USA suggests that trans people experience sexual violence at concerning rates in a variety of professional, help-seeking contexts such as from police and health professionals.[29] The Hohou Te Rongo Kahukura – Outing Violence survey provided evidence in Aotearoa New Zealand that there are a range of perpetrator relationships, including sexual violence perpetrated by friends (30% of those responding); work colleagues (7%); someone just met (32%) and strangers (34%). While this will include perpetrators of hate motivated sexual violence, it also indicates, as with other survivors, that LGBTIQ survivors can experience sexual violence in many contexts as adults.

Research confirms that coercion techniques from all perpetrators towards LGBTIQ survivors may include alcohol and drugs, guilt and perceived emotional vulnerability.[30] In addition, sexual violence towards trans people may include pressures to be sexual (such as touching body parts which trans people do not want touched, or being touched in ways trans people do not want touched) which do not respect trans people's gender identity. Trans men may have masculinity undermined by forced vaginal penetration, or by touching their breasts, for example. It is also typical for perpetrators to tell LGBTIQ survivors that no one will believe them because of their sexuality or gender identity.[31]

Many of these strategies were used to perpetrate sexual violence against people responding to the Hohou Te Rongo Kahukura – Outing Violence survey, as noted in Table 3.

## Focus on LGBTIQ Survivors – Cultural Contexts

[29] Responding to Transgender Victims of Sexual Assault, (2014); Let's Talk About It: A Transgender Survivors Guide to Accessing Therapy, (2015).

[30] Fenaughty et al (2006); Culturally Competent Service Provision to Lesbian, Gay, Bisexual and Transgender Survivors of Sexual Violence, (2009) and Hohou Te Rongo Kahukura – Outing Violence (2015) – Bisexual Survivors, Gay Survivors, Lesbian Survivors and Trans and Intersex Survivors.

[31] Fileborn, B. (2009); Let's Talk About It: A Transgender Survivors Guide to Accessing Therapy, (2015).

LGBTIQ people share experiences of not fitting gender or sexuality norms, and the related discrimination, stigma and exclusion this creates. But there is no such thing as a typical LGBTIQ person – sexuality and gender identity are just one aspect of someone's identity. LGBTIQ people vary in age, come from diverse ethnic and religious backgrounds, may be disabled or able-bodied, and come from any socio-economic background. Transmasculine (transitioning from female to male) and transfeminine (transitioning from male to female) experiences can be very different. It's important for mainstream crisis support services to treat each LGBTIQ survivor as an individual, and honour all of who they are, in order to provide the most respectful and appropriate services.

For Māori, Pacifica and migrant and refugee survivors who identify as LGBTIQ, the most important thing may be survivor services which are kaupapa Māori or otherwise culturally specific.[32] If in doubt, ask the survivor – they are the experts of what they need.

In order to recover after sexual violence, it's critical mainstream crisis support services acknowledge the ways in which discrimination, stigma and exclusion can impact on healing processes for LGBTIQ survivors.[33] Years of messages that something is wrong with your body, your sense of your gender, and/or your attractions to others create shame, isolation and a lack of entitlement to being treated with respect which contribute to sexual violence not being recognised or being seen as 'just how it is' for LGBTIQ people. Seeking help after sexual violence will also typically involve needing to 'come out' as sex, sexuality or gender diverse.[34]

**Trans and Gender Diverse Survivors**

Trans and gender diverse people in Aotearoa New Zealand often have extraordinary coping strategies and resilience in order to survive a world which often fails to recognise their experiences. It's common to experience difficulties accessing healthcare you need (whether to transition or for other matters); discrimination in housing, education and employment; and harassment and violence.[35]

Transitioning is not straightforward for either transmasculine or transfeminine people. Social transitioning involves acknowledging your gender identity yourself, and beginning to share with others in your life. This may include changing clothing, appearance, name and pronouns to fit with how people see themselves. Sometimes equipment such as binders (to flatten chests and appear more masculine) or breast or hip forms (to create softer curves and appear more feminine) may be used by trans people.

For other trans and gender diverse people, medical transition may feel important for safety or sense of self. In order to access hormones or other health related gender affirming procedures such as hair removal, surgeries or voice training, trans people in New Zealand must either bear the full and considerable costs themselves, or go through referrals from mental health systems which often still treat trans people as pathological.[36] Hormones in particular may feel very important for trans people wishing to masculinise or feminise their appearance and so be recognised in their preferred gender. Gatekeeping by mental health practitioners is

[32] Fenaughty et al (2006).
[33] Culturally Competent Service Provision to Lesbian, Gay, Bisexual and Transgender Survivors of Sexual Violence, (2009).
[34] Fenaughty et al (2006).
[35] To Be Who I Am: Report of the Inquiry into Discrimination Experienced by Transgender People, (2008).
[36] Let's Talk About It: A Transgender Survivor's Guide to Accessing Therapy, (2015).

frequently reported, and there is no consistent healthcare pathway around the country despite all available evidence indicating the significant positive impacts on mental health of transition related healthcare. This means trans people in New Zealand are not sure how to access what they need; often get conflicting advice when they try to access healthcare, and frequently report being misgendered (called 'he' when they prefer 'she' or vice versa), having confidentiality breached, and being called derogatory names as well as having to educate healthcare providers about trans issues.[37]

It's also common for trans people to be asked invasive and inappropriate questions about their bodies, genitals and sexual practices by healthcare professionals and others. Therefore, many trans people have negative experiences of healthcare and mental health systems which may make help-seeking difficult. There are also fears for many that disclosing sexual assault may impact on access to gender affirming healthcare.[38]

Because trans people may not have bodies typically associated with their preferred gender, the idea of trans people as 'dishonest' or 'deceptive' about their gender is a popular misconception. Being fooled about someone's trans status was used as an excuse for perpetrating violence towards people attending Hohou Te Rongo Kahukura – Outing Violence community hui. On one occasion, a trans woman called the Police after her husband sexually assaulted her. They had been married for ten years, but he successfully argued that he had been so shocked to find out she was a trans woman, that he sexually assaulted her. No action was taken by the Police.

Often this idea of 'dishonesty' or 'deception' is exacerbated by legal documents which are not in the same name or gender identity as that a trans person currently uses. The reality is, changing legal documentation can be time-consuming and expensive and may not be the first priority for trans people. This should not be taken as evidence they are not telling the truth about sexual violence or anything else.

As a small, often isolated community, trans and gender diverse people share experiences online of services they access, so people can avoid experiencing discrimination.[39] Fears about services, especially sex-segregated services which have not respected people's gender identities, can become widely known inside trans communities very quickly. Perceptions of sex-segregated services as unfriendly to trans people are common in Aotearoa New Zealand.

Trans, sex and gender diverse people may experience victim-blaming that focuses on their sex or gender identity, which may exacerbate the trauma of sexual violence.[40] Trans status was used as an excuse for perpetrating violence towards people attending Hohou Te Rongo Kahukura – Outing Violence community hui.

Trans people may have complex relationships with their bodies, whether they have had surgeries or not. This impacts on the kinds of sexual violence people may experience, such as having parts of your body being

[37] To Be Who I Am: Report of the Inquiry into Discrimination Experienced by Transgender People, (2008).
[38] Responding to Transgender Victims of Sexual Assault, (2014).
[39] Implications of the 2004-2005 Transgender Sexual Violence Survivor Research, (2005); The Impact on Individuals and Communities: Sexual Violence and Individuals who Identify as LGBTIQ (2012) Responding to Transgender Victims of Sexual Assault, (2014); and Let's Talk About It: A Transgender Survivor's Guide to Accessing Therapy, (2015).
[40] Hohou Te Rongo Kahukura – Outing Violence: Trans and Intersex Survivors, (2015).

touched you do not want to think about, which may increase trauma and sense of shame.[41] It also may mean disrobing for health treatment or forensic examinations is particularly difficult, especially if it also means people will no longer be identified as their preferred gender. It's also very common for trans people to use different names for their body parts than are typically used (e.g. front hole might be used by trans men for their vagina, trans women may call their penises their clits).[42]

**Lesbian, Gay and Bisexual Survivors**

Fears and experiences of homophobia and biphobia are common for lesbian, gay and bisexual survivors. Regular failures to acknowledge the possibility of similar-gender partners is a common occurrence for lesbian, gay and bisexual people in education, employment, social, health and other social service related contexts. Constructions of same, both and all-sex attractions as sinful and disgusting still inform many ways lesbians, gay men and bisexual people are talked about or imagined in the world. This may make it complex to disclose sexual violence, as people often feel strong desires not to open LGBTIQ communities up to negative scrutiny.

Sexuality education typically focuses on sexual relationships between (non-transgender) women and men. This may make lesbians, gay men and bisexual people who are just coming out particularly vulnerable to sexual violence in terms of pressures to be sexual in particular ways, being targeted by more experienced people and not having information to navigate desires and consent practices. Differences in age and experience have been found to enable coercion in Aotearoa New Zealand in sexual encounters between men and were frequently raised in Hohou Te Rongo Kahukura – Outing Violence community hui.[43] Much of lesbian and gay culture is a reaction to homophobia, and creating safe spaces to meet others, including to be sexual. Bars, clubs, casual sex sites and websites set up for gay, lesbian and bisexual people to hook up often heavily feature alcohol, and may make assumptions that consent has been established merely by being present or being online.

Gay, bisexual and takatāpui tāne may experience pressures to engage in unsafe sexual practices.[44] Bisexual people are often stereotyped as promiscuous and wanting sex all the time; bisexual women often report being pressured into threesomes.[45] Bisexual people may also be particularly isolated as biphobia often means they are perceived as undecided about their sexuality, or dishonest because they are 'really' either gay, lesbian or straight. This means bisexual people are much less likely to be 'out' than other sexualities.[46]

In addition, lesbian, gay and bisexual people may experience victim blaming which focuses on their sexuality, either because their sexualities are seen as deviant, or because they are seen as over-sexed.

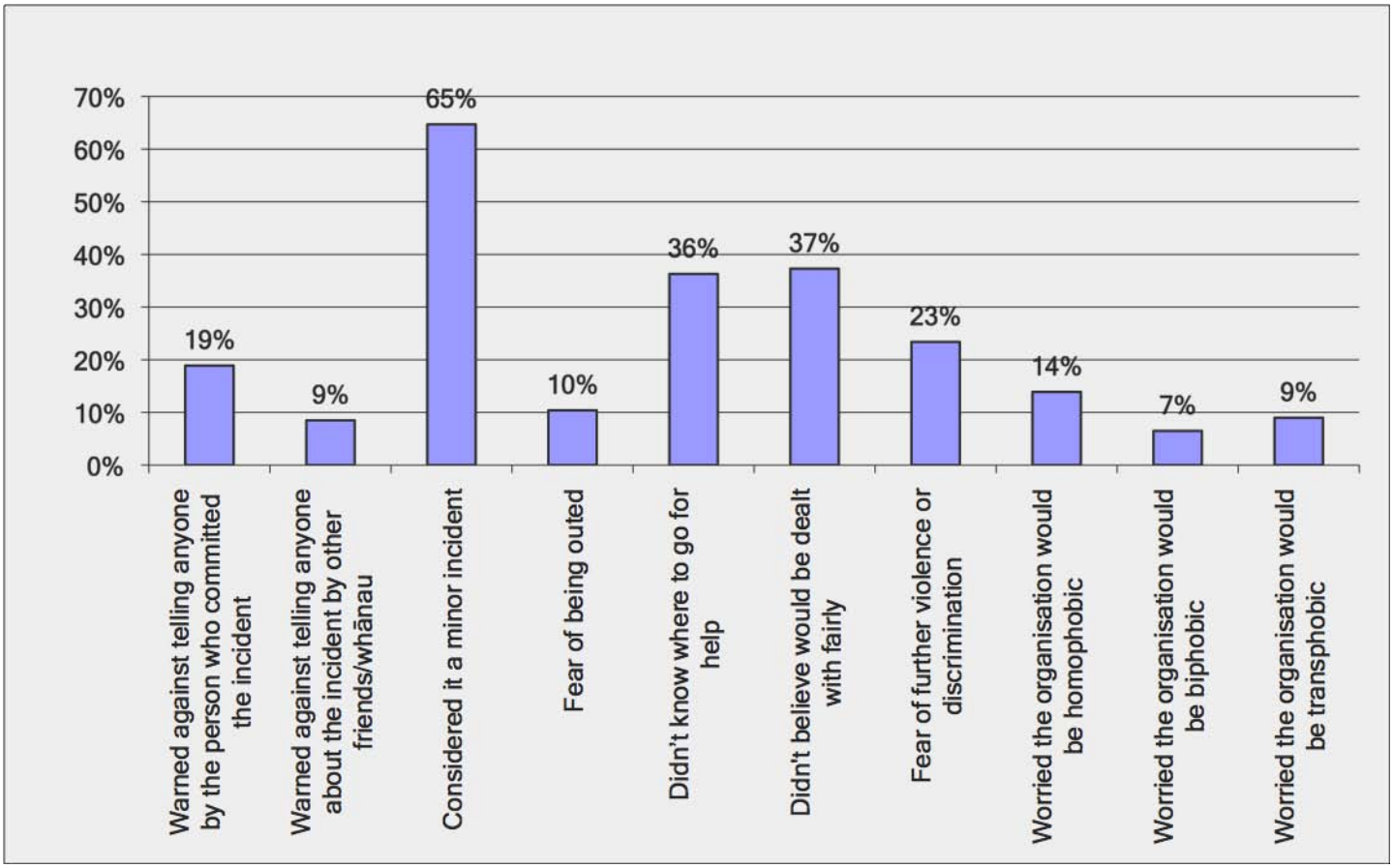
[41] Culturally Competent Service Provision to Lesbian, Gay, Bisexual and Transgender Survivors of Sexual Violence, (2009); Setting the Stage: Strategies for Supporting LGBTIQ Survivors, (2010).
[42] Implications of the 2004-2005 Transgender Sexual Violence Survivor Research, (2005) and The Impact on Individuals and Communities: Sexual Violence and Individuals who Identify as LGBTIQ (2012).
[43] This issue was raised in Hohou Te Rongo Kahukura – Outing Violence community hui and the workshops for this project. Also discussed in Fenaughty et al (2006).
[44] Fenaughty et al (2006) and Hohou Te Rongo Kahukura – Outing Violence: Gay Survivors, (2015).
[45] Hohou Te Rongo Kahukura – Outing Violence: Bisexual Survivors, (2015).
[46] Private Lives 2: The second national survey of the health and wellbeing of GLBT Australians, (2012).

## Barriers to help-seeking after sexual violence for LGBTIQ survivors

LGBTIQ survivors experience the same barriers to help-seeking as other survivors, and additional barriers, many due to shared experiences of discrimination, stigma and exclusion. In the Hohou Te Rongo Kahukura – Outing Violence survey, 150 respondents indicated they needed a specialist response to the sexual violence they experienced, yet only 40 respondents accessed a specialist sexual violence agency.

The survey asked respondents why they didn't ask for help after sexual violence. Responses are shown in Figure 2. Despite the serious impacts noted in Figure 1, respondents were still most likely to not seek help because they thought it was a minor incident (nearly two thirds). One in five respondents had been warned by the perpetrator not to seek help, and one in ten had been warned by someone else. Other reasons people did not seek help are discussed further below.

**Figure 2: If you didn't report what was happening or ask for help from a professional organisation why not? (tick all that apply) (n=201)**




### Pathology – Sexual Violence Explains Being LGBTIQ

One of the biggest fears for LGBTIQ survivors, and a barrier to help-seeking identified in research, discussed in the workshops for this project, and noted in the Hohou Te Rongo Kahukura – Outing Violence survey, was being told they are lesbian, gay, bisexual, transgender, intersex or queer because they have experienced

sexual violence.[47] This has been experienced by LGBTIQ survivors seeking help from mainstream crisis services in Aotearoa New Zealand.

**Lack of Visibility of Services**

In the Hohou Te Rongo Kahukura – Outing Violence community hui, rainbow communities around the country often did not know where they could go for help. While all survivor agencies were not well-known, male survivor services and kaupapa Māori services were almost completely invisible in LGBTIQ communities. It's common for there to be a lack of outreach to LGBTIQ communities; lack of LGBTIQ-specific resources; a lack of relationship with LGBTIQ community groups, and a lack of resourcing to address these barriers.[48] More than a third of respondents in the Hohou Te Rongo Kahukura – Outing Violence survey answering the question about barriers to help-seeking said they did not know where to go for help.

**Assumptions that people are straight, not-transgender, or about perpetrators**

LGBTIQ survivors also report fear about experiencing, or actually experiencing, homophobia, biphobia and/or transphobia when they seek help to recover from sexual violence. This includes assumptions that they are straight or not acknowledging their gender identity. It also includes the misconceptions noted earlier that men cannot be raped, and women cannot rape, and a sense of protectiveness and not wanting to draw more negative attention to the LGBTIQ community. [49] A third of respondents to the survey also identified fear of being treated unfairly, one in four identified they did not believe they would be safe accessing services and 14%, 7% and 9% respectively identified fears of homophobia, biphobia and transphobia stopped them accessing help.

**Fear of Outing**

To seek help after sexual violence for most LGBTIQ survivors will involve coming out. This may be enough of a barrier on its own, particularly for trans people that are usually recognised in their preferred gender; younger LGBTIQ survivors; and LGBTIQ survivors in rural areas where everyone knows everyone or in smaller LGBTIQ communities (e.g. the only trans woman of Asian descent in a community will be very recognizable).[50] Trans people may be 'outed' if they have examinations that reveal they have body parts which are typically associated with another gender; if their identity documents have another name; or if someone discloses on their behalf.[51]

One in ten respondents to the survey who answered this question did not access specialist help after sexual violence because of fear of being 'outed'.

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[47] Implications of the 2004-2005 Transgender Sexual Violence Survivor Research, (2005); Practical Tips for Working with Trans Survivors, (2008); Culturally Competent Service Provision to Lesbian, Gay, Bisexual and Transgender Survivors of Sexual Violence, (2009); Why It Matters: Rethinking Victim Assistance for Lesbian, Gay, Bisexual, Transgender and Queer Victims of Hate Violence and Intimate Partner Violence, (2010); Responding to Transgender Victims of Sexual Assault, (2014).

[48] Why It Matters: Rethinking Victim Assistance for Lesbian, Gay, Bisexual, Transgender and Queer Victims of Hate Violence and Intimate Partner Violence (2010).

[49] Fileborn, B. (2012) and The Impact on Individuals and Communities: Sexual Violence and Individuals who Identify as LGBTIQ (2012).

[50] Responding to Transgender Victims of Sexual Assault (2014).

[51] The Impact on Individuals and Communities: Sexual Violence and Individuals who Identify as LGBTIQ (2012) and Responding to Transgender Victims of Sexual Assault, (2014).

**Fear of the Police**

Many LGBTIQ people, especially multiply marginalised groups such as LGBTIQ people who are Māori, Pacifica or from other ethnic minority groups of colour; trans sex workers and/or young LGBTIQ people may have had negative experiences with the police, which can block help-seeking.[52] There are common misconceptions that help-seeking must include reporting to the police.

**Shame**

Shame and self-blame are issues for many survivors. For LGBTIQ people, taught by homophobia, biphobia and transphobia to view their bodies and/or sexual desires and attractions as deviant and wrong, sexual violence involves an additional layer of shame.

**Inappropriate services**

LGBTIQ survivors may believe mainstream crisis support services will be unlikely to help them or take sexual violence seriously. They may not recognise sexual violence as an LGBTIQ issue; they may not believe their sexuality or gender identity will be respected. This may have been informed by anecdotes about existing services which have been shared in LGBTIQ communities such as services judging survivor's gender identity by looking at them; LGBTIQ survivors being told they have been sexually assaulted because of their sexuality or gender identity; or partners and support people not being recognised when they attend in support of survivors.

Lack of training in LGBTIQ issues may mean that staff and volunteers at mainstream crisis support services do not recognise homophobic, biphobic and transphobic practices or barriers.[53]

Mis-gendering a trans survivor may mean they never return to a service, as being recognised in their preferred gender may be their most important criteria for safety.[54]

**The elephant in the room** for LGBTIQ people engaging with mainstream crisis support services is sex and gender. Many services in Aotearoa New Zealand are sex-segregated (separate for males and females) and treat sex as binary (only male and female) and immutable (does not change from birth). Because the LGBTIQ community includes people who do not identify as male or female; people who feel the sex they were assigned at birth does not describe them; and people who may have been harmed by people of all genders, sex-segregated services provide unique challenges for LGBTIQ people.[55] For trans and gender diverse people, especially those who are not always recognised in their preferred gender, sex-segregated services may be particularly uncomfortable.[56] In the USA, trans people's rights to access services in their preferred gender has been reinforced by legislation prohibiting discrimination.[57]

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[52] Implications of the 2004-2005 Transgender Sexual Violence Survivor Research (2005).

[53] All these issues were raised explicitly in the Hohou Te Rongo Kahukura – Outing Violence community hui. See also Why It Matters: Rethinking Victim Assistance for Lesbian, Gay, Bisexual, Transgender and Queer Victims of Hate Violence and Intimate Partner Violence (2010) and The Impact on Individuals and Communities: Sexual Violence and Individuals who Identify as LGBTIQ (2012).

[54] Responding to Transgender Victims of Sexual Assault, (2014).

[55] Let's Talk About It: A Transgender Survivors Guide to Accessing Therapy, (2015).

[56] Responding to Transgender Victims of Sexual Assault, (2014).

[57] The Impact on Individuals and Communities: Sexual Violence and Individuals who Identify as LGBTIQ (2012) and Sheltering Transgender Women: Providing Welcoming Services, (2014).

## LGBTIQ Recommendations for Mainstream Crisis Services

LGBTIQ cultural competence is an ongoing commitment to understanding and relationship with LGBTIQ communities and individuals. It's not a checklist but a process, that will change over time as LGBTIQ culture changes. It's important not to over-promise and be clear and honest about who can access your service. If you only serve lesbians and bisexual women but not trans women, gender non-conforming people or male survivors of any kind, say that, rather than describing yourself as LGBTIQ friendly. Cultural competence involves staff understanding their assumptions about LGBTIQ people, and engaging in ongoing reflection about homophobia, biphobia and transphobia.[58]

Because of these things, it may be important to assess your agency's capacity to respond to LGBTIQ survivors and address organizational issues like staff training, policies and relationships with LGBTIQ community groups before reaching out to LGBTIQ survivors, to avoid responses which may alienate and be shared with other LGBTIQ people.[59]

As with other survivors, the first response an LGBTIQ survivor receives will have a significant impact on whether they will continue to engage, and on how that survivor recovers over time. Be aware that many LGBTIQ people will have little trust of the Police or healthcare agencies, and this may impact on their willingness to engage.

These suggestions are not exhaustive, but may help mainstream crisis services better serve LGBTIQ survivors.

**Relationships with LGBTIQ Community**[60]

Develop relationships with local LGBTIQ services to increase cultural competency and find out how your service is perceived in your community – do LGBTIQ survivors know what you do?
Collaborate on creating resources for your websites, posters and pamphlets which are LGBTIQ appropriate and name specific ways sexual violence happens for LGBTIQ people.
Create websites, posters and promotional material which features diverse images of LGBTIQ people, including similar gender couples.
Attend LGBTIQ events, advertise in LGBTIQ media and ensure outreach reaches LGBTIQ individuals.
Consider partnerships or supervision with gender diversity experts to address any transition related issues which come up.
Name not just homophobia but transphobia and biphobia too in your websites, posters and promotional material to send a message that your service is open to LGBTIQ survivors, not just gay and lesbian survivors.

**Staff and Volunteers**[61]

[58] Culturally Competent Service Provision to Lesbian, Gay, Bisexual and Transgender Survivors of Sexual Violence, (2009) and The Impact on Individuals and Communities: Sexual Violence and Individuals who Identify as LGBTIQ (2012).
[59] Creating Inclusive Agencies: Sexual Violence and Individuals who Identify as LGBTQ, (2012).
[60] Assessment: How Inclusive Is Your Agency to LGBTIQ Survivors?; Creating a Trans-Welcoming Environment: A Tip Sheet for Sexual Assault Providers; Is Your "T" Written in Disappearing Ink? A Checklist for Transgender Inclusion; Setting the Stage: Strategies for Supporting LGBTIQ Survivors, (2010); Why It Matters: Rethinking Victim Assistance for Lesbian, Gay, Bisexual, Transgender and Queer Victims of Hate Violence and Intimate Partner Violence (2010); Creating Inclusive Agencies: Sexual Violence and Individuals who Identify as LGBTQ, (2012).

Advertise paid and voluntary roles in LGBTIQ media.
Include sexuality and gender identity in discrimination policies which protect staff and survivors.
Train all staff and volunteers in sexuality and gender diversity and update regularly, as the language is fluid and evolving.
Include LGBTIQ issues as a regular item on staff meeting agendas and peer supervision sessions.
Ensure all staff follow discrimination policies which interrupt and address LGBTIQ phobias with other agencies, staff members or survivors.

**Physical Environment**[62]

Because help-seeking for LGBTIQ survivors may be more difficult, make sure they feel welcome in your agency. First impressions count.
Communicate that your service celebrates, not just tolerates, LGBTIQ individuals and communities through positive images, posters and signs in your public spaces.
Create an environment which celebrates gender and sexuality diversity and also understand that this may still not feel safe enough for some survivors to disclose in.
Ensure at least one bathroom is private and gender neutral, to allow all survivors somewhere safe to change and go to the toilet.

**Confidentiality and Language – Survivors are the expert of their own experience**[63]

Ask and mirror the language LGBTIQ survivors use for their bodies and body parts - trans people will often use non-traditional language for their genitals and other sex-linked body parts. Mirroring this language is particularly important, to respect gender identities which may have been undermined by sexual violence.
Ask and mirror the language LGBTIQ survivors use for their partners, relationships and identities. Do not assume partner's gender and avoid heteronormative language or pronouns. Do not assume someone with a same sex partner is lesbian or gay, ask them how they identify to avoid biphobia.
Ask and mirror the names and pronouns LGBTIQ survivors wish to use, whether they are present or not.

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[61] Assessment: How Inclusive Is Your Agency to LGBTIQ Survivors?; Creating a Trans-Welcoming Environment: A Tip Sheet for Sexual Assault Providers; Quick Organizational Audit: LGBT Visibility and Inclusion, (2001); Practical Tips for Working with Trans Survivors of Sexual Violence, (2008); Culturally Competent Service Provision to Lesbian, Gay, Bisexual and Transgender Survivors of Sexual Violence, (2009); Setting the Stage: Strategies for Supporting LGBTIQ Survivors, (2010); Creating Inclusive Agencies: Sexual Violence and Individuals who Identify as LGBTQ, (2012); The Impact on Individuals and Communities: Sexual Violence and Individuals who Identify as LGBTIQ (2012); Sheltering Transgender Women: Providing Welcoming Services (2014); Let's Talk About It: A Transgender Survivor's Guide to Accessing Therapy, (2015).

[62] Assessment: How Inclusive Is Your Agency to LGBTIQ Survivors?; Creating a Trans-Welcoming Environment: A Tip Sheet for Sexual Assault Providers; Quick Organizational Audit: LGBT Visibility and Inclusion, (2001); Setting the Stage: Strategies for Supporting LGBTIQ Survivors, (2010); Creating Inclusive Agencies: Sexual Violence and Individuals who Identify as LGBTQ, (2012); Sheltering Transgender Women: Providing Welcoming Services (2014); Let's Talk About It: A Transgender Survivor's Guide to Accessing Therapy, (2015).

[63] Assessment: How Inclusive Is Your Agency to LGBTIQ Survivors?; Creating a Trans-Welcoming Environment: A Tip Sheet for Sexual Assault Providers; Practical Tips for Working with Trans Survivors of Sexual Violence, (2008); Setting the Stage: Strategies for Supporting LGBTIQ Survivors, (2010); Creating Inclusive Agencies: Sexual Violence and Individuals who Identify as LGBTQ, (2012); The Impact on Individuals and Communities: Sexual Violence and Individuals who Identify as LGBTIQ (2012); Pronouns and Transpeople, (2012); Terms Paradox, (2012); Responding to Transgender Victims of Sexual Assault, (2014); Sheltering Transgender Women: Providing Welcoming Services (2014); Let's Talk About It: A Transgender Survivor's Guide to Accessing Therapy, (2015).

Do not make assumptions about the gender of the perpetrator – ask open questions if the information is needed.

Explain confidentiality policies and respect LGBTIQ survivor's rights to direct who knows about their sexuality and gender identity – inside and outside your service. Disclosing someone's sexuality or gender without their consent mirrors patterns of power which may have been part of sexual abuse.

**Intake Forms and Processes**[64]

If your service is sex-segregated, stated identity should be enough to access – if someone identifies as a woman, they should be able to access your service. If this is not the case, make it explicit in your outreach materials, so trans women (or trans men) survivors do not face the humiliation of not having their gender identity respected when they try to get help after sexual violence.

Do not ask gate-keeping questions about people's body, genitals, hormones or surgery or require extra 'proof' for trans people as this is discrimination.

Create inclusive intake forms, client history forms and body maps which allow people to self-identify their sexuality and gender and are appropriate for LGBTIQ people.

Be aware that coming out for LGBTIQ people may take time, as survivors test whether this is a safe space in which to talk about themselves. This is not a sign of dishonesty.

**Respect**[65]

Do not make assumptions about, or pathologise LGBTIQ identities. Do not assume sexual violence caused someone's sexuality or gender identity.

Recognise trans people have unique relationships with mental health services as they have to navigate these in order to access transition-related healthcare, which may create lack of trust. Recognise fears around disclosing sexual violence and the impact this may have on accessed transition-related healthcare.

Acknowledge experiences of discrimination and stigma, and check in about what this means for resilience. Be aware if someone discloses their sexuality or gender identity to you, it is a sign of trust.

If you get someone's pronoun or sexuality wrong, apologise and move on. Don't make it a big deal, just try and get it right next time.

Explain why you are asking questions about bodies or sexual contact as LGBTIQ people, especially trans people, are used to being asked invasive questions to satisfy curiosity.

Take care and time when supporting LGBTIQ people with forensic examinations after sexual violence, as sexual violence may have involved parts of their bodies people would rather not think about which may create additional trauma. It may also 'out' people as trans, so survivors will need you to demonstrate respect for their preferred gender identity. Explain what is going to happen and why, and ask for permission at every stage. Use the words the trans person uses for their bodies.

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[64] Assessment: How Inclusive Is Your Agency to LGBTIQ Survivors?; Creating a Trans-Welcoming Environment: A Tip Sheet for Sexual Assault Providers; Practical Tips for Working with Trans Survivors of Sexual Violence, (2008); Setting the Stage: Strategies for Supporting LGBTIQ Survivors, (2010); Creating Inclusive Agencies: Sexual Violence and Individuals who Identify as LGBTQ, (2012); Sheltering Transgender Women: Providing Welcoming Services (2014); Let's Talk About It: A Transgender Survivor's Guide to Accessing Therapy, (2015).

[65] Assessment: How Inclusive Is Your Agency to LGBTIQ Survivors?; Practical Tips for Working with Trans Survivors of Sexual Violence, (2008); Creating Inclusive Agencies: Sexual Violence and Individuals who Identify as LGBTQ, (2012); Responding to Transgender Victims of Sexual Assault, (2014); Let's Talk About It: A Transgender Survivor's Guide to Accessing Therapy, (2015).

Using the language LGBTIQ survivors use for themselves, their bodies, partners, names and pronouns is validating and will help LGBTIQ survivors feel safe in your service. This is important after the trauma of sexual violence.

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# Crisis intervention for Muslim women experiencing sexual violence or assault.

**Fariya Begum and Anjum Rahman.**

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This research was undertaken by Shama (Hamilton Ethnic Women's Centre), with the report prepared by Fariya Begum (Social Worker) and Anjum Rahman (as a secondary contributor). Anjum is a member of the ACC advisory panel for the Mates & Dates programme, and involved in prevention work undertaken for the Campaign for Consent Hamilton group.

Research oversight was provided by Dr Julie Wharewera-Mika, Lead Researcher for the Good Practice Responding to Sexual Violence project. Specific support included review of the literature, analysis of the interview content, and editing of the report.

The research team would like to acknowledge the participants who generously shared their time and expertise, contributing to the development of the recommendations for Good Practice that follow.

**Abstract**

Muslims within New Zealand increasingly belong to diverse class, ethnic, professional and educational backgrounds. Statistics show that in New Zealand, the Muslim population is the most rapidly growing religious group, with the Muslim population increasing six-fold between 1991 and 2006. Today, Muslims comprise 1% of the whole country's population (Ward, 2011) but the services that cater to this community are scarce. This report focuses on understanding sexual abuse and assault in a Muslim context and the needs of Muslim women from sexual violence crisis support services. From this information good practice recommendations for service delivery have been identified, including workforce development, to better meet the needs of this community.

This qualitative study aims to provide solutions and specific guidelines that can be implemented to provide support that better caters to the needs of Muslim women. A literature review is included but is not exhaustive, as there is an abundance of international literature supporting the fact that Muslim women facing sexual and intimate partner abuse have specific issues and needs when in such a crisis situation. This report is limited to sexual abuse suffered by Muslim women, with males as perpetrators.

A focus group was conducted, comprising members of the Muslim community, to discuss how women could be helped and supported in such circumstances. In addition to the focus group, semi-structured interviews were also conducted with Muslim community leaders and key stakeholders. Thematic analysis of the focus group discussion and the interviews generated three categories: sexual violence in a Muslim context, cultural and mainstream support systems accessed by members of the Muslim community and recommendations. These categories are further broken down into themes namely: shame, reluctance, blaming the victim, support, lack of rights, and knowledge.

The findings not only break down the guidelines into specific and exclusive needs but also reveal the barriers that women face in accessing mainstream services. The findings from this report will form a base for the development of good practice guidelines when working with Muslims, for the 'Good Practice Guidelines for Mainstream Crisis Support Services (round two)' report.

## Background and Analysis of Sexual Abuse

Almost 50,000 people in New Zealand identify as Muslim, making up 0.9% of the total population (Nazari, 2014). This community comes from different ethnic groups and nationalities, such as Iran, Malaysia, Turkey, Indonesia, Afghanistan, Pakistan, the Balkans, India, Bangladesh, Somalia, Bosnia, Djibouti, and Fiji. There are approximately 3,000 of European descent and also a growing community of Maori Muslims (Nazari, 2014).

Auckland Sexual Abuse HELP states that one out of three girls and one out of five New Zealand women suffer serious sexual assault. These assaults are mostly perpetrated by people known to the victim/survivor (HELP, 2015). There appears to be a gap in the collection of reliable sexual assault statistics for Muslim women. This can be for many reasons such as lack of research within the Muslim community, lack of acceptance and acknowledgement of sexual violence amongst this community, or victims not disclosing or feeling a strong reluctance to disclose, which makes it difficult to gather data on this issue. Many other countries also lack information and resources on abused Muslim women (Alkhateeb & Abugideiri, 2007) and there is no data available (Shalhoub-Kevorkian, 1999a; Alkhateeb, Ellis & Fortune, 2001).

However, it cannot be concluded from the absence of data that sexual violence and abuse do not exist in the Muslim community. Muslim women are not safe from this devastating crime which also occurs in other Muslim and western countries (Gohir, 2013).

## Sexual violence in intimate relationships

The United Nations recognises women as having fundamental rights to be safe from male violence and "two parallel transformations" have been developed that are central to this declaration. One is to advocate for "increased recognition of the extent to which rape typically involves intimates". Koss & Heise (1994) suggest that "normative rape" is defined as "genital contact that the female does not choose, but that are supported by social norms" (Rozee as cited in Koss & Heise, 1994) and where refusal is objected to or not accepted by society. For example, "acquaintance rape" within marriage or a partnership or with someone familiar to the woman is included in the definition of "normative rape" (Koss & Heise, 1994). Muslim society, affected by local cultural traditions, is also influenced by the traditions of patriarchy, which is discussed further in the report. In some Muslim communities there is a perception that "a wife is her husband's sexual property and he can treat her as he wills" (Barlas, 2006). In 2009,

Afghanistan was considering a controversial law for its minority Shi'a population, making it a requirement for wives to have sex with their husbands "once every four days" (Barlow, 2009). Barlas (2006) explains why this is wrong, and that in a Muslim marriage the wife and husband are each other's "awliya" (friend and guide). They are required to have mutual respect for each other in each and every aspect of their lives, including their sexual desires. Much sexual violence may be counted as domestic violence, but the scene may not be treated as a crime scene and husbands may not be seen as perpetrators.

The other type of rape identified by Koss & Heine (1994) is "non-normative rape" where there "is a lack of choice or consent by the woman to engage in sexual intercourse" and there is evidence of "illicit, un-condoned genital contact that is both against the will of the woman and in violation of social norms for expected behaviour".

In both situations, whether rape by a stranger or rape by a husband, the woman goes through trauma and Muslim women face specific issues with that. Legal and mainstream social services are part of the solution but alone cannot suffice the needs of Muslim survivors. There is a need for an environment where women are not blamed, feel safe and supported and most importantly are empowered to help themselves and be a resource to others. Along with services, there is a need to understand the background, culture and history of the woman who has faced sexual abuse.

## Sexual violence in the Muslim community in a New Zealand context

There are some services for domestic violence provided by a Muslim-led organisation (e.g. FATIMAH Foundation) and some research done on mental health issues and services (Shah & McGuinness, 2011; Affinity Services; Culbertson & Shah, 2011). However, the local Muslim community lacks any specialised service or research for Muslim women suffering sexual abuse and intimate partner violence. An exploration is required of this issue that is almost invisible within the Muslim community, but before this it is necessary to understand the target client. The following paragraphs review the status of women in terms of the religion of Islam; how rape and sexual violence is viewed by Muslims within the cultural, religious and patriarchal realms; and the barriers to disclosure.

## Health Issues

Studies report that psychiatric symptoms such as stress, depression or anxiety are associated with violence and help-seeking behaviours are influenced by factors such as the "hostile environment of violent relationships" (Naeem, Irfan, Zaidi, Kingdon & Ayub, 2008). Research on Muslim women who have suffered Intimate Partner violence shows it has led to health issues such as "decreased self-respect, sexual function defects, eating disorders, post-traumatic stress disorders, and even suicide" and further mention that chronic stress and anxiety may result in somatic disorders. In addition, the research indicates that physical and sexual abuse may result in pregnancies and may lead to "serious pregnancy-related complications" and further health deterioration like "prenatal bleeding, foetal fractures, chorioamnionitis, maternal infections, uterus, lung or spleen rupture, abortion, stillbirth and premature birth" (Akyüz, Yavan, Şahiner & Kılıç, 2012). People who migrate under refugee status have different medical issues in cases of sexual abuse and torture such as "damage to cervix and uterus, fissures, fistulas, pain from the testes, irregular periods, etc…" (Ministry of Health, 2012).

This research is particularly focused on Muslim women - refugees who are settling in New Zealand come from countries that are predominantly populated by Muslims like Afghanistan, Iraq, Somalia, Ethiopia (which are amongst the top five source countries of quota refugees in New Zealand), Djibouti and Somalia (Ministry of Health, 2012). As the data is entered in the terms of ethnicity, it is difficult to accurately determine the numbers by religious groupings. Throughout this research, the issue of lack of data and statistics on religion has been common. These health issues cannot be assumed to be limited to Muslim women. However, the approach that Muslim women have towards health care after incidents of sexual abuse and/or sexual violence from a family member must be given attention. Fauzia Lodhi (2006) suggests culturally appropriate health care for Muslim woman is needed, and mentions that there may be barriers for women approaching health services, for example:

- "Insensitivity" to the modesty of many Muslim women, such as the hospital gown and the procedures that a woman has to go through (particularly following sexual abuse).
- "Lack of education, intimidation, and lack of exposure to the world"- Woman hesitate to enquire and question consultants (as it is seen as questioning their capability) about the process and also do not take

part in making informed decisions about their treatment, as they are unaware of their rights.

- Lack of research on every aspect that affects Muslim women, such as medicine, mental health or social problems.
- Religious beliefs - Muslim women may believe that these issues are from God and may accept the situation they are in. They may also believe that patience and enduring pain is the way to gain forgiveness.
- Mistrust of the wider population and media- Stigmatisation of the Muslim community in general, and women in particular, is a barrier for them to approach healthcare services.
- The cultural attitudes held by some Muslim women of putting their family and family honour before themselves (Lodhi, 2006).

## Islam and Women

> "And among His signs this that, that He created
> For you mates from among
> Yourselves that ye may
> Dwell in tranquillity with them, and
> He has put love
> And mercy between your (hearts)" (Chapter 30, Verse 21 of the Quran)

Prophet Mohammed (PBUH), regarded by Muslims as their leader and the last Prophet of God, has himself condemned men hitting their wives and there is no account of him hitting any woman or child in his lifetime. In the last sermon by Prophet, he emphasised to men that "they must be kind to their women" and further stressed that "wives have rights over their husbands in addition to husbands having rights over wives; that wives are to be treated well, for they are their husbands' partners and committed helpers" (Faizi, 2001).

The Prophet has also stated that "the strong man is not the one who can use the force of physical strength, but the one who controls his anger" (Faizi, 2001). The importance of reciprocal kindness and mercy are clearly expressed in the previous passage and explain the status and position of women in Islam. Thus any form of domestic violence or 'zulm' (torture, injustice, tyranny, cruelty, deprivation) in marriage is a "clear violation of Islamic law". Women have the right to equity, freedom and kindness and they also should have freedom from "fear of any human being, freedom from all oppression, the right to justice, freedom from defamation, and the right to peacefulness even during divorce"(Faizi, 2001).

But the interpretation and translation of Arabic words by many scholars has resulted in giving power to men to exercise violence in the name of religion. Aspects of obedience and "qawwamun" (protection, maintenance and safeguarding) have been misinterpreted leading to demands for women to be submissive, overpowered and to be put in a degraded category by abusive men (Faizi, 2001).

**Sexual Abuse and assault**: Shalhoub-Kevorkian (1999a) argues that "rape is a cross-cultural crime stemming primarily from patriarchal ideologies and gender power" and further states that various cultural groups have yet to understand the effects of this heinous crime on the victims (Shalhoub-Kevorkian, 1999a). Through the article, this author aims to highlight the "multidimensionality" of the crime and to further explore the "intricacy of social reactions to rape, the rape victim and abuse of women, deriving from a socio-cultural need to protect and/or control victims". The article suggests that factors like hiding the occurrence of rape, preserving virginity, silencing the victim to preserve family dignity and honour leads to weakening and "re-victimising" the victim. The research further argues that there is "no universal method of dealing with rape victims and those professionals who are assisting victims of rape need to anchor their efforts within the cultural context, while at the same time treating each victim as a world unto herself".

This research was conducted in Palestine, which is predominantly a Muslim populated country and the author explains that it is the social context and values that inform and shape the concept of rape, victim and abuser, and therefore the ways we attend to the needs of the victim. There is a need to be aware of and to explore the different power structures and the socio-cultural context that the victim is in and how it affects the victim herself. Shalhoub-Kevorkian (1999a) reminds us that there is also a need to be aware that "no single model of intervention should be imposed indiscriminately; rather, the uniqueness of each case needs to be taken into consideration".

## International research: Sexual Violence and Patriarchy

A research report from Pakistan provides facts on violence against women and mentions that 8,539 women were victims of violence in the 2011 year. It further stresses that there was an increase in sexual assaults, acid-throwing and honour killings (Shaheen, 2014). Although these crimes were gradually increasing and constant reports of such incidences were in the media, neither the state nor society was interested in any form of measures against them. Sources included in this report noted 800 women had committed

suicide because of domestic violence and of these 28.66% reported sexual violence and 93% reported marital rape. Shaheed (as cited in Shaheen) also highlights that the reason for violence is related to male dominance and mentions that not meeting the demands of their husbands or dishonouring a member of the family may lead to violence. Another article mentions that a woman may suffer and stay in such a relationship because of the religious beliefs that her husband or others in the community may instil in her. Similarly, an account of an incident is mentioned wherein a woman's religious convictions caused her to stay in an abusive relationship. This shows that sometimes a misunderstanding of religious rights and laws may become an obstacle for the victim (Faizi, 2001).

From a religious perspective, Islam is a faith with the main drive of creating a fair and just 'ummah' (community) yet many Muslims turn a blind eye towards scriptural foundations and are unaware of both the rights of a woman and the boundaries of marriage. Although justice is the main purpose of Islam, injustice is overwhelmingly entrenched in the "traditional fabric of the way Muslim women are treated" (Alkhateeb, Ellis, Fortune, 2001). Most importantly, Islam does not demand submission of a woman to her husband as "submission is only to God" but traditional practises override the interpretations of religious texts and sources. Unfortunately, some women are suffering through the devastating effects of violence and are "locked in hierarchies of power where women are at the bottom" (Alkhateeb, Ellis, Fortune, 2001).

## Cultural and religious identity and context:

To understand Muslim women, it is important to understand the religious and cultural context they come from as these most importantly contribute to "people's perceptions, interpretations and responses to the phenomenon of domestic violence" (Abugideiri, 2011). Religion and culture are deeply intertwined and influence different perceptions. Immigrants from Muslim countries may follow practises from their home countries that are untouched by any challenges or contradictions. On the other hand, the practises of a Muslim person growing up in a Western country may be different to those of an immigrant.

Religious sects include mostly Shia and Sunni. Further, the literature explains that there may be further affiliations depending on the level of religiousness or practises. For example, some groups believe in the literal meaning of Quran whilst others believe that the Quran may be interpreted in more than one way; some believe in the equality of both men and women in Islam and some believe that men are treated better than women

(Abugideiri, 2011). They may range from being extremely conservative to being liberal or secular. Authors suggest a typology that categorises Muslims according to their practise: “traditional (strongly practising), bicultural (moderately practising), acculturated (marginally practising), assimilated (non–practising) and recommitted (strongly practising)” (Alkhateeb & Abugideiri, 2007). Or they can be categorised by their “degree of literalism” by which they interpret Quran: “orthodoxists (literal interpretation of the Quran and Sunnah), inclusionists (a selectively modernist interpretation of the Quran using the Sunnah as a complement), reformists (a modernist interpretation of the Quran using primarily the essence of the Sunnah - practises of Mohammed pbuh), and minimalists (belief in the essence of the Quran without engaging in ritual practises, and rejecting virtually all the Sunnah as outdated)” (Abugideiri, 2011; Alkhateeb & Abugideiri, 2007).

## Disclosure of sexual violence:

A disclosure of sexual abuse makes the crime visible and known to the wider public, for example the family, legal personnel, doctors and members of society, rather than keeping the event private and confidential. Shalhoub-Kevorkian (1999b) agrees that knowledge of abuse by the wider community “not only calls for societal reaction to it, but also forces members/groups of society to take responsibility by either reacting (i.e. protecting/blaming the victim or defending/criminalizing the offender) or consciously choosing not to act (silencing and denying victimization)”. Further, the author states that the outcomes may affect the victim’s physical, social and psychological state of mind (Shalhoub-Kevorkian (1999b).

Another piece of research on the Muslim community in America also highlights the issue of disclosure and states that “for every case of abuse reported, almost fifty are unreported and that less than two percent of victims actually seek help” (Alkhateeb & Abugideiri, 2007). Nevertheless very little research and support is provided in the American Muslim community. Karmaliani, Irfan, Bann, McClure, Moss, Pasha & Goldenberg (2008) state that “Disclosure of violence is inhibited by fears of escalating abuse, feelings of shame and embarrassment, concern about confidentiality, fear of police involvement, and denial”. On the other hand, immigration may also create barriers. For example, the wife may be a dependent of the principal applicant (mostly men in cases of families coming from other countries) which gives power into the man’s hand to decide the woman’s fate (Alkhateeb & Abugideiri, 2007; Abugideiri, 2011). Simply to save her ‘izzat’ (honour) women surrender to such a destiny. Morfett (2013) believes that disclosure is not an issue where one can take a neutral stance; one has to

"either believe or you don't believe what you are being told". Hence disclosure can divide families and communities.

## Project Overview

## Method and Participants

This qualitative study involved a total of 11 participants, seven women from the Muslim community who participated in a focus group discussion, and four Muslim community leaders/key stakeholders who participated in individual interviews to identify recommendations for good practice guidelines for mainstream sexual violence crisis support services working with Muslims. The women focus group participants came from different ethnic and professional backgrounds and most of them have resided in New Zealand for more than 8 years. The median age of participants was 38 years, which ranged from 22 to 44 years. Three of the participants identified as Pakistanis, one from India, one from Djibouti and two were from South Africa. Of the four Muslim community leaders/key stakeholders who participated in individual interviews all had resided in and been a part of the local Muslim community in Hamilton for more than 10 years, being of Indian (Male), American (female) and Somali (Male) descent. Written informed consent was obtained and the participants were given complete information of the background of this research.

## Interview Procedures and Data Analysis

The focus group was held at Shama (Hamilton Ethnic Women's Centre). The participants involved in the focus group received vouchers as an acknowledgement of their involvement. Interview questions for the focus group and the interviews were framed around the needs of the survivors. Probing questions and an activity was used to get their perspectives and ideas around sexual violence. The first part of the focus group was around the understanding of sexual abuse and its prevalence within the community and how the group perceived it as Muslim women. This was followed by a discussion about their ideas around what Muslim men thought about this issue and about Islamic values regarding Muslim women. The second part focused more on what services are seen as appropriate when such events occur and how unique the needs of these survivors are. Interviews were audio-recorded with the participants' consent and transcribed to ensure accuracy and to assist with analysis.

## Results

The results from the focus group and semi-structured interviews are classified into three categories and are further discussed in themes.

- ❖ **Sexual Violence in Muslim context**
- Shame

The participants in the focus group were provided with a list of crimes (attached as an appendix) from which they were asked to pick the crime which they thought was the worst. Sexual abuse or assault was unanimously seen as the worst crime. For the participants who belonged to Asian countries like India and Pakistan, the immediate reply was rape being the worst crime but the participants from South Africa were undecided between murder and rape.

> *"With murder you die but with rape, you have to live with it. It will be a constant reminder for the rest of your life. Probably rape is worse than dying. From a woman's perspective I don't want to live with rape. No."*

> *"We also have this side where it is swept under the carpet. We don't want anyone else to know. Things are happening but it's not spoken about because of the shame of the family. And we don't want other people to know and other non-Muslims to know that it's happening in our Muslim community. Sex is very private in our community."*

It's a difficult irony that women feel and experience a loss of their and their family's dignity (Jamal, 2012) when they are a victim of rape. Along with bearing the trauma and consequences of rape, a woman also encounters further issues like isolation, being considered unsuitable for marriage, worthlessness or banishment. It is the fear of these consequences that add to the importance of virginity and women protect it more than their life.

- Impact on the whole family/community

It is not only the woman who has experienced assault who faces despair. The family and siblings also face consequences, such as the siblings not getting marriage proposals and parents feeling ashamed of their daughter's situation. Some parents may feel that they have been at a loss to provide protection for their child where as others feel that it was because of their daughter's faith that this happened to them. They blame it on her lack of faith.

> *"If it's a man whose wife or sister or family member is being raped, then the person is equally affected. But if you are a married person your husband will suffer with you just as much."*

> *"In a country where Muslims are a minority and the community already feels the weight of bigotry and discrimination, the community often feels very uncomfortable with having more negative publicity attached to them by way of disclosure of a sexual assault. Often the community are concerned with the greater consequences of increased discrimination - which can lead to reduced chances of employment, verbal harassment in public, or worse. This can lead to greater pressure on the victim to keep silent about the abuse."*

Sometimes, as mentioned earlier by one of the participants, the crime or assault is 'swept under the carpet' to maintain the façade that the girl is chaste and can be respected. The literacy level and ethnicity of the parents may also have an impact on how they perceive this crime and what they decide to do about it.

- Rights of women in the Quran

When asked to consider if the perpetrator was within the family (in particular the husband), the participants provided ideas from a male's perspective and also highlighted the issues and impact from a religious perspective rather than a social or cultural perspective. "The fact that marital rape happens within the boundaries of a conjugal contract seems to give the man more authority on the basis of how society positions him and how the man takes the responsibility of protecting the woman which is mistaken to be 'submission' by the woman.

> *"Things are still happening as people are away from Quran, they don't understand the meaning of Quran and they take their own personal prejudices and I think it's more cultural as well. A lot of things are cultural and not religious."*

> *"But in our religion it's not like Quran talks only about relationship and rights. It also talks about 'aadaab' like the protocols of being around your spouse, talks about everything in detail."*

> *"Male perspective – if the partner/husband is the abuser then he wouldn't think of it as a crime. Yea he doesn't - that's part of his life."*

These situations usually continue due to uncomfortable silences in the family. Although the woman may reveal the violence she suffers, the family or in-laws may choose to ignore her or blame the woman for not obeying her husband. The sexual relationship comes across as a duty, an obligation for a woman whereas through a religious perspective, this intimate relationship calls for "mercy" and "compassion". A man is believed to be "violating divine orders" if he practises a sexual relationship outside these "Islamic dictates" and surely is accountable for the abuse he has caused (Alkhateeb & Abugideiri, 2007).

- Lack of awareness of personal rights/Misinterpretation of Women's rights in Islam

It is most likely that families coming from Asian countries like India, Bangladesh, Pakistan or even Middle Eastern countries prefer to marry their daughters in adolescent age. In the effort to protect their daughters from any "mishap" or to fulfil their duties of being responsible parents and successfully settling their daughters with their spouse, families are convinced that marrying girls early is the solution. As agreed by our participants:

> *"We are also taught by our elders that once you become 18 you need to get married, first thing; the most religious thing is that you get married.*
>
> *Then whatever the husband does you have to put up with it, but now you are married and you can't come back to us. And you have to accept the situation the way he is."*

On the other hand, the parents make little effort to give sexual education or discuss with their daughters the rights of a Muslim woman. They miss the opportunity to educate the young woman and inform her of her role and inform her that she is a partner, a wife that has equal rights and not a submissive slave. "Lack of physical and mental readiness to build a family" may also contribute to the state of an abused woman (Laeheem, 2014).

> *"She is not aware of her own rights in Islam or even of the legal system here. The girl is warned that if you say no then tomorrow I will pack you up. She will say yes for the abuse."*
>
> *"A wife is made to feel wicked or sinful for refusing sexual relations of her husband, regardless how tired or unwilling she feels. He may have just hurt her feelings in any number of ways, but she can be made to feel bad for not putting that aside and*

*making herself available. This makes it easier for the abuser to take advantage of her."*

Along with this, lack of education and empowerment adds to her misery, as she is not able to understand her legal rights nor access available resources.

- **Cultural and mainstream support Muslims have accessed**

- Helpful vs Unhelpful resources- Imams and Muslim organisation

Participants suggested that similar to their process and support systems back in South Africa they would prefer to access advice from Imams (who are knowledgeable in both 'Shariah'- Islamic jurisprudence and the legal laws of the land) for issues related to sexual abuse in intimate partnerships.

*"I wouldn't stand for that [specifically for abuse within partnership] I will go to the mosque and I will see the Imam and I would take a divorce. In South Africa you actually had Imams especially skilled, whereas here we don't."*

But on the other hand, from a youth's perspective, one of the participants, was in disagreement and did not support the idea of approaching the Imam as she believed that the Imam's Islamic knowledge will not be enough to understand a youth's perspective and their issues, nor to support them in cases of sexual abuse or assault.

*"Youth goes to them and says hey look I've got this issue and they take it in the context of you doing this wrong and you doing this haram (illegal, forbidden act/thing/food), because they are not specialised and they don't have any background in such issues and because they know only Quran they say Islamicly this is not acceptable and they have a upper hand because they know Quran and they lead the prayer."*

*"And even if we go to the Imam or religious leader they say its 'kufr kufr kufr'(denial)."*

*"Due to lack of confidentiality that exists within many communities, most Muslim women would be reluctant to seek advice from the Imam or want them involved."*

On the same lines, Alkhateeb argues that Imams or religious leaders unfortunately blame it on the woman (Alkhateeb, Ellis & Fortune, 2001). They look at the issue with a strongly religious perspective and may not be able to support youth because they may not have a perspective that understands the youth.

> *"There are a few issues with Imams:*
> *1. They are often from overseas so don't understand the New Zealand culture and context, & may even have pre-existing stereotypes of what life is like in a Western country.*
> *2. They have training in religious studies but no training in counselling or social work, so don't have any specialist skills that will help them to deal with these situations, and for some of them, not even the personal skills to deal with a person in crisis in a way that isn't silencing for the victim.*
> *3. Imams are all male and many women or young girls would feel embarrassed having their personal details of abuse disclosed to a male community leader of this kind.*

The Muslim community may lack appropriate support from the Imams in New Zealand, and as mentioned in the above statements, there is a huge barrier in the knowledge and skills that the Imams have; so they are not well equipped.

Some believe that family and parents may put the needs of the victim in jeopardy. Memon (n/d) lists a number of reasons where a family or community may not be supportive or may go against the victim. Most of the times family members may find it difficult to intervene in private family issues and turn their eyes away from the abuse. Other reasons may include: lack of confidence to seek help, finding it hard to reach help, hopelessness, keeping the relationship intact for the sake of the children, and above all, lack of Islamic knowledge.

> *"I have a bit of a problem in having the family make the decision to take the matter further. I think the needs of the victim have to be paramount – if she doesn't want to take it further then she shouldn't be forced to do so by her family; similarly, if she wants to lay a formal complaint then the practitioner needs to think about what kind of support she will need if the family is absolutely against it. The victim may be placing herself in emotional/psychological danger if she proceeds with no support from immediate family or the community."*

> *"Families may also be unable to react with such situation and may react in a way which is detrimental to the victim for example with some of the high school girls, when they got in to trouble, they would tell teachers that their parents would ship them out of the country and back to their country of origin if they got into trouble."*

- Perception of mainstream services

An account narrated by a participant (who was a nurse by profession) highlights the level of trust this woman has in mainstream services. Although there are services available, people appear to be unaware of them. Again as mentioned earlier, disclosure also becomes an issue for various reasons like the fear of losing residency visas, children, better lifestyle and the unhealthy situations in the country the dependents have come from.

> *"When asked what happened she said I just gave a police complaint and now he may track me down and she bought her baggage and wants to run away."*

> *"We also lack knowledge of the system and social workers from other cultures don't understand where we come from. They just think we are oppressed women that have to be rescued. Social workers, doctors and other professionals need to be informed that we need to be supported not rescued."*

> *"For example, the girl who came to the clinic, they were here because they had applied for the residency that is why the girl was hanging on for three or four years. Because when we inform to someone we will think that there will be police involvement and we will lose our residency. Then if there are kids also we will think what should I do after I go back home and life is much better here."*

Victims are often unaware of how mainstream services run and what they can expect in services such as Women's Refuge. They are unsure as to whether or not these services have the facilities to meet their family's need and whether the women (as followers of Islam) will get the proper and appropriate level of support.

> *"The Muslim community do not have an understanding of how local services work, and so have a fear of them. For example, they think that approaching Women's Refuge will mean that the refuge staff will immediately try to split up the family; or that counsellors give advice that is contrary to Muslim beliefs – because they don't understand that counsellors listen and help someone find solutions, they don't tell the person what to do or what the answers are for their own lives. So the person providing services to a Muslim would need to have a discussion about these kinds of stereotypes and fears in terms of what the counselling or support involves and what it doesn't involve."*

> *"If you go to mainstream services, they will tell you pack your bags off. It's an intervention we will take you away and that's*

> *when a woman becomes reluctant and says o no I am not going to ruin my family home" (narrated by a participant- teacher by profession).*

Instead women clearly expressed their thoughts about having an organisation where they can directly approach a qualified person who is informed about the legal system in New Zealand and who can help them to develop a plan. Similar services in America have also identified issues like women's shelters not being able to provide appropriate services for Muslim women. Instead the women face negative stereotyping and discrimination because of "a lack of preparedness in cultural competence" and Faisi (2001) also agrees that non-Muslim services are not well equipped for Muslim needs.

- Cultural Incompetence

Many professionals, not only those related to providers of sexual violence services but also others such as doctors and nurses, fail to provide a safe environment for these women. Muslim women reportedly face a lack of competency from some of these professionals.

> *"The doctor believes that the lady keeps coming always and these people don't know how to fight with their husbands. She keeps asking for help why doesn't she stand up for herself. Without getting the facts right he was assuming that she wants attentions and acting up. That shows a man perception without any consideration."*
>
> *"When our women and children are out of the community they are more vulnerable."*
>
> *"Not fully. The average Kiwi service providers are applying their views and expectations and have very little compassion or understanding that things often worked."*
>
> *"This is such a case by case, culture by culture situation it cannot be pinned to one scenario. Everyone involved in this study needs to realise when dealing with Muslims you are also dealing with 80 or more different cultures/nationalities. You need to know Islamic teachings and realise that they are not always applied uniformly based on culture being intertwined."*

- Victim blaming

Victims have to face either being blamed by others around them like the doctor or nurse or other professionals or they are influenced by macro

factors. Burman & Chantler (2005) believe that "psychotherapeutic approaches" often insist that women can make choices and women staying in abusive relationships "are getting some of their needs met by maintaining their victim status".

> *"I don't know. She was like she didn't look physically afraid. I felt blurred that if the woman is taking the advantage or the man. She could have something else planned as well. Something else could also be planned."*

> *"People living from quite a while are getting Westernised and getting pulled towards to Western society and Western ways of living. Mostly in teenage. The people coming from other countries like refugees are suffering such issues. But if you travel willingly with your husband knowing that he will treat you in such a way then I wouldn't be going away from my support system."*

They further analyse that individualistic approaches pathologise women and do not take into account the fact that "domestic violence exists on a number of complex societal levels" which not only normalises the situation but also tends to leave the violent relationship open with the existing support. Burman & Chantler (2005) state that the choice to remain or leave are mostly "determined by wider social and economic systems such as housing, income/benefit levels, immigration status, disablism, racism, sexism, and responses of helping agencies".

- Stereotyping

> *"In a setting I have to discuss openly with doctor and colleagues, you know when you talk about this with your colleagues, they start building an image of every Muslim being so, you know! that stereotyping and all that."*

> *"The fear of walking into a police station with the scarf on, and giving the people a topic to talk about, it will again highlight the prejudices about our religion and culture. And our women will think that shame is better than this shame of facing the whole world."*

> *"Even before we engage in any ideas of what Muslim support looks like, we need to be portrayed by media in the way we are, we are getting highly influenced because of the things that are happening outside New Zealand. It is important that the statutory services like police, doctors and social workers understand and realise why we need these specific services."*

The views of participants included in this section may come across as a reluctance to approach mainstream services but they also highlight the fact that the Muslim community believes that sexual abuse and sexual violence by an intimate partner is a crime that belongs to this community. These ideas reiterate and reinforce the fact that the victim needs to be worried about the honour of her community before her own well-being, and that the victim is the one who should be ashamed of what has happened to her. These provoking thoughts also call for services that can provide awareness about sexual abuse and provide evidence to the Muslim community and other communities that the predators are from any community and "they have no respect for girls and women of any faith or culture and will target those who are most accessible" (Gohir, 2013).

- **Summary of results**

The results collected from the focus group and individual interviews highlight a constant variable of shame. Shame has not only created a barrier for Muslim women to approach support services but also shifts the focus on the victim rather than the perpetrator in the context of sexual abuse or violence. This is caused by other variables like the lack of Islamic knowledge and the perceptions of mainstream support services. Mainstream services should not be generalised but some changes and proactive involvement in cultural competency, specifically related to the need of Muslim women may be helpful.

Some areas urgently need further work by people from the Muslim community such as cultural support, Islamic jurisprudence, spiritual support, and the rights of Muslim women. Issues associated with sexual violence can be challenged and set right by Muslim leaders and clerics. However, the issue of cultural ignorance around the rights of Muslim women are compromised if these leaders and clerics do not have the appropriate training. The recommendations listed below are for the purpose of forming guidelines; crisis situations following a sexual assault or disclosure of sexual abuse; informing volunteers and professionals that work with Muslims, workforce development; and to highlight the need for 'by Muslim for Muslim services'.

- **Recommendations for sexual violence crisis support service delivery:**

Guidelines for volunteers and professionals in crisis services who are working with Muslims (e.g. cultural competency training):

- Workforce development: Training and education for sensitivity to Islamic values that pertain to gender roles, marital relationship and family dynamics from Islamic perspective.
- Cultural awareness: Assessing the extent the Muslim woman has assimilated into the western culture. Gauge her present situation for example her education, employment, relationship, culture, ethnicity, amount of time she has stayed in New Zealand, to what extent are Islamic values important for her and so on.
- Cultural competency training: Appropriate cultural workshops are a necessity that are provided by Muslims who are competent or have the skills to work with people (e.g. leaders who are aware of the social issues, social workers, people who work with minorities and immigrants, etc.).
- Understanding a NZ Muslim context: This is such a case by case, culture by culture situation it cannot be pinned to one scenario. When dealing with Muslims you are also dealing with 80 or more different cultures/nationalities. You need to know Islamic teachings and realise that they are not always applied uniformly based on culture being intertwined.
- Client choice and consent before engaging with family, and Muslim-specific supports are essential.
- Language barriers: Muslim families when they come they don't know English and they don't exactly understand the context of the situation they are in, so there have to be people of their own language who explain this to them.
- Understanding the broader impact of sexual violence on not only the victim/survivor but also her wider whanau and community (related to shame and judgement).
- An awareness of any stereotypes one might have about the Muslim community, and a readiness to address these by accessing further education about the Muslim faith. This will include understanding the Muslim ethos (underpinnings) that support women's rights and do not accept the sexual abuse and violence of women, and keeping an open mind and being informed of the diverse views and cultures that may or may not approach any cultural supports. Again an awareness of the victim's level of assimilation into the culture that they bring along with them. For example a Muslim from India may have a different worldview than a Muslim woman from a Middle Eastern country.
- Understanding social issues in a NZ Muslim context: The women would greatly fear loss of the children and inability to provide for

them. Many would likely not have managed or ever paid bills. There would be a need for a huge upskilling in their own lives.

Crisis service delivery:

- Access to appropriate support services, both cultural and sexual violence experts.
  - Mainstream services:
    - Muslim women are cautious of accessing mainstream services due to negative experiences associated with stereotyping and a lack of cultural understanding. There is a need for professionals working with Muslim women to understand the cultural context of the victim/survivor "knowing where we come from".
    - There is a need for cultural competency similarly when we think of cultural competence we fail to address the fact that culture is (in many places) intertwined with religion. This is "a dimension of cultural competency that is often overlooked or subsumed under the larger cultural competency umbrella"(Fowler, 2012). Not only is religion (Islam) a part of Muslim identity, it defines the way Muslims live - it is a system.
    - Prioritising staff training and education: Workshops in aspects of sensitivity training in cultural and religious needs.
- Workforce development should be a priority to address the needs of Muslim victims/survivors. This should include a focus on recruiting young Muslim crisis support workers because most of our experiences show that the best support is provided by peers who Muslim victims identify with. . The focus on recruiting a skilled workforce who possess dual competency (this refers to the ability of one to possess skills of cultural and religious knowledge of a Muslim world view, as well as expertise in the delivery of sexual violence crisis support) is also highly recommended.

  - Cultural supports – Imams (Shariah) are seen as leaders in the Muslim community, and beacons of support for some. However there is a sense of mistrust of such people (in power) as there is a lack of understanding of how to respond to someone who has experienced sexual violence and a lack of knowledge regarding appropriate supports and healing pathway for

victims/survivors. It is seen that this is an area of potential support in the future that should be progressed with caution. That is, the willingness of Imams to engage in relevant education with regard to responding to sexual violence is vital.

Family support and education (client focused): need for social support (emergency housing), parenting support and education:

- Workshops for new settlers (both refugees and migrants) as they may experience culture shock and this may lead to them being more possessive and sceptical about the surroundings that their children are growing in.
- Provide good understanding on the topic of sexual abuse. Create an appropriate workshop that will be beneficial both for children and parents for building open relationships.
- Being aware that Muslims from different cultures bring their traditions and home rules along with them. Building rapport with the parents so that the workers can understand the issues from cultural and religious perspectives.
    - Help parents understand that their culture and religion is a part of their new identity of being a New Zealander and help them understand the rights and benefits that they can avail.

  It becomes necessary that parents attend workshops to be able to have conversations with their children about sexual abuse and so they can be approachable when necessary. This helps in breaking the barrier of lack of communication and alienating their children.

  - By Muslim for Muslim services:
    - An organisation with competencies of both the New Zealand legal system and Islamic knowledge to act on behalf of the victim/survivor.
    - Require lawyers to be informed of both the Shariah and New Zealand law.
    - Counselling is very important and Muslim counsellors should be aware of both the religion and the legal system.
    - An ability to engage in 'Mushwarah' (consultation) in a way that is culturally appropriate.
    - Knowing the 'shariah' (theology and jurisprudence) of Islam and providing services like counselling.

Further recommendations to support Muslim victims/survivors:

- The development of consultative (panels) groups that can provide their cultural expertise on such matters. A need to develop panels in this country from various ethnic/religious groups who are given a short course on social work/counselling issues and who can be called on in cases of family violence or sexual violence or for consultation by corrections, where the panel can provide expertise in the specific cultural or religious aspects that need to be taken into account. Membership of such a panel would be a paid position, and could work at a national level servicing practitioners throughout the country, in a variety of fields – maybe even health and mental health.
- Development of appropriate resources, such as a database of contact people or Imam or spokespeople who can provide for spiritual needs.
- Interpreters, and educated Muslim women who understand both the individual's view but also the general Islamic teachings and societal structures.
- Keeping the new migrants and families of victims connected with the Muslim community as this may provide some cultural support.
- An organisation that deals with the statutory organisations straight away. An organisation that is in charge, that takes these matters seriously in their hand, and does the job in an Islamic ethical way and not deal with it in a western way. For example it might provide some kind of advocacy and support service where qualified professionals from Muslim community:
    - Can deal with CYFS and police
    - Will be able to deal with doctors and WINZ
    - Be able to deal with the leaders in our own community
    - Be able to deal with school and other relevant organisations necessary in supporting the woman/girl and family.

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# Working with Asian survivors of sexual violence

**Dr Jennifer Hauraki and Dr Vivien Feng**

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A project to inform Good Practice Responding to Sexual Violence – Guidelines for mainstream crisis support services for survivors. Round Two. TOAH-NNEST 2016.

Funded by a grant from ACC.

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# 1. Overview

This report contributes to a larger, more comprehensive project initially commissioned by the Ministry of Social Development that examined "good practice" in response to sexual violence across a number of population groups, focusing on "what best practice might be in the delivery of crisis support services to survivors in our communities" (McPhillips, Black et al. 2009). Round two of the project has been initiated by Te Ohaaki a Hine National Network Ending Sexual Violence Together (TOAH-NNEST) and is funded by Lotteries New Zealand. This reports aims to:

- Identify what is "good practice" for mainstream crisis support services when working with Asian survivors of sexual violence, through examination of the key points garnered from a review of overseas and New Zealand (NZ) literature/research, as well as focus groups/interviews with Asian stakeholders/professionals in Auckland who have experience in working with Asian survivors of sexual violence.
- Establish a foundation for continued development of "good practice" for working with Asian survivors.
- Develop this "good practice" into recommended guidelines for mainstream crisis support services to inform their service development and practice.

# 2. Definitions and Relevant Literature

## 2.1 Definitions

**Asian** is a broad term used to refer to individuals who originate from a plethora of countries and cultures on the Asian continent, from the east of and including Afghanistan, through to the south of and including China (Rasanathan, Ameratunga et al. 2006). Although the term Asian brings homogeneity to a hugely diverse range of ethnicities, cultures and communities, we have chosen to use the term Asian for purely pragmatic reasons so that we may identify common themes that draw experiences of Asian survivors together.

According to Statistics New Zealand (MacPherson 2015), the Asian population is one of the fastest growing populations in NZ, and according to NZ's 2013 census, the Asian population (12% of the entire population) was the third largest major ethnic group in NZ, and Auckland was the most ethnically diverse region in NZ, with 18.9% of its population identifying with the various Asian ethnic groups. The eight largest Asian ethnic groups in NZ are: Chinese, Indian, Korean, Filipino, Japanese, Sri Lankan, Cambodian and Thai, with Chinese and Indian being the two most prevalent (Te Pou 2010).

## 2.2 Common cultural values in Asian communities

***Collective culture.*** Asian cultures are collectivistic (Futa, Hsu et al. 2001; Te Pou 2010), which differs from the more individualistic orientation of mainstream New Zealanders. There is a tendency for Asian cultures to place more value on family duty, tolerance of hardship and achieving success (Te Pou, 2010), and the needs of the group are often emphasised over the needs of the individual (Futa, Hsu et al. 2001). Therefore, the behaviours of the individual are seen as a reflection of the entire family, including family ancestors and future generations. In order to preserve the reputation, unity and harmony within the family, problems may be suppressed and family needs prioritised over individual needs (Futa, Hsu et al. 2001).

***Family structure.*** Asian families tend to be more structured and hierarchical. Family members generally adhere more strongly to defined and expected roles, positions, obligations and expectations. These roles serve to preserve family harmony and reduce overt conflict within the system. Males and elders are respected and given more power, as they are seen as authority figures which have decision making powers over other genders and the younger generations (Futa, Hsu et al. 2001).

***Conformity.*** There is a strong emphasis on conformity to rules and guidelines, and an unspoken rule within Asian cultures to respect boundaries (Futa, Hsu et al. 2001). Keeping harmony and obeying rules tends to be valued over individual creativity, assertiveness and initiative.

***Shame and guilt.*** The concept of shame, or "loss of face" is common for Asian peoples. (Te Pou 2010). It is a powerful concept, as it not only brings shame to the individual, but all those who are associated with the individual, such as his or her immediate and extended families. The sense of guilt for bringing shame to the family is a powerful motivator to not disclose problems, or to suppress one's true desires or needs.

***Attitudes towards sex and sexuality***. Asian cultures tend to hold more conservative attitudes towards sexuality. This topic (and all associated issues such as sexual violence) is seen as too taboo for public discussion, and is often met with embarrassment and awkwardness, and hence associated with secrecy, confusion and mystery (Futa, Hsu et al. 2001).

## 2.3 Sexual violence in Asian communities

So considering the growing proportion of individuals living in New Zealand who identify as Asian, as well as the distinct needs arising from cultural values (when compared to mainstream New Zealand), it is pertinent to:

- Discuss the influence of Asian cultures and ethnicities on views around sexual violence and survivors, particularly the barriers that impede help seeking within New Zealand, and to

- Consider how mainstream crisis support services can provide for Asian survivors of sexual violence.

Within Asian communities living in predominantly Western countries, some populations are more vulnerable to sexual violence. For example, immigrants and refugees can arrive with traumatic histories in their home countries, and may have had to endure unsafe immigration routes, or escaped violence in civil or international conflict zones and refugee camps. They may not disclose these victimisation experiences for many years or even consider seeking help (Asian & Pacific Islander Institute on Domestic Violence 2011).

Although there is limited research into the extent of sexual violence within these Asian communities (e.g., United States of America, United Kingdom), there are recurrent themes of under-reporting noted (Allnock, Radford et al. 2012; Kanukollu & Mahalingham, 2011). Some studies have found rates as high as 40 to 60% of Asian American women (47% Cambodian American, 60% Korean American, 60% South Asian American) acknowledging that they have experienced sexual assault or coercion from their intimate partners (Yoshioka and Dang 2000). This compares with national reporting data which show only 10.5% of Asian American women having reported rape and sexual assault compared to 25.5% of Caucasian women and 38% of African American women. Researchers have highlighted a number of barriers faced by Asian communities that may lead to the true incidence of sexual abuse being under reported, including cultural stigma towards reporting sexual assault, concerns of cultural values that might bring fear and shame upon the family, the fear and distrust of institutions harboured by Asian communities that intervene and protect them, as well as language barriers (e.g., limited availability of language appropriate resources).

## 2.4 Barriers to accessing help

Asian communities living in predominantly Western countries have often been painted as a "model minority", a highly thriving group portrayed with lower rates of crime, juvenile delinquency and divorce (Sue, S., Nakamura, Chung & Yee-Bradbury, 1992) and better levels of physical health (Takeuchi, Zane et al. 2007). However, this portrayal has often masked a level of need, and the myriad of barriers to accessing mainstream health and mental health services (Ministry of Health, 2006).

Accessing psychological therapies for mental health difficulties is uncommon in many Asian cultures, with stigma and denial being common barriers (Rastogi et. al., 2014). Traditional therapies (e.g., meditation or herbal remedies) are more commonly used in their home countries, and there

tends to be a reliance on self-help measures and immediate social networks compared to more formal help-seeking (Te Pou 2010). In addition, the individual's level of acculturation to and internalisation of dominant Western culture and values can influence help seeking and, generally, those who are younger, educated and more acculturated tend to access help more than the older generations (Te Pou 2010). Furthermore, somatisation is a significant impediment (since physical health concerns are more acceptable and removes the stigma and sense of weakness attached to mental health difficulties) and means that help seeking tends to be from more medically-focussed professionals (Futa, Hsu et al. 2001; Te Pou 2010).

If individuals in Asian communities already face such barriers to accessing health and mental health services in general, it is widely believed that these barriers are further compounded when examining help-seeking in the aftermath of sexual violence. Here Asian survivors face not only the barriers identified for survivors in general (McPhillips, Black et al. 2009), they are also bombarded with unique challenges rooted within their Asian cultures which further prevent or discourage help seeking. These include language issues, perceived lack of diversity amongst service providers, and lack of culturally appropriate or sensitive services which honour their cultural identities, needs, beliefs, and styles of expression (Ohio Alliance to end sexual violence 2014; Robertson, Chaudhary et al. 2016).

Fear of the stigma and shame attached to sexual violence means it is common for Asian survivors to hide or deny the occurrence of and subsequent difficulties arising from these experiences, especially if the stigma and shame has far reaching effects for not only the survivor themselves but also their immediate and extended family (Kanukollu & Mahalingham, 2011; Rastogi, Khushalani et al. 2014; Robertson, Chaudhary et al. 2016; Yoshioka & Dang, 2000). Like the findings for mental health, Asian survivors of intimate partner violence (including sexual violence) were more likely to seek help from informal (e.g., friends, family) than formal sources of support, and acculturation appeared to have a buffering effect on stigma since those who were more acculturated, were more likely to seek help from formal sources (Kim and Ingrid 2015).

Symptom presentation may also differ in Asian survivors. For example, somatisation is common, and one study found that the younger generation of South Asians (e.g., those under 40 years of age) commonly present with stress symptoms, whilst the older South Asians tend to present with major mental health illnesses (Rastogi, Khushalani et al. 2014). Levels of acculturation also seem to impact upon help seeking in Asian survivors, with higher levels of acculturation leading to greater openness to formal help seeking, perhaps due to a greater internalisation Western concepts (Kanukollu and Mahalingam 2011).

Studies have found that cultural dynamics have a significant impact on the views held about sexual violence within Asian communities. The way sex and sexual violence is talked about often reinforces patriarchal norms and values (e.g., the cultural acceptance and focus on men's sexuality and rights to satisfy needs), where the male voice not only dominates within the immediate and extended family, but governs the communities in which survivors live. This dominance often affects whether a survivor's experiences are even labelled as sexual violence. Survivors, namely women, are encouraged to remain silent about their experiences to maintain honour within the family and minimize shame, especially since it is often the survivor's (and not the perpetrator's) 'purity' and reputation that is questioned (Cowburn, Gill et al. 2015; Kanukollu & Mahalingham, 2011).

## 3. Methodology

The researchers utilised their existing networks gained from research and professional experience to access the participants for this report. The participants targeted were professionals (e.g., social workers, counsellors, therapists, nurses, doctors, support workers) who have extensive experience working with the Asian communities in Auckland, New Zealand, and in particular with Asian survivors of sexual violence. A total of nine (three male and six female) participants took part, with four identifying their ethnicity as Chinese, three as Korean and two as Indian.

In terms of methodology, this current report has drawn from the larger, more comprehensive Good Practice Guidelines for Mainstream Crisis Support Services project (McPhillips, Black et. al, 2009), and the various reports looking at targeted populations (e.g., Good Practice Guidelines – Working with LGBTI+; Good Practice Guidelines – Working with Men; Good Practice Guidelines – Working with Muslim Women). The researchers completed two focus groups and an individual interview with the participants. The semi-structured focus groups and interview explored the opinions and experiences of the participants with regards to several different areas:

- The views held by Asian communities with regards to sexual violence/sexual abuse
- The barriers faced by Asian survivors in disclosing sexual violence/sexual abuse, and the barriers to accessing support
- The need of Asian survivors in the aftermath of sexual abuse/sexual violence and how these translate into recommendations/guidelines for those working in mainstream crisis support services

The participants' responses were then qualitatively analysed for emergent themes, which are discussed in the Results section below.

## 4. Results: What did we learn?

The opinions and experiences garnered from the participants are discussed in two sections for the purposes of this report: the first section, 'Essential Knowledge' is a summary of the knowledge that is essential in working with Asian survivors of sexual violence; the second section, 'Essential Practice' is how this essential knowledge translates into practice guidelines and ways of working with Asian survivors for mainstream crisis support services.

### 4.1 Essential Knowledge – What you need to know

In examining the knowledge that was essential for crisis support workers in working with Asian survivors of sexual violence, there were several recurrent themes in the narratives of the professionals that participants felt needed to be understood.

***Tackling the 'model minority' myth.*** In order to tackle the 'Model Minority' phenomenon described by researchers (Sue, S., Nakamura, Chung & Yee-Bradbury, 1992; Takeuchi, Zane et. al, 2007) participants felt that professionals needed to recognise the fact that comparatively low sexual violence statistics in Asian communities does not mean that sexual violence is not occurring in Asian communities.

> *"Be open and keep in mind that sexual abuse can happen to anyone regardless of colour and race".*

***Attitudes towards sex and a lack of knowledge around sexual violence.*** If significantly conservative attitudes surround sex and sexuality within Asian communities, the topic of sexual violence is seen as even more taboo. Like overseas research (Futa, Hsu et al. 2001; Ohio Alliance to end sexual violence 2014; Robertson, Chaudhary et al. 2016) our participants felt that there is a lack of necessary space for discussion and education around sex and sexual violence, and this silence is modelled and permeates through the generations in Asian communities.

> *"Parents are uncomfortable talking about sex, they may feel embarrassed, so children learn this through their parents, so don't speak up, it's shameful to talk about sex, it's seen as I'm being promiscuous".*

The participants felt that the meaning of rape and sexual abuse may differ for different individuals and cultural groups within Asian communities. There is often a lack of terminology or concepts for unwanted and unacceptable sexual behaviour, and individuals who have experienced sexual violence are often labelled as 'victims' due to the lack of an equivalent of 'survivor' in various languages spoken.

> *"[Asians] often have difficulty articulating the incident…they don't even know it was not ok?"*

> *"Sex, do not talk about it, it's a taboo subject, this lack of dialogue means people are being conditioned to not talk about such a topic. The definition of sexual abuse is broader in New Zealand compared to back at home, which makes it more confusing."*

The participants also felt that the lack of space to discuss and consequent lack of knowledge surrounding sex and sexual violence has a flow-on effect. It meant that there is limited knowledge around the rights of an individual, the potential difficulties that one may face in the aftermath of sexual violence, as well as the services available to support survivors and how to access these.

> *"Where or who do they seek help from? There are different types of help available back home, which is no longer available in NZ…it does not exist in NZ"*

> *"Male rape is not a crime in home country, it's scary to seek help, do I really need it? Since staying put allows consistency and predictability. They hold onto hope, that caring person will come back, everything will be back to normal again"*

***Shame and stigma.*** The emphasis placed on family duty and harmony, coupled with the far-reaching effects of shame and stigma, often meant that the consequences of disclosing their experiences of sexual violence is at the forefront of many Asian survivors' concerns. The participants felt that this fear of bringing shame on oneself and one's immediate and extended family often poses as a huge barrier to seeking help, given the greater focus given to family in the collectivistic nature of Asian communities. Survivors are often plagued with guilt for exposing and bringing to light such a 'shameful' subject, and it is common for the individual to remain silent in order to prioritise the reputation of their family, a finding echoed in overseas research (Kanukollu & Mahalingham, 2011; Rastogi, Khushalani et al. 2014; Robertson, Chaudhary et al. 2016; Yoshioka & Dang, 2000).

> *"If they open up, they fear that they will be stigmatized for life, it creates a sense that the cost of disclosing outweighs the benefits. The impact on marriages for the younger generations, the effect it might have on family businesses".*

As a result, the focus is often on "getting on with life" and denial or minimisation is a form of coping often used by many in order to avoid shame, stigma and even blame.

> *"Let's not rock the boat, keep harmony, and sweep it under the floor, as long as I carry on as normal, I'm not crazy".*

> *"Mental health is taboo, sex [and sexual violence] is even more taboo, ignore it"*

Participants also felt that ethnic minority status and the consequent smaller communities (when compared to countries of origin) in New Zealand further compounded the effects of stigma and

shame. Asian survivors and their families fear being exposed and labelled, particularly if they encounter members of their community in the process of help-seeking.

> *"What if they find out it's me? We all know everyone in this community, what will they think of me?"*

In addition, participants pointed out the role of religious groups or organisations that the survivor and their family are deeply rooted in, where a whole community may be the source of pressure for the survivor to remain silent to minimise shame, "save face" and maintain harmony within the community.

> *"Coercion from religious groups to not disclose, a threat to the community, for fear of further stigma for already stigmatised model minority".*

***Somatisation.*** As discussed in both international and New Zealand research (Futa, Hsu et al. 2001; Kanukollu and Mahalingam, 2011; Rastogi, Khushalani et al. 2014; Te Pou 2010), participants felt that there may be a tendency for Asian survivors to somatise and present under the guise of other issues (e.g., stress, asking a question for a friend) in order to reduce the aforementioned shame and stigma. They felt that professionals needed to be aware of these "tell-tale" signs as perhaps an indication that further exploration may be needed.

> *"It is common for them to see the doctor for physical problems, then complain about sleep or anxiety, use these as an excuse to go to a professional".*

***Cultural dynamics and patriarchal norms.*** The dynamics underlying the beliefs and values surrounding sex (and consequently sexual violence) in Asian communities often reinforces patriarchal norms and values (Cowburn, Gill et. al., 2015; Kanukollu & Mahalingham, 2011). These dynamics champion male rights, dominance and authority, and participants felt that this was at the heart of whether a survivor's experience was even recognised as sexual violence to begin with.

> *"Patriarchal or male dominance is the norm, the idea of ownership within a marriage is seen as normal, there is no such thing as marital rape, it is a concept that simply does not exist.*

Participants felt that this patriarchal dominance, coupled with the formal and hierarchical nature of families in Asian communities (Futa, Hse et. al., 2001), meant that the decision to disclose or seek help for experiences of sexual violence often did not rest with the survivor. Individuals (usually male) within a survivor's immediate/extended family, and even wider community, often influenced the decision of whether they sought help and where this help came from. This, along with the effects of stigma and shame, meant that informal sources of support (e.g., talking with relatives or friends) were often relied upon.

> *"Who defines or decides what's right or wrong? Respect for authority means obeying whatever decision is made within the family, those who hold the most power are mostly males, fathers, or those who are older, like grandparents. So it is the men who make decisions for the person".*

Participants felt the strong influence of patriarchal norms and values also meant more endorsement of rape myths (widely held and inaccurate beliefs about sexual violence) in Asian communities, where the blame may rest with the survivor and they may be questioned about their role in precipitating the sexual violence.

> *"Why did you wear such as short skirt? You asked for it, it's no one's fault but your own".*
>
> *"Tendency to internalise or personalise issue, "what did I do wrong?"*

***The role of acculturation.*** As highlighted by previous research and literature (Futa, Hsu et al. 2001; Kanukollu & Mahalingam, 2011; Kim & Ingrid, 2015; Te Pou, 2010), the participants felt that an individual's level of acculturation to and internalisation of Western culture and values needs to be considered. They stressed that acculturation affects the level to which the aforementioned issues, such as stigma, shame and adherence to patriarchal norms, influences an Asian survivor (and their family) and their decision to disclose and seek help. One example discussed, was the effect of immigration and consequent acculturation on gender roles within a family.

> *"Following immigration, gender roles change, more equality for the two genders, their ideas of a husband and wife's role shifts".*

***Vulnerable populations within Asian communities.*** The participants saw some populations within Asian communities in New Zealand as more vulnerable, including international students, visitors/tourists, refugees and recent migrants. These individuals may have more idealised perceptions of New Zealand (often garnered from and endorsed in their countries of origin), and the limited time spent here may mean less understanding around individual rights and boundaries regarding acceptable/unacceptable behaviour. This vulnerability is further compounded by the lack of an established support network of family, friends or individuals from their communities.

> *"New Zealand is a no crime, clean and green country. This creates a false sense of security; New Zealanders don't take advantage of people".*
>
> *"New Zealanders are friendlier, it's normal to hug and kiss, even if it makes me uncomfortable, it's normal in NZ."*

## 4.2 Essential practice: What you need to do

In looking at how the aforementioned essential knowledge translates into ways of working with Asian survivors for mainstream crisis support services, there were a number of recommendations highlighted by the participants.

***"One size does not fit all".*** First and foremost, the participants all highlighted the importance of taking an individualised approach in working with Asian survivors due to the vast diversity amongst the different communities and since "one size does not fit all". This approach would hold all the issues discussed in the 'Essential Knowledge' section, whilst focusing on the individual needs of each survivor. It would take into account the issues, beliefs and values that are important to the survivor's culture and country of origin, and examine how these intertwine with the survivor's own experiences as an individual within their own culture and community, as well as in New Zealand, paying particular attention to acculturation and exposure to and internalisation of Western concepts and values.

> *"Work with what works for the individual, ask them what they want. Don't generalise, depending on their culture and level of acculturation, their needs will differ. They may be close in culture, but not the same community."*

For some Asian survivors, it may be helpful and important to have a professional who matches their gender, age, culture and language, an individual who they feel may more intrinsically understand their cultural identity, needs, beliefs, and styles of expression. However, professionals need to keep in mind that automatically assuming the need to culture match may be a deterrent for some. This is especially when having such a member from their community further augments the fear of exposure to the stigma and shame attached to being a survivor due to the smaller nature of the various Asian communities in New Zealand (when compared to countries of origin). Furthermore, participants felt that it is essential to clarify whether adhering to the widely held beliefs, values and ways of working associated with a certain Asian culture may be beneficial to an Asian survivor. One such example discussed was the assumption that an Asian survivor may automatically want to involve or include their family due to the collectivistic and hierarchical nature of many Asian families. Here participants spoke about sensitivity towards this more collectivistic and family-oriented focus whilst also gaining an appreciation of the dynamics within the survivor's family, and understanding whether involving family is helpful for the survivor (e.g., it may provide much needed support or it may augment shame and blame).

> *"Don't be in a rush, take time to figure out what is important to the survivor, don't rush in [with assumptions]."*

> *"Figure out who is in charge within the family. Balance collective culture and the individual's need for privacy/trust. Test the waters, test out who can you involve, prepare them for a family meeting before launching into one"*

Overall, participants felt that working effectively with Asian survivors means having a service that is able to match the gender, age, culture and language of an Asian survivor if needed. But it also means professionals being able to "pick and choose" from a culturally appropriate and sensitive "toolbox" of knowledge and skills if they are not from a survivor's culture, thus being able to tailor one's approach to the individual needs of each Asian survivor.

***The crucial role of rapport building and confidentiality.*** The participants repeatedly stressed the importance of spending time on rapport building and ensuring confidentiality in order to address the significant effects of stigma and shame attached to being a survivor of sexual violence and speaking about such experiences. They felt that trust often dictates the level of disclosure and openness, and Asian survivors tend to "test the waters" and may present under the guise of other complaints or queries (e.g., stress, asking a question for a friend)

> *"Safety and confidentiality matters more so for Asians than mainstream clients, being upfront with the client, have the ability to listen, use appropriate language for that community".*
>
> *"Build that rapport first; you won't go anywhere if they don't trust you"*
>
> *"Reiterate confidentiality, provide a sense of safety, be sensitive, and collaborate, they put a lot of faith into professionals, professionals are seen as doctors or experts, so some are more willing to disclose because of this, although this depends on the type of trauma".*
>
> *"It is common for victims to seek therapy for another issue, like insomnia, or anxiety. When safe, they may open up. They tend to need lots of time to warm up. Even when they do open up, they won't give a lot of details."*

***The importance of normalisation and education.*** Due to the stigma attached to sex and sexual violence and the resultant lack of information and discussions, participants felt that it was of utmost important to normalise a survivor's experiences and fears (particularly with regards to disclosure and help seeking). They stressed the value of providing some information around boundaries of behaviour and individual rights, particularly in helping the survivor label their experiences. They also emphasised the need for education about sexual violence, the common experiences of other survivor's in the aftermath of such trauma and the supports and services available in the community.

*"Give them the vocabulary to name the incident, what is ok, what isn't"*

Some participants suggested a more general approach to raising awareness about sexual violence in providing education to the wider Asian community. This will not only educate and empower Asian survivors to recognise the need to seek help and the appropriate services, but also provide the platform to increase knowledge and reduce stigma in their communities, paving the way for greater recognition and support amongst family and friends, who are often the first-port-of-call for Asian survivors. Participants felt that providing language-appropriate resources is a good way to promote education, including written materials about what is acceptable and unacceptable, when to seek help, the services available and how to access these. Other forms of resources can include audio or video recordings of Asians talking about sexual violence, to further provide education, reduce shame and stigma, and normalise help seeking.

*"This is not your fault, plant the seed for help seeking"*

***The role of cultural consultation.*** The participants felt that, in addition to general specialist training with regards to sexual violence, it was imperative for professionals working with Asian survivors to have access to ongoing cultural consultation. This consultation with allow for continued recognition and discussion of the issues identified in the 'Essential Knowledge' section, and is vital to tailoring an individualised approach to each survivor.

*"[Professional] being aware of own limitations. Rather than ask the client to explain, can access what's available in the community. There is no need to burden the client with providing cultural understanding"*

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# Working with Pacific survivors of sexual violence

**Sarah Va'afusuaga McRobie**

A project to inform Good Practice Responding to Sexual Violence – Guidelines for mainstream crisis support services for survivors. Round Two. TOAH-NNEST 2016.

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Research oversight was provided by Cabrini Ofa Makasiale (Cultural Supervisor) and Dr Julie Wharewera-Mika, Lead Researcher for the Good Practice Responding to Sexual Violence project. Specific support included collaborative analysis of the interview content and editing of the report.

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## INTRODUCTION

This report contributes to a larger, more comprehensive project looking at good practice in response to sexual violence across a number of population groups. The report aims to:

- Establish what is 'good practice' for mainstream crisis support services when working with Pacific survivors of sexual violence? This was examined through a review of the literature and focus groups and interviews with Pacific representatives from the sexual violence sector.
- Develop this 'good practice' into recommendations for guidelines which can be used by mainstream crisis support services to inform their service development and practice when working with Pacific survivors.

### 1. Pacific People in New Zealand Today

Pacific ethnic groups' diverse and multicultural vibrancy enriches New Zealand's population. The 2013 census revealed that 7.4% of New Zealand's population comprises Pacific ethnic groups. A total of 295,941 people identified themselves with one or more Pacific ethnic groups: Tongan, Samoan, Cook Islands Māori, Niuean, Tokelauan and Fijian. Pacific peoples as a group had the highest number of children aged 0–14 years (35.7%) compared with other major ethnic groups such as European, Māori, Asian and Middle Eastern/Latin American/African. Samoan continues to be the largest Pacific ethnic group at 48.7% or 144,138 people. Other large groups are Cook Islands Māori at 20.9% or 61, 839 people, Tongan at 20.4% or 60, 333 people, and Niuean at 8.1% or 23,883 people. Most Pacific ethnic groups live in the North Island (92.9% or 274,806 people) (Statistics New Zealand, 2013).

Auckland is known as the Polynesian capital of the world (Makasiale, Silipa, & Va'afusuaga McRobie, 2011). The majority of Pacific people live in the Auckland region (65.9% or 194,958 people), with 12.2% or 36,105 living in the Wellington area. Only 7.1% or 21,135 lived in the South Island at the time of the 2013 census and Canterbury had the largest number of any city in the South Island at 12,723 Pasifika people (4.3%) (Statistics New Zealand, 2013). The profile of Pacific identity

is complex, with 62.3% or 181,791 people of Pacific ethnicity living in New Zealand being born there. In 2013 the New Zealand-born groups were Niuean 78.9%, Cook Islands Māori 77.4%, Tokelauan 73.9%, Samoan 62.7% and Tongan 59.8% (Statistics New Zealand, 2013). In the midst of the diversity of a young growing Pacific and multi-ethnic population, however, there are challenges, particularly in the area of mental health.

## 2. Prevalent Health Issues for Pacific People

The increase in mental health issues impacting Pacific people is a growing concern in New Zealand. According to Foliaki and colleagues (2006), the rate of mental health disorders among Pacific peoples in New Zealand is high compared with the total population, and there has been an increase in suicidal behaviour among Pacific people. A higher prevalence of mental health disorders has been identified among New Zealand-born Pacific peoples in relation to the total Pacific population (Foliaki et al., 2006, pp. 207–208). This is reflected in the suicide-related research on Samoan young people by Tiatia (2007), Samu (2003) and research into the views of Tongan parents and caregivers about the various factors that may have contributed to the suicide of their child (Sinisa, 2013).

Reasons that have been identified for Pacific people's health issues include socio-economic and cultural factors such as income, poverty, employment, occupation, education, housing, and ethnicity (Ministry of Health, 2014). On average there are relatively more Pacific people experiencing hardship than other groups, and living in overcrowded homes, as they are less likely to own their homes. Also, the unemployment rate for Pacific people is nearly twice the national unemployment rate (Ministry of Health 2014).

Research into Pacific ethnic identities has highlighted issues of cultural conflicts. One cultural conflict is that between New Zealand-born and Island-born Pasifika people. Agee, McIntosh, Culbertson, and Makasiale (2013) have examined cross-cultural perspectives; Culbertson and Agee (2007) Pasifika Afakasi (part-Caucasian) men; Berking, Fatialofa, Lupe, Skipps-Patterson and Agee (2007) Pasifika Afakasi

women; Anae (1998) the ever-changing Pasifika identity. Recently, Manuela and Sibley (2012) proposed the Pacific Identity and Wellbeing Scale (PIWBS).

Pacific people's view of healthcare is influenced by their lifestyle which includes their values and preferences. They tend to under-utilise primary and preventative healthcare services and have lower rates of secondary care interventions (Ministry of Health, 2014). Pacific people also under-utilise mental health and addiction services, and therefore only a small number of Pacific people are referred to talk therapy (Te Pou o Te Whakaaro Nui, 2010).

Pacific people and sexual abuse is a complex health issue that traumatically impacts the foundational fabric of family and spiritual values, therefore can become a barrier to accessing crisis services and also primary, preventative and secondary care services. An example of this is that sexual violence in some of our Samoan and Tongan families occurs in both church and community settings, just as it does in other human families. Often these situations are shrouded in secrecy and silence in order to maintain traditional values of respect, solidarity and resilience within families and the wider community. When abuse happens, these values are shattered and, although the restoration of these values may occur over time, the reality is that in some cases it may not happen at all because of the ongoing and unpredictable nature of the healing journey for the clients and families involved. Due to maintaining values and preferences, sexual abuse in our Pacific families and church communities is not always reported (Va'afusuaga McRobie & 'Ofa Makasiale, 2013).

## 3. Sexual abuse and Pacific People

### What is 'good practice' for mainstream crisis support services when working with Pacific Island sexual abuse survivors?

Pacific people who do report sexual assault present to mainstream crisis support services. The literature review revealed a Ministry of Social Development 2009 report outlining Tauiwi responses to sexual violence and how mainstream crisis

support services met the needs of Pacific people who had reported sexual assault (p.56-59). This report named Auckland Pacific specialist sexual assault agency Pacific Island Women's Health project as an agency that provided both crisis, support and recovery services at that time. Another Auckland service employed a Pacific male to deliver Bodysafe in the area of education and prevention. However, the issue of limited Pacific workforce capacity was highlighted in the area of Pacific Island sexual assault counsellors or services, with no ACC counsellors working in the Asian and Pacific community. On the other hand, the report noted that providers stated there is no specific sexual violence agency for Pacific peoples who are referred to general places as often "Pacific women want to stay in mainstream for anonymity" (p.58). The report summary recommended the development of referral processes and relationships with sexual assault service providers who are providing culturally appropriate for Pacific survivors. There was also support for a specialist crisis intervention service, support and recovery that focussed on Pacific Island survivors' needs (p.59).

ACC's Sexual Abuse and Mental Injury: Practice Guidelines for Aotearoa New Zealand (2008) emphasise the significance of cultural identity and diversity.For Pacific sexual abuse survivors, there is no one model of practice, yet there are strong elements of Church, Christianity, Spirituality and Family "as the central unit", and their community. It is also, suggested workers be prepared to make home visits to families, where appropriate (p.28). Furthermore, the ACC practice guidelines recognise the difference in cultural ideology of European or Pakeha as being influenced by individualism, and those societies which "value a collectivist philosophy of life that emphasises cooperation and closeness between people and groups" (p.27). The guidelines advise that practitioners need to be aware that culture impacts on therapy, that where possible and favoured by the client, a therapist and client match is preferable, whether this be ethnic, religious, gender or otherwise. The guidelines highlight the need for counsellors to have a good understanding of their own culture as well as the culture of their client, and to access cultural supervision or consultation. It is important that counsellors are able to recognise their own limits of competence when working with a client of a different culture. All this is in response to creating a "therapeutic culture of safety, respect and acceptance" (p.28).

**Pacific women and sexual violence**

The WHO (World Health Organisation's) study on women's health in ten countries (Samoa, Thailand, Bangladesh, Brazil, Peru, Namibia, Ethopia, Japan, Montenegro, Serbia and United Republic of Tanzania) reported a significant rise in physical and sexual violence that women experience from their partner. Those who experienced partner violence were likely to be in poor general health, emotionally distressed and have considered or attempted suicide (Garcia-Moreno, Heise, Jansen, Ellsberg, Watts, 2005). The New Zealand studies conducted by Fanslow and Robinson (2004, 2011) showed partner violence as high as that found in many WHO developing country sites and confirmed a high increase and that the types of violence reported by New Zealand women were physical, sexual and psychological/emotional. Furthermore, NZ VAW (New Zealand violence against women) study in the two sites of Auckland and North Waikato, revealed ethnic specific rates of IPV (intimate partner violence) with Māori women being over-represented in experiencing child sexual abuse and intimate partner violence, being physical or sexual. Pacific women had the second highest rate of abuse, Asian third and European or other fourth. For all women who experienced child sexual abuse, 86% of male perpetuators were identified as family members (p.1173-1186).

**Pacific men and sexual violence**

Literature for Pacific men and sexual violence is insufficient and there is no specific focus given to Pacific male survivors. However, ACC Sexual Abuse and Mental Injury Practice Guidelines for Aotearoa New Zealand (2008) suggest that practitioners develop an awareness and understanding around sexual violence issues reported by men, such as concerns about their sexuality, shame with being a "victim" and feeling "less of a man", shame about normal male physiological responses to genital touching and not being taken seriously when the perpetrator was a woman (p.29).Ministry of Social Development's(2009) report on *Tauiwi Responses to Sexual Violence: Mainstream Crisis Support and Recovery and Support Services and Pacific Services* identified one focus area as responsibilities to Pacific men who are offenders and perpetrators. Discussions were about Pacific male offenders who were isolated from their churches and families and the need to restore dignity and respect for Pacific men. The report asserted that this "does not

detract from the seriousness of perpetrator or offender behaviour and its impact on victims and the families of both victims and perpetrators" (p.114).Also, in working with Pacific men who were offenders and perpetrators, barriers identified were God, the church and the devil being used to avoid the responsibility of addressing problems, and perpetrators and offenders hiding their stories and shame and guilt about what they had done and feeling bad and guilty about this. Anae and colleagues (2000) report emphasised Pacific or ethnic-specific models to inform Pacific workers' practices Included in these ethnic specific models are "gendered approaches males work with males; females work with females" in client-worker matching in the field of sexual violence (p.112).

**Fa'afafine**

Ministry of Social Development's (2009) report identified that "*fa'afafine* are vulnerable to sexual violence and sexual abuse". Barriers for workers include information, resources and support (p.117).

**Pacific children, young people and sexual violence**

A Ministry of Pacific Island Affairs (2010) report stated that research in the Pacific and in New Zealand found that young people of diverse Pacific ethnicities had experienced noticeable rates of unwanted sexual touching (Adolescent Health Research Group, 2008; Lippe et al, 2008: Paterson et al, 2007). The national Youth 2007 survey stated13% of Pacific female secondary students and 6% of Pacific male students had experienced one or more episodes of unwanted sexual behaviour from another person in the previous twelve months (Helu et al, 2009). Of those, 27% said the abuse was severe and more than half had not told anyone (p.6). Sexual violence has long term effects. Dennehy and Newbold (2001) state "research into child development has found that exposure to prolonged physical, psychological and sexual abuse is deleterious to an individual's chances of healthy mental and social development" (p.72).

**Current crisis support services for Pacific sexual abuse survivors**

In Auckland, presently there are community-based agencies such as Counselling Services Centre in Papatoetoe and HELP in Mt Eden that operate 24/7 crisis support

services used by Pacific sexual abuse survivors. A review of the Ministry of Social Development 2009 list of “services by population group” (p.138) is included later on in this report in the section ‘Recommendations and Guidelines for Sexual Violence Crisis Support Services for Pacific Peoples’.

**ACC Registered (Sensitive Claims) Counsellors**

The ACC Sensitive Claims unit did not respond to my email query about how many Pacific counsellors/psychotherapists are registered for ACC purposes. A small number of ACC-registered counsellors work in sexual abuse trauma work. Yet, accessing who they are on ACC’s online website is difficult. ACC does not provide information for survivors seeking therapy, around therapists’ ethnicity. For example, the only information available identifies ‘cultural experience’ such as working with ‘Samoan’, ‘Tongan’, ‘Niuean’ and other Pacific groups, and, ‘languages spoken’ such as ‘Samoan’, as opposed to the therapist’s level of cultural competency or identity ( ‘www.Findsupport.co.nz,2015).

Some Pacific counsellors have chosen not to register with ACC or an affiliated professional counselling association because of the complex process of registration and criteria. For some of the elder Pacific counsellors, English is their second language and having to apply through registration processes and writing client reports was off putting and too overwhelming (Va’afusuaga McRobie, 2010).

**The Ministry of Women’s Affairs**

The Ministry of Women’s Affairs commissioned researchers Kingi, Jordan, Moeke-Maxwell and Fairburn-Dunlop (2009),to look into recovery assistance programmes available for women, men and transgender who had experienced sexual violence, with the idea that a specialised response was needed. Their findings were that “a consistently high level of service provision was lacking. While many instances of good practice and commendable service were found, the research also uncovered multiple instances that suggested variable service delivery” (p.xxi).

Watts (2009) stated that there was a need for a ‘Pacific for Pacific’ approach in dealing with sexual violence by Pacific Island groups in their own language and culture. She identified cultural language protocols as a contributing barrier to sexual violence work and challenges the Pacific Island community to develop a cultural

methodology, a “model of practice that is in line with our language and cultural difference to our mainstream providers” (p.59). Tiatia (2008) reinforces this view that “there is limited awareness amongst the small number of Pacific sexual violence providers of other approaches, paradigms or models addressing sexual violence amongst Pacific communities. That there needed to be a better co-ordinated approach to service delivery and, the gathering of evidence that supports the development of effective service models and programmes for Pacific communities” (p.97).

This raises the question about the use of the term ‘good practice’? ‘Good practice’ is indigenous practice. There are a small number of Pacific sexual violence providers who practice therapeutically and who incorporate indigenous values and elements into their crisis work with Pacific survivors of sexual abuse. Their indigenous practice wisdom and development of indigenous practice adds value to ‘good practice’.

**Sexual abuse crisis counselling**

Initial disclosure of sexual abuse can be the beginning of a traumatic process for a Pacific survivor. In counselling Pacific survivors of sexual abuse who present in crisis,the indigenous value of talanoa (to have a conversation and to talk story) is important. Talanoa is key in firstly acknowledging the survivor has had the courage to tell and to break her/his silence. One-to-one counselling with the survivor takes time as counselling needs to be at their pace. It is when the survivor is ready with their appropriate support person/s that talanoa begins with their family members. Talanoa enables the family to talk and make a safety plan together to deal with the issue, and with the shame and disgrace of what has happened, together to develop a way forward.

Those involved in the talanoa process could be representatives from families, church or community members as talanoa brings forth the issue of sexual abuse or incest (Va’afusuaga McRobie & Makasiale, 2013). In our talanoa process, metaphoric narratives are used. Matai’ia (2006) explains how indigenous metaphoric narratives of laumei can be used as a way to address the taboos of sexual abuse and incest that can happen within families. Laumei refers to a turtle that during the mating season mates with its own offspring. *Mata-i-fale* is a term of indescribable shame, for

it describes a situation in which one's eyes have turned to one's own family and home environment for sexual gratification (p. 146).

Va'afusuaga McRobie and Makasiale (2013) describe how these indigenous values of metaphors, proverbs and values such as family and spiritual faith can, in time, be used to restore balance and honour to our *aiga* (family), relationships, kinship ties, and village interconnectedness, so that the survivor and their extended families can heal, be reconciled, and continue on with day-to-day life. The metaphoric narratives provide a way forward to ensure that *le lumana'i* (the future generations) of kinship ties and relationships are maintained. However, in saying this there are sexual abuse crisis cases where, due to the survivor's choice, these values are not taken into account, therefore there are family cases where relationships are not restored.

## Indigenous Pasifika Wellbeing Methodologies Relevant to Sexual Abuse Crisis Work

Broad definitions of Pacific wellbeing relevant to sexual abuse crisis work have focused on working holistically, incorporating concepts such as culture, spirituality and family.

Pulotu-Endemann (2001) developed the Fonofale model of Pacific mental health and wellbeing in the New Zealand context. From the early 1970s up until 1995, Pulotu-Endemann conducted workshops with Pacific ethnic groups—Samoan, Cook Island, Tongans, Niuean, Tokelauan and Fijian—in order to consult Pacific groups in nineteen regions on their values and beliefs on issues of HIV/AIDS, sexuality and mental health. The significance of these workshops were to refine his model and add further explanatory notes to different aspects of the model. Key concepts of this model—family, culture and spirituality—were identified as being significant (Pulotu-Endemann, 2001, p. 2). Fonofale uses the metaphor of a Samoan *fale* (house) to capture a Pacific model of what is important to the cultural groups, with its four poles labelled physical, spiritual, mental and other (culture, family, context, time and environment) respectively (see Figure 1).

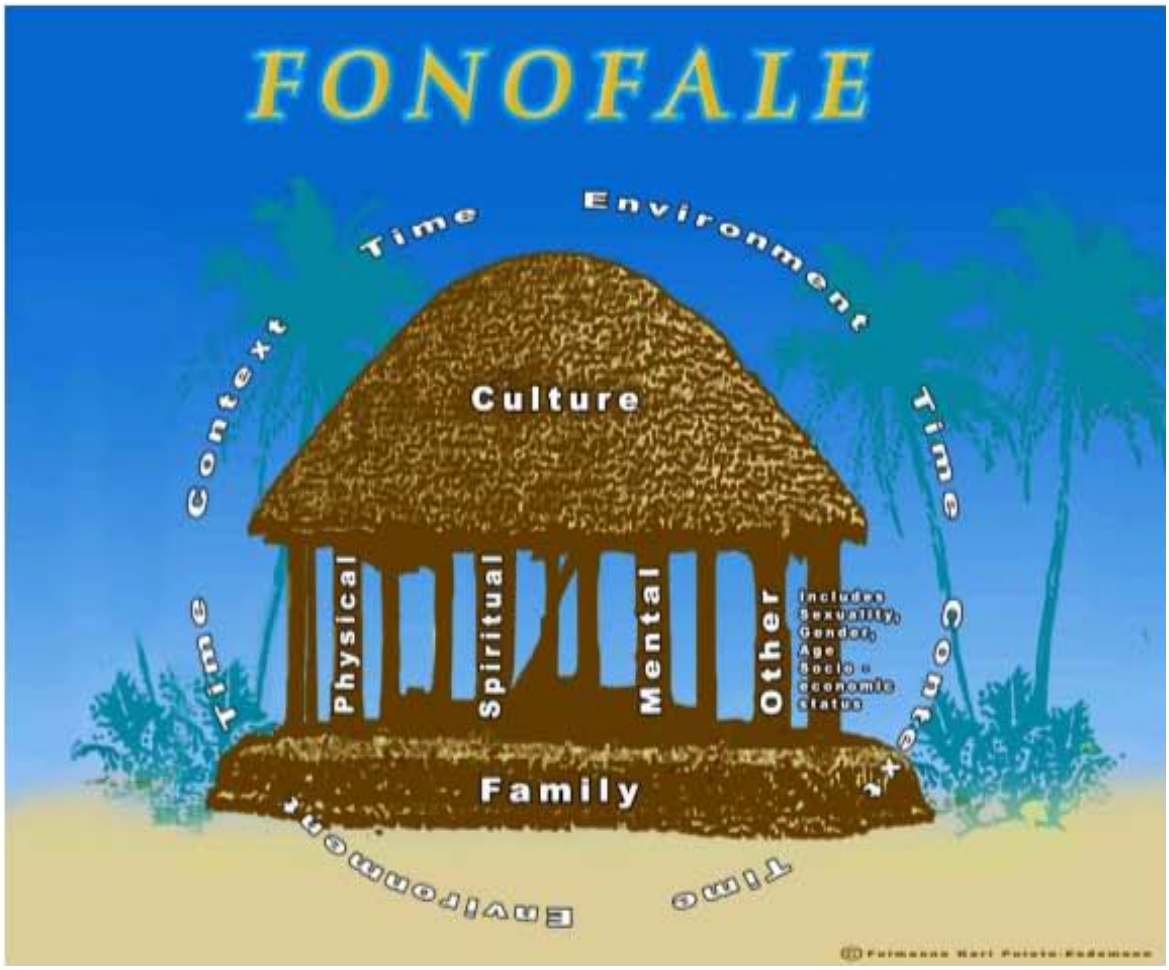


**Figure 1: The Fonofale Model *(used with permission of the author)***

The circular movements in this Samoan house metaphor capture the way in which the foundations, floor, posts and roof "have an interactive relationship with each other" and endorses holistic approaches and ongoing continuity (Pulotu-Endemann, 2001, p. 3). These four elements are described in turn below.

**The Foundation:** This represents family, whether it be nuclear, extended, kinship ties through marriage, or titles that form the central basis of social organisation for Pasifika. The *gafa* (genealogy) is foundational in a family which connects them to their titles, lands, island, sea, spirituality and other cultures.

**The Posts:**

*Spiritual*: Relates to the sense of wellbeing, whether it be Christianity or traditional spirituality relating to nature, spirits, language, beliefs, ancestors and history, or a combination of both.

*Physical*: Relates to biological or physical wellbeing. It is the relationship of

the body which comprises anatomy and physiology as well as physical or organic and inorganic substances such as food, water, air and medications that can have either positive or negative impacts on the physical wellbeing.

*Mental*: Relates to the wellbeing or the health of the mind which involves thinking and emotions expressed as well as the behaviours exhibited.

*Other*: Relates to sexuality, gender, age, socio-economic and status.

**The Roof:** Cultural values and beliefs provide a roof covering that gives shelter from the elements of life. Culture is evolving and there are differences between New Zealand-born and Pacific-born families, where traditional Pasifika cultural values and beliefs maybe influenced by Pālagi (European) worldviews. These can include beliefs in traditional methods of healing as well as Western methods.

All of the above characteristics of health occur within the environment, context and time period pertinent to that individual. There are variables such as, gender, sexuality/sexual orientation, age, socio-economic status and New Zealand born or Pacific Island born.

**Environment:** Environment addresses the relationships and uniqueness of Pasifika people to their physical environment, whether they may be in a rural or an urban setting.

**Time:** Actual or specific time in history that impacts on Pasifika people such as Samoan, Cook Islander, Tongan, Niuean, Tokelauan and Fijian ethnic groups.

**Context:** The context that is relevant to that individual, whether they are New Zealand-born or Pacific Island-born.

## Pacific values, proverbs, metaphors and symbols used in sexual abuse crisis work

### *Va*

Va is a Pacific term that relates to honouring space. It is honouring the space between you and a Pacific survivor of sexual violence. This usually happens in the first meeting, where you are trying to build relationship, rapport and trust with a Pacific survivor in a respectful way. Anae (2010) further defines va as a sacred space: “our va with others is sacred...to not teu le va in relationships can incur the

wrath of the gods; the keepers of tapu and positive successful outcomes will not happen. That if there is violation, relational arrangements will need to be readdressed and realigned" (p.234). The report *Tauiwi Responses to Sexual Violence: Mainstream Crisis Support and Recovery and Support Services and Pacific Services (2009)* affirms the significance of va and va fealoloa'i. Va fealoaloa'i is "one such covenant that recognises that people are sacred beings and that there are obligations and duties to ensure that the primacy of the other is meaningfully valued" (p.106). In working with perpetrators, victims and families, va fealoloa'i implies that all relationships between people are sacred. However, when sexual violence occurs, "these violations of va fealoaloa'i are serious breaches of the boundaries which protect and enhance the value of human life, the relational boundary which has been trampled and desecrated" (p.110).Therefore, when a Pacific survivor in crisis enters your room, their own personal va is likely to have been violated, shattered and broken. As a practitioner, the responsibility for building rapport and relationship begins, within the va of the room, the nurturing relational space, all the more so if the survivor is new and is accessing crisis support for the first time. Teu le va is the obligation to maintain this as sacred space, to tend and care for it and keep it clear so that real meeting, connection and healing can take place. This means giving time to the survivor to talk about their connections, their support people and community of care (church or other) around them.

So how do you engage Pacific survivors of sexual violence? It is through honouring a va-centred approach to relationships, emphasising that they are sacred and inclusive of harmony balance, reciprocity and mutual respect (Mila-Schaaf, 2006). The Samoan worldview and the Samoan relational self cannot be separated from the va or relational collective space between individual and parents, siblings, grandparents and community members. That the tapu and sacredness in relationships is recognised (Tamasese, Peteru, Waldegrave, & Bush, 2005, p. 303).

When relational connections have been formed, the Pacific survivor is willing to step into the *va'a/vaka/paopao (meaning indigenous outrigger)*, the journey begins. As Te Pou o Te Whakaaro Nui(2010) states, the therapist needs the confidence and skills of navigation of "fishing for what is important in a round-about or indirect" way. It

involves seeking information and allowing the Pacific survivor to tell their story and

this may take time.(p. 24). Direct questioning related to self-exposure or self-assertion can be perceived as rude and intrusive by Pacific families (Waldegrave, 1990).

***Teu le va***

*Teu le va* (to value, nurture look after and if necessary to tidy up the va) is a Samoan cultural reference to the Samoan self as relational and as someone who relies on relationships that are occurring in the va or space between. The indigenous value of teu le va as a paradigm in which relationship is key has been applied by Anae (2010) as a research practice in Pacific educational contexts. Anae (2005) explored Samoan discourses on the va, *va feoloa'i* (spaces between relational arrangements), *va tapuia* (sacred spaces of relational arrangements) and teu le va. All these point to the importance of the space between the practitioner and the Pacific survivor.

Anae (2010) further defines va as a sacred space: “our va with others is sacred...to not teu le va in relationships can incur the wrath of the gods; the keepers of tapu and positive successful outcomes will not happen. That if there is violation, relational arrangements will need to be readdressed and realigned” (p.234).Honouring that space is part of relational connectedness between counsellor and client. This means giving time to the client to talk about their connections, their support people and community of care (church or other) around them.

Teu le va in research relationships is also holistic. It acknowledges the sacred relationship with God, relationship with family and kinship ties. Makasiale and colleagues (2011) state that a holistic approach is an element of wholeness relating to God who is committed to the person “inside and outside” (p.5). This commitment to a Pasifika person is open-ended and for life and beyond. There is a connection that remains right through, not cut at the umbilical cord as we are never severed from God and that the person is a child of God forever (p. 5) and that spirituality is a form of resilience as people experience deep fulfilment with God (Tiatia, 2007).

**Gender Values**

*Feagaiga* is a binding and sacred covenant (Tuimaleali'ifano, as cited in Huffer & So'o, 2000, p. 172) which refers to the status of the sister and to the covenant

between sister and brother. This relationship has as its focus the treasured and

protected status of sisters, and by extension, of women generally (Aumua, Mata'itusi & Simanu, 2002; Huntsman & Hooper, 1996). The respect inherent in the relationship included a prohibition on sexual talk, jokes or sexual content in media such as films where brothers and sisters were present (Aumua, Mata'itusi & Simanu, 2002). In Samoa this forms the basis of gender relationships.

**Christian spirituality**

A Ministry of Pacific Island Affairs report (2010) on *Pacific Pathways to the Prevention of Sexual Violence* stated that traditional protective factors against sexual violence identified safe connections to support church communities in which "Christian principles and Biblical teachings could be viewed as protective factors against sexual violence...that Christianity had had a significant impact on cultural views of sexuality and premarital virginity" (p.13).This same report also stated that the Church was also a vehicle for community education for Pacific communities on sexual violence and the possibility of incorporating sexual violence intervention in their theological curriculums. On the other hand, other participants in this report perceived the church as a current or potential barrier to prevention of sexual violence in which some leaders in positions of power have sexually abused and there were suggestions from these participants of the value of a "contextualised Christian theology to help address attitudes and the current silence from the church on issues relating to sexual violence" (p.16).

**Other Values**

Ma'ia'i (2010, p. 639) identifies key Samoan values as *fa'amafafa'ina* (empathy), *pa utonu* (compassion) and *fai pe e fa'alia fa'atasi ma le malosi* (respect). Therapeutic empathy is trying to understand your client's world. Bohart and colleagues (2011) state therapeutic empathy is like entering into another's world and walking in their shoes in that a counsellor makes an effort to perceive the subjective world of a client and has an unconditional positive regard for the client (p. 436). Rogers (1995) affirms this, stating that having a warm regard for a client as a person is vital: To have a deep empathetic understanding is to be able see our client's world through their eyes (p. 34).

Values of love, compassion and care towards Pasifika clients empowers them in the therapeutic change process. Ma'ia'i, (2010) describes the Samoan language for this

as le tiagafusia iga; tigalofa; feaga'ialofa (p. 564). Also, Lewin (1996) defined compassion as "a virtue that comes from an appreciation of links binding us to each other, a pursuit of kindness in which compassion is a central feature of search for creative potential" (p. 36). Compassion is in our human spirit and clients respond to the caring and kind human elements of a counsellor. Compassion bridges a counsellor's world with a client's world and provides a platform for a client's creative potential to come to the forefront in their therapeutic healing journey.

## Methodology

The purpose of this report was to establish what is good practice for mainstream crisis support services when working with Pacific survivors of sexual violence and to recommend good practice guidelines which can be used by mainstream crisis support services to inform their service development and practice when working with Pacific survivors.

### *Talanoa* methodology

Given the Pacific landscape of the topic, the purpose of this research and the scope of this study, a qualitative, exploratory approach using fono focus groups and individual interviews were chosen as the most culturally appropriate. Writing about qualitative research, Wiesenfeld (2000, p. 205), emphasised aspects of "shared knowledge" and "joint reflection" with participants when describing the kind of environment and attitudes that qualitative approaches require and which are consistent with Pacific values.

The Talanoa research methodology was agreed upon as our Pacific people are orators and like to talk story.

### Research Participants

There were eleven Pacific research participants in total, 9 female and 2 male. The females were aged 40 to -63 years, and males aged 35 and 53 years. Their ethnicities were Tongan (Tongan born), Tongan (New Zealand born), Niuean/Māori, Niuean, Samoan (New Zealand born) and Samoan (Samoa born).

### Development of the questioning guide

The talanoa in the fono and individual interviews began with the researcher

respectfully checking in to see if there was a cultural protocol and inviting the participant to open up their talanoa, as Morrison & Vaioleti, (2008) stated:
"A talanoa approach is a traditional Pacific reciprocating interaction which is driven by common interest, regard for respectfulness, and is conducted mainly face to face" (p.11). There were three open-ended questions (Appendix C) to start the conversation with and out of respectful reciprocity of talanoa, it was planned that there was extended time and space given for any informal openness for both the participant and researcher to reflect back, to add to or clarify the meaning of what had been said, to check native language use and indigenous meaning, and to discuss further where needed. Reminder prompts in relation to these questions were 'what were the kind of supports needed for Pacific survivors when in crisis following sexual assault/abuse (physical, mental, emotional, spiritual, cultural)', 'talanoa around the sexual abuse crisis mainstream/Pacific services/counsellors and how these needs translate into recommendations/guidelines for those working with Pacific crisis survivors'.

**Research Process**

A participant information sheet (Appendix A), participant consent form (Appendix B), and a questioning guide for the interviews (Appendix C) were prepared. Through word of mouth and snowballing, eleven participants were recruited and agreed to take part in this research. Personal face to face contacts, phone calls, texts and follow-up emails led to the researcher emailing and dropping off the Participant Information Sheet and Questioning guide prior to meeting. This allowed each participant to read through what was involved in the research process and gave them time to make a decision as to whether or not they wanted to take part. As a result, two fonos were held. The first fono took place in a Community-based Missions Centre building and the other fono took place in a Church hall. Prior to the participants signing the consent form, we discussed confidentiality and the use of numbers to protect their identity in the analysis phase. Hot drinks and dinner were provided. All participants understood the process and no questions were asked by them. The fono was digitally audio recorded and where there was indigenous language used, the participant and researcher worked together to capture the spelling and meaning of the words used so that when it came to transcribing the

different languages (Tongan, Niuean and Samoan) this was accurately recorded as best as possible. Participants were invited to give feedback on draft results and they were able to read through, check and make any changes.

**Data analysis**

The participants were then presented with the results, the emergent themes, at the second fono and there was opportunity for any further translations, corrections or final comments or input to be made. Also, this part of the process provided a check that through this final verification, creating theory from the ground up, that it was truly grounded in the participants' words. Participants used Pacific languages (Tongan, Niuean, Samoan) in their interviews and these were transcribed which enabled me to experience the richness of their worldview, therefore their correct spelling and their authentic meaning needed to be confirmed by the participant. In using the participant's words, I captured the participants' experiential knowledge and ensured that I did not make assumptions, as outlined in the ethical considerations below.

## Ethical considerations

Through reflexive practices I recorded my own thought process, values and beliefs. Pienaar (2011) describes reflexivity as a reflection process in which values and emotions may influence the research. There is a need, as Hodge (2005) states, "to be aware of any value conflicts and to ensure that no counter transference happens" (p. 85). As an 'insider researcher' collating Pacific practitioners' experiences and stories of what is 'good practice' for mainstream crisis support services when working with Pacific survivors of sexual violence, I wanted to be ethically respectful of them as people and as fellow professional Pacific counsellors. "Insider research has to be as ethical and respectful, as reflexive and critical, as outsider research" (Smith, 1999, p. 139). Accountability for my own lenses was important to address any subjectivities or assumptions I may have. As an insider researcher, the need to journal 'my Pacific self' while conducting my research was therapeutic and enabled me to record 'process notes' consisting of my own personal memorandums of ideas shared and points of difference. This was consistent too with grounded theory in

which keeping memos is a key component in the process of auditing and analysing data, together with the constant comparative method.

## Trustworthiness and Validity

As mentioned above, accountability for my own lenses through journaling and regular supervision sessions which were held with two supervisors -Lead researcher of the overall project Dr Julie Wharewera-Mika and Pacific counsellor Cabrini ‘Ofa Makasiale. To avoid any research-bias, any subjectivities or assumptions were addressed at supervision times.

Both supervisors had input into, read and provided constructive feedback on the research material. Regular meetings were held with Cabrini ‘Ofa Makasiale and Pacific practitioners to ensure that the researcher’s meaning and data interpretation was objective and if subjective, it was checked with the in-depth notes of the research process.

Maintaining trustworthiness in this current study required that all research data was kept in a secure place so audio tapes, consent forms and transcribed notes were kept in a locked filing cabinet.

Establishing trust was particularly important in this project as the researcher knew the female participants who worked in the same field. This was mentioned to both supervisors and also in the talanoa process with the participants.

Teu le va and client-centred concepts were used in the talanoa process to ensure that in interviewing participants it was ethically and culturally safe, such as providing that sacred space (teu le va) and providing unconditional positive regard to the participants. As Rogers (1995) stated, “having a warm regard for a client as a person is vital…that this person is of value…an acceptance of positive and negative attitudes…to have a deep empathetic understanding to be able see our client’s world through their eyes” (p. 34). All this was needed to further establish a research relationship with each participant, in order that their indigenous life stories and language would be captured through the talanoa process, recorded and then analysed in their individual interview.

## Results

The results from the fono (focus groups) and semi-structured interviews of two male and nine female participants. The objective of this study was to establish what is 'good practice' for 'mainstream' crisis support services when working with Pacific survivors of sexual violence, and to develop this 'good practice' into recommended guidelines for 'mainstream' crisis support services to inform their service development and practice.

During the fono and individual interviews, stories were told of the participants' life experiences and clinical knowledge, as people and as professionals, revealing that they approached their work from a place of dignity, courage and strength. While there were unique aspects to each participant's experiences and approaches to their practice, there were common strands that emerged from the talanoa with each participant, interweaving in the pattern that was revealed through the analysis of the interview transcripts.

The following are emerging themes:

**Pacific indigenous values**

- Teu le va ma va fealoa'i (sacred relational space)

Some practitioners emphasised the importance of creating a safe, therapeutic space in holding crisis clients:

> *"Sexual violence is a violation of that sacred relational space between two people. For Pacific people, crisis services need to be acutely sensitive and not further violate that space by powering over clients and providing instant solutions. This space needs to be respectfully navigated" (Practitioner 6).*

One practitioner further described this relational space as "feagaiga". *Feagaiga* is a binding and sacred covenant (Tuimaleali'ifano, as cited in Huffer & So'o, 2000, p. 172). It is gender based which refers to the status of the sister and to the covenant between sister and brother. This relationship has as its focus the treasured and protected status of sisters, and by extension, of women generally (Aumua Mata'itusi Simanu, 2002; Huntsman & Hooper, 1996). The respect inherent in the relationship

included a prohibition on sexual talk, jokes or sexual content in media such as films where brothers and sisters were present (Aumua Mata'itusi Simanu, 2002). In Samoa this forms the basis of gender relationships:

> *"Cultural understanding of what it is of being Samoan and the whole feagaiga concept and as crisis workers you are trying to see if they are in that space or not or in a different space and they are not in either space" (Practitioner 4).*

**Silencing and shame**

All practitioners spoke about underlying factors in the perpetuation of silencing and shame around sexual abuse by those in positions of authority whether in the church, the community, or their own family. "Complex dynamics (a cultural clash of spiritual values, the conflict of ethics, societal hierarchical structures of power and authority, the silencing of dissent, to name a few), as well as tension associated with values and ethics" (Va'afusuaga McRobie & 'Ofa Makasiale, 2013, p.138) lead to silencing. Two practitioners remembered their clients' comments on their own silencing and shame:

> *"They carry with them a cloak of shame that exacerbates their already muted voices" (Participant 6).*

> *"I had to keep the secret to protect my family, especially my parents back in the Islands; shame if anyone finds out; shame on my family if I tell someone; shame if the church people find out" (Participant 8).*

Therefore working therapeutically with Pacific crisis survivors of sexual abuse involves talanoa (that is, to have a conversation, to talk story). The talanoa process has the capacity to ensure that relationships continue on for the future generations and to maintain kinship ties. This process involves acknowledging the survivor who had the courage to break the silence and secrecy. This may also include identifying one support person in their cultural and social context:

> *"With Pacific peoples in crisis, it is who they can relate to and there's not alot of Pacific out there. My team are all European and my Crisis teams and that's really important. That is one of the things we do is ask the survivors do they want to be referred to a culturally appropriate service or is there anything cultural to know and most of the time they say no but I think it so important to know if they actually had someone who knew where they come from" (Participant 5).*

Another practitioner spoke about the perpetrator/offender's shame which needs to be bought out into the talanoa:

> *"The survivor's needs is what we work with, but absolutely with the perpetrator/offenders there's got to be a discussion and whatever way it goes. Even if they don't go to jail, it's the shame of it that needs to be brought out, it still needs to be talked about in the whole church and the shame of it" (Participant 5).*

**The impact on family**

The initial disclosure of a sexual abuse crisis in a Pacific family is tense and volatile:

> *"Pacific people need to remember that when dealing with sexual abuse in the family, the act of sexual abuse changes family dynamic and the issue needs to be addressed and not swept under the carpet. The offender does not get a free pass for the sake of peace in the family. Family don't abuse each other" (Participant 11).*

In addressing the issue, talanoa with families happens in order for them to deal with the issue and with the shame, and together to develop a plan for the way forward. Two practitioners referred to indigenous metaphors and proverbs used when working with Pacific families who have experienced sexual abuse *(Participant 6 and Participant 8)*, consistent with literature:

> *"Metaphoric narratives and proverbs can be used in this talanoa process as described by Matai'a (2006) an indigenous metaphoric narrative of laumei to address the taboos of sexual abuse and incest that happens within families (p.146). Laumei refers to a turtle whose nature during mating season is to mate with its own offspring. Mata-i-fale is term of indescribable shame, for it describes a situation in which one's eyes have turned to one's own family and home environment for sexual gratification (Va'afusuaga McRobie & 'Ofa Makasiale, 2013,p.140)*

With Pacific sexual abuse crisis survivors, indigenous values of talanoa (to have a conversation and to talk story), metaphoric narratives of *laumei* (turtle) and the significance of forgiveness can be used. Talanoa is key in firstly acknowledging the survivor has had the courage to tell and to break her/his silence. One-on-one counselling with thesurvivor in crisis is crucial as their safety is paramount. It is when the survivor is ready with their appropriate support person/s that talanoa begins with their family members. Talanoa enables the family to deal with the issue, and with the shame and disgrace of what has happened, and together to develop a way forward.

Those involved in the talanoa process could be representatives from families, church or community members as talanoa brings forth the issue of sexual abuse or incest (Va'afusuaga McRobie & Makasiale, 2013).

**The impact on Pacific young people and sexual violence**

Most practitioners spoke about the importance of working with the families of Pacific survivors:

> *"Work with the family first and make sure the young person is safe. The biggest concern is the impact on Mum or Dad...I would probably work with crisis team who work with the families as that's a crucial point for young people" (Participant 4).*

> *"Parents have their own issues too and usually are blaming. You know the poor daughter and they do think it's their fault that if they had not done what they had done then this would not have happened. So they have their issues and poor daughter is trying to cope with this and doesn't want to upset the parents and just wants to forget it" (Participant 5).*

From her own personal experiences as a survivor of sexual abuse as a young person, this practitioner reinforced the complex and challenging dynamic of her parent's initial response in the crisis:

> *"My mother unloaded a lot of her own issues on me and wanted to know all the details about what had been done to me. There needs to be a boundary where the parent is respectful. I don't think that victims should fully disclose to their parents what happened because it'll only cause more hurt and victims shouldn't be feel forced to say. The one good thing my mother did was that she made sure I had a good support system. I had an aunty that was there for me when I was dealing with court. Even though my Mum couldn't be there in the way I needed she was able to provide someone who could. There are many cases where families are under resourced and it's important that the victim is provided with someone who can be there to support them when going through the court process" (Participant 11).*

Pressure from family members, guilt and self-blame are significant issues for young people experiencing sexual violence:

> *"Parents shouldn't manipulate their children who are victims e.g. saying 'they are family', for example, I had to attend family functions where the person who abused me was present and I just had to put up with it. I was expected to just be ok with it. Parents need to acknowledge to the victim and not minimise their pain. Just because someone is family that*

*does not make it ok, we need to remember that sexual abuse is wrong regardless of relation. I feel as a victim of sexual abuse that my parents made me feel guilty because I went to the police and my brother went to prison and I had to fight to get my voice heard. Parents should just say I support you and deal with their emotions elsewhere" (Participant 11).*

**Pacific men and sexual violence**

One Pacific male practitioner who worked in a Pacific community mental health and disability agency commented on the use of prayer in the initial disclosure and crisis moments:

*"When a Pacific male has disclosed sexual abuse, I listen to him and pray with him. I then refer him onto one of the church leadership who then refer him onto a professional social worker or counsellor" (Participant 7).*

**Pacific and Western approaches**

Most practitioners talked about the differences between Western and Pacific counselling approaches being due to perceived contrasts between European/Western thinking and Pacific values such as spirituality and concepts such as ifoga, the indigenous Samoan term for forgiveness, as described above.

With different values, different counselling models that originated in the Western context are used in pālagi educational institutions. To the participants in this study, these Western models did not seem to recognise the importance of Pacific clients' oral traditions and spiritual beliefs. One counsellor spoke about Freud's 'weirdness' when she encountered his ideas and Bowlby's attachment theory which

seemed different from her own Christian background.

"*Our Pacific way is more like a fine mat, full of colour, threads and*

*interconnection" (Participant 3)*

This was in contrast to a reference in the literature, Bowden's (2013) statement that the :

> *Model and modalities imported from overseas have served us well and provided important ideas to build on… people who come here from the East have profound philosophical approaches to hardship, despair, and suffering, quite different from the belief systems that produced psychodynamics. The Eurocentric tendency is to separate spirit from matter, meaning from analysis, and abstraction from reality.*

Yet, in contrast to this, all counsellors also acknowledged their use of the client-centred approach, a Western model, as a baseline into which they would integrate their own Pacific indigenous approaches. These include the use of prayer and the Fonofale model (as described in the literature review).

**Cultural and Mainstream crisis support services that Pacific peoples have accessed**

All practitioners agreed that effective crisis support services were those that had awareness and understanding of cultural values of family, spirituality in God and were knowledgeable in New Zealand laws regarding CYF, Children, Young Persons and their Families Act, ACC, Family Court, law and Police, as captured in this reference:

> *"Disclosures by survivors of sexual abuse to school counsellors and staff can sometimes lead to a statutory and judicial process via Child Youth and Family (CYFS) notifications. Police evidential video units (EVU), Accident Compensation Commission's sensitive claims unit, ACC sexual abuse trauma counselling and if there is enough evidence, eventually to court...Also provides psychoeducation to survivor's support person whether it will be a*

*close family member (s) or friend (s) in that working with them has enabled a shift in their thinking from tribal, clannish thinking to public social justice thinking" (Va'afusuaga McRobie & 'Ofa Makasiale, 2013, p.134)*

- Limited Pacific practitioners in the sexual violence field

Presently there are limited Pacific crisis social workers, ACC approved counsellors and trained sexual violence practitioners working in the area of sexual violence. Practitioners spoke about building capacity for Pacific practitioners:

*"I wonder about students coming through counselling training and they come out and often there's a gap between coming out and getting a job and having people around them, not just actually mentoring while they're studying but when they come out" (Participant 4).*

*"Mentoring and walking with others" (Participant 3).*

- A Pacific brown face in the crisis process

One participant spoke about having a brown face to facilitate the crisis space for Pacific survivors:

*"Crisis process definitely needs a brown face. It's nothing more comforting than seeing someone come in and it's a brown face. I'm not saying that our European colleagues are not able to show empathy but it's just that feeling of a brown face coming in and being part of that crisis or seeing that family...a brown face who is able to facilitate that space for the families, for the victim or survivor, to hold that space for the family of that survivor" (Participant 3).*

- The need for cultural competency training

However, other participants argued that while there is a shortage of Pacific sexual violence specialists and ACC counsellors, as long as there is someone who is supportive, that is what counts. In reality, Pacific sexual violence survivors are

seeing Pakeha practitioners, therefore cultural competency around cultural principles is needed for Pakeha:

> *"Someone who will support the victim and someone to mediate with the family and understand the culture and they are sensitive. So if there's Pakeha there has to be some benchmarks around the cultural principles...differences for Samoans...differences for Niuean and it's important to know those sort of things...culturally competent" (Participant 1).*

- The need for cultural assessment right at the very beginning

Practitioners emphasised the importance of a cultural assessment for Pacific crisis survivors to ensure access and availability to resources:

> *"Cultural assessment right from the start. Assess according to language, culture, background and cultural connectedness. A cultural assessment maybe done by a Tongan or Samoan worker in the crisis team. Cultural assessments are different from professionals' assessments and police internal processes. Police use legal processes and there can be pressure from a Pacific family, church or community on the survivor to not to report to the Police, therefore a cultural assessment is needed to support the survivor" (Participant 2).*

- The need for cultural supervision for Pacific and non-Pacific practitioners
  *"For non-Pacific counsellors they need cultural supervision, that's a must when they work with Pacific people and be familiar with the cultural competencies that need to be developed. We developed some for Alcohol and Drugs so there should be some around or maybe look at that and work from there" (Participant 2).*

- There is no cultural competencies developed yet for Pacific people in the area of sexual violence.
  *"There is none (no cultural competencies), specific for Pacific for sexual abuse. Forget about that specific for Pacific, its integrated or multidisciplinary*

*where there is a Pacific person, there needs to be supports put in place for that one person" (Participant 2).*

Access to resources such as crisis counselling is needed for Pacific when in crisis following sexual assault/abuse:

*"Counselling should be provided to assist them emotionally and it's important to have a safe person who is not emotionally involved and does not know them personally. It should be compulsory to go if you are under eighteen, because you're not equipped to deal with sexual assault/abuse. There should be a set number of sessions that are mandatory and what the victim chooses to discuss is up to them. A Pacific person may say that they don't need it but they won't know unless they go to counselling themselves" (Participant 11).*

- Lack of cohesiveness of services for Pacific crisis survivors and their families

One practitioner courageously shared from her personal experiences as a mother of a survivor and offender in one family that "due to confidentiality between agencies", she struggled with the lack of cohesiveness of all the crisis services involved:

*"Reading out a powerful and moving poem of a Pacific, single mother's perspective of a daughter who was sexually abused by her own brother. As a mother, the dilemma that I had to face and the frustration with crisis services. As a mother who has sat on both sides where a sister has been sexually violated by a brother and having to go through a court process...our family has been smashed to bits...going through the criminal justice system to hear that disclosure...making sure my girl is safe and we go through all these agencies that don't help us...my heart is split as a mother and as a therapist and to be able to support both because both are victims and then in that situation what I would say in going to court...I wish there was more cohesion (from agencies involved). There is so much about Confidentiality and how agencies had this*

*information and how much information I gave to agencies...one point of contact at the beginning before the professionals got involved...I feel like my son wouldn't be in prison today if only a provider had taken seriously the SAFE referral" (Participant 2).*

Other practitioners spoke that the one point of contact at the beginning of the crisis process was important and a Pacific Island perspective of Project Restore was mentioned:

> *"An awareness of restorative justice for Pacific Island crisis clients and their families/church/community is needed, that one point of contact at the beginning. A Pacific Island version of Project Restore (a community based not for profit organisation that has been providing services since 2005 for those who have been harmed by sexual violence. They offer services such as criminal justice processes, police and restorative justice conferences between those who have been harmed and those who caused the harm). Pacific professionals who are there right from the beginning of a crisis process and who are available to offer cultural advice, consultancy and co-ordinate restorative justice conferences for Pacific survivors and their families" (Participant 8).*

**Indigenous restorative justice**

The use of indigenous principles such as *ifoga* in her counselling practice influenced the therapeutic healing process for one practitioner's clients. *Ifoga* is a Samoan principle of forgiveness, in which an offender and victim's families and/or church support can be involved in the restorative justice process.

> *"If we think about Samoan ifoga, the Samoan concept of forgiveness you know that's another thing in terms of spirituality is that forgiveness is a concept that is very much inherent in us and it's something that we actually . . . ahmm . . . you know, we practice. It's an actual principle that we hold quite dearly you know like the ifoga kind of concepts. That was her starting point to heal was repairing that and some forgiveness (practising principles of ifoga)" (Participant 2).*

Another practitioner also used indigenous principles such as ifoga in her counselling practice expressed the view that her "Western counterparts wouldn't have any understanding" of this, perhaps because it did not come from a counselling textbook but from her indigenous knowledge:

> *"Thinking in a way that was not actually in a book, it's not in a book. These kind of things you know, you just have to know, eh? If I am thinking about some of my Western counterparts, they, they wouldn't have any understanding and that's not to put them down or demeaning about their practice but it's just this is part of who we are. We just have that kind of understanding. I don't know the words for it" (Participant 10).*

**Christian spiritual values in God as a healing tool**

All practitioners commented on mainstream services looking down and dismissing indigenous values such as Christian spiritual values in crisis moments:

> *"We talk about Christian spirituality which mainstream look down upon for Pacific spirituality, but it is very acceptable for them to talk about crystals, mother earth and Buddha's mindfulness and so all of those are very good at accepting Eastern mythologies and gods. So that needs to be articulated around Christian Spirituality" (Participant 3).*

In crisis moments, Pacific survivors of sexual abuse present to mainstream services with a broken heart and brokenness in spirit:

> *"Wholistic brokeness in spirit, heart and mind. Spiritual faith for Pacific*

*is part of the holding in crisis times" (Participant 8).*

Therefore, the Pacific heart and spirit needs to be acknowledged and be embraced with warmth, love and care towards them *(Participant 6)*:

> *"As early as the 1940s, American psychologist Carl Rogers proposed that the therapeutic heart required empathy/interpathy and unconditional positive regard for one's clients (Kahn,1997). Perhaps Rogers carries some unconscious knowing of the heart of the Pacific Islander. In the Christian belief system, warmth, love and respect have always been among the core tenets of a relationship with God, others and self. The emphasis on being in the presence of God and in the presence of the other with love and attunement has been inherent, to a greater or lesser degree, in the spirituality of the theistic traditions"('Ofa Makasiale, 2007, p.130*)

All participants agreed that spirituality is a healing tool:

> *"Talk about spiritual you know the bible says when a man and a woman lie down that's a spiritual act. For me when someone does that (sexually abuses) to a vulnerable person, they not only rape them physically, culturally, mindfully. Spiritually that was the most ultimate violation against vulnerable people...in saying that, spiritual healing is very important and needs to take place and this is where you come in and praying that God can actually heal and I believe God heals that violation and that's why it is important to have spirituality attached to our practice"(Participant 3).*

According to one practitioner, sexual abuse is sexual sin and conversations need to happen:

> *"In talking about this, sexual sin is the only one that changes you from the inside out and really impacts our personality. I get concerned about spirituality*

*in that it's all about forgiveness, I forgive you and that's it. I say there needs to be conversations about when we are talking about spirituality, where is the God space we are talking about that is healing, holding, that alot of us know and experienced and where is it again where it can be abusive. We are talking about faifeaus, uncles...they abuse the positions they have and we need to have conversations around that as to what is spirituality for Pasifika and what is not and then we can help people with their whakama when they sit on that continuum" (Participant 1).*

Other practitioners agreed and challenged Pacific people, community and churches to start talking:

*"...we need to lift that shame veil off, talk about it and invite our families to make a safety plan. Talk about prevention, early intervention and postvention and raise awareness around dealing with sexual abuse crisis" (Participant 3).*

**"Lift that shame veil off" training and Education**

All practitioners agreed with the following practitioner that there needed to be training and education for Pacific families, churches and communities in dealing with sexual abuse:

*"Pacific around/for Pacific abuse campaign on sexual abuse crisis and support services. Education in churches, information, radio, pamphlets in the Pacific Island languages for schools, churches, communities on appropriate sexual touch. Social media to raise awareness. A website for Pacific similar to that of family violence and suicide intervention" (Participant 1).*

As a survivor of child sexual abuse, this participant stated the issue of sexual abuse needs to be talked about:

*"The issue of sexual assault/abuse needs to be discussed more with Pacific people because it happens too frequently yet no one is addressing how to prevent this. We need to break the barrier of 'we don't talk about this'.We need to talk about it in church, at home, school, youth group so that people don't feel so embarrassed. Children should be allowed to not have to*

*kiss/greet every relative if they don't feel comfortable because it's their body. The child has a choice and this can help teach them about 'safe touch' for example when you tell a child 'you must give your aunty a kiss'. (Participant 11).*

**Summary**

Overall, all practitioner's recounted stories of their experiences in mainstream crisis support services when working with Pacific survivors of sexual violence. These stories incorporated their personal identities, connection to kinship ties, and their organic grassroots as people and as practitioners.

Creating the space for Pacific clients in crisis right from the start was significant; a space where clients' identities, connections and spirituality could be welcomed and acknowledged, formed a very important part of their work. All ten practitioners perceived that when this cultural and spiritual awareness is there, then the overall effect on Pacific survivors' therapeutic, change process and wellbeing will be positive.

All practitioners felt that education on cultural competency and awareness in mainstream crisis support services was needed and appropriate when engaging first-time Pacific survivors and their families in crisis. Participants also described the ways in which they integrated the use of Pasifika values with counselling approaches and strategies, such as client centred approaches that are identified as Western in origin but are in common use across ethnic groups.

## Limitations

Nevertheless, the results of this study need to be considered in relation to its limitations as well as its strengths. The scope of the study was limited, as ten practitioners and one young person interviewed were a small sample. In saying this, the information from this research reflects female, male and a young person's perspectives, and further investigation would be needed to obtain the views of those living with disability and from a transgender viewpoint. In addition, unless a larger scale research study was undertaken, the results could not be seen as representative of the views and practice of all Pacific practitioners.

## Strengths

The talanoa with these Pacific practitioners' was sacred. As a counsellor and researcher, Teu Le Va, in being respectful of their relational space provided a platform of reverence as their stories were powerfully told with dignity, pride and strength. The practitioners felt they benefited from taking part in this research in that their stories strengthened their own personal resilience in their practices but also can encourage and inform other Pacific and non-Pacific practitioners who work with Pacific clients. They gained satisfaction from contributing to the collection and dissemination of professional knowledge that benefited themselves and others.

**Recommendations and guidelines for sexual violence crisis support services working with Pacific peoples**

As has been noted, although it has been a small scale study the results of this research can contribute to cross-cultural training and education for all therapists who work with Pacific clients. As ‘Ofa Makasiale (2007) suggests, the following guidelines are valuable in working cross-culturally:

> “1. Frequent exposure to interacting and working with Pacific Island clients is paramount in formal and informal settings.
>
> 2. Engaging a Pacific Island supervisor who is bilingual helps to provide an environment for clinical discussion, analysis, and theological dialogue.
> 3.Taking Pacific Island case studies to cross-cultural study group settings enables knowledge of other cultural therapeutic tools to further sculpt and refine one’s own learnings and discoveries” (p.120).

It was clear from the results that there are both misunderstandings and limited knowledge among practitioners across difference ethnicities and cultures about the diversity of modalities and approaches being used in mainstream crisis support services, and about others’ world views. More opportunities for talanoa and dialogue across perceived cultural differences would be valuable for all—Pacific, Māori, Palagi and others including those who themselves are multi-ethnic. Therefore, cultural competencies specific for working with Pacific survivors can become a start in the talanoa as this needs to be developed by Pacific practitioners, as a contribution to good practice guidelines for mainstream crisis support services.

Developing cultural competencies for working with Pacific survivors would provide a basis for conversations around implementing cultural assessments right at the very beginning of a crisis support process, as this research reinforced that indigenous Pacific values are critical in the healing process for a Pacific survivor who has experienced sexual violence. Part of this indigenous healing process is the possibility of exploring restorative justice from a Pacific perspective (similar to work that Project Restore does) and how this maybe integrated into the crisis support services right

from the start. As one participant noted, one point of contact for a Pacific survivor and their family is crucial to ensure there is cohesiveness and consistency in the delivery of crisis support services. A recommended outcome of this would be training in cultural competencies and cultural assessment guidelines in mainstream support services responding to sexual violence for Pacific people. This training would be for Pacific and non-Pacific practitioners.

Encouraging Pacific practitioners and other community and Church leaders to undertake psychoeducational work within the Pacific community to educate people on what is sexual violence and provide information. As part of this information, to provide a directory of names and 0800 Rape Crisis or HELP/Counselling Services helpline numbers of mainstream crisis support services responding to sexual violence.

Education on accessing ACC counselling for sexual violence and how it can support the Pacific survivor emotionally in positive ways seems urgent at a time when the pressures they experience are increasingly complex. In addition, encouraging Pacific practitioners to write about their practice, engage in research that demonstrates the creativity and effectiveness of their approaches, and disseminate information about their work would enrich the work of others and benefit the Pacific community.

- Guidelines for crisis service volunteers and professionals working with Pacific:
  - Increased cultural awareness and understanding of Pacific values of family, talanoa, and respect of spirituality in God.
  - Understanding a Pacific context including the unique impact sexual violence has on Pacific survivors, families and communities.
  - Access Pacific cultural supervision.

- Crisis service delivery:
  - Support the development and implementation of Pacific cultural competencies.
  - Pacific workforce development focussed on active recruitment of dually competent Pacific clinicians

- Improving access to appropriate support people and services for Pacific peoples. This should include both sexual violence services and Pacific cultural workers, and improved access to cultural specific interventions (such as spiritual support through prayer, and indigenous models to work with Pacific families).
- Increased engagement with Pacific communities, including establishing relationships with relevant Pacific services and partners (such as local churches) .Psycho-education.
- Provide access to Pacific cultural supervision.
- List ofservice providers who provide sexual abuse crisis support for Pacific survivors of sexual violence (Appendix D).

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# Appendices

## Appendix A Participant Information Sheet

### PARTICIPANT INFORMATION SHEET

### Working with Pacific

### Good Practice Guidelines for Mainstream Crisis Support Services – Round 2

Talofa lava, Malo e lelei, Kia Orana, Ni sa bula vinaka, Fakalofalahiatu, Talohani, Halo oloketa, Fakatalofa atu and Warm Pacific greetings to you all

### Invitation

In conversation with my clinical cultural supervisor Cabrini 'Ofa Makasiale, we as Pacific counsellors/clinical psychologists need to update the previous 'Good Practice Guidelines' and identify specific guidelines for working with Pacific survivors/victims. Therefore, we will be seeking feedback from services, service partners and key stakeholders. For this purpose, given your expertise in this area we would like to invite you to participant in this project.

### Objective

- To establish what is "good practice" for "mainstream" crisis support services when working with Pacific survivors of sexual violence
- To develop this "good practice" into guidelines which can be used by "mainstream" crisis support services to inform their service development and practice

The purpose of this project is to update and extend existing 'Good Practice Guidelines', building upon the findings of an initial study conducted in 2009. The aim of the guidelines is to support good practice across the country to a range of population groups, including Pacific, and provide increased transparency and accountability with service partners, NZ Police and DSAC trained medical staff, with services funders and our communities.

### Fono

In working together with our fellow colleague Dr Julie Wharewera-Mika, a TOAH-NNEST researcher from Te Ohaakii e Hine – National Network for ending Sexual Violence Together, we will be hosting a fono. This fono is to speak with invited

people to discuss the needs of our Pacific survivors/victim when in crisis, from mainstream crisis support services, on:

Date: **Saturday 18th July 2015**

Time: **4pm-6pm**

Where: **EPICOR Building, 20 Amersham Way, Manukau City (level six, MissioNZ centre)**

## Project Description

The purpose of this project is to update and extend existing 'Good Practice Guidelines', building upon the findings of an inital study conducted in 2009. The aim of the guidelines is to support good practice across the country to a range of population groups, including Pacific, and provide increased transparency and accountability with service partners, NZ Police and DSAC trained medical staff, with service funders and our communities.

## Project Team

The Working with Pacific project is being conducted by Sarah Va'afusuaga McRobie, (Research co-worker and member of the Good Practice Guidelines Advisory Group) with the support of Dr Julie Wharewera-Mika (Lead Researcher, Good Practice Guidelines, TOAH-NNEST). The Good Practice Guidelines project has a team over fifteen other members who make up the project advisory team, which includes: Kathryn McPhillips (Principle Project Supervisor) and Andrea Black (Project Supervisor). They are supported by the research advisory group: Melanie Calvesbert (Wellington HELP), Wendt Laird (SOS, Rape Crisis), HariataRiwhi (Whangarei Rape Crisis), Louise Nicholas (Survivor Advocate, Rape Crisis), Dr Christine Foley (DSAC), Mike McCarthy (NZ Police), Hera Pierce (NgaKaitiaki Mauri, TOAH-NNEST), Joy TeWiata (NgaKaitiaki Mauri, TOAH-NNEST), Ken Clearwater (Male Survivors of Sexual Abuse Trust), Ellie Lim (Women's Centre), AychMcCardley (Rainbow Youth), Ezekiel Robson (Disability sector), and Dayna Cooper (Youthline).

- *Process:* The fono will be approximately two hours in duration, and will be taped by digital recorder to ensure all the in-depth korero is captured.
- *Rights of participants:* You are under no obligation to accept this invitation to participate. However should you choose to participate, you have the right to decline to answer any particular questions/s and withdraw at any time, without having to give a reason.
- *Confidentiality:* If you agree to take part you will be urged to keep the identities and matters discussed at the workshop confidential. Due to the nature of the gathering, your identity cannot be kept anonymous, but you will be asked to keep the identities of other participants and the matters discussed confidential.

- *Expected outcome/benefits:* The outcome of the fono will assist with the development of 'Good Practice Guidelines' for mainstream crisis support services provision for Pacific survivors of sexual violence.
- *Estimated project timeframe:* The fono will be conducted on Saturday 18th July 2015 with the final Working with Pacific report completed in September 2015. Once all of the Good Practice Guidelines projects are completed, the findings will be collated (incorporating feedback and consultation) and documented in a report that will be disseminated to participating communities, services, government funders and policy departments, uploaded to the TOAH-NNEST website, and presented to the sector, in mid 2016. It is also hoped that a website will be established so ongoing feedback and consultation can be provided.

We appreciate and thank you for your time and consideration in participating in this project. God's richest blessings as you continue to work in with our Pacific survivors/victims. Should you have questions please do not hesitate to contact the research team.

Fa'afetai tele lava mo lau feasoasoani. Ia fa'amanuia tele le Atua i tatou tagata Pasifika i mo le lumana'i.

Soifua lava,

Sarah Va'afusuaga McRobie

Reseach Co-worker

Advisory Group member – Good Practice Guidelines for Mainstream Crisis Support Services

ACC registered counsellor

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Dr Julie Wharewera-Mika

Lead Researcher - Good Practice Guidelines – Researcher – TOAH-NNEST

Clincal Psychologist

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## Appendix B Consent form

## Appendix B Participant Consent Form

## CONSENT FORM

## (Participant)

**Project title:** Working with the needs of our Pacific sexual abuse survivors/victims when in crisis from mainstream crisis support services.

**Researcher:** Sarah Va'afusuaga McRobie

I have read the Participant Information Sheet, have understood the nature of the research and why I have been selected. I have had the opportunity to ask questions and have them answered to my satisfaction.

- I agree to take part in this research.

- I understand that I am free to withdraw participation at any time, and to withdraw any data traceable to me up until two weeks after my interview.

- I agree to be audio recorded and understand that my audio files will not be returned to me.

- I understand that my confidentiality will be maintained, but that my anonymity cannot be guaranteed. I will choose or be given a pseudonym so that my name will not be used in the research report.
- I understand that I will be given an opportunity to view the transcripts of my interviews and to ask for any portion to be removed if I do not want it involved in the analysis.

- I understand that a third party who has signed a confidentiality agreement will transcribe the recordings.

- I agree that I will not disclose anything discussed in the focus group.

- I understand that data will be kept for six years, after which they will be destroyed.

- I wish/ do not wish to receive a summary of findings.

Name _____

Signature _____ Date _____

## Appendix C Questionnaire

### Good Practice Guidelines

### Working with Pacific questionnaire

## Appendix D

## List of service providers in Auckland who provide sexual abuse crisis support for Pacific survivors of sexual violence

| Service | Telephone crisis service | Emer-gency call out | Face to face crisis support service | Ongoing support and recovery |
|---|---|---|---|---|
| ACC<br>https://findsupport.co.nz/ | 0800 735 566 | No | Initial/acute ACC funded counselling | Yes |
| HELP<br>Mt Eden – phone 623 1700 for address | Yes<br>Women<br>Men<br>Young adults<br>Children | Yes | Yes | Yes<br>ACC Counselling |
| Counselling Services centre<br>22 Alexander Avenue, Papatoetoe | Yes | Yes | Yes | Yes<br>ACC Counselling for children, youth, women, men and families |

| | | | | |
|---|---|---|---|---|
| **EAP Employee Assistance programmes** | **Yes 24 hour capacity for self-referrals or company referrals** | **No** | **No** | **Yes for 3-6 sessions and then referral on, if needed** |
| **The Anglican Trust for Women and Children** | **Ph (09)276 9761** | **No** | **Yes** | **Yes ACC Counselling for children, youth, women, men and families** |

# Working with male survivors of sexual violence

**David Mitchell**

A project to inform Good Practice Responding to Sexual Violence – Guidelines for mainstream crisis support services for survivors. Round Two. TOAH-NNEST 2016.

Funded by Lottery Community Sector Research Fund.

This report was prepared by David Mitchell. He has been involved in a range of research projects specifically aimed at surfacing the voices of groups that can be considered marginalised and/or silenced in society. More recently these projects have involved men's understandings and thoughts on family violence and, in this case, the insights of adult male victims of child sexual abuse. Research oversight was also provided by Ken Clearwater (Manager, National Advocate, Male Survivors of Sexual Abuse Trust).

Participants from marginalised groups are not used to being asked about their experiences, and are understandably cautious about participating. The research process utilised manages these tensions through several stages, over time, building trust that results in credible and authentic results.

We wish to thank the participants for their preparedness to give of their time in talking about their experiences and thoughts on a topic of such a deeply personal and isolating journey.

# 1. Overview

This report contributes to a larger, more comprehensive project looking at good practice in response to sexual violence across a number of population groups. The report aims to:

- Establish what is 'good practice' for mainstream crisis support services when working with male survivors of sexual violence, through a review of the literature and hui with appropriate people.
- Develop this 'good practice' into recommended guidelines which can be used by mainstream crisis support services to inform their service development and practice.

## 2. Sexual abuse and males.

Since the 1970's the women's movement has done much to both draw attention to the experiences of female victims of sexual violation as well as to develop appropriate support systems. While effective in many ways, this initiative has also had the effect of contributing to the sense of isolation experienced by male victims of sexual violation (Davies, 2002).

Several authors have supported this view stating that the literature relating to child sexual abuse (CSA[1]) has been almost exclusively based on the experiences and associated effects with female victims, with limited or no attention given to male victims (Rodriguez-Srednicki & Twaite, 2006; Nicholls, 2014). Nicholls (2014) points to a more recent increase in research related to male victims of CSA and suggests that this may be due to media reports such as those which draw attention to abuse of boys in religious establishments. However, it is estimated that initiatives involving awareness of, and support of male victims lag 20 years behind those for female victims (Davies, 2002).

The literature review carried out for this project identified that while the majority of literature related to child sexual abuse (CSA) is based on women's experiences, the past 10 years has seen a wide range of literature relating to men's experiences published. However as the bulk of literature continues to explore women's experience of CSA, careful attention needs to be paid to interpreting sources, particularly research literature, where the gender of participants is not clear.

The literature is clear and relatively consistent in espousing that for many victims of CSA, the effects can be complex and deeply traumatising. These include, but are not limited to, anxiety and social withdrawal, disabling levels of shame and self-blame, suicide, alcohol and drug use, a drop in socio-economic status, teen pregnancy and parenting, relationship and sexual difficulties, family violence and involvement in crime (Jacob & Veach, 2005; McPhillips, Black, & Nicholas 2009). These points are supported by Maniglio (2009) who describes how CSA contributes to a range of medical, psychological and behavioural disorders for both sexes. In many ways the effects are similar for males and females (Yarrow & Churchill, 2009). There is evidence that the situation affecting males is not well researched. This point is supported by Easton (2013) who described male victims of CSA as a 'stigmatized, under-studied, and marginalised population'. It should also be noted at this stage that a number of victims of CSA move on to live relatively functional lives (Fortier and DiLillo, 2010).

[1] CSA will be the term and experience focussed on throughout this report. While sexual abuse of men is an important issue the literature is primarily related to CSA and the participants in this project were all victims of CSA.

While the consistencies above are commonly described in the literature it should be understood that there is also considerable variability in three main areas.

First of all, there is considerable variation in the severity of effects. Victims of CSA have been cited as more likely to develop mood, behaviour and personality disorders, Post Traumatic Stress Disorder (PTSD) and dissociative disorders which can persist into adulthood. However, despite the "overwhelming evidence of deleterious outcomes of CSA, it is commonly agreed that the impact of CSA is highly variable and that a significant portion of victims do not exhibit clinical levels of symptoms. This can be explained, in part, by the extremely diverse characteristics of CSA which lead to a wide range of potential outcomes" (Collin-Vézina, Daigneault and Hébert, 2013). Secondly, considerable difference exists in reported prevalence rates of CSA due to varying definitions, methods of data collection, geographical and cultural perspectives. Some authors report 1 in 5 females as victims and 1 in 10 males (Collin-Vézina, Daigneault, & Hébert, 2013), others report rates of abuse as high as 1 in 4 females and 1 in 6 males (Monk-Turner & Light, 2010) for similar populations. And finally, while most research reports differences between rates of abuse for males and females, it is not yet clear how much of this difference relates to a difference in rates of disclosure.

## Disclosure

The evidence is clear that, while females experience sexual violation more frequently than males, males under-report to a much larger extent than do females. Stoltenborgh et al. (2011) described a Canadian study which found that whereas 16% of female victims had never disclosed the abuse, this proportion rose to 30% for male victims. This is supported by O'Leary & Barber (2008) who add that male victims are less likely than females to disclose CSA at the time it occurs and also take longer to discuss their experiences. This delay has been quantified by a number of authors with O'Leary & Gould (2009) stating that men typically disclose abuse 10 years later than women. Nicholls (2014) extends this time stating that men in her study delayed disclosure for 10-15 years.

Perhaps the most telling aspect of difference between female and male experience of sexual abuse, is the impact of myths and stereotypes generally, and more particularly the impact on disclosure patterns.

## Myths and stereotypes regarding males and sexual abuse.

- Societal beliefs about males being self-reliant and dominant, relatively immune to expressions of vulnerability or helplessness are commonly understood and believed. For many survivors, seeking help is almost unimaginable, almost a worse outcome than non-disclosure (Barnett et al, 2011; Romano & De Luca, 2001). Situations where the abuser is a woman considerably worsens the contradiction between societal expectations, self-image and the experience of abuse (Davies, 2002). While the victim's self-blame, for at least in part, somehow contributing to the abuse is no doubt true of both male and female victims, Davies (2002) suggests that men, because of their internalised beliefs surrounding masculinity, are at greater risk of believing they may have provoked the abuse in some way.
- The prevailing paradigm within services and society in which violence, particularly sexual violence, is seen as an abuse of power. For example the statement, "We believe that sexual violence is an abuse of power. It occurs primarily due to the way society defines the roles of women and men and supports a patriarchal system that views others as property, while also

rewarding those who exercise power and control over others with no regard for human rights or dignity" (TOAH-NNEST TC Inc., 2009, 4.1.6). Given that crimes such as rape and sexual abuse are primarily associated with women, this invariably isolates male victims of sexual abuse. This isolation can lead to the belief that abuse has only happened to them (Nicholls, 2014). This isolation is further deepened for male victims of sexual abuse which was perpetrated by a female as this is an absolute contradiction to the prevailing ideology outlined above.

- The belief that survivors of CSA move on to perpetrate abuse on others, creating a cycle of abuse. That is, the victim moves on to become a perpetrator. Olgoff et al. (2012) report that this assumption is incorrect. They cite research that found 95% of survivors do not move on to become perpetrators (Olgoff et al., 2012). Regardless of the accuracy of this belief, that it actually exists contributes to male survivors not disclosing their experience of CSA (Nicholls, 2014). Further, this belief can inhibit male survivors from entering into and enjoying relationshps, parenting and being with children.
- Drawing from the points above, the lack of belief that males are sexually abused. Nicholls (2014) observes that males are less likely to be believed than females when they disclose a history of abuse. Also problematic is the idea that sexual abuse has little effect on males or at least that abuse is not as severe for males as it is for females. One specific gender stereotype is the view commonly held which sees males as seeking and appreciating early sexual experiences regardless of the nature of these experiences (Stemple & Meyer, 2014). The isolation, anxiety, depression and self blame resulting from this myth can lead to a loss of hope and subsequent suicidality. While a range of health and social issues result for victims of sexual abuse, the situation for males is worrying. O'Leary, & Gould, (2009) report that those men who are victims of CSA consider suicide at 10 times the rate for Australian men generally with 46% of victims having made at least one attempt.
- Questions or self-examination about sexual orientation, particularly for heterosexual males. This is not uncommon, especially if the victim sustained an erection during anal penetration.(Stemple & Meyer, 2014). Doubts about sexual orientation can also occur if a heterosexual man was not a willing partner to a woman who wanted sex (Davies, 2002). Violence leading from anti-gay or homophobic views is well documented. Davies (2002) suggests that up to 10% of anti-gay violence can develop into sexual abuse.
- The refusal by society to believe that female offenders exist (Saradjian & Cortoni, 2010), or that female offending is in some way less traumatic for the victim than male perpetration. With male victims of CSA there are a considerably higher proportion of female offenders than exist for female victims.

In conclusion, considering the estimated high prevalence of sexual abuse and limited numbers of men who seek help, it is possible that many males (both children and adults) endure prolonged suffering and many never receive necessary intervention.

- **Methodology**

## 3. The Current initiative

This current initiative has been commissioned by the Tauiwi Caucus of TOAH-NNEST to establish what good practice might be for specialist sexual violence crisis support services when working with male victims/survivors.

As Nicholls (2014) points out, overall there's a scarcity of information about how, when and where male victims of CSA seek/find support and how they perceive the quality and helpfulness of this support.

## 4. Project overview

This qualitative project used two consecutive focus groups of the same participants. The groups aimed to provide qualitative information that was authentic, credible and represented the considered opinions of those present. This process was followed in the belief that group discussion, combined with reflection over time (i.e. between the two group discussions) can produce insights that would not be uncovered through any other research process, especially 'one off' or 'snapshot' approaches to data collection such as in surveys or interviews.
Apart from managing issues to do with anonymity and confidentiality, a primary ethical concern was that group discussion asks the participants to reconnect with the original trauma they experienced. However, rather than a negative experience, those present considered the experience very positive. As Close & Peel (2012) observe, professionals can often overstate the case for the need for participants to be protected from the trauma of reliving their experiences. Conversely, individuals may find the process a healing, positive experience.

There were 10 participants.

- Six were European and four were Māori.
- Ages ranged from 35 to 70 years with the average age being 50 years.
- The majority of participants first 'presented' to mental health services and two to their GP.
- The time period before disclosure ranged from 10 – 62 years with the average being 32 yrs.
- Reasons for presentation varied but mostly because of behavioural/psychological concerns.
- The only option for assistance was counselling.

Analysis was done by developing themes that emerged from the group discussions. These were verified with the participants and are presented below as two major themes and associated subthemes.

## 5. Results

### a. The initial engagement with professionals

- **The importance of a sense of trust in the professional.**

McPhillips, Black, & Nicholas (2009) cite a range of characteristics of the development of a trusting relationship. These include, but are not limited to, a focus on partnership, being patient, not expecting trust, listening and not judging. While these foci would understandably be at the core of any professional relationship there were several points of difference in relation to trust that were mentioned by the participants.

> *"With abuse you learn not to trust early on so why would you trust a stranger? Trust is a hard thing to gain. It's gone on for so long."*

> *"You never get anywhere near trusting people. We don't get the feeling of trust. People that did what they did to us, we trusted them, but we still got hurt. Trust is something that builds over time."*

> *"You get [that confusion] in your head, can I trust this person or not? I've got it wrong so many times in the past."*

Nicholls (2014) points to the hyper-vigilance experienced by victims when first encountering a professional. This experience was broad in that it related to the environment as well as the interpersonal characteristics of the professional. Certificates, family portraits and suchlike were felt to be unsettling. McPhillips et al (2009) describe how participants in their study felt exposed, as if those presented knew their story before it had been disclosed.

Other factors mentioned ...

> *"She listened to me, respected my story, gave me choices. She did all the right things. I pretty much trusted her from day one. I have more trust in women professionals. I'm working through this."*

> *"What was good is that she had a methodology she was following. It helps if they have some knowledge."*

> *"What're you going to tell a 25yr old? What do they know?"*

Not being seen as an individual again featured strongly in the discussions. The sentiment was 'to be seen as a person, not as a cash cow'. This point related both to initial contact with professionals and to ongoing contact with others (eg. Counsellors).

> *"I didn't want somebody just to hear my story I wanted somebody who would be [closer to me a person] not to see me as a cash cow. I wouldn't want to share anything with somebody like that. [I need] somebody walking with you, somebody that cares. It just helps. Get rid of the clock. You feel as though you're forgotten about as soon as you leave the office."*

> *"Going to the counsellor, you go through the same old thing. They make you feel like a victim."*

> *"They go that little bit extra. When I went to Court my counsellor came with me. Restorative justice, my cop wanted to come with me. Sort of like walking alongside you. Outside the parameters ....."*

There was a belief expressed that professionals had little or no understanding of the grief and loss experienced by victims. The following quotation is typical of the experiences discussed.

> *"I've walked away from an engagement and a marriage because I couldn't stand the closeness involved. The [professionals] never touched on that. They never talked about that. That's something we have to deal with ourselves. All the losses*

*involved. The losses destroy us and that's what happened to us [with the original abuse]."*

- **The need for professionals to assess for abuse and to assist with early referral.**

While most professionals are aware of the existence of CSA of males, few understand the need to enquire or assess for this, or that most clients (and almost all men) even with questioning will not initially disclose previous abuse (Nicholls, 2014). Havig (2008) found that those professionals that did enquire often used ineffective methods, with most having little training and confidence in managing this. However, the participants in the current project were clear about the importance of this enquiry.

*"Nobody asked the right questions, they just thought I was being a little brat. My parents thought I was misbehaving so I got punished by them as well. Nobody thought to ask the question."*

*"Nobody asked. Professionals need to ask the questions that will get us right. Training is needed. They should acknowledge the importance of sexual abuse. It's not acknowledged. It's just not right."*

*"You go to GPs because you're struggling within yourself. It's where you naturally go. It was my GP that asked whether something had happened to me in the past. I couldn't sleep, my wife and I were fighting. I broke down when the GP asked."*

*"[It was my GP] as well. I was [being treated through] mental health [services]. They didn't ask the right questions. My GP was the only one that would listen. There was no help anywhere else. They just didn't want to know. My GP got me on the road to recovery. She listened, didn't judge, gave me information, referred and followed up to see how I was."*

Nicholls (2014) observed that it wasn't just the need to enquire about a history of abuse but the need to respond to any disclosure in a positive, informed and otherwise supportive manner. Further, that enquiry may need to be repeated as the men she worked with did not initially disclose.

The participants in the current project were also clear about the need for early referral firstly to a peer group of male survivors of CSA and secondly to other agencies. A peer group was seen by the participants as absolutely vital to moving on. The sense of isolation experienced by male susvivors of CSA can be alleviated by groups, whether peer or facilitated (Fisher, Goodwin & Patton, 2008). In this case the particpants were talking about a peer run, peer group. The positive feelings and support the participants experienced from a peer group cannot be overemphasised.

*"I can't remember anybody saying 'a counsellor saved my life' but I've heard several people say this about the peer group."*

*"There's more trust in the peer group. You want answers like 'why am I like this?' Professionals don't talk, you talk and they listen. The answers come so much faster in the peer group. We needed to get into a group more quickly than what we did."*

> *"They need to get people into peer group support far, far quicker than they are. [With professionals] you can't choose not to talk as you can in the peer group. We just need to options out there. The options need to be clear and early on."*

Davies (2002) advises that, because of the importance of peer group support, this resource should be known to front line services (e.g. medical, psychiatric and police) and referral supported as soon as possible.

- **The need to respect and appreciate the emotions and processing involved.**

While not only related to male victims of abuse, disclosure may well lead to further distress. As Ullman, Foynes & Tang (2010) explain, rather than being beneficial, disclosure is an ongoing, complex process. This process can be extremely harrowing.

> *"It's more like a rollercoaster… I find that, once the anxiety starts snowballing with not the correct answers and the length of time it takes to go through the process, [the anxiety] just builds and builds and that's what costs. It compounds and get worse before it gets better."*

In their project, Mitchell & Chapman (2014, p26) noted that the male victims participating in their project frequently failed to keep to appointment times, sometimes being absent for a number of weeks. Mitchell & Chapman recommended the need for flexibility in supporting deeply traumatised male victims of CSA, with the time allocated needing to be generous. The support also needed to be available outside usual working hours. The authors questioned whether this level of support was sustainable in most professional settings.

- **The need to respond to the clients' need for information.**

Victims of CSA have considerable difficulty linking the original abuse with their life of often extreme difficulty. The participants in the current project frequently emphasised that they were desperate for answers. While the following quotations are mainly about ongoing counselling, this point has implications for support around initial disclosure as well (Foster, Boyd, & O'Leary, 2012).

> *"We need answers and they just don't do that. You talk and talk and talk but you don't get any answers. You go away still looking for answers. It doesn't work. It seems they want all the answers to come from me."*

> *"Counsellors focus on the abuse, they want to go back to that. But we seem to be saying that we need answers to questions about why are we like this. If they focussed on that, why am I angry, frustrated, drinking or whatever. It was always going back to that point over and over again. I want to move forward. We were treading water in the past. It's a lot of wasted sessions. Counsellors need to ask us what we want from sessions."*

> *"We want answers not pills. why did he do it?"*

*"The counsellor didn't actually explain why rapists would do this, what goes through their mind. One counsellor could tell me about this because he worked with offenders as well."*

This point also extended to information needed about the participants' concerns about sexuality, particularly concerns in hetereosexual men about homosexuality. This occurs even if they have never experiened sexual interest in males nor negative attitudes towards gay people. This adds to the need for silence in male victims of CSA (O'Dell, 2003).

*"I want to know why I would think about being gay."*

*"It's ruined my sex life. I can't have sex with my partner. I ask 'am I gay?' I don't know what it is. There is no feeling there because of this man. I ain't gay but I want to know why I'd think that."*

## b. Service provision generally.

- **A need for specialised services and people**

*"It's like a desert out there. There is a general thing about not seeing men as victims. Women's Refuge have two houses [where I live], there's very little for men. There's a big gap."*

Sexual violence services providing crisis support have existed in New Zealand since the 1970s with the establishment of a number of Rape Crisis groups. However, the lack of specialised services for males is well established. While services specifically for women have grown, there has been no corresponding growth in services for men (Mitchell & Chapman, 2014; Nicholls, 2014). Monk-Turner & Light (2010) observed that, in their locality, only 5% of intervention services provided support with male victims in mind.

- **Strengthening interagency processes and communication.**

*"It feels like being pushed from pillar to post, continuously let down. There's a lack of consistency. They need to collectively work together offering the same channels. Restorative justice, the Police and the Courts talking together would be an improvement."*

*"My GP filed a Sensitive Claim report. It took one year before ACC got back to me."*

*"Generally victims are shy, lacking in confidence. My anxiety just snowballed. People, in the early stages, don't know the answers to the things they're going through."*

Nicholls (2014) observed that with male victims of abuse there was often a narrow window where there was an opportunity for disclosure and connection. Because of this, professionals needed to be quickly responsive to the event and have clear pathways to link to other services.

*"I've had issues with Doctors and mental health services over the past 2 weeks. They need to get their systems in order. It's just bollocks, one department saying they haven't got [the information] another saying they have. You're just left out on the street wandering around in circles. Nowhere to go. I'm put on the backburner."*

*"They don't treat you like a person. I want help but there's nothing there."*

*"I'm now 70. My abuse happened when I was 6. It's taken me 62 years to bring it out because in my generation you didn't say anything. Today we need more publicity, more education for professionals."*

*"I went for 40 counselling sessions but I was just wasting time. I wanted to rewire myself with positive thoughts towards the future. Not negative ones. It took a long time (40 sessions) to look at the past but the counsellor didn't seem to know how I could move forward."*

- **The need for specialised education – both undergraduate and inservice.**

The limited education avilable for those entering professions where contact with victims of CSA is likely is limited. In relation to the situation affecting male victims education is largely non-existent.

*"How many people are specialised in working with victims of abuse? If they haven't got anything on sexual abuse in courses, that's a major failing. They need to connect with current research on sexual abuse."*

*"Is the training for professionals connected to a body of knowledge about sexual abuse of males?"*

Survivors and professionals would benefit markedly from working together as direct input from survivors is one way of raising awareness as well as developing strategies to aid disclosure and identify areas of support. Additionally, being able to assist in developing good practice guidelines is viewed as enhancing the wellbeing of survivors (Kia-Keating, Sorsoli, & Grossman. 2010).

*"I was trying to prepare the guy for what he was going through and about to go through. I think that's really important for people going through the system, having survivors to help. Lots of advice and things to watch out for."*

*"They need to listen to us. (we want to help). The professionals need to know what happens in this group. We could go to them."*

## 6. Conclusions

The participants in the project identified a number of areas that were of importance to them in aiding both disclosure and support through the process of recovery. These included:

- The importance of a sense of trust in the professional.
- The need for professionals to assess for abuse and to assist with early referral.
- The need to respect and appreciate the emotions and processing involved.
- The need to respond to the client's need for information.
- A need for specialised services and people.
- Strengthening interagency processes and communication.
- The need for specialised education – both undergraduate and inservice.

These points, while obviously relevant to the participants, would no doubt be equally relevant to women who are victims of sexual abuse. This raises the question of 'what is there that differs between the experience of male victims of CSA with that of female victims?'

Qualitative projects such as the project reported here have a number of limitations. However, one limitation is of particular importance and answers the question above. The particular methodology employed in this project aimed for a group consensus and asked the participants to develop constructive suggestions to assist professionals to engage with them in a supportive and positive manner. This process avoids criticism or at least presents criticism as constructive critique.

What is missing from the report is a sense of the distress expressed by the participants at what they generally viewed as a lack of interest, engagement and skill in supporting them in relation to their history of CSA. These shortcomings are directly related to the last point above about the need for education. The participants (as well as the literature) are clear that education must begin with a process of awareness-raising about the stigma and stereotypes related to men's experience of CSA prior to skill development. These were detailed earlier in the report. This approach is as an essential beginning to any educational programme. Without this awareness-raising professionals as well as victims will continue to both believe and thereby reinforce the myths and stereotypes.

## Identifying Good Practice Guidelines – What can crisis services do to support male victims/survivors?

- **Volunteers and professionals (specific behaviour, approach, intervention, knowledge required e.g. needs of men, difficulty in reporting)**

Workforce development, training professionals about sexual abuse of males – what do professionals need to know?

a. The prevalence of myths and stereotypes regarding CSA and male victims

The myths and stereotypes that impact directly on male victims of CSA has been well detailed in the main body of the report. Nevertheless we cannot overemphasise that unless this area is addressed by professionals in their professional development, their ability to both engage with and otherwise

support male victims of CSA will be severely compromised. We are unaware of any formal education in this area that debunks the myths and stereotypes surrounding male victims of CSA, so it can be assumed that in the main, professionals will subscribe at least in part to these myths and stereotypes as well. Expecting professionals to somehow manage the complexities around supporting disclosure and subsequent support without targeted education in this area is a dangerous assumption. Professionals will most likely be seen as authority figures by victims of CSA and the dynamics of the original abuse create an inherent distrust of anybody who is perceived as an authority figure. Further it is suggested that male victims of CSA have an inherent and intense fear of being controlled by others.

This area, of awareness raising and skill development, needs to be seen as the priority.

b. Shame and guilt

The presence of shame and guilt is a major reason for men not presenting and disclosing CSA. Victims typically have difficulty linking the original abuse with these feelings as well as with the negative impacts these have had on their lives. This dynamic underpins resistance to disclosure and again emphasises the importance of awareness-raising and skill development with professionals.

Many individuals exposed to sexual abuse believe that in some part they were responsible for the abuse. Research with male victims indicates that chronic shame inhibits the victim's ability to connect with others including professionals. It is important to understand that here 'shame' is experienced as 'self as shame', not as a shamed aspect of self but an all-encompassing dynamic supported by the belief that others will see them in this manner. Indeed, it is suggested that this dynamic makes re-establishing a positive view of self incredibly difficult if not impossible.

Given these dynamics it is not surprising that concealment of abuse is a common response generally and with males in particular.

c. Issues with sexuality following CSA

Heterosexual males questioning their sexual orientation following abuse by a male perpetrator is common and causes considerable ongoing distress in victims. This distress presents in differing ways, for example men moving on to despise male homosexuals. Alternatively, if the perpetrator is female this also impacts on the victim's questioning of 'normal' relationships and sexual behaviour. Difficulties in future relationships with a female are a common occurrence. If the male victim is homosexual the impact the abuse has on the victim's understanding and experience of future relationships with male partners is similarly affected.

a. How can crisis services best support men given the difficulty in disclosing (e.g. increased validation and acknowledgment of difficulty in coming forward and reassurance that the crisis service will do the best to meet his needs)?

We refer back to the need for in-service and undergraduate education on stereotypes and myths surrounding male victims of CSA being foundational if this area is to be addressed constructively. This education should be broadened to offer a comprehensive awareness-raising and skill development package for professionals. Overall it needs to be recognised that CSA involves a profound breach of trust and this is known to result in mistrust, avoidance and suspiciousness in relationships especially those relationships involving a person perceived to have power over the client.

Research has indicated that male victims of CSA want to be asked about any history of abuse but that this needs to occur in a respectful and skilled manner. It should be noted that because of the original trauma experienced by men many situations with professionals can act as 'triggers' profoundly affecting their ability to cope with issues of trust. These triggers are varied and difficult to predict. They can be to do with the environment as well as with both non-verbal and verbal aspects of the interaction with professionals. Again, the need for professionals to be aware of the importance of this in their work is vital.

a. Are there specific needs of men in processing emotions that crisis services need to be aware of?

The first thing to understand is the anger, even rage, which invariably underpins male victim's response to CSA. Victims are acutely aware of this anger as well as the fear it creates in them. Discounting violence, professionals need to be aware that anger is an emotion that is common in male victims of CSA. Further, this anger should be an expected response underpinning engagement with male victims. Professionals need to be comfortable and empathic with the expression of anger and not immediately equate this with a potential for violence. The expression of anger should certainly not be inhibited by professionals. Anger must be seen as part of the process of the victim coming to understand and link the complexity of their lives with the original abuse.

- **Overall services (policies, staff training, workforce development)**

a. What might these services look like?

Regardless of the gender of the professional, a male friendly environment is essential. One common example of where this is compromised is in interview rooms where information regarding males involves posters/information on violence depicting men as perpetrators. These have an immediate and negative impact on men seeking help. Otherwise, service environments tend to encourage a soft, calming atmosphere which is in stark contrast to the frustration, even rage, that many male victims experience. It is not suggested that a torrid environment is required but that this contrast is appreciated in the design of services. Overall an environment that is designed to both acknowledge and respect men as victims is vital but uncommon. With this point in mind a critical assessment of working environments needs to be undertaken preferably by skilled people from outside the organisation.

Early networking with other agencies is important given the relatively high degree of isolation males experience in their lives. Key 'go to' organisations with people experienced in working with distressed men should be identified and effective interagency relationships developed. Our experience is that where these organisations exist they are not well known nor well accessed. Generally professional services believe they are well placed to meet the needs of their male clients. This may well be the case in many circumstances but because of the lack of targeted education in the particular needs of male victims (e.g. victims of CSA) early referral to specialist services is vital. Additionally, mainstream services should seek advice, guidance and training from specialist male services.

b. When is it more appropriate to access support from a male or female?

This a personal choice of the victim and the choice may well change over time. It is essential that victims are initially asked their preference and this should be respected in the first instance. However, we believe it important that future discussion is encouraged about the reason for this initial choice. These discussions can lead to the victim critically reflecting on the choice and exploring the reasoning around it. This is an important point whether the perpetrator was male or female.

Otherwise, services should be readily available and certainly available outside normal hours. When men decide to seek help, delays such as in accessing an answer phone and waiting for long periods for an appointment will not support this process. The working lives of men as well as men's isolation (relative to women) increase the importance of these points.

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# “EVERYTHING, WITH US”
## Working with People with Disabilities

**Ezekiel Robson**

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# OVERVIEW

## Purpose of this Report

The global human rights and disability movement banner 'Nothing about us, without us' continues to usefully serve people with disabilities in our efforts to promote greater awareness and achieve meaningful responsiveness on issues of exclusion and inaccessibility.

While the social model and a rights-based approach to addressing disability are becoming further integrated in all aspects of society, judgements of what is, and is not, considered 'about us', and whose choice that is, are now being challenged routinely, for they are at the core of advocacy for genuine autonomy and equitable participation. A subtle shift in thinking around fairness, justice and equality for all suggests that, simply put, for anything which is to be done, everything must be done, with us.

This strand of research and consultation contributes to a broader update of 'Good Practice Guidelines for Mainstream Crisis Support Services' (TOAH-NNEST, 2009), with a purpose to explore particular issues for people with disabilities who experience sexual abuse/assault, their access to crisis support services and the capacity of those services to support them.

This project includes a review of available literature on what the historical evidence base is, and what good practice might be, in terms of provision of mainstream crisis support services to disabled survivors of sexual abuse/assault. Key informant interviews with relevant sector leaders and professionals are analysed for qualitative experiences illustrating the concerns of disabled people, disability services, and sexual violence services.

This final report was developed to highlight areas of need, document the overall findings, and offer recommendations and appropriate good practice guidelines for mainstream crisis support services.

## Notes on Language

The terms 'disabled people' and 'people with disabilities' or similar, are used interchangeably throughout this report on the understanding that person-first language is desirable in emphasising the intrinsic value all human beings have. On the one hand it moves us beyond being defined by impairment, but on the other, it suggests locating disabilities with(in) individuals, when in fact impairments only become disabilities when in interaction with poorly arranged and/or discriminatory external social and environmental factors. Whereas 'impairment-first' labelling seeks to contain, define and generalise people's needs within easily understood or known categories, and is also a gateway to self- and group-identification within wider community. Just as disabled people can be regarded as a distinct group in society, they are equally diverse in nature with divergent and overlapping interests. A capital 'D' is used by people who are Deaf to indicate cultural and linguistic allegiance to Deaf communities and New Zealand Sign Language (NZSL). Of particular importance is respecting one's humanity, and recognising abilities rather than restrictions, ahead of other elements – 'wheelchair-bound person' becomes 'person using a wheelchair' or 'wheelchair user'.

## BACKGROUND

### Disability and Sexual Violence in New Zealand

Disabled people include those who have long-term physical, mental, intellectual or sensory impairments which, in interaction with various barriers, may hinder their full and effective participation in society on an equal basis.

This report considers all impairments as can be encompassed by definitions in the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), except where psychosocial impairments were either not previously present, and/or were likely caused by experience of sexual assault itself. This is due to the significant amounts of existing research and practice which aims to address factors of mental injury resulting from sexual abuse/assault, and as ACC Sexual Abuse and Mental Injury Guidelines sets out a comparative framework for good practice in this area.

The post-Census 2013 Disability Survey found that 24 percent of the New Zealand population identified as disabled, a total of 1.1 million people. People aged 65 or over were much more likely to be disabled (59 percent) than adults under 65 years (21 percent) or children under 15 years (11 percent). Māori (32 percent) and Pacific (26 percent) people had higher-than-average disability rates, after adjusting for differences in ethnic population age profiles. For adults, physical limitations were the most common type of impairment. Eighteen percent of all people aged 15 or over, 64 percent of disabled adults, were physically impaired. For children, learning difficulty was the most common impairment type. Six percent of all children, 52 percent of disabled children, had difficulty learning. Just over half of all disabled people (53 percent) had more than one type of impairment. Four percent of disabled adults are living in residential care facilities.

The overall findings below of Te Toiora Mata Tauherenga, the Ministry of Justice's 2009 Report of the Taskforce for Action on Sexual Violence aligns with the experiences of those in the disability community/sector, with some interesting and minor variations or re-enforcements to be explored throughout this report including:

- *Sexual violence is prevalent in our communities.*
- *Some groups are more at risk than others (including people with a disability).*
- *Sexual violence is a highly gendered crime.*
- *Victims often know their offenders.*
- *Sexual violence is one of the most costly crimes to individuals and society.*
- *Offenders are getting away with it (due to very high rates of sexual offences going unreported, or failing to secure a conviction).*

*Sexual violence has significant physical and mental health impacts on victims, including physical injury, sexually transmitted infections, post-traumatic stress disorder and depression. High numbers of mental health patients report a history of sexual violation.*

The first round of development of the good practice guidelines made recommendations that in order to improve the responses of sexual assault support workers towards survivors with disability, steps to take would include: training for sexual assault support workers, co-ordination between police, sexual assault support workers and disability support workers, information available in a form specific to a survivor's needs and disability, and agencies resourced to enable staff to have time to work with clients at a pace and in a format that suits them. This report follows on from this starting point to further define the qualities of the physical environment, and qualities of interpersonal interactions which will better meet the needs of disabled people.

Sexual abuse/assault of disabled people encompasses the usual realms of physical, sexual, psychological/mental/emotional violence.

Michael Roguski's 2013 exploratory study of 'The Hidden Abuse of Disabled People Residing in the Community' in the Tairawhiti region is one of the best sources of evidence we currently have setting the scene for disabled people's experiences of violence in New Zealand:

> ***"Types of Abuse –*** *Participants discussed having experienced abuse in residential services, institutions, home-based environments and in the community.*
>
> - *Residential services – abuse within residential settings occurred through either a staff member or client associated with the organisation. This type of abuse assumes the victim is a resident of a residential service. Residential services include specialised residences, usually designed for up to six residents, with 24-hour care worker supervision. The types of services include nursing homes, specialist residences for people who have experienced a brain injury (including stroke), mental health, intellectual disabilities and homes for people in need of care.*
> - *Institutional settings – institutional abuse occurred through staff associated with an organisation. Most commonly, participants referred to hospitals as a primary site for institutional abuse. This type of abuse assumes the victim was temporarily placed in the institution.*
> - *Home-based environments – abuse within the home occurred through home-based care workers, landlords and the individual's partner or family/whanau. Managers of home care service organisations were also discussed as facilitating abuse by failing to appropriately action reports of abuse.*
> - *Community settings – abuse in community settings was referred to as either occurring opportunistically by someone unknown to the victim or, for example, in the case of financial abuse, through local businesses and neighbours" (*Roguski 2013; pg21*).*

Roguski also refers to abuse using terms of silencing (pressure not to complain, normalisation of complaints being ignored), locked-in abuse (situations in which a disabled person's mobility and/or ability to communicate are removed) and dehumanising processes and treatment (where an

individual's choices and voice are invalidated, the removal of rights, social exclusion and invisibility). Similarly, a 2010 UK Government Department of Health report outlines the specific risks of situations of neglect and acts of omission, discriminatory behaviours and institutional practices.

- ***Neglect and acts of omission*** *- including ignoring medical or physical care needs, failure to provide access to appropriate health, social care or educational services, the withholding of the necessities of life, such as medication, adequate nutrition and heating.*

- ***Discriminatory behaviours*** *- including abuse based on a person's race, sex, disability, faith, sexual orientation, or age; other forms of harassment, slurs or similar treatment or hate crime/incident. Discriminatory abuse can lead to people being excluded from mainstream activities.*

- ***Institutional practices*** *- neglect and poor professional practice. This may take the form of isolated incidents of poor or unsatisfactory professional practice, at one end of the spectrum, through to pervasive ill treatment or gross misconduct at the other. Repeated instances of such treatment may be an indication of more serious problems.*

*The difference between poor practice and abuse can sometimes be hard to determine. Abuse may be perpetrated as a result of deliberate intent, negligence or ignorance (*UK Government Department of Health Social Care Group, 2010; pgs 9-10).

Disabled people are members of every gender, ethnicity, culture, class and community of identity or interest. Within marginalised communities, experience of disability further marginalises. Unlike for other communities, disabled boys and men experience both physical and sexual violence in large numbers. Women with disabilities who have children and do escape violence may run the risk of losing custody of their children because authorities may question their ability to care for them alone.

Roguski (2013) identifies structural issues that serve to maintain high levels of on-going abuse in society, specifically:

- *"a low level of societal awareness of disability abuse*

- *a variety of silencing processes*

- *a lack of appropriate monitoring*

- *poor management practice of a variety of disability-related residences and services*

- *inadequate reporting options*

- existing legislation, and powers emerging from legislation, are inadequate. This is especially problematic in that the disabled individual does not receive adequate protection during an investigation of abuse" (Roguski, 2013; pg 30).

### United Nations Convention on the Rights of Persons with Disabilities (UNCRPD)

The purpose of the UNCRPD is to promote, protect and ensure the full and equal enjoyment of all human rights by people with disabilities, and to promote respect for their inherent dignity. The UNCRPD re-enforces that people with disabilities must have the opportunity to be the key decision-makers in their own lives. It makes people with disabilities 'rights holders', with an expectation and obligation of full participation in formulating and implementing plans and policies which affect them.

States that ratify the UNCRPD are legally bound to treat persons with disabilities not just as victims or members of a minority, but as subjects of the law with clearly defined rights. States have to adapt their domestic legislation and policy implementations to the international standards set out in the treaty. The UNCRPD promotes human rights standards and their application from a disability perspective, promoting equal citizenship after a long history of discrimination. There are eight guiding principles that underpin the UNCRPD and each of its specific articles:

1. *"Respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons;*
2. *Non-discrimination;*
3. *Full and effective participation and inclusion in society;*
4. *Respect for difference and acceptance of persons with disabilities as part of human diversity and humanity;*
5. *Equality of opportunity;*
6. *Accessibility;*
7. *Equality between men and women;*
8. *Respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities" (*United Nations Convention on the Rights of Persons with Disabilities, 2008; Article 3 Pg 5*).*

The New Zealand Government ratified the UNCRPD in 2008, and regularly reports against progress in implementing measures to address a range of relevant articles.

**Article 13 – Access to justice**

> "1. States Parties shall ensure effective access to justice for persons with disabilities on an equal basis with others, including through the provision of procedural and age-appropriate accommodations, in order to facilitate their effective role as direct and indirect participants, including as witnesses, in all legal proceedings, including at investigative and other preliminary stages.
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> 2. In order to help to ensure effective access to justice for persons with disabilities, States Parties shall promote appropriate training for those working in the field of administration of justice, including police and prison staff.

**Article 14 – Liberty and security of person**

1. States Parties shall ensure that persons with disabilities, on an equal basis with others:

a) Enjoy the right to liberty and security of person;

b) Are not deprived of their liberty unlawfully or arbitrarily, and that any deprivation of liberty is in conformity with the law, and that the existence of a disability shall in no case justify a deprivation of liberty.

2. States Parties shall ensure that if persons with disabilities are deprived of their liberty through any process, they are, on an equal basis with others, entitled to guarantees in accordance with international human rights law and shall be treated in compliance with the objectives and principles of the present Convention, including by provision of reasonable accommodation.

**Article 15 – Freedom from torture or cruel, inhuman or degrading treatment or punishment**

1. No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his or her free consent to medical or scientific experimentation.

2. States Parties shall take all effective legislative, administrative, judicial or other measures to prevent persons with disabilities, on an equal basis with others, from being subjected to torture or cruel, inhuman or degrading treatment or punishment.

**Article 16 – Freedom from exploitation, violence and abuse**

1. States Parties shall take all appropriate legislative, administrative, social, educational and other measures to protect persons with disabilities, both within and outside the home, from all forms of exploitation, violence and abuse, including their gender-based aspects.

2. States Parties shall also take all appropriate measures to prevent all forms of exploitation, violence and abuse by ensuring, inter alia, appropriate forms of gender- and age-sensitive assistance and support for persons with disabilities and their families and caregivers, including through the provision of information and education on how to avoid, recognize and report instances of exploitation, violence and abuse. States Parties shall ensure that protection services are age-, gender- and disability-sensitive.

3. In order to prevent the occurrence of all forms of exploitation, violence and abuse, States Parties shall ensure that all facilities and programmes designed to serve persons with disabilities are effectively monitored by independent authorities.

4. States Parties shall take all appropriate measures to promote the physical, cognitive and psychological recovery, rehabilitation and social reintegration of persons with disabilities who become victims of any form of exploitation, violence or abuse, including through the

provision of protection services. Such recovery and reintegration shall take place in an environment that fosters the health, welfare, self-respect, dignity and autonomy of the person and takes into account gender- and age-specific needs.

5. States Parties shall put in place effective legislation and policies, including women- and child-focused legislation and policies, to ensure that instances of exploitation, violence and abuse against persons with disabilities are identified, investigated and, where appropriate, prosecuted." (UNCRPD, 2008; Pgs 11-12)

**Article 28 – Adequate standard of living and social protection**

"[…] 2. States Parties recognize the right of persons with disabilities to social protection and to the enjoyment of that right without discrimination on the basis of disability, and shall take appropriate steps to safeguard and promote the realization of this right, including measures:

[…] b) To ensure access by persons with disabilities, in particular women and girls with disabilities and older persons with disabilities, to social protection programmes and poverty reduction programmes; […]" (UNCRPD, 2008; pgs 11-12)

### The New Zealand Disability Strategy (NZDS) & Disability Action Plan

The vision of the NZDS, published in 2001, is of a society that highly values the lives and continually enhances the full participation of disabled people. It provides a framework to guide government agencies making policies and providing services that impact on disabled people.

The more contemporary Disability Action Plan for 2014 - 2018 sets out priorities as determined by the Ministerial Committee on Disability Issues for actions that advance implementation of the UNCRPD and the NZDS. These priorities emphasise actions requiring government agencies to work together, as well as in collaboration with disability sector organisations and others. For example:

***"Reduce the number of disabled children and adults who are victims of violence, abuse or neglect***

*a) Review the current care and support processes for disabled children who are (or are likely to be) subject to care under the Children, Young Persons and Their Families Act 1989 to establish whether they are being treated equitably and fairly, and in their best interests and, if not, to provide advice on changes needed to legislation, operational policy, operational delivery and/or monitoring and enforcement. Lead: Ministry of Social Development.*

*b) Explore options to reduce violence, abuse (all types, including bullying) and neglect of disabled people and understand the impact of different cultural contexts. This work will include:*

- *building on previous work to educate disabled people about their rights*
- *ensuring the needs of disabled people are built into the Family Violence work programme*
- *scoping a new work programme for abuse by non-family members."* (NZDS, 2001; pg14)

### Domestic Legislation

Sexual violence often occurs alongside other forms of violence and abuse for people with disabilities, with varying degrees of legal protections provided by New Zealand legislation.

- **Crimes Amendment Act 2011 –** The Crimes Amendment Act came into effect in March 2012. It instigates a new regime of criminal liability for persons caring for and working with some adults (defined in the Crimes Act as 'Vulnerable Adults') who because of their circumstances and situation are not able to remove themselves from a risk of serious harm.

  There is no statutory body or systems approach to support individuals and organisations with understanding their roles and responsibilities to safeguard those adults identified under the Act. In contrast, the White Paper for Vulnerable Children sets out how everyone can play their part to keep children safe from harm.

- **Domestic Violence Act 1995** – The Domestic Violence Act sets out procedures to protect people from abusers. Police powers and the tools available under the Act do not protect all victims of violence and abuse as they can only be issued in the context of a domestic relationship. The definition of household in the Domestic Violence Act excludes the types of homes in which people with disabilities commonly live, due to the presence of paid carers. Under current legislation, these homes are defined as workplaces and the relationship between the carer and the person with a disability is not regarded as a domestic relationship. Definitions under Section 4 of the Domestic Violence Act do not include all relevant perpetrators, for example: paid care workers and staff.

  In addition, the Domestic Violence Act does not cover all forms of abuse experienced by 'vulnerable' adults, for example: neglect, poor care and discriminatory abuse. Currently police are not enforcing this legislation in a way that encompasses all situations of a 'domestic' nature.

- **Protection of Personal Property and Rights Act 1998** – When looking at legislation to protect those most vulnerable to abuse and neglect the Protection of Personal Property and Rights Act 1988 (PPPR Act) provides personal and property protection for individuals who for various reasons are not capable of looking after their own affairs. There are concerns around the use of the Act and the lack of accountability to ensure safety and well-being of a protected person under the Act.

## LITERATURE REVIEW

### Prevalence

Exploring factors of disability in relation to sexual violence prevention and treatment services is an under-researched topic. While studies often acknowledge the association between sexual violence and disability is clear, comprehensive population level prevalence information is lacking, and detailed knowledge such as how often disability preceded or was a consequence of sexual violence cannot be quantified.

Studies often cited, such as Sobsey and Doe, (1991), are outdated or use small sample sizes, but show that disabled women are between 2 and 12 times more likely to be victims of violence and at least twice as likely to be raped and abused as non-disabled women. They estimated 90% of people with developmental disabilities are sexually assaulted with only 3% of these assaults reported. Sobsey and Doe, (1991), studied 162 reports of disabled victims. Eighty one point seven percent were female and of these, 49.6% were sexually abused more than ten times, 20.4% two to ten times and 11.7% once. Sobsey and Doe's research found that the perpetrator was identified in 95.6% of cases, yet only 22.2% were charged.

Similarly, Wilson and Brewer's (1992) Australian research also showed women with developmental disabilities are 10.7 times more likely to be assaulted sexually.

More recently and relevant, Kingi and Jordan (2009) noted that 31 percent of survivors in their New Zealand-based study self-identified as having a psychological or physical disability, often with co-morbid conditions.

A population sample study in the United States has calculated that women with disabilities are four times more likely to experience sexual assault than women without disabilities (Martin, Langley, & Millichamp, 2006). Another in Canada found that 83% of women with a disability will be sexually abused in their lifetime (Stimpson & Best, 1991, cited in Rajah, Frye, & Haviland, 2006), with caregivers often being the perpetrators.

Another study shows that women with disabilities experience abuse at similar or higher rates than those without disabilities (Plummer & Findlay, 2012). It was found that rates of physical abuse matched across the social groups, however a disabled woman was four times more likely to have an experience of sexual assault. In a study of 1,152 women interviewed at family practice clinics, women who reported experiencing some type of abuse (physical, sexual, and emotional) in their current relationships were more than twice as likely to report having a disability (Plummer & Findlay, 2012). Evidence also suggests that women with disabilities experience abuse for longer periods than the non-disabled. Increased dependency from an emotional, physical and emotional point of view increases the risk of abuse. Risks of learned helplessness are high, as are difficulties with identifying disability-related abuse. It has been argued that women with disabilities are exposed to a higher proportion of potential perpetrators of violence than their non-disabled peers. Examples given include intimate partners, family members, and health care providers. Most commonly abuse was perpetrated by husbands, live-in partners and men. A link has been found in research between dependence on medical care and the prevalence of abuse. It has been recognized that women with disabilities often do not recognize abuse owing to its insidious nature. It has been noted that disabled people lack knowledge surrounding victimisation and are generally fearful of where they might live in the event that they report abuse.

Unique aspects of sexual violence for Deaf communities and targeted responsiveness for Deaf people are explored in Obinna (2005) and Smith & Hope (2015).

### Person-Centred Practice

Raffensberger (2009) argues that the disability sector remains the expert on how to address the needs of clients with intellectual disability, particularly seeing as there is a lack of outcomes-based research for this client group. Unfortunately, low cognitive ability remains the focus of what little outcomes-based research is available. The personal assets of disabled people remain unknown in mainstream service contexts. It has been noted that many people living with disability are accustomed to having their health needs unmet and consider this a norm. This suggests that disabled clients are less likely to make themselves known to mainstream service providers and that it is the responsibility of the disabled community to ensure that knowledge regarding possible service provision is available.

This potential shifting of responsibilities onto vulnerable groups and victims/survivors, to keep themselves safe is regarded as having dangerous consequences. The Fifth Report of the Family Violence Death Review Committee (2014) emphasises the need to stop asking victims to keep themselves safe from abusers, that practitioners need to proactively make sure victims are safe, and to provide long-term assistance rather than one-off safety advice, and in doing so, must recognise violence as being not just physical, but also carried out through control, coercion, and intimidation - behaviours often deployed against disabled victims.

Probst et al. (2011) discuss the importance of using patients' sexual victimisation histories in choosing treatment models. However, it is identified that owing primarily to denial and dissociation patients/clients are less likely to be forthcoming about their experiences of sexual abuse. It has been identified that in order for screening to be effective, it needs to be ongoing, women need to be spoken to confidentially without carers present, the screener needs to stop regularly to clarify questions and explain concepts and to get a response to how the client/patient is feeling about the assessment. It has been identified that at present there is no screening tailored for men with disabilities. Literature identifies how dependence can significantly alter a survivor's perceptions in how to best respond to sexual assault, particularly in terms of feeling unable to escape their perpetrator or feeling they must appease them. This problem is relevant across the disability community, not just those identifying as living with intellectual disability.

According to McEachern (2012) using behavioural techniques such as role-playing, rehearsal, and reinforcement are recommended. Training also must be provided to facility staff and caregivers with a focus on detecting victim signs of sexual abuse, helping clients stay safe, communication skills, advocacy, and support. Clinicians need to be aware that any intervention needs to focus on the context of the disabled person i.e. disability awareness akin to cultural sensitivity. A team approach is strongly recommended in the medical context. Awareness of warning signs and mandated reporting practices are vital. Sexuality education arises here as important for those with disabilities.

### Criminal Justice Processes

Howe, (2000), looked at a study done by the National Police Research Unit and Flinders University in Australia. They found women with an intellectual disability were 10 times more likely to be sexually assaulted. Howe points out the widespread community acceptance of abuse towards disabled women. Her literature review of violence towards disabled women found the common thread of

those responsible for support and protection; failing to believe the victim; protect against the violence continuing in the future; or report the perpetrator to the police.

Triggs et al., (2009) examined factors and outcomes of sexual violence cases in the New Zealand criminal justice system, and noted 15 percent of survivors had a psychiatric, intellectual, physical, or other disability, as determined by a doctor. Almost a third of those who had made previous allegations of sexual violence had a psychiatric or intellectual disability. The most commonly recorded offences were less likely to result in convictions – that is, those involving acquaintances and intimate partners. Cases involving victim/survivors in vulnerable population groups such as those with intellectual disabilities were more likely to be classified as 'false complaints'. The cases involving people who are most likely to be victimised are least likely to proceed through the criminal justice process and to result in a conviction.

### Barriers to Reporting and Accessing Services

Murray & Powell (2008), suggest the challenges to reporting can be significant, such as the word 'rape' being excluded from communication devices, carers may control access to telephones, organisations may have a lack of policies and procedures for responding to sexual violence, or have policies and procedures which take decision-making out of the survivor's hands, organisations may consider sexual assault as an 'incident' rather than a crime, the organisation may move or restrict the survivor rather than responding to the perpetrator, or the survivor might be dependent on the perpetrator.

For some women with an intellectual disability, recognising what has happened to them as an assault may be difficult. Women with psychiatric disabilities may face particular problems. They may fear being disbelieved and/or being institutionalised if they report a sexual assault. Mobility problems or deafness may hinder some women's ability to get help, both at the time of the assault or later (Rajah, Frye, & Haviland, 2006).

In 2007 the Ministry of Women's Affairs consulted with disabled women on effective interventions for adult victims of sexual violence, who raised these concerns:

- **Communication and attitudes –** Misunderstandings in society, creating an artificial divide between physical and mental disabilities, hindering communication and creating silos in responses to people with disabilities. Struggles with attitudes among the general public on an everyday basis, plus as victims of sexual violence, a disproportionate disadvantage at the point of disclosure, less likely to be believed and often perceived as asexual. 'Acting out' as a means of communication for those who feel they cannot be heard otherwise, although it may be misunderstood by carers, family and friends.

- **Access to services -** Disabled people understanding their rights, including the right to seek and receive help, and having few options in terms of where to seek help, due to location (e.g. living in rural areas) and/or due to a disability. A lack of service options due to inadequate funding and/or attitudes of sexual assault services regarding accessible services as an additional burden. Ideally services are not only accessible but also

- welcoming. Lack of training on sexual violence within disability services, leading to instances where sexual violence is known to occur, and a lack of action allows it to continue. Staff members protect each other rather than their clients. Disabled people often feel undermined as witnesses when engaging with the criminal justice system. Support is needed to help victims make complaints and to support them throughout the process.

- **Gatekeepers and dependence –** more vulnerable to abuse from those who also act as gatekeepers (family, friends and support workers), and so as a consequence, some people live in unsafe conditions everyday but cannot seek help, e.g., potential to be punished by caregivers if they do not comply with demands or rules. They may stay in violent relationships because they do not have anywhere else to go, or are unable to access services on their own. It can be difficult to engage families where victims of sexual violence are isolated from helping services. In some instances, speaking out about sexually violent staff or carers can present a different type of risk, as the service might be the only one available.

McEachern (2012) highlights how disabled people are less likely to disclose abuse than non-disabled people, not only because of the emotional consequences but also a literal inability to disclose. It has been suggested that the statistics surrounding rates of sexual abuse of disabled people reflect a lack of reporting, or at least some degree of underreporting making it more difficult to capture the scope of the issue. Disability status needs to be added as a variable to child abuse registries so that more data is available on the incidence of child abuse/sexual assault. Introducing preventative programs in areas that house disabled people is crucial, as it appears disabled people are more likely than non-disabled people to go extended lengths of time with no treatment.

McEachern (2012) argues that there is little research into how effective sexual abuse prevention programmes really are, and that they generally focus on acquired knowledge rather than skills. Teaching successful protective behaviours included the following: (a) increasing knowledge by providing information and instructions on ways to cope with sexual lures, (b) modelling and rehearsing verbal and behavioural responses to use with perpetrators, and (c) testing out skills learned through in vivo assessments. Best practice is also maintained if children are taught these skills in early childhood so that later they only need to be maintained rather than re-taught. Disclosure is enabled in instances where people feel they are protected by another trusted adult. The challenge is that it is sometimes, or is often suggested, that those with intellectual disabilities do not make credible reporters because they lack sexual knowledge and may not even be able to discern whether sexual abuse has occurred.

### Children with Disabilities

Historically, research into abuse pays little attention to the perspectives of children and young people with disability or to factors that promote their personal safety. Robinson (2016) explored what helps children and young people with disability and high support needs to feel and be safe in Australian institutional settings. She states that it can be hard for children to know what is safe or unsafe, where there is complexity in relationships and that families and professionals tend to

regard young people's understanding of safety as limited. While some children and young people with high support needs are unable to protect themselves against harm, many others have or can develop basic self-protection skills but find it very difficult to identify or understand more systemic risks or to avoid or respond to more insidious abuse.

Wyber (2012) explored risk factors in the abuse and maltreatment of children with disabilities in New Zealand. The study looks at Child, Youth and Family practices to support children with disabilities. Wyber states that Ministry of Social Development statistical reports do not distinguish between disabled and non-disabled children, meaning children with disabilities remain invisible even when placed on child protection registers. Support to reduce parental stress and form secure attachment can reduce the risk of child abuse and maltreatment.

### Institutional Abuse

Chenoweth, (1993), looked at violence against disabled people living in residential/institutionalised homes. Chenoweth found a critical characteristic of the sexual abuse of disabled people was the number of perpetrators hired as caregivers, personal care attendants, residential care staff, psychiatrists etc. Chenoweth saw in one study of residential settings that direct care staff were responsible for 85% of the abuse of residents. When abuse was reported to management, it rarely went to the police, leaving the abuser free to continue the abuse, knowing they will not be reported.

Another study (Oktay and Tompkins, 2004) examined rates of abuse by personal assistance providers in a group of 84 disabled people who received some sort of care from personal assistance providers. The majority of the participants were men (n = 60), who comprised 71% of the sample and 24 women (29% of the sample). The participants were questioned regarding maltreatment from their primary personal assistance providers and other personal assistance providers. Thirty percent of the sample indicated that they had suffered abuse at the hands of their primary personal assistance provider and 61% disclosed some form of abuse at the hands of other personal assistance providers.

### Re-victimisation

No single factor leads to re-victimisation, but co-occurring risk factors can work together to increase vulnerability. One such consideration is potential for abuse in institutional care contexts, where perpetrators may actively target women perceived as vulnerable, perhaps because they have a disability, experience mental illness, or are in an aged care setting regardless of their age.

Perpetrators of sexual abuse may be especially keen to exploit women with cognitive disabilities because abusers perceive these women as those that will not tell or will not be believed. Cognitive disabilities (e.g., limited learning behaviour, limited social skills) can interfere with procedures of investigation and criminal prosecution. Perpetrators frequently select their victims for their perceived powerlessness and vulnerability – and for their seeming limitations. (Elman, 2005).

Women in these situations often have a high degree of contact with paid service providers, from doctors and psychiatrists to orderlies and volunteers, on whom they rely for physical care, emotional support and companionship. There is evidence that some perpetrators target sites that give them access to vulnerable women. As a result of the silence, disbelief and lack of awareness that often

surround these survivors, particularly in institutional settings, they have an increased risk of exposure to potential abusers and to ongoing and repeated sexual violation, but a decreased ability to avoid repeated violation (Elman, 2005).

Initiatives to address re-victimisation must, therefore, consider perpetrators' behaviours and strategies, and acknowledge that some will be chronic offenders (Hanmer et al., 1999), with well-established ways of legitimising, justifying and hiding their offending.

Professionals have also noted that re-victimised women's fears and trauma symptoms can be triggered by the presence of male workers who are not abusive.

### Involuntary Sterilisation as Sexual Violence

Intellectually disabled people, where they are considered to lack competence, do not have the same legal rights and/or protection against involuntary medical procedures as people without this form of disability. Under New Zealand law intellectually disabled people may be sterilised without their consent. The legal basis for involuntary sterilisation 'if at risk of pregnancy from sexual assault' is often used as grounds without further addressing the human rights or need for consent of the disabled adult or child. The courts rely heavily on medical expert evidence in their determinations and it appears that generally the medical model of disability is still predominantly followed.

### Commitment and Capacity of Crisis Support Services

New Zealand research is limited by the lack of data collected by police and social service providers, amongst others. This is a serious problem because service delivery is commonly based on the results of research.

A survey (Hager, 2007) of 39 refuges affiliated to the National Collective of Independent Refuges investigated the number of women with mental illness and drug and alcohol problems that the refuges had had contact with over a six-month period in 2006. This was anecdotal information, as few records are kept of mental health status, especially for women unable to access refuge because of pre-admittance processes.

During this six-month period, 347 women were accepted into refuges that were identified as having mental health or drug and alcohol problems. The women brought 447 dependant children with them. Seventy-nine of these 347 women were moved out of refuge because the refuge staff felt either that they were a threat to the other women and children in the refuge, or that they – the refuge staff – didn't have the expertise and skills to work appropriately with them. This affected 81 children. A further 178 women are known to have been denied access to refuge because of mental health and/or substance abuse problems. This figure is an under-estimate as most refuges do their screening via phone and don't keep any records of how many women are screened out. It is not known how many children were affected by this.

Outcomes for women asked to leave or denied access to refuge include: going back to the abuser, short term solutions such as moving into caravan parks or with friends and family, living on the streets or going into psychiatric wards or substance abuse services – which means placing children with the abuser or others.

Two hundred and fifty-seven women with mental illness and drug and alcohol problems, many with children, were denied refuge over a six-month period. This indicates an acute need for constructive responses to meet these women's complex needs.

An environmental scan of NZ sexual violence agencies (Mossman et al., 2009b) found that almost half of the service providers said they had limitations in meeting the needs of survivors with disabilities (47 percent of agencies rated their service delivery as average or less). These survivors face a range of barriers to accessing mainstream services. Some of the areas identified include a lack of wheelchair access to buildings, information in Braille, access to sign language interpreters, and professional development for sexual violence staff who work with people with intellectual disabilities.

Brouner (2004), states that *"The public policies and service models we design to address sexual assault and disability are only as strong as the values and attitudes that inform them"*. She believes workers in this field need to examine their thinking about sexual assault and about disability. They need to, *"…turn toward (their) fear and resistance about questioning or adapting the service to better accommodate people with disabilities."*

### Disability Statistics and Data Collection

Bartlett and Mears (2011) highlighted that systematic collection and analysis of disability related service-based data can vastly increase understanding of sexual violence. They surmise that it is extremely challenging to devise a single, multi-use data collection solution with multiple collection and entry point capability. The data system must maintain reliability and objectivity and adopt standardised definitions and classification standards. It must be robust enough and secure enough to protect personal information and adhere to legal standards of privacy and data collection. They state that services should collect data in a way that makes it possible to disaggregate for comparison with data collected in other services and between geographic regions. Databases developed primarily for case management, law enforcement and crime prevention purposes are rarely suitable for, or used for, the purposes of monitoring, policy development, public awareness, research or calculating the wider impact and cost of sexual violence. Publishing and disseminating evidence-based data is important to achieving lasting positive societal change.

### Sexuality Education

Benedet & Grant (2012-2013) have identified how processes exclude intellectually disabled women from having their stories heard in court. Owing to the legal processes of confronting and accusatory approaches, it is likely that a disabled survivor who goes through the criminal justice system will see unjustified acquittals or prosecutors deciding not to pursue a case. Issues surrounding process, recall and communicating information have been identified. It is vital that those with disabilities receive the same sex equality in terms of their education if they are to have the possibility of identifying what is safe and unsafe sexual conduct towards them. Victim support needs to take into account the needs of disabled citizens, both intellectual and otherwise. Those with intellectual disabilities have a right to have questions clarified for them so that they can meaningfully participate in the justice system. Doing so assists in identifying the truth within legal process, and allows people identified as disabled to maintain authority in their own recovery. Best practice has been identified

recommending that judges should also be given explicit legislative authority to intervene to disallow questions that do not respect the survivor's/witnesses' abilities, thereby arguably upholding the fair trial rights of both parties.

Access to sex education needs to be accepted as part of good support services for survivors. Swango-Wilson (2009) identifies that those with intellectual disabilities may lack the experience to define their sexual boundaries, and that this problem leaves this group particularly open to sexual abuse. Vulnerability in this area has commonly been denied by society at large. Society holds to the myth that disabled people hold no interest in their own sexuality or the sexuality of others. This makes inaction in this area easier to justify. Women with intellectual disability commonly do not recognise abuse, and in the event that they do, they are generally discouraged from reporting. Sexual abuse significantly alters a survivor's pattern in terms of sexual relations later in life. They are more likely to be passive and make poor relational decisions.

Lofgren-Martinson (2012) has identified that even in instances where sex education is compulsory, the presence of special education programs often hinders access to these programs. Concern regarding unwanted pregnancies, sexual abuse and other sexual risk situations make personnel uncertain about how to best approach the subject. It is difficult to determine who must get their needs met over others, and whose interests are being served. Stereotyped gender norms where girls are orientated towards love and relationships, and boys are orientated towards sexuality make it more difficult for young people with intellectual disability to find a suitable way to act. Sexual risk remains a focus in what little sex education is available to disabled people.

Lofgren-Martinson (2012) develops the argument that student access to information about their own bodies, sexuality and relationships still appears deficient in high school education programs targeted to disabled people. It has been acknowledged that the aim of providing a quality curriculum in sex education is difficult to attain for disabled people, particularly as the curriculum is not written with their needs in mind. It is also difficult to identify in special education contexts those responsible for conveying knowledge regarding sex and sexuality, while still appeasing the expectations of interest groups such as parents. It has been identified that staff commonly lack training in how to address the gap of knowledge in terms of sexuality for those identified as disabled. Lofgren-Martinson (2012) identifies that this means that collectively young people with intellectual disability do not have the same access rights to sex education as their non disabled peers. The same lesson can be drawn when considering the circumstances of those experiencing physical impairment.

Gougeon (2009) argues that best practice in terms of sexuality education for the disabled takes into account the ignored curriculum. The ignored curriculum is defined as the curriculum learned incidentally outside the classroom through peer interaction. Gougeon (2009) argues that substandard sex education promotes sexual incompetence, which results in social exclusion, legal implications and ultimately denial of citizenship in the community. It is assumed that exclusion is an asset for safety, whereas having more knowledge would make it possible for those with disabilities to credibly identify what is safe and unsafe sexual conduct. This would make it possible for them to be believed in the event of disclosure. Best practice from a critical pedagogy perspective shows the ethics behind language used and its potential influence on behaviour; takes into account lived

experience; promotes interdisciplinary knowledge; and is inclusive. Best practice is argued as being systemic, concrete and peer-taught. While it might not always be possible for those with intellectual disabilities to teach their peers, it is possible for a similar age peer to be involved in instruction. Achieving a balanced programme relies on input from policy-makers, healthcare professionals, administrators, students, teachers and parents.

Gougeon (2009) has identified the need to be proactive rather than reactive in sex education, especially for those with disabilities. To be clear, this means giving access to a comprehensive sex education before students become sexually active. A proactive sex education enables self-advocacy, decreases risk of sexually transmitted disease, and encourages appropriate socio-sexual behaviours. The risks in special education with a proactive sex education is that at present practices can be indirect, vague and euphemistic (referring to birds and the bees). The risk is also that information is presented in an overly technical manner. Best practice is identified as referring to pleasure, emotions and the relational perspective. Best practice, it is suggested, needs sexuality to be taught across subject areas in different modalities so that it is not simplified to a unit of a health class within the physical education curriculum. Arguably, this is particularly important in the special education context as it is increasingly likely that disabled people miss out on content delivery if it is exclusive to one subject area which may not be considered relevant to their citizenship.

## METHODOLOGY

This project has endeavoured to uphold a commitment to inclusion of and partnership with people with lived experience of disability at every stage in the process. At the project's inception, an Advisory Group was established to oversee the development of the research and completion of updated good practice guidelines. The Advisory Group included suitable representatives of the population groups and crisis services which are the focus of the project. Engagement and investigations within each population group were co-ordinated through the selection of appropriate project leaders and co-workers with relevant knowledge and skills related to the target population.

Disabled people have led and directly shaped the findings of this final report, in addition to contributing disability perspectives across other segments of the broader project. All prospective participants were given information on the background of this research (see Appendix One) and written informed consent was obtained from each participant (see Appendix Two). Interview questions were framed around the needs of the disabled survivors of mainstream crisis services for sexual abuse/assault (see Appendix Three). Interviews were digitally recorded and transcribed to assist with analysis and reporting.

Twelve participants were invited to contribute as key informants to share their particular expertise as:

- Disabled people as advocates or researchers (5);
- Representatives of Disability Support Services organisations (4);
- Representatives of violence support services (3).

All participants were female, six identified as disabled women. Participant's professional or personal experiences were representative of a cross section of mobility, visual, hearing and learning impairments, as well as chronic health conditions and so-called 'invisible' disabilities.

## RESULTS

Awareness about occurrence of, and support services for, sexual abuse/assault amongst disabled people mirrors the relatively low levels found in wider society. Some disabled people experiencing abuse may not: understand that what is happening to them is abuse (abuse is normalised); have the ability to report the abuse; know who they can tell about the abuse; know how to tell someone about the abuse; feel confident to tell someone about the abuse because they are fearful of repercussions, or may not want to get the abuser in trouble.

*"Often the information on how to access those services is hidden. And it's a shameful kind of concept in the community so often it's not widely discussed. So because of that you know Deaf people often don't know the extent of sexual violence in their own community," (disabled advocate).*

One participant described the thinking and issues a disabled victim/survivor might go through: *"One issue is even recognising that what's happening to me is not okay. The second thing is if I've realised that what's happening is not okay then I have very limited options of what to do next, who to contact. I have probably limited people in my life who I might trust enough to even ask is this okay or is it not? So I'm probably quite isolated, don't know who to talk to or get information or get support from. Following that is to decide if I want to do something about it or not. And then I start wondering well what can I do? Do I just have to live with this? The planning then is quite complex behind the scenes without putting me in another dangerous situation. If the perpetrator is somebody providing support to me in some way and it most likely is, that creates an added complexity that not many services would understand. Then you get to the very practical stuff around can I use the phone [to get help]? Does my text get responded to? Can I get to the door to let somebody in? When people recognise I'm disabled, do they respond respectfully and appropriately to me? Do they believe me? Do they consider what I'm saying is abusive or do they think I'm acting out; do they take the time to communicate with me in appropriate format? Do they bring in an interpreter to me if I'm deaf and need to explain using an interpreter? So you know just huge number of issues around information and how I'm treated in that very first contact" (disability advocate).*

Participants highlighted that barriers to participation and experiences of exclusion in society can compound vulnerability for disabled people.

*"Because I am devalued in the community and not seen as having value I probably don't value myself and so, I don't recognise that what's happening is a crisis and needs to be stopped right now" (disability advocate).*

*"[limited opportunities mean] disabled people generally exchange one oppressive situation for another" (disability advocate).*

Participants believed there was a general unfamiliarity with disability on the part of crisis services.

*"They don't have policies about keeping people safe during um investigations. They, they don't understand what that means. I don't think there's a good understanding of what abuse means for disabled people. Sexual violence services are more aware of people with mental illness because they understand the mental health effects" (disability advocate).*

*"There's often comments that Deaf people feel additionally discriminated against or even oppressed because those services don't know how to work with them" (disability advocate).*

*"One survivor [with a learning impairment] that I spoke to is very upset because she was going to a child's room with children's toys when she quite clearly said 'I'm an adult'" (violence service manager).*

Participants reported that violence services were not in the habit of providing details on accessibility in their public information. Disabled people often encounter problems with a lack of transport, the high cost of transport, or services located away from public transport routes, on a regular basis, so this becomes a further barrier for emergencies such as escaping an abusive relationship.

*"You can't just rock up somewhere and expect that you're going to be able to park in the carpark and you may have to take your luck on the street. Well I mean other people don't have to ring up so why should we? It gets very annoying [but] the reality is we do" (disability advocate).*

*"Are there any indications that disabled people are welcome here? Is it somewhere I can park? Is the doorway wide enough? Is there a bathroom that is accessible? Is there a lowered desk that I can see over?" (disability advocate).*

A person who has reported the abuse may be at an increased risk of further abuse due to: not being taken seriously, being silenced, and/or the number of barriers or obstacles of accessing support and services.

*"Disabled People have considerably fewer paths to safety and this often means they are subjected to violence for significantly longer periods of time" (disability advocate).*

*"There are three Deaf or at least signing counsellors in New Zealand I think. I don't know what their experience would be or their specialist knowledge would be, whether they include sexual violence. But in general there's a real paucity of information about sexual violence in the Deaf community and there's certainly no dedicated professionals or programmes to teach Deaf people about it or what to do if it happens" (disability advocate).*

Disabled people face a number of additional challenges and barriers to reporting. It is easy to target disabled people when they are not believed when a report is made. Participants said that effective communication is critical and some disabled people are denied the language to understand and explain violence and abuse.

*"They might have a ramp and an accessible toilet but it doesn't mean that they have any staff that feel confident communicating with people who communicate in non traditional ways" (disability advocate).*

Participants noted that written English is a second language for Deaf users of NZSL, meaning written information distributed or made available online were not always useful for those with lower English literacy levels. Captioned video resources and solutions such as Video Remote Interpreting may be good alternatives, although a lack of trained interpreters brings additional safety and privacy concerns and constraints.

*"Having online video services is quite important; the issue that you've got there though is that the Deaf community is quite small. So you know Deaf people are always going to know the interpreter and vice versa. The team of video relay interpreters is very small, they don't bring in a selection of interpreters from the community, they're the same five or six" (disability advocate).*

Participants felt that services may have difficulty with the diversity of responses needed for different people, including extra challenges presented by some clients who might need the presence of interpreters or carers/assistants, and that this might be unsatisfactory for all parties involved.

*"What's accessible for somebody else is going to look totally different from what's accessible for me" (disability advocate).*

*"I know counsellors that will be very unhappy working with a third person in the room that they know nothing about" (disability advocate).*

*"if you're using a partner or a daughter or whatever as the person helping with, whether it's sign interpretation or whatever it is, then the person may be put in a position where they actually have to share more than they would want to with that family member" (violence service manager).*

*"It's much better to have services available that are signing that Deaf people can contact directly." (disability advocate).*

Participants highlighted that assumptions of 'normal' behaviours could negatively impact on the course of support provided.

*"I think talking to the individual person and asking them what they need and so you don't make assumptions about people. Like when people see me [in my wheelchair] in that they make the assumption I can't walk. Well, I can you know. Who knows for how much longer but I can at the moment so..." (disability advocate).*

*"Somebody turns up, maybe with speech impairment, and they sound like they're drunk, or they walk like they're drunk, that's the way their disability, their impairment affects them. Then how do people respond to that in terms of taking that person's complain seriously when they actually sound drunk?" (violence service manager).*

Counselling services are only one part of the system that victims attempt to access. Barriers exist in relation to services and facilities under direct Government control. Addressing the accessibility of police stations, courthouses, and hospital emergency rooms is critical in responding to how inaccessibility affects the total experience of a disabled victim.

*"The Disability Action Plan says we need to educate disabled people about what abuse is and what their rights are. But we actually need to educate [crisis] services what the abuse of disabled people is and people's rights so that they respond" (disability advocate).*

*"I think probably every service provider would have policy around people being safe. And yet, what actually happens when somebody says I don't feel safe? The experiences I've heard are that if people are believed, then the easiest option is, to do nothing. If you're a staff member and you are concerned well then you might just minimise it as a kind of a one off, or you know 'that was last week so we've moved on from there, somebody who's just having a bad day, it's not likely to happen again or we'll look at their kind of behaviour', but the fact that you now live in an environment where you have experienced abuse and you feel unsafe every day, might not actually be taken seriously" (disability service provider).*

Disabled people who receive disability services funding from ACC, do not want their information about sexual violence incidence and recovery also being handled by ACC as there is concern about a lack of confidentiality between ACC staff and providers.

Disabled people are concerned that if they were to have a DSM diagnosis prior to being sexually abused/assaulted, ACC may consider the mental harm caused by the sexual violence as a pre-existing problem.

*"Able-bodied culture operates from the belief system they need to 'help us' and 'do it for us'. We need social services that have counsellors, managers, social workers, doctors, and psychologists etc. that look like us and have our lived experience of disability" (disability advocate).*

Labelling an individual as a vulnerable adult can be stigmatising and can lead to unfounded assumptions that she or he lacks the ability to direct her or his own life. The 'label 'can be misunderstood, because it seems to locate the cause of abuse with the victim, rather than placing responsibility with the actions or omissions of others.

*"Professionals should keep in mind that the consideration that an adult is 'at risk' or 'vulnerable' should not be confused with a decision about his or her capacity" (disability advocate).*

Participants linked the lack of adequate funding with broader attitudes towards disability in society.

*"To me the lack of resources is indicative of how little value people put on [disabled people], how little value people put on the people who work in them" (disability advocate).*

While chronic under-resourcing of crisis services ensures accessibility and responsiveness is poorly or not addressed at all, historically any increases in funding have seen services broadly address unmet client demand or take up funding tagged for more politically-driven priorities.

*"The capacity at the moment is dependent on individuals and their personal skills" (disability advocate).*

Participants recognised gaps in knowledge and systems within disability service organisations.

*"Something that would be helpful would be [training for] what are the triggers for our staff to look out for to recognise whether there's been abuse or neglect" (disability service provider).*

*"Confidentiality, it would be helpful to explore information sharing, not to be a barrier to being able to support people, but still being mindful for the need for appropriate information sharing" (disability service provider).*

Participants said that there are no standard procedures to follow for disabled people needing emergency accommodation.

*"We can apply for approval from the Ministry of Health for a motel bed for example which has happened on occasion but it's not a service as such, it's an exception process and unfortunately these crisis situations are becoming more and more frequent" (disability service provider).*

Recognising the prominence of feminist thinking in the establishment or at the foundations of many crisis services, this may subconsciously influence how services operate or respond to disabled women. For example, there may be tensions unwittingly present, given the dissonance between feminist ideals of abortion on demand, especially as originally advocated for on the grounds of a 'handicapped child', with a disabled person's inalienable right to life. While the ability to terminate an unwanted pregnancy is an important part of women's ability to take control over their lives, for most non-disabled women, the discovery that a foetus has a physical or learning disability may, in itself, transform a wanted pregnancy into an unwanted one.

In addition, disabled women's personal liberty and social dependency due to physical limitations and inaccessible built environments generally goes unchallenged, compared with concepts of male economic dependency.

Therefore, it is especially important to note the need to educate/re-enforce a deep understanding of and commitment to challenging assumptions about the quality of life of disabled people, examining the judgements of self and others, and to ensure government laws, policy holders, funders, service providers and their staff must not attribute to an individual, notions of greater 'emotional and financial burden' as a result of disability, in terms of quality of life, while also understanding the social and economic costs and dynamics of disability.

*"I think people are generally good hearted, and have good will and may well recognise their own discomfort and want to do the best they can. But, may well look to support people to answer questions rather than the person themselves or family member, or just struggle to get over a barrier within themselves and their own lack of knowledge and experience" (disability advocate).*

Participants commented on the capacity of services to offer sustainable responses for disabled people experiencing sexual violence.

*"At the moment we just cobble together the best response we can for each individual with the time and resources available" (violence service manager).*

*"Disability is part of our risk assessment and is highly likely to trigger our more comprehensive response. Frequently there are simply not appropriate services available to refer on to, and we can only provide for the safety needs, when often the person is facing a whole range of other needs that we have no capacity or skill to address. Safe house accommodation is very rarely available for people with severe physical disabilities" (violence service manager).*

*"[Our service has] lots of gaps. We use interpreters and Relay and emails/texts a lot to communicate. We tried to get material converted to easy-read but there is no resourcing available" (violence service manager).*

*'It needs to be a multi-agency response where everybody understands their roles and responsibilities as an individual for their agency and within that multi-agency response" (violence service manager).*

## RECOMMENDATIONS

### Recommendations for Sexual Violence Crisis Support Services

Ideally survivors would be able to choose and access a range of high quality services that best meet their needs. It is unrealistic to expect that all survivors will be aware of, or need to access, specialist sexual violence services. General health and disability services have a role to play in screening for sexual violence as an underlying factor for presentation, and referring survivors to appropriate support. Mainstream crisis services should have some specialist staff capacity which would enable them to support survivors until further specialist services could be arranged if required. Ideally mainstream agencies would find ways to ensure that they offered effective services for disabled survivors.

**Provide accessible support** - Services should assess their operations to see to what degree they still have barriers for disabled people and find ways to promote accessible and successful support. Facilities need to be physically accessible, as well as providing communication for Deaf people and those with cognitive impairments. Services need to be flexible and knowledgeable about ways to meet the different needs of disabled people. Furthermore, support services have to address access for Deaf people especially and ensure the presence of Deaf staff and volunteers, as well as members who can sign. Crisis services need to approach accessibility enhancement as a process, not a one-time task.

Ensure support is always on the terms of the disabled person and not organised based on the views and experiences of the non-disabled counsellors or professionals. Therapists must not confirm/re-enforce beliefs of helplessness, the individual always in need of being looked after by others - the perpetual passive recipients of care. Avoid negative frames of 'vulnerable adults' instead recognising vulnerability as a dynamic equation of protective factors minus risk factors.

Promote integrated systems for safeguarding of adults across crisis services, health, justice sectors, developed through training and service models co-designed and co-delivered by disabled people.

**Address attitudinal barriers and provide training** - to reduce lack of awareness and knowledge among non-disabled counsellors currently providing support. The training should address the specific situation of disabled people, the different manifestations of violence perpetrated against them and social model understanding of disability.

**Employ disabled women** - Support services should emphasise the participation of disabled women in leadership and management and ensure that they are involved in decision-making. This is an important way of ensuring that support to disabled people, especially women, is grounded in their experiences.

**Actively raise awareness of violence against disabled people** - Support services and women's organisations should acknowledge oppressive processes or social structures that work against disabled people. They should publicly take a stance with disabled women and take part in awareness-raising about violence against them. Support services and women's organisations should participate in awareness-raising and projects that increase awareness among general public and specific professional groups and that address violence and stereotypes.

**Adopt Performance Indicators -** The USA Vera Institute of Justice's Centre on Victimization and Safety has developed a 'Measuring Capacity to Serve Survivors with Disabilities' tool to support organisations that sexual violence to track their progress in serving survivors who have disabilities.

The set of performance Indicators can be used by organisations at all stages of addressing how effectively they are serving survivors with disabilities. The guides provide step-by-step information on implementation, with separate implementation and scoring tools for: disability organisations, domestic violence programmes, rape crisis centres, and programmes that address domestic and sexual violence.

The indicators in the guide are organised into two primary areas: commitment and capacity. Commitment is demonstrating willingness and determination to address domestic violence against people with disabilities and Deaf people. Capacity is having the knowledge, skills and resources to do so.

Adopting measurement tools can lead to the recognition of best practices and identify areas for improvement. It can also demonstrate effectiveness through statistics, as well as provide valuable information for funding opportunities to address violence against people with disabilities.

### Recommendations for Disability Support Services

**Recognise risk and engage in violence prevention** – It is important that disability service providers recognise that disabled women and men are at greater risk, especially of sexual violence, abuse and neglect and that they find ways to address that in the organisation of their services. Disability service providers should develop protocols for the identification of situations of violence and address risk factors in their services. They should furthermore make reforms aimed at eliminating discrimination against service users and promote their independent living and self-determination.

**Improve access to information** – about accessible support to disabled people, through outreach projects in collaboration with disabled survivors, specialist services, and DPOs. They should distribute information in multiple formats about violence and provide details of accessible support for those who have experienced violence.

**Promote awareness-raising** - disability services should emphasise awareness-raising about the rights of disabled people, discrimination and violence against them. They should participate in projects that increase awareness among general public as well as among specific professional groups who work with disabled women and men.

**Endorse independent living** - disability service providers should promote the empowerment of disabled people, especially women, and discontinue institutions and service arrangements that cultivate and sustain power imbalances between service users and service providers. Disability services should promote, fund and execute projects that involve independent living and empowerment strategies such as workshops for disabled people.

**Promote knowledge among staff** - disability service providers should promote an attitudinal change within their services and ensure staff are sensitive to violence against disabled people. This should be done by providing training about violence against disabled people and accessible support options available, for all staff. It is imperative that staff receive training about the rights of disabled people, the social model of disability and the UNCRPD.

**Collaboration** - to enhance access, work with coalitions of victim services advocates and disability advocates to educate and promote reforms in policy and law.

### Recommendations for Disabled Persons Organisations (DPOs)

**Participate in efforts to eliminate violence** - It is important that DPOs recognise and advocate for the rights of people with disabilities to live a life free from exploitation, violence and abuse, as articulated in Article 16 of the UNCRPD. DPOs could advance the position that services must become fully accessible as a pre-requisite for government funding.

**Collaborate with organisations that provide support to disabled people that have experienced violence** - DPOs should actively collaborate with crisis support services and other organisations that support disabled people who have experienced violence. For example, providing disability equality training or help organisations to identify and address accessibility issues. A united effort would also make for a more coordinated lobbying for implementation and funding.

**Promote information about accessible services for survivors of violence** - DPOs have an important role in providing information and directing disabled people to accessible support services.

**Advocate for inclusive and accessible sexuality education and primary prevention approaches in society** – As part of DPOs efforts to uphold and promote disabled people's sexual and reproductive rights, education and prevention efforts need to pay particular attention to women with disabilities.

### Other Recommendations

Crisis services, disabled people and DPOs, and disability service providers should collaborate, to:

**Evolve legislative settings and government policies in alignment the UNCRPD** – Enhance protections under the Domestic Violence Act, and Crimes Act 'Vulnerable Adults' regimes. Advocate for legislation prohibiting the use of sterilisation on boys and girls with disabilities, and on adults with disabilities, in the absence of their prior, fully informed and free consent.

**Encourage and facilitate on-going disability and violence related research** - Areas for future research and exploration could include:

- Disability awareness and responsiveness in, and co-design with disabled people of, mainstream crisis support services for perpetrators with disabilities, noting the complexities of blurred boundaries between victim and perpetrator when irregular power dynamics are present in relationships, particularly in relation to people with psycho-social or intellectual disabilities.
- How non-specialist 'frontline' services in the health and disability sector should and have responded to disclosures of sexual assault/abuse e.g., Needs Assessment & Service Co-ordination agencies, Disability Information & Advice Services, as well as Disability Support Services organisations contracted to provide Home Based Support Services.

## GOOD PRACTICE GUIDELINES

People with disabilities who experience sexual violence have the same needs as other women and men. In addition, they may have specific needs that are related to their disabilities.

### Of critical importance is…

- Knowing that they can contact crisis support services and get help.
- Knowing that policies and practices of those organisations won't impede gaining access to support.
- Having access in appropriate ways to all necessary information while using services, and to help them make informed decisions on appropriate referral options.
- Having safe, accessible routes into and within service facilities.
- Having appropriately trained staff who understand and can meet their needs.

The following guidelines summarise what is most important to ensure that people with disabilities can access in crisis support services.

### Services should understand the strategic, philosophical, legal contexts of providing accessible support for disabled people

Services need to be familiar with the UNCRPD, the dynamics of social model, medical model, and rights-based approaches to disability. Services must recognise the links between government actions in health and disability services, sexual violence services, and meeting the needs of disabled victims/survivors on an equal basis with others. Services should be orientated to implement actions around concepts of universal design, reasonable accommodation and supported decision-making.

### Services should be prepared and willing to support disabled people in practice

Services need to define people with disabilities as a target group and organise their services in order to reflect that. Services should assess their operations to identify any barriers for disabled people and find ways to promote accessible and effective support. Services must be willing to undertake any necessary changes to provide accessible and effective support to disabled people. Services should be designed and operated in ways that ensure they are accessible for people with disabilities. Services need to approach accessibility enhancement as a process, not a one-time task.

### Service information should be accessible to disabled people

Services need to make information about their services readily available in appropriate formats and promote themselves directly to people with disabilities. Services must ensure disabled people can obtain information about services' accessibility features and know if facilities are appropriate to their needs.

Services should distribute information to areas where it is likely to reach people with disabilities (such as appropriate disability services and other locations) to support informed choice. Telephone contacts or referral pathway information is especially important for services which maintain a confidential address for security reasons.

For example:

- Provision of information in plain language, Braille, large print and accessible electronic formats, captioned/audio-described video clips, information in NZ Sign Language.
- Provision of information on accessible websites or via social media platforms (and at the next time of upgrading a website, ensuring that the new design conforms to international web content accessibility guidelines).
- Use of international symbols for wheelchair access etc. to indicate the accessibility of facilities.

### The physical environments where crisis support is offered should be appropriate and accessible for people with disabilities

There can be an assumption that 'physical access' relates only to people using wheelchairs, whereas services should provide access for all disabilities – physical, mobility, visual, hearing, or cognitive. Travel routes to services and building entrances should be safe and accessible.

Services should be laid out to allow people with disabilities to be as independent as possible in all common areas. Accommodation services must also ensure accessibility modifications extend to bathrooms, kitchens and laundries, outdoor areas, and any other standard components of the service used by all clients.

Services must ensure equal access to emergency equipment and notifications of emergencies, and that evacuation plans are inclusive of people with disabilities.

For example:

- Mobility Parking spaces, proximity to public transport routes, good clear signage, Braille markings on doors, audio announcements in lifts.
- Ramps and step-free entry/exit and within internal spaces, high contrast markings on edges of steps, adequate lighting, grassed areas to toilet guide dogs.
- Bathrooms with non-slip surfaces, equipped with hand rails, easy to reach and turn/control taps.
- Doors easy to push open, wide doorways, door handles, telephones and light switches in easy reach.
- Hearing loops, visual fire alarms, telephones with adjustable volume and large keypads.

### Communication with disabled people should meet their different access needs

Effective communication can be a significant barrier to disabled people accessing services. Successful communication can only be achieved when adaptations are readily available and easily achieved. If disabled people are unable to tell their story, ask questions, and learn about services, they will not be able to benefit from valuable and needed support available.

Services need to be flexible and knowledgeable about ways to meet the different needs of disabled people. Services must become familiar with, and practiced in, how to share all necessary information in ways which are appropriate to their needs, and accessible to them. A particular focus is needed on access for Deaf people, and availability of crisis support service staff with at least basic understanding of NZ Sign Language.

Staff should provide supports grounded in the will and preferences of the disabled person and not organised solely based on the 'specialist' views and experiences of the non-disabled professionals.

For example:

- Working with NZ Sign Language Interpreters, the NZ Relay Service, client interaction primarily by email, SMS or telephone typewriter (TTY).
- Opportunities for staff to receive training on using communication boards and other assistive devices.

### Service policies and procedures should be inclusive of and appropriate for disabled people

Services need to recognise that disabled people are experts in their own lives and experiences and promote support service options that are valued by them. Simple screening and assessment procedures to enable early identification of a self-disclosed disability are the beginning of provision of tailored support.

Services must ensure policies and practices do not unfairly exclude or create delays in service provision, or make that service more difficult to obtain for disabled people. Services should adapt

more flexible policies where required, or create new policies to accommodate the needs of people with disabilities.

While staff may well adapt their approach as they work with a client, without inclusion of relevant instructions in formal procedures there is a risk that new or inexperienced staff may not be aware of what approaches have been agreed upon by the organisation. These policies should be integrated within existing documents so that they are not overlooked or allowed to become out of date.

To access a safe environment, people with disabilities who have experienced violence may lose access to personal support (either funded services, or practical support in real terms), so policies and procedures need to recognise that access often depends on availability of personal assistance if required.

For example:

- Service planning takes an individualised approach to assimilate with people's use of mobility aids or service animals, use of medication or portable medical equipment, need for information in alternate formats, or support of a professional carer.
- Providing reader/writer assistance to complete forms, providing services in more accessible locations, allowing for longer times in interviews.
- Discretion for people with cognitive or psychiatric disabilities who might not be able to understand or consistently conform to following service rules.

### Service staff should have adequate awareness and skills

Services need to address the general lack of disability awareness and/or attitudinal barriers or misunderstandings staff have about disability, and ensure staff have skills to adapt their support to the needs of people with disabilities.

Job descriptions and recruitment processes should include seeking disability awareness, knowledge and skills, or willingness to acquire it.

Staff training should address the specific situations of disabled people, the different manifestations of violence perpetrated against them, and social model and human rights understandings of disability.

For example:

- Services must not reinforce myths/beliefs of dependence, helplessness, disabled people as perpetual passive recipients of care, and avoid negative frames of 'vulnerability', instead recognising the complex interactions between protective factors and risk factors, in context for that particular disabled person.

### Partnerships should be developed with the disability sector

Services need to build trust with disabled people by networking through relevant organisations such as Disabled People's Organisations, and improving their service responses through collaboration

with disability support service agencies.

Services must invest in creating links between agencies for development and better co-ordination, and referrals, between supportive environments which meet the needs of people with disabilities.

Services should establish good networks to draw on the expertise and resources of disabled people, and to increase disabled people's awareness of violence and crisis services available.

These partnerships need to extend to all crisis services supporting all people who experience violence, e.g. sexual assault services, police, judicial systems, and health services.

Services (and particularly women's organisations) should acknowledge oppressive processes of social structures that work against disabled people, and participate in projects that increase awareness among the general public and specific professional groups.

Services should aim for all cross-sector training and integrated service models to be co-designed and co-delivered with disabled people.

### Disability data should be collected, and used to improve services

Services should keep statistics on the number of people with disabilities accessing their services, gain an understanding of how many disabled people live in the community the service covers, and collect feedback from disabled people about their experience of accessing services, and ideas for improvement.

Services should document any limitations and challenges faced by their service in their attempts to assist people with disabilities, and the strategies they have successfully utilised to overcome any challenges faced in providing a service to people with disabilities. All of this information should be used for service planning.

Services need to adopt performance indicators to track progress in serving people with disabilities, in terms of both commitment and capacity.

### Leadership and management practices should show a commitment to accessibility, and planning that meets the needs of disabled people

Services need to emphasise the participation of people with disabilities in the management of services to ensure that they are involved in decision-making regarding policies and practices. Services should have a strategy to employ disabled people in a variety of roles (not necessarily specific to directly serving disabled clients). This helps to ensure that support provided to disabled people, especially women, is grounded in their experiences.

People with disabilities should be represented in service consultations, and disability accessibility issues included in any submissions on government policy/legislation being prepared.

Service budgets and funding proposals need to be prepared so that appropriate plans and allocations can be made to incorporate disability accessibility issues, including costs for translation and updating of materials, providing interpreters, and/or provision of training and support for staff.

For example:

- Strategic and operational documents incorporating formal disability action plans.
- Disabled people with expertise as Board members, and/or as an external disability advisory group providing input into design, delivery, evaluation and improvement of services.
- Using networks within disability organisations to disseminate job advertisements and providing job advertisements, job descriptions, and contracts in accessible formats.

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APPENDIX ONE

# PARTICIPANT INFORMATION SHEET

## Working with People with Disabilities

## Good Practice Guidelines for Mainstream Crisis Support Services – Round 2

### Project Description

The purpose of this project is to update and extend existing 'Good Practice Guidelines', building upon the findings of an initial study conducted in 2009. The aim of the guidelines is to support good practice across the country to a range of population groups, including people with disabilities, and provide increased transparency and accountability with service partners, NZ Police and DSAC trained medical staff, with services funders and our communities.

### Project Team

The Working with People with Disabilities project is being conducted by Ezekiel Robson and Katherine Rees, with the support of Julie Wharewera-Mika (Lead Researcher, Good Practice Guidelines, TOAH-NNEST). The Good Practice Guidelines project has a team of over 15 other members who make up the project advisory team, which includes: Kathryn McPhillips (Principle Project Supervisor) and Andrea Black (Project Supervisor). They are supported by the research advisory group: Anjum Rahman (SHAMA), Melanie Calvesbert (Wellington HELP), Wendt Laird (SOS, Rape Crisis), Hariata Riwhi (Whangarei Rape Crisis), Louise Nicholas (Survivor Advocate, Rape Crisis), Dr Christine Foley (DSAC), Mike McCarthy (NZ Police), Hera Pierce (Nga Kaitiaki Mauri, TOAH-NNEST), Joy Te Wiata (Nga Kaitiaki Mauri, TOAH-NNEST), Ken Clearwater (Male Survivors of Sexual Abuse Trust), Ellie Lim (Women's Centre), Aych McCardley (Rainbow Youth), Ezekiel Robson (Disability sector), and Dayna Cooper (Youthline).

### Invitation

In order to update the previous 'Good Practice Guidelines' and identify specific guidelines for working with disabled survivors, we will be seeking feedback from disabled people, disability-related organisations and groups, mainstream services, and key stakeholders. For this purpose, given your expertise in this area we would like to invite you to participate in this project.

***Focus groups, interviews and questionnaires:*** We will be undertaking online surveys, one-to-one and group interviews to speak with invited people to discuss the needs of disabled survivors when accessing mainstream crisis support services.

- *Process:* Links to participate in online surveys will be emailed directly to invited people, with relevant closing dates advised. Interviews will be approximately 1-2 hours in duration, and will be taped by digital recorder to ensure all the in-depth korero is captured.
- *Rights of participants:* You are under no obligation to accept any invitation to participate. However should you choose to participate, you have the right to decline to answer any particular questions/s and withdraw at any time, without having to give a reason.

- *Confidentiality:* If you agree to take part you will be urged to keep the identities and matters discussed at any group interview confidential. Due to the nature of such a gathering, your identity cannot be kept anonymous, but you will be asked to keep the identities of other participants and the matters discussed confidential.
- *Expected outcome/benefits:* The outcome of participation will be to assist with the development of 'Good Practice Guidelines' for mainstream crisis support services provision for disabled victims/survivors of sexual violence.
- *Estimated project timeframe:* The surveys and interviews will be conducted in January 2016 with the final Working with People with Disabilities report completed in February 2016. Once all of the Good Practice Guidelines projects are completed, the findings will be collated (incorporating feedback and consultation) and documented in a report that will be disseminated to participating communities, services, government funders and policy departments, uploaded to the TOAH-NNEST website, and presented to the sector, in mid 2016. It is also hoped that a website will be established so ongoing feedback and consultation can be provided.

We appreciate your time and consideration in participating in this project. Should you have questions please do not hesitate to contact the research team.

Ezekiel Robson

Project Co-ordinator and Advisory Group Member

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Julie Wharewera-Mika

Good Practice Guidelines – Researcher – TOAH-NNEST

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APPENDIX TWO

# PARTICIPANT CONSENT FORM

## Working with People with Disabilities

## Good Practice Guidelines for Mainstream Crisis Support Services – Round 2

**Please tick the boxes to indicate your agreement:**

☐ I have read and understood the Participant Information Sheet.

☐ I agree to take part in this research project.

☐ I understand I can decline to answer any particular question/s during the online survey or interview and withdraw my consent at anytime, without having to give a reason.

☐ I give consent for my interview to be audio-taped and transcribed. (if applicable)

☐ I give consent for my comments to be included in the research report with the understanding that my identity will remain anonymous.

☐ I agree to keep the identities and matters discussed at any interview confidential.

I _____ *(full name)* hereby consent to take part in this study.

Signature: Date:

| |
|---|
| Full name of researcher gaining consent: Ezekiel Robson |
| Contact phone number for researcher: 021 897 257 |
| Project role: Project Co-ordinator and Advisory Group Member |
| Signature: |
| Date: |

A copy of this consent form should be kept by you and by the researchers.

**For further information**

Contact person: Julie Wharewera-Mika toahnnestresearch@gmail.com

Ezekiel Robson ezekiel@salubrious.org.nz

APPENDIX THREE

# INTERVIEW QUESTIONS

## Working with People with Disabilities

## Good Practice Guidelines for Mainstream Crisis Support Services – Round 2

- Please generally describe your organisation's work or interests in relation to people with disabilities and access to mainstream crisis support services for survivors of sexual abuse/assault. For example, an organisation led by disabled people, a provider of disability support services, an independent human rights advocacy organisation etc.
- Please comment on the importance of service information about crisis services being accessible to people with disabilities?
- Please comment on the importance of the physical environment being appropriate and accessible for people with disabilities?
- Please comment on the importance of interpersonal communications with people with disabilities to address their different access needs?
- Please comment on the importance of service policies, procedures and practices being inclusive of and appropriate for people with disabilities?
- Please comment on the importance of service workers having an awareness of issues of violence for people with disabilities, and the skills to work with people with disabilities?
- Please comment on the importance of partnerships between crisis services and disability services (as well as police, justice and health services) to improve access and service response provided?
- Please comment on the importance of usage data and client feedback being collected, on services used by people with disabilities?
- Please comment on the importance of leadership and management practices that show a commitment to access for people with disabilities, and ensuring that planning considers the needs of people with disabilities?
- Please comment on any other issues or recommendations that the good practice guidelines should consider/address

http://toahnnestgoodpractice.org/