Malatest International

Formative evaluation report:

Specialist Sexual Harm Services

May 2018 – updated July 2018

Acknowledgments

This formative evaluation of the Ministry of Social Development funded Specialist Sexual Harm Services (SSHS) was commissioned to understand how recent changes have affected SSHS and whether opportunities are available to strengthen them.

This report is based on in-depth interviews with many specialist sexual harm service providers, all of whom were incredibly busy but took time to meet with us.

We are grateful to all the providers who welcomed us into their services and shared their stories with us. Thank you for making time for our evaluation, for your candid discussion and for supporting this mahi.

Thanks also to our advisory group and Te Ohaakii a Hine –National Network Ending Sexual Violence Together (TOAH-NNEST) who provided valuable input as we developed the evaluation.

We thank everyone who was able to complete our online workforce survey. We look forward to watching the picture of SSHS grow as we repeat the survey each year.

Above all, we acknowledge the commitment of the people we met in this sector to improving the lives of those affected by sexual harm in Aotearoa/New Zealand.

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Background

Budget 16 increased government investment in specialist sexual harm services

On 18 May 2016, government announced $46 million operating funding would be invested through Budget 2016 to design and implement new specialist sexual harm services (SSHS) and maintain existing services. The funding would be provided over four years with the aim of:

- developing a more effective integrated national system which delivers the right support and services that can reach more of the people who need them
- and by doing so reducing the impact of sexual harm and improving outcomes for individuals, families/whānau and communities.

MSD funds four specialist sexual harm service streams

- Sexual harm crisis support services (SHCSS) that take a trauma-informed approach to service provision and include: callout support, advocacy, crisis social work support, crisis counselling, advice, information, and links or referral to aligned services.
- Services for male survivors of sexual abuse (MSSA) that include peer support for male survivors of sexual abuse and their support networks.
- Services to address harmful sexual behaviours (HSBS) that include the delivery of information, assessment and treatment for non-mandated adults who have engaged in concerning or harmful sexual behaviour.
- A (multi-channel) National Sexual Violence Helpline – Safe to talk - He pai ki te kōrero: that provides 24-hour helpline support with other ways of engagement such as webchat and text messaging.

The Ministry of Social Development (MSD) has commissioned an evaluation of the changes from Budget 16 and beyond

The evaluation aims to:

- assess the implementation of service development and outcomes of SSHS
- evaluate the changes in each separate provider initiative workstream and the extent the services achieve the desired aims
- evaluate the extent the service changes improve access for people who need the services and reduce the impact of sexual harm.

The evaluation team worked collaboratively with the MSD project team, specialist service providers and TOAH-NNEST to plan the evaluation. An overarching logic model provides the foundation for the evaluation and sets out the national level activities and outputs and how they align with service provider activities and outputs to achieve the desired outcomes.

The evaluation includes a formative, process and an impact evaluation.

This report is the formative evaluation report – the first evaluation report

It describes the four specialist services funded by MSD to minimise the impact of sexual harm, and service providers' perspectives on what is working well and what is challenging. The report covers overall SSHS workforce demographics, confidence and competence in working with Māori and other cultural groups. Changes to the sector through Budget 16 preceded the start of the evaluation.

Information to inform this report was sourced from:

- A review of relevant documents comprising Select Committee documents, iMSD evaluation plans and MSD background documents and workforce development plans. We also completed a limited review of the literature to inform the development of our evaluation plan.
- Interviews with 42 of 43 MSD funded specialist sexual harm service providers 31 SHCSS, eight MSSA services and three HSBS). Most interviews were completed in-person. It is important to note that services held multiple contracts with agencies and supported clients and whānau in a variety of ways. Services self-defined as kaupapa Maori or tauiwi services.
- An online survey of the specialist sexual harm provider workforce to describe the workforce and changes in the workforce in response to

the additional funding for the sector. Service provider managers were asked to complete the surveys themselves and to send an invitation email and a link to the survey to their teams who worked on MSD funded SSHS for adults, including part-time and full-time permanent and contracted staff, administrators and volunteers. The survey was completed by 133 people.

Sector leadership, management and governance

Developing an integrated national system requires national leadership through government and national service provider organisations.

Government leadership is important to:

- develop the overarching strategic approach to SSHS and ensure alignment with other government initiatives
- identify service models and mix and geographical locations required to meet the needs of clients
- provide effective project management to support SSHS sector wide changes, lead SSHS sector consultation (with national bodies and service providers).

An expanded SSHS team at MSD is leading changes to the sector and a cross-agency advisory group is in place to align government initiatives and examine workforce development.

The formative evaluation identified areas where government leadership is required to strengthen the sector by responding to sector challenges related to service models, funding levels and funding gaps, and integrating contracts between government agencies.

Crisis support services (SHCSS)

SHCSS have a dedicated and mainly stable workforce who are in the sector because of the satisfaction they receive from the changes they make in people's lives. Changes for clients were mainly described as changes in wellbeing. These changes contributed to clients and whānau having increased ability to engage with life.

SHCSS provide client-focused support that ranges from support during the crisis event only, to 'wrap-around' support that may extend over a much longer period. Support can include ensuring clients and whānau have their basic needs met, advocacy with other agencies (especially Work and Income), and specialist social work and trauma counselling. The breadth of services different SHCSS provide is influenced by what other services are available in the locality. For example, in some rural locations, the SHCSS

may have to provide the full breadth of support for whānau because there is no-one they can refer whānau to.

MSD funds support during the crisis period and the Accident Compensation Corporation (ACC) funds long-term treatment and recovery services including specialist counselling. SHCSS is available for all adults who need it whereas ACC counselling has legislated eligibility criteria. Waiting times for ACC services provided constant challenges for many providers. Some providers noted that clients' perceptions of financial benefits from ACC counselling may lead them to seek ACC counselling when other forms of support may be more appropriate for them.

SHCSS providers described themselves as working at or over capacity. Despite being over capacity, providers said they did not turn anyone away. They drew on resources to ensure clients had basic needs met and were safe. Awareness that SHCSS will not turn clients away contributed to some other local agencies referring people who do not strictly meet the eligibility criteria to SHCSS for support.

Budget 16 changes for SHCSS saw:

- a move to three-year contracts to provide more certainty for providers and enable investment in workforce development and infrastructure.
- consultation with the sector to develop service guidelines and a results measurement framework (RMF).
- development of a funding allocation model to ensure a consistent and strategic approach to the distribution of funding across the country. The funding allocation model was developed using a social investment approach.
- a two-phase procurement process to fill identified geographical gaps in SHCSS services around the country.
- commitment to continuous improvements by reviewing the guidelines with the sector.

The impact of government's investment in SHCSS

Government's initial investment through Budget 16 has had a positive impact on the sector that has contributed to:

- **increased sector stability**: The challenges of short-term contracts for providers have been widely reported as barriers to workforce development. Extended contracts are helping to provide stability in the sector.
- **building service capacity**: Additional funding has enabled some providers to extend their workforce, for example, to employ other roles such as social workers to provide holistic support for clients.
- **improved service capability**: Consultation and the development of service guidelines, alongside funding for the Te Ohaakii a Hine – National Network Ending Sexual Violence Together's (TOAH-NNEST) online learning platform are likely to contribute to building sector capability.
- **an integrated service network with improved geographical coverage, availability and accessibility:** Gaps funding for some providers and the establishment of the national helpline Safe to talk - He pai ki te kōrero are progress towards an integrated service network. The helpline will ensure there is support available throughout New Zealand, even if not face-to-face. However, there are remaining gaps in the geographical coverage of SHCSS. Although many welcomed the helpline there was concern in the sector about the capacity of the sector to respond to changes in demand that may arise from raising awareness of sexual harm.

A new national helpline – Safe to talk - He pai ki te kōrero

Budget 16 funded the establishment of a new national 24/7 multi-channel sexual harm helpline with the aim to:

- provide support everywhere in New Zealand for all people affected by sexual harm including victims/survivors as well as perpetrators, or those with concerns about others regardless of age, gender, sexual orientation, special needs, or ethnicity
- provide counselling and social work services through multiple modes of communication, including social media, texting, and web-based services
- service a proportion of latent demand.

The impact of government's investment in Safe to talk - He pai ki te kōrero

Homecare Medical is the helpline provider. A series of workshops introduced the service to providers and offered opportunities for consultation and discussion.

Safe to talk - He pai ki te kōrero was implemented in Christchurch as a pilot in February 2018 and nationally on April 16, 2018, increasing the availability of 24/7 contact for people who want to talk about sexual harm. Although some providers already have a 24-hour phone line in place, the new helpline provides increased resources and a standardised approach.

Providers see some areas of Safe to talk - He pai ki te kōrero as potentially highly beneficial to clients. The option to contact services online was considered particularly useful for clients who may be nervous about disclosing in-person. It may also be more appealing to younger people who are comfortable with online spaces. Early indications suggest most Safe to talk - He pai ki te kōrero service users to the end of June had required service in the moment, but once they had been listened to and de-escalated, did not want to be referred onto another service at that time.

As Safe to talk - He pai ki te kōrero is rolled out the evaluation will focus on the reach of the service, the interface with other providers and the outcomes for clients.

Services for male survivors of sexual abuse (MSSA)

Services for male survivors of sexual abuse (MSSA) provide peer support for male victims/survivors of sexual abuse and their support networks. Peer supporters are men who were survivors of sexual abuse.

MSSA provides holistic support for clients and helps to build trust and link their clients to the specialist and treatment services they need.

The provision of effective specialist sexual harm services has the potential to reduce the impact of sexual harm and improve wellbeing for victims/survivors. However, while there is evidence of the benefits of peer supporters in other parts of the health and social sector, there is limited evidence to date in the specialist sexual services sector.

Budget 16 changes for MSSA saw:

- improved funding certainty through a move to Outcome Agreements (yearly contracts) where previously funding had been provided through grants
- year on year increases in funding for the MSSA sector ($500,000, $650,000 and $750,000 from FY17 through to FY19)
- development of service guidelines, and a RMF and outcome measures in 2017 for a service that had not previously had any documentation defining the service.

The impact of government's investment in MSSA

MSSA are provided by the same providers and at the same capacity as prior to Budget 16 changes. However, services now have some funding certainty through one-year contracts.

There is a focus on identifying 'good practice', service development to consistent 'good practice' standards and establishing data collection to understand client outcomes. A national body, Male Survivors Aotearoa (MSA) have been resourced by MSD to provide sector leadership.

MSA has taken some time to become effective. However, the participating members now feel that it is an effective and organised national voice for male survivors.

All MSSA services now use the client management system PAUA to help track and manage their clients. Use of PAUA provides opportunities for robust information about how MSSA support clients. Later stages of the evaluation will draw on client interviews and data from PAUA to track client journeys and outcomes.

Services to address harmful sexual behaviour

MSD funded harmful sexual behaviour services (HSBS) include the delivery of information, assessment and treatment for non-mandated adults who have engaged in concerning or harmful sexual behaviour. HSBS offer specialised treatment services. Interventions are based on evidence-based programmes. Providers estimate their recidivism rates for clients who completed the intervention at 10-15% for non-mandated adults.

In response to our workforce survey, several SSHS providers reported they were supporting people with harmful sexual behaviours. Kaupapa Māori providers often supported the survivor, the perpetrator and whānau. Where the survivor and perpetrator were the same whānau, long-term recovery required whānau focused support and treatment. There was

some discussion/debate amongst providers on whether the three core services should be expanded or whether training and resources should be provided to existing generalist services to allow them to develop skills to support HSBS clients.

The evaluation will explore further the way all specialist services provide treatment for harmful sexual behaviours.

Budget 16 changes for HSBS saw:

- an increase in funding to extend available places in assessment and in existing treatment programmes, thereby clearing current waiting lists and meeting some additional latent demand
- a move to two-year contracts.

The impact of government's investment in HSBS

A design sprint, facilitated by PwC[1], was held at the end of 2016 with the aim of defining and incorporating best practice recommendations from recent and future research on effective delivery of HSB assessment and treatment services. The HSB non-mandated service guidelines were created from the sprint.

Government investment increased the capacity of assessment and treatment places. One service has increased from a total of 11 yearly places to 30 for assessment and 24 for treatment. Another has moved from 10 treatment places to 29. However, demand has also increased, and providers reported they were still managing waiting lists. The level of unmet need is not known.

The evidence base for HSBS is substantially drawn from international evidence. A kaupapa Māori pilot has been funded to develop evidence about what works for Māori. Evaluation of this pilot is out of scope for this evaluation.

New client management systems will provide good information about client volumes, demographic profiles and completion rates.

Kaupapa Māori services

Kaupapa Māori providers are best placed to support Māori in minimising harm from sexual violence. Across the health and social services, those provided by Māori for Māori have been shown to be successful in identifying and meeting community, whānau and individual needs in ways that mainstream services cannot.

[1] https://www.pwc.co.nz/

Further developing kaupapa Māori services sits across all aspects of an integrated national system, as was an expectation of the Social Services Select Committee[2]. Kaupapa Māori providers and many tauiwi providers interviewed for this evaluation considered building the cultural competence of tauiwi providers was not sufficient to meet the needs of Māori. Good practice guidelines such as the TOAH-NNEST guidelines[3] encourage Māori services for Māori.

There are few kaupapa Māori SSHS resulting in many Māori clients being supported by tauiwi providers. There is an urgent need to support the development of further kaupapa Māori services.

In the interim, where kaupapa Māori services are not available in a locality, cultural safety provides a robust framework for providers to better reach and serve Māori. The concept of cultural safety was developed by Irihapeti Ramsden[4] in response to growing evidence showing poor Māori health outcomes were a result of conscious and unconscious racism, including institutional racism. Culturally safe practice encompasses age, gender, sexual orientation, socioeconomic status and class, ethnicity, religion, and disability.

The SSHS workforce

Providers are regarded as "specialist" if their service provision focuses mainly on sexual violence and if their staff have specialised knowledge and skills about issues stemming from sexual harm. The workforce also includes people working with generalist scopes of practice such as nursing, social work, kaiāwhina. Provider teams comprised of a mix of professional groups.

Based on responses to the workforce survey, the SSHS workforce is mainly female, is an older and stable workforce, with many working part-time. However, the inflow of new staff approximately matches the numbers who reported they may leave in the next 12 months.

Despite the challenging work, extensive workloads and for many, relatively low salaries, there were high levels of job satisfaction. SSHS practitioners valued the difference they could make for clients. Many who responded to the workforce survey specifically noted teamwork and the people they worked with as one of the reasons for satisfaction with their jobs.

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[2] Report of the Social Services Committee (Dec 2015). Inquiry into the funding of specialist sexual violence social services.
[3] http://toahnnestgoodpractice.org/
[4] Ramsden, IM. Kawa Whakaruruhau: Cultural Safety in Nursing Education in Aotearoa, Wellington, 1995

Practitioners responding to the survey felt well supported with professional supervision. However, access to professional development was limited by cost and time pressures.

Challenges to the SSHS workforce included:

- the older age of the workforce which does not match the age profile of clients, many of whom are in the 19 to 24 age group
- the need for more men in the workforce
- a lack of specialist training applicable to the sector – as a result staff were frequently developed using an apprenticeship model of on the job training
- workforce shortages which limit access for clients, especially shortages of Māori and Pacific counsellors
- competition to recruit specialist staff because of higher rates of pay by ACC providers and Safe to talk - He pai ki te kōrero employees reported by providers.

Next steps to strengthen the sector and reduce the impact of sexual harm

Budget 16 was the start of funding to support changes in the sector. There are some remaining challenges for the sector that government aims to consider over the next three years. Many of the opportunities to strengthen the sector and improve support for clients and whānau were common across all four existing service streams.

Increased awareness is leading to increased demand

Increased demand was associated with social media campaigns such as the #MeToo movement, more media visibility and high-profile court cases and prosecutions. Despite increasing public awareness, many providers described the need for a societal shift in understanding sexual harm. National media campaigns and education from early childhood to tertiary study would further raise awareness, reduce the stigma of disclosure (especially for men) and inform the community and health and social sector providers of where they could refer people for help.

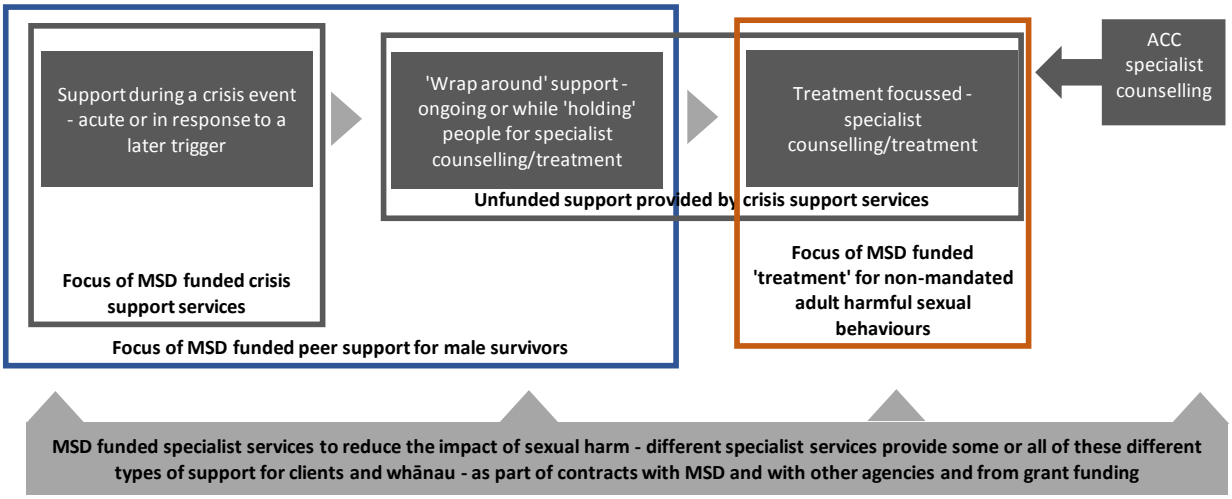
The sector remains underfunded

Although Budget 16 had increased funding for the sector, all providers described unmet demand and the need for more funding to meet demand. Many providers were managing multiple contracts with different agencies and spending time and resources in fundraising to cover funding shortfalls.

The impacts of MSD funding must be considered in the context of multiple contracts held by providers. In some cases, MSD funding represented only a small proportion of provider funding.

There were also aspects of service delivery that were not funded, as described in the diagram below:

- for SHCSS unfunded support included 'holding time' while waiting for specialist counselling, funding for people not eligible for ACC services, funding counselling for those who did not want ACC counselling, and funding for those under 18.
- for HSBS services, treatment for concerning sexual ideation was not funded.



Providers also described challenges with the funding model that included:

- insufficient funding for travelling time
- funding through the gaps contracts that could make it difficult for smaller providers to provide 24/7 cover. For example, where funding is less than 1 FTE it can be logistically difficult to provide the cover required
- funding that does not adequately recognise differences in the way kaupapa Māori providers support clients. Additional time may be required for whakawhanaungatanga and manaakitanga and accountability is to whānau, hapū and iwi
- how to adequately fund support for victims/survivors and whānau who have complex needs that extend beyond crisis support
- the need for flexibility in the balance between assessment and treatment places for HSBS.

There is inadequate funding for infrastructure development

There were no consistent measures of client outcomes for MSD funded services, and client case management systems varied with some being hard copy. Developing consistent ways of recording client information and measuring client outcomes would provide much needed information about who is being reached and changes over time, enabling estimates of demand.

Developing client outcome measures and further understanding of how clients are supported will be the next focus of service development and the evaluation. However, funding for computerised case management systems is essential as a foundation for continuous improvement.

The sector needs cross-agency support for capability building

Providers welcomed opportunities to network and share information and learnings. They suggested the idea of an annual conference. Considering workforce development opportunities and ways to fund meetings and networking for providers to share learnings, is an important part of a continuous improvement process.

Current workforce development was described by providers as having a strong focus on family violence and there were gaps in training programmes about responding to trauma. The TOAH-NNEST tauiwi e-learning tool will contribute to filling this gap but there is a need for more access to tertiary education about how to support victims/survivors of sexual harm.

Improving outcomes for clients and whānau

Reducing the impact of sexual harm requires:

- reaching the people who need to be supported – awareness of sexual abuse has been increased by recent social media campaigns and high-profile court cases. Providers are seeing increased demand as a result. Many providers also highlighted the need to raise awareness of SSHS and how to access them and to reduce stigma for victims/survivors.
- minimising any barriers for clients to accessing support – waiting lists, travel times and lack of services.
- improving access to kaupapa Māori services for Māori clients, as a shortage of kaupapa Māori services is a barrier to accessing support in many localities.

- providing clients with the 'right' support to meet their needs – although some clients only require support through the crisis event, many need 'wrap around' support across many aspects of their lives as well as specialised treatment interventions.
- reaching and supporting people who are thinking and acting in sexually harmful ways to reduce further acts of sexual violence.

Budget 16 changes to specialist sexual harm services

Sexual violence causes significant social, health, and economic costs to individuals, families, and communities. The Treasury has estimated that it is Aotearoa's most expensive crime. Based on the Treasury's research into the 2003/2004 costs of crime, the estimated equivalent annual cost of sexual violence in 2012 was $1.8 billion.

Stable and effective specialist sexual harm services (SSHS) have the potential to significantly reduce the costs of sexual violence—both to society and to individuals[5]. The definition of a specialist sexual harm service provider used by MSD is as defined by TOAH-NNEST:

> *"... a non-government organisation that provides services with a sole or primary focus on delivering psycho-social support to people affected by sexual violence"*[6]

Recommendations from the Social Services Select Committee enquiry

In December 2015, an enquiry by the Social Services Select Committee[7] into the funding of specialist sexual harm services concluded that current services do not provide consistent, effective cover and that current funding approaches are insufficient.

The Social Services Select Committee enquiry provided 32 recommendations to government to improve the integration, coverage and practice standards of these services and to ensure they meet the needs of Māori and other cultural groups.

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[6] As defined by Te Ohaakii A Hine – National Network Ending Sexual Violence Together (TOAH-NNEST)
[7] Ibid

Government's response

Government's response[8] to the recommendations of the Social Services Select Committee included acceptance of the issues raised and actions to response to the recommendations.

On 18 May 2016, government announced $46 million operating funding would be invested through Budget 2016. The funding would be provided over four years to design and implement new specialist sexual harm services and maintain existing services.

The aim of the investment:

- was to develop a more effective integrated national system which delivers the right support and services that can reach more of the people who need them
- and by doing so, to reduce the impact of sexual harm resulting in improved outcomes for individuals, families/whānau and communities.

Ministry of Social Development funded SSHS

MSD funds four specialist sexual harm service streams:

- Sexual harm crisis support services (SHCSS) that take a trauma-informed approach to service provision and include: callout support, advocacy, crisis social work, crisis counselling, advice, information, and links or referral to aligned services.
- Services for male survivors of sexual abuse (MSSA) that include peer support for male victim/survivors of sexual abuse and their support networks.
- Services to address harmful sexual behaviour (HSBS) that include the delivery of information, assessment and treatment for non-mandated adults who have engaged in concerning or harmful sexual behaviour.
- A (multi-channel) National Sexual Violence Helpline – Safe to talk - He pai ki te kōrero, that provides 24-hour support via phone, text, email or webchat.

Budget 16 changes to Ministry of Social Development funded SSHS

The main changes to the four service streams are outlined below.

[8] https://www.parliament.nz/resource/en-NZ/51DBHOH_PAP68769_1/0971ad93d3900992320b34999904504e318aa489

Sexual harm crisis support services:

- a move to three-year contracts to provide more certainty to providers and enable investment in workforce development and infrastructure
- consultation with the sector to develop service guidelines and a results measurement framework
- development of a funding allocation model to ensure a consistent and strategic approach to the distribution of funding across the country. The funding allocation model was developed using a social investment approach. It is based on three key principles:
    - using a client-centric approach – understanding who clients are and where they are located
    - using an evidence-based approach – using 50+ datasets to build the model
    - applying specialist knowledge and expertise to the data.
- a two-phase procurement process to fill identified geographical gaps in SHCSS services around the country
- commitment to continuous improvements by reviewing the guidelines with the sector.

Services for male survivors of sexual abuse

- improved funding certainty through a move to Outcome Agreements (yearly contracts) where previously funding had been provided through grants.
- year on year increases in funding for the MSSA sector ($500k, $650k and $750k from FY17 through to FY19).
- development of service guidelines, a results measurement framework and outcome measures in 2017 for a service that had not previously had any documentation defining the service.

Services to address harmful sexual behaviour.

- an increase in funding to increase available places in assessment and in existing treatment programmes, thereby clearing current waiting lists and meeting some additional latent demand.
- improved geographic coverage and tailoring of services to minority groups.
- defining and incorporating best practice recommendations from recent and future research on effective delivery of HSB assessment and treatment services. A design sprint, facilitated by PwC, was held at the end of 2016 to define the harmful sexual behaviour service. The HSB non-mandated service guidelines were created from the sprint.

- a move to two-year contracts.

Safe to talk - He pai ki te kōrero

- funding to establish a new national multi-channel helpline
- consultation with the sector to launch the helpline.

The evaluation of specialist sexual harm services

The purpose of the evaluation

MSD has commissioned a three-year evaluation of the four SSHS. The evaluation aims to:

- assess the implementation of service development and outcomes of SSHS
- evaluate the changes in each separate provider initiative workstream and the extent to which the services achieve the desired aims
- evaluate the extent the service changes improve access for people who need the services and reduce the impact of sexual harm.

While the focus of the evaluation is the four specialist services, there are activities that need to occur at a national level to support service development. MSD has a key leadership role in enabling changes for service providers by providing a coherent policy framework and supporting infrastructure, demand and coverage analysis, data collection and management, research and evaluation, sharing good practice standards and a workforce development plan[9].

MSD's activities are also included in the evaluation (Figure 1). An overarching logic model (Appendix 1) provides the foundation for the evaluation and sets out the national level activities and outputs and how they align with service provider activities and outputs to achieve the desired outcomes.

Separate logic models have been developed for each of the four specialist services to provide the foundation for the evaluation of how each service stream contributes to the overarching goals.

[9] MSD budget template

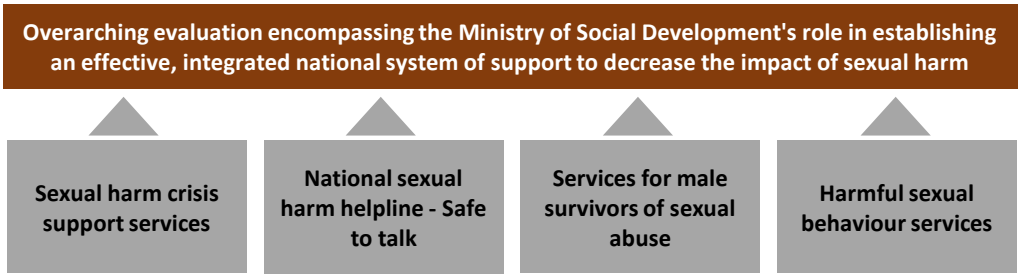

Figure 1: The specialist services included in the evaluation

The evaluation phases

The evaluation comprises the following:

- **Formative evaluation (February – June 2018)**: to refine and develop the evaluation measures and indicators and approach to information gathering, including client data collected by providers.
- **Process evaluation (July 2018 – December 2020)**: focusing on providers to assess services delivered, changes in provider capability and capacity and to track and provide feedback on progress. Information for the process evaluation will include monitoring reports based on administrative data collected by service providers.
- **Outcomes (summative) evaluation (January 2021 – June 2021)**: will consider to what extent accessible, co-ordinated, connected and sustainable specialist services have been developed and their effectiveness in reducing the impact of sexual harm and improving outcomes for individuals, families/whānau and communities.

Consultation with the sector

The evaluation team has worked collaboratively with the MSD project team, specialist service providers and TOAH-NNEST to plan the evaluation.

Ongoing communication with the sector will be through sending summaries of evaluation findings, presenting at meetings and being responsive to sector queries and feedback about the evaluation. Our aim is that ongoing collaboration will make the evaluation useful to the sector by ensuring SSHS providers receive information from the evaluation they can use to inform the development of their services.

The evaluation advisory group

Alongside TOAH-NNEST, we invited service providers to share their knowledge and expertise with us by being part of an advisory group. The

advisory group includes members of the Ngā Kaitiaki Mauri whare and the Tauiwi caucus of TOAH-NNEST.

Consultation with the advisory group complements general feedback from service providers and from MSD.

Particular areas where advice is sought were:

- the evaluation design and what information is feasible for providers to collect
- how the evaluation examines whether the needs of Māori clients are met and how kaupapa Māori services are supported in the sector
- how the evaluation examines whether the needs of Pacific clients and clients from other cultural groups are met
- reviewing the conclusions we draw from the evaluation to bring all perspectives, especially Māori and Pacific world views, to the analysis
- discussing the implications of the evaluation findings for SSHS.

The focus of this report is the formative evaluation

This report describes the four specialist services, and their perspectives on what is working well and what is challenging, and covers SSHS workforce demographics, confidence and competence in working with Māori and other cultural groups.

Analysis of service provider administrative data to provide profiles of clients, interviews with clients and development and analysis of outcomes measures will be the focus of the next report. Most funded providers were positive about the use of de-identified administrative data and including client voices in the evaluation. Information from this report will inform the development of the Budget 2019 bid.

The main information sources for this report were:

Document review: We reviewed relevant documents comprising Select Committee documents, iMSD evaluation plans and MSD background documents, and workforce development plans. We completed a limited review of the literature to inform the development of our evaluation plan. We reviewed documents from the SSHS providers such as information brochures, organisational charts, and larger pieces of work such as

Whakatokia te kakano o te haa – Planting the seeds of life.[10] We also reviewed digital media.

Interviews with providers: MSD provided us with a list of the SSHS providers they funded and the services they were funded to deliver. We completed interviews with 42 of the 43 MSD funded SSHS providers. However, it is important to note that although services were funded by MSD to provide a particular specialist service, many held multiple contracts with agencies and supported clients and whānau in a variety of ways.

Providers were asked if they were a kaupapa Māori service. In this report, services that did not identify as kaupapa Māori are referred to as tauiwi services. We recognise that within these broad definitions there are Māori practitioners within tauiwi services who provide kaupapa Māori support to whānau and that kaupapa Māori services may also employ tauiwi practitioners.

No Pacific-specific services were identified but Pacific practitioners worked within other specialist services to support Pacific aiga. Interviews with a new Pacific Collective were also included in the evaluation.

Most interviews were completed during visits to the services, although a few providers visited us when they were in Wellington and a small number of interviews were by telephone or videoconference. Interviews were led by a semi-structured interview guide that ensured key points were covered but allowed providers flexibility to also talk about what was important and different about their organisations.

The providers we interviewed included:

- SHCSS – we interviewed 31 crisis support providers comprising:
    - Kaupapa Māori services – six providers who identified as kaupapa Māori services. These services ranged in size from two counsellors, to large Māori social service provider organisations that delivered a range of services.
    - 25 providers that did not identify as kaupapa Māori providers
- MSSA – we interviewed eight providers
- HSBS – we interviewed three providers.

Workforce survey: An annual workforce survey is included in the evaluation to describe the workforce and changes in the workforce in

[10] Whakatokia te Kakano o te haa. Planting the seeds of violence prevention. Te Puna Oranga Support Services. Ministry of Justice

response to the additional funding for the sector. The formative evaluation report includes the findings of the first workforce survey.

The survey was drafted to align with the logic model. The wording and content of the survey was reviewed by MSD and by the evaluation advisory group. The survey was distributed as an online survey with response options of a hardcopy or free phoneline also available. Service provider managers were asked to complete the surveys themselves and to send an invitation email and a link to the survey to their teams who worked on MSD funded SSHS for adults, including part-time and full-time permanent and contracted staff, administrators and volunteers. To ensure confidentiality, we did not collect any information to identify the service or the person completing the survey. The survey was closed on Sunday 17 June, 2018.

We received a total of 133 survey responses comprising full survey responses from 111 and partial responses meeting the criteria for inclusion from 22. Partial responses were included if at least two-thirds of the survey questions had been completed. A profile of respondents is provided in Table 1. Managers from two HSBS providers declined to participate in the workforce survey. This first workforce survey does not include Safe to talk - He pai ki te kōrero staff.

Table 1. Profile of survey respondents (n=133 – some participants omitted some questions)

Characteristic		Survey respondents
Gender (n=112)	Wāhine / Female Tāne / Male Gender diverse / Momo rerekē o te ira tāngata	92 (82%) 17 (15%) 3 (3%)
Age (n=111)	Under 30 30-39 40-49 50 or older	6 (5%) 15 (14%) 20 (18%) 70 (63%)
Ethnicity (total count)[11] (n=111)	Māori Pacific European/Pākehā Other ethnic group	35 (32%) 8 (7%) 83 (75%) 10 (9%)

[11] Unless otherwise stated, we used a total count approach to analysis of ethnicity and role where people were counted in all the ethnic groups and all role types they identified.

Roles (total count)[11] (n=133)	Kaiwhakahaere / Manager			32 (24%)
	Kaiwhakahaere / Manager and other role/s reported			*16 (12%)* 1 (1%)
	Kaumatua/ Kuia			24 (18%)
	Administration / Coordinator			57 (43%)
	Counsellor/ other clinical role			27 (20%)
	Kairuruku / Social worker			32 (24%)
	Kaiāwhina / Support role / Peer support			
Region (n=112)	Northland	16 (14%)	Manawatu-Whanganui	14 (13%)
	Auckland	17 (15%)	Wellington	15 (13%)
	Waikato	4 (5%)	Nelson-Tasman	6 (5%)
	Bay of Plenty	6 (5%)	West Coast	1 (1%)
	Gisborne	1 (1%)	Canterbury	17 (15%)
	Hawke's Bay	2 (2%)	Otago	3 (3%)
	Taranaki	5 (4%)	Southland	4 (4%)

Analysis

We used an analysis framework developed from the logic model to guide our analysis of information from the survey and interviews. We analysed the qualitative data from interviews and responses to open-ended questions to identify key themes. Key themes are reported using the terms all, many, some or few services to describe how frequently service providers mentioned the topic.

We exported quantitative data from the survey to the Statistical Package for the Social Sciences (SPSS) and analysed the data using descriptive statistics.

Strengths and limitations of the evaluation report

This report is the first evaluation report exploring changes aiming to improve the integration and effectiveness of SSHS. Although this is the first report, changes have been in place since Budget 2016 with the aim of stabilising the sector.

The evaluation planning was strengthened by input from the MSD team, TOAH-NNEST, an evaluation advisory group and an expert advisor.

A key strength of the evaluation was the willingness of service providers to contribute. Almost all 43 MSD funded services took the time to contribute

their views in individual or group discussions. Most interviews were kanohi ki te kanohi and most were at the service providers locations. Some service providers said they supported the evaluation because they saw it as a chance to "*have our voices heard*".

Interviews were complemented by a workforce survey that provided an opportunity to collect the views of service provider teams. The survey was distributed to provider staff involved with MSD funded SSHS. However, it was difficult for providers to identify staff that specifically worked on MSD funded services. This made it difficult for us to determine the response rate to the survey and to understand whether those who responded differed from those who did not. Although only two managers declined to distribute the survey we do not know what proportion of the teams completed the survey. However, responses came from all regions and the age and ethnic profile of those who responded aligned with what we heard in interviews, suggesting the findings are broadly representative of the sector.

Workforce survey findings were reported back to the sector as part of TOAH-NNEST's May and June roadshows and comments incorporated into this report.

Crisis support services (SHCSS)

Crisis events are acute events where the victim/survivor receives immediate support or events arising from triggers identified by an individual or whānau or abuse disclosed during counselling for other aspects of a person's life. Crisis is not defined by an actual event, but by a person's (and their family and whānau) response to that event. Anger, family violence, addictions and other mental health issues, may be responses to sexual violence.

MSD funds Sexual Harm Crisis Support Services (SHCSS) for adults aged over 18 affected by sexual harm after an incident of sexual violence or a crisis event (an event that triggers the trauma of sexual violence experienced in the past). SHCSS take a trauma-informed approach to service provision and include: callout support, advocacy, crisis social work, crisis counselling, advice, information, and links or referral to aligned services.

SHCSS services need to be:

- immediately available and accessible to all victim/survivors, with sufficient specialist staff to respond
- at no cost to the victim/survivor

- available 24/7, 365 days a year where possible (as sexual harm can occur at any time, but anecdotal evidence suggest it is more likely to happen at night. Similarly, flashbacks, nightmares, and disabling terror can happen anytime, but often at night)
- linked into local communities so appropriate referrals can be made.

Funding changes in Budget 2016 aimed to:

- provide support for all victim/survivors - everywhere in New Zealand - regardless of age, gender, sexual orientation, special needs, or ethnicity
- service a proportion of latent demand
- deliver counselling and social work services of adequate duration and intensity through appropriately specialised, trained staff
- cover overheads, including training and workforce development.

The evaluation focus for crisis support services

The evaluation focus for SHCSS is to examine the extent additional funding and changes in funding allocation for the sector, alongside a transition to three-year contracts from July 2018 have achieved:

- increased sector stability and a co-ordinated and integrated service network (including a co-ordinated interface with Safe to talk - He pai ki te korero)
- improved service capability and capacity
- improved geographical coverage, availability and accessibility of services
- crisis support services that meet the needs of clients and improve outcomes.

Some changes funded through Budget 16 were already in place at the start of the evaluation including additional funding and changes to three-year contracts for some providers and funding to fill geographical gaps in service provision.

Where crisis support services are located

Most SHCSS services were in the North Island, reflecting the population distribution (Figure 2).

Figure 2. The location of MSD funded sexual harm crisis support services

The size of SHCSS differed and many specialist practitioners were part of a larger service that offered a range of different types of support (Figure 3). The MSD funded component of SHCSS budgets varied, as many held multiple contracts with different government agencies and received additional funding from grants from charitable organisations.

SHCSS located in provincial towns supported whānau in the surrounding rural localities either through small outreach services or by travelling to rural locations. Travelling to other locations was a significant investment in time for many providers. Requirements for 24/7 availability was challenging for smaller providers who had to juggle staff availability to manage unpredictable and irregular patterns of demand for crisis support.

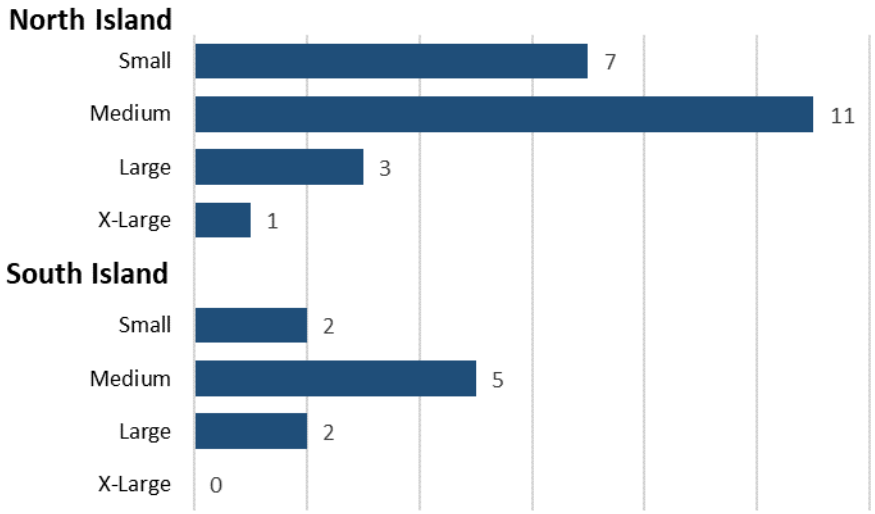

Figure 3. Size of MSD funded sexual harm crisis support services[12] [13]

Services we visited were in a range of different settings. Some urban services were situated in large city buildings. Others were upstairs in industrial areas and many services were in residential streets. Some were mindful of signage. Not all services were in a physical building.

A city sanctuary

"The lift doors opened, and I found myself pushing a buzzer for a small waiting room. It was furnished with comfortable sofas, a coffee table and a place to hang coats. All around the walls were colourful art and inspirational quotes. There were fresh flowers in a vase. A smiling woman greeted me warmly and offered me a cup of tea. Another woman came in from the lift. When she accepted her cup of tea her hands were shaking. We chatted about the cold weather outside and how the colourful, warm waiting room felt like someone's home." Evaluator description

Many SHCSS, especially those in smaller localities, were an integral part of their communities.

[12] As we were unable to interview one provider, the organisation's size is not known. They have therefore been included in the map but not the size chart.
[13] Sizes were determined as follows: small = 5 or fewer staff; medium = 6-14 staff; large = 15-24 staff, x-large = 25+ staff.

On the road with a kaupapa Māori provider

"The importance of connection was strongly apparent when we were out and about in the community with one of the kaupapa Māori providers. We were welcomed into an Iwi Leaders Forum where the mahi of the provider was acknowledged. Afterwards as we sat in a cafe we were warmly approached by a wide range of locals. Most shared whakapapa links with one of the counsellors. Others heard about the SSHS and wanted more information. For example, the local hairdresser asked if she could have some brochures or cards to give her clients when they told her their troubles. The providers and their work are known and respected in the community, which allows them to reach a wide range of people who require support." Evaluator description

Clients and whānau

Quantitative information about the demographic profile of clients will be sourced from SHCSS provider data and reported in the first process evaluation report.

The SHCSS providers we interviewed said most of the clients they supported were female, although there were also male clients. A few providers supported couples, especially where sexual harm was disclosed during couples or whānau counselling for family violence.

Kaupapa Māori providers and some mainstream providers also supported whānau. Whānau includes those connected by whakapapa and by kaupapa. If individual clients presented at kaupapa Māori services, providers generally tried to connect them with whānau because the whole whānau required support to make changes for long term sustainability.

Most referrals to SHCSS were self-referrals or came from Police. Some providers also received referrals directly from hospitals and emergency departments, courts, victim support, other agencies and community-based organisations. People may enter a SHCSS under another contract and then disclose sexual abuse further down the track once they have established trust and begun to feel safe.

People with complex needs are over-represented as victims of sexual harm. This over-representation reflects the impact of sexual abuse on participation in society including on education and employment. The intergenerational effects of sexual harm were described by providers and are evidenced in the literature. Many providers and particularly kaupapa Māori providers described whānau who were struggling to access basic needs such as healthcare, housing and food. Some had been turned away from multiple agencies or faced barriers in getting to support in the first place.

> *"So, although you're providing a sexual abuse, sexual violation, call it what you will, service – you're working within so many other areas as well. There's physical violence, emotional abuse, anxiety, depression, suicide so you need to know about all that and fortunately, because we're in a small community you know where these people are." – Kaupapa Māori provider*

SHCSS providers described themselves as working at or over capacity. They described recent increases in self-referrals following social media campaigns and high profile Court cases. Others noted the impact of events such as earthquakes and road closures that resulted in an influx of workers to small communities. Some providers noted increases in local refugee populations as increasing demand for their services.

Despite being at capacity, providers said they did not turn anyone away.

> *"I've noticed that the people coming in that I see have not been able to get in anywhere else and they are desperate. They have been turned away or on a waiting list. A woman who was in this morning was told she had to pay $180 an hour and that's from organisations that are well resourced. What do you do?" – Kaupapa Māori provider*

Not turning anyone away resulted in challenges for providers in managing inappropriate referrals.

> *"I have done a lot of work with local GPs and they are great at sending out hordes of mental health clients and patients but we keep on saying to them, that's not what we are being funded for. We are getting funding for the sexual abuse ones." – Kaupapa Māori provider*

> *"I mean there's a huge amount of need out there and people need someone to talk to and they don't need to necessarily solve their problems. They just need someone to talk to and I think having that and the fact that it's been set up indicates that there is a need for it and we know that mental health services are in crisis and so we're seeing more of it." – Tauiwi provider*

They know we can't just turn whānau away

A kaupapa Māori provider who provides both SSHS and family violence services got a call from Work and Income at 3:30pm on a Friday afternoon. A Māori woman and her children had no accommodation, no food and no money for the weekend. They had been waiting in the Work and Income office for most of the day. The children were hungry, and the whānau only had the clothes they were wearing. Staff assisted the family without question. This meant finding emergency accommodation and enough food and clothing to last the weekend. As a kaupapa Māori organisation they felt a responsibility to whānau in their community that extended beyond contracts and 9-5 working hours, but this mahi takes its toll and the workforce is stretched.

How crisis support services support clients and whānau

Building trust and engagement was the first step for SHCSS in supporting clients. All providers emphasised the importance of privacy and confidentiality and of people being able to disclose safely.

> *"They're coming to talk about really intimate things that's happening in their lives to a complete stranger, so our first visit is really just manaakitanga and just looking after them…Making them feel safe here and feeling safe with their worker and just going through our brochure that we have about confidentiality – because (name) is a small place, there's often a fear of somebody else finding out so that's absolute priority" . – Kaupapa Māori provider*

Whanaungatanga and manaakitanga were two critical foundations for kaupapa Māori services engaging with clients. One provider described their 'frontline' staff as kaikaranga and talked about having the right person in this role, who is able to properly acknowledge and greet whānau. Other providers talked about the importance of the receptionist in welcoming clients. Sharing kai and getting to know each other were also an important part of being welcomed into a kaupapa Māori service, so that whānau felt part of the service.

> *"And people say 'oh yeah, we do that in counselling' – actually we spend a lot more time on it, we talk about whakapapa, where you're from, who you're related to, and part of that is identifying key people that they see as their pinnacles or idols that they want to aspire to. But also seeing the bad side of their whānau, that it tells them, you don't have to keep looking back at that, let's keep moving forward." – Kaupapa Māori provider*

Manaakitanga

"On a residential street, a house that looked no different to the others is the whare of a kaupapa Māori SHCSS provider. A beautiful garden surrounded the house and stretched down to a vegetable patch. Sunlight poured into the waiting area. Wāhine were waiting for me and I was immediately embraced into the service. We sat in the sunshine sharing cups of tea, kai, connections and stories." Evaluator description

Client pathways

Providers described the different client pathways through their services (Figure 4) as including:

- support through the crisis event only, although providers also said that some who received support through the crisis event would come back later for additional support
- support through police and justice system processes
- holistic and non-specialised social work and counselling support for refuge, housing, entitlements and other needs
- specialist trauma and sexual violence social work support
- support to engage with and receive specialist counselling, either from ACC or other specialist trauma counsellors
- support for people while they waited for specialist support or for those who did not qualify to for ACC services.

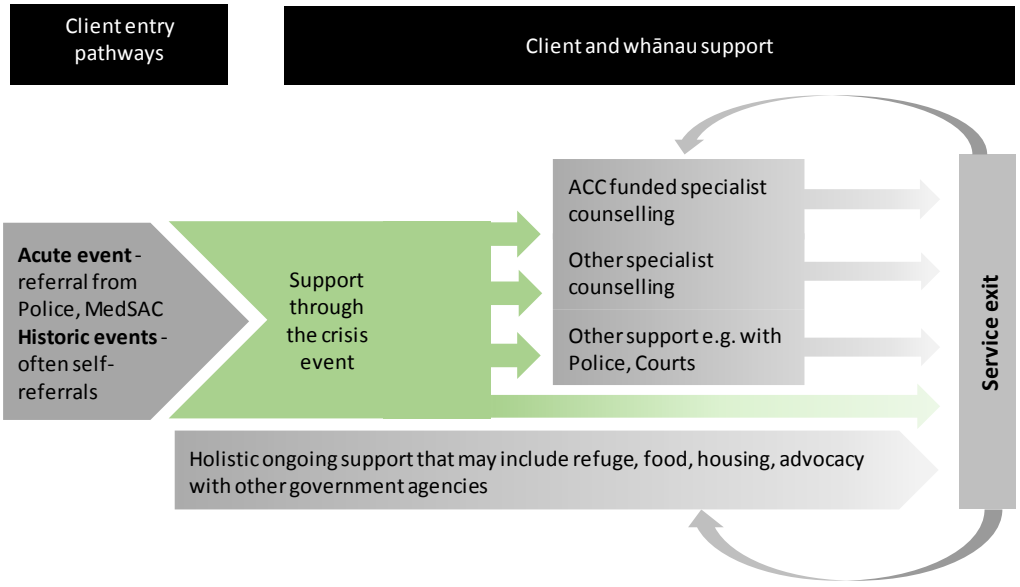

Figure 4. Components of the support SHCSS provide to whānau

Different providers focused on some or all of the aspects of client pathways:

- Some SHCSS focused on specialist sexual violence counselling and/or social work and linked whānau with social services to provide wider support.
- Some services described themselves as offering holistic or wrap around support including helping whānau with kai, housing, and advocacy with agencies.

> *"You can't pigeonhole support." – Tauiwi provider*

- All kaupapa Māori services viewed clients holistically and supported them in the context of whānau.

People with complex needs required multi-agency support that also included support for whānau. Many providers held multiple contracts that enabled them to provide holistic support by seamlessly transferring clients from one contract to another.

Many of the 103 survey respondents who provided crisis support services also indicated they provided other types of support for victims/survivors (Figure 5). Supporting whānau could also include the perpetrator. Some services referred to HSBS and others provided counselling themselves for harmful sexual behaviours. When whānau were not safe the perpetrator was kept separate from them.

> *"What we also find is when you're working with quite a large whānau group, especially if the abuse is happening within that whānau – might be a granddaughter who speaks out and you'll get a daughter in the same and you'll suddenly – you've got all these people within that same whānau disclosing." – Kaupapa Māori provider*

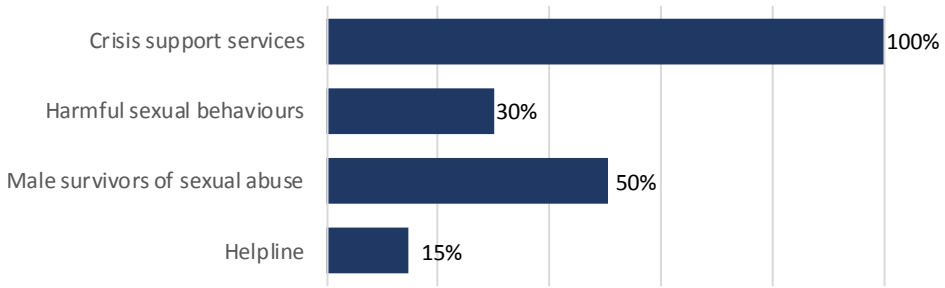

Figure 5. Other types of support SHCSS provided (Source: Workforce survey n=103)

Different providers had different approaches to providing ongoing support for individuals and whānau. One kaupapa Māori provider described

activities that helped people connect with nature and with their wairua such as gardening or spending time at the beach. Some kaupapa Māori providers offered mirimiri and rongoā and another worked with Te Kawa o te Marae in a physical model that could be pulled apart for tangible, kinetic activity while learning.

Example of support: Bertie the therapy dog

"We were greeted at one of the SHCSS providers by a fluffy and enthusiastic little dog named Bertie. Bertie is joyful and very busy. He likes to say hello to visitors and is uniquely welcoming.

Bertie gained fame on TVNZ recently and his story highlighted an innovative way of creating a safe space for people who access SHCSS. For some, having Bertie 'see' them after hiding away is an awakening. For others, patting and rolling with Bertie provides the first opportunity in a long time to physically touch in a safe environment. Bertie has brought comfort to staff and clients of a service whose mahi involves talking about very difficult and painful things." Evaluator description

Example of support: Genograms

"One provider described how they used genograms. A genogram is a graphic representation of a family tree that displays detailed data on relationships among individuals. It goes beyond a traditional family tree by allowing the user to analyse hereditary patterns, cultural connections and roots, and psychological factors that punctuate relationships.

The provider used colours to describe relationship strengths and challenges. Building the genogram enabled conversations about where abuse had occurred and where people felt happiest in their lives and why." Evaluator description

Kaupapa Māori services

Practice of tikanga Māori throughout kaupapa Māori organisations enables the ability to properly connect with and support whānau. Connection with the community, and responsibilities to iwi, hapū and whānau mean that accountabilities of kaupapa Māori providers go beyond funding and linear time. Kaupapa Māori providers have much wider accountabilities to tūpuna and to future generations. These accountabilities cannot be taught in cultural competence.

> *"It's this cultural thing again. Would you hear me if I said I had somebody with me? Would you believe me if I said dah, dah, dah my Nannie's talking to me because a lot wouldn't and there's that*

barrier between tauiwi and my cultural upbringing." – Kaupapa Māori provider

Sexual abuse and family violence are violations of tikanga. Kaupapa Māori services differ between regions but are share a common understanding of Te Ao Māori. Te reo Māori captures concepts that are not always able to be articulated in English language. Kaupapa Māori practitioners weave pūrākau throughout their treatment programmes and also focus on tikanga by other models such as Te Kawa o Te Marae.[14]

Kaupapa Māori services do not accept a deficit approach to their communities. They are proud of their communities, and of their histories. Being Māori is celebrated, and importantly, being Māori is normal. Kaiwhakahaere, kaimahi and all staff reject the negative portrayals of Māori people and Māori culture that have been and continue to be prevalent throughout the New Zealand media and education systems.

"We can just be ourselves, we can use our own models of practice and we don't have to excuse ourselves to do that." – Kaupapa Māori provider

Specialist counselling

Specialist counselling provides a pathway to recovery. The MSD funded model requires SHCSS providers to either have internal capacity to provide further care and recovery services[15] or to have links to further care and recovery services[16] and make active referrals to such services. ACC providers and other counsellors provided different forms of trauma support for clients consistent with their professional disciplines. These included cognitive behavioural therapy, art therapy, narrative therapy and trauma counselling.

Generalist providers employed or contracted staff with specialist capability such as specialist sexual violence counsellors and/or ACC approved providers or referred whānau to external specialist ACC providers. SHCSS providers without in-house ACC counsellors had to find external ACC providers as needed by clients.

"I would find it really useful to have an actual relationship with other providers so that it's easier to move people to another organisation for counselling for example rather than calling around interminably looking for someone." – Survey response

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[14] Te Whare Ruruhau o Mere -Evaluation Report 2, Te Puni Kōkiri, 2009
[15] Any further care and recovery services are not covered by the contents of this guideline.
[16] Such as Integrated Services for Sensitive Claims (ISSC) through ACC.

Most localities had waiting times for specialist counselling, whether counsellors were employed by the organisation or external. Sometimes the client and the ACC counsellor did not gel, and the process would have to start again. SHCSS described holding people while they were waiting for ACC counselling. Some providers felt this time was important as wider needs had to be met to enable people to focus on counselling and addressing their trauma.

> *"You can't just support in a crisis – also need to provide non-crisis support." – Tauiwi provider*

Providers discussed some challenges at the interface with ACC counselling including:

- a shortage of Māori and Pacific ACC counsellors

  > *"… she was given the list from her GP of the ACC providers and when she went through the providers list for (region) she didn't have a Māori name, she didn't have anyone Māori. So she contacted the non-Māori ones who said that they couldn't fit her in, she would have to wait… she said she couldn't wait for ACC, I need some help now. It's just an example of what is coming through our doors. She is Māori/Pacific Island, she qualifies for ACC, all of that is fine except she couldn't find a Māori or Pacific Island ACC registered counsellor." – Kaupapa Māori provider*

- a 'mismatch' between the ACC pathway, described by some as a business model, and the holistic support they provided.

Some providers questioned the different motivations of clients in accessing ACC services. For example, some clients wanted to use ACC counselling services because of the perceived potential of financial gain, without understanding they would become a mental health client. Providers considered a lack of information and advocacy could lead to clients making an ill-informed decision to undertake this counselling.

> *"We've just had one who came here, she did marvellously long-term and then decided she – someone must have told her about the money - so she toddled off to ACC. She came back … I don't want to be there, I'm coming back." – Tauiwi provider*

Not all clients wanted ACC counselling. Kaupapa Māori providers described some whānau who did not want ACC counselling because of a mistrust of government agencies resulting from multiple generations of not being supported by social services, being wards of the state, and bad experiences with police.

Some providers noted that other forms of support may meet people's needs as well as ACC counselling. Some clients had to be supported in

other ways because they were not eligible for ACC counselling. For example, when the abuse happened overseas (migrants).

Service exits

Providers emphasised that sexual harm crisis support does not fit within definitive timeframes. Services are provided for as long as clients need them.

> *"The service lasts as long as they want it to last but also when they leave that's not the end – you come back, don't let yourself get to where you were when you came here – it's important that something may trigger you … but you feel that you've finished with counselling, absolutely ring us and come back." – Kaupapa Māori provider*

Clients returning to the service did not necessarily reflect a failure of the service to provide ongoing coping tools and skills. Some providers discussed ongoing support after a client exited and explained they continued to be available if the client needed them.

> *"…It's just they weren't ready at that time and that can be around their own stuff or Oranga Tamariki might be involved, or it's too raw or they've got drug and alcohol issues. We have that open door…if it's not right now…we don't close that door…we always leave it with 'come back to us when you're ready'…and they do come back…" – Tauiwi provider*

> *"But people have that assumption that they're going to be perfect when they leave here – no, no, no we are addressing your confidence, your self-esteem, your ability to deal with whoever or whatever because if you learn how to do this, that and the other thing, you'll be fine. Ring me up if you can't." – Kaupapa Māori provider*

Client outcomes

The client outcomes MSD aims to see[17] are physical, emotional and psychological safety for victims/survivors.

Providers described success as changes in wairua, improved overall wellbeing, increased self-esteem/efficacy and restoration of mana.

Measuring success

[17]MSD (July 2017) Sexual Violence Crisis Support Guidelines

The effects of sexual harm are wide and pervasive. Despair and lack of self-worth can spiral into joblessness, mental, physical and spiritual issues, alcohol and drug addiction, family violence, crime and incarceration. SHCSS providers agreed that success looks different depending on the client. For some, putting on clean clothes, stepping out the door and saying hello to another person was a big step. For others, addressing housing issues, budgeting and other basic needs enabled moving forward with treatment. Success for clients followed peaks and troughs. Re-entering the service through further crisis was not a failure, but a moving forward.

ACC counsellors are required to report ACC client progress using a set of psychometric assessment tools mandated by ACC. However, it is more difficult to measure the outcomes for clients receiving social support in response to a crisis. Some SHCSS providers used objective measures such as rating scale questions and client experience/satisfaction feedback forms.

One of the challenges for providers was collecting information about client outcomes when they were not sure whether clients they supported during a crisis would come back:

> *"... she actually just disappeared one day and we couldn't contact her and we thought, 'Oh well it's just one of those things' and you hope it's not you and then she came up and she was like, 'I feel so bad I never went back but you guys were so amazing,' and she got back with her partner but everything she learned had been really useful but she just disappeared and didn't bother to give us the feedback but then you think, 'Oh we did do a good job'." – Tauiwi provider*

Infrastructure

Many SHCSS started as volunteer services and have grown and expanded into a different structure. Many still had volunteer Boards. Many were part of collectives and some were independent services. Some of the larger services employed experienced managers who did not carry a case load.

There are core costs and accountability processes that are similar for small and large organisations in the sector. However, the relative costs of supporting necessary infrastructure are proportionately higher for small organisations. Co-operatives and collectives helped to spread the infrastructure costs but required members to share philosophical approaches to service design and delivery.

IT and client management systems are a key component of an organisation's infrastructure. Three-quarters (78%) of crisis support service staff responding to the survey said they had adequate access to an efficient work computer. A few had shared computers or used personal computers.

> *"The service does not have the funding for all to have a computer available on their desk, but we have 1:2 ratio." – Survey response*

There were a variety of client management systems and ways providers tracked information for their performance management reporting.

- Commonly used case management systems included Penelope and Excess. Expertise in using Penelope to extract reporting data varied.
- Some providers used Microsoft programmes such as Excel to record client data.
- Some providers used hard copy files and tracked reporting requirements using hard copy records.

Provider staff had different levels of confidence and expertise in using client management and reporting systems.

> *"Introduction of [client relationship management] impacted on staff retention – long-term staff across providers left as a result of having to report back using the system." – Tauiwi provider*

Lack of standardised ways to collect and report client data limited the ability to analyse data and use it for performance reporting, continuous improvement and service provider collaboration across a locality.

> *"We have VIP, [provider] has Excess and [other provider] have Penelope…you can't even pull [data from] across the district…We should be able to collate…it's very hard to plan…" – Tauiwi provider*

There were also privacy risks associated with a lack of IT infrastructure such as use of standard Microsoft software.

Funding

MSD funds crisis support services and ACC funds specialist counselling for victims/survivors. Budget 16 extended the duration of contracts and increased funding for some SVCSS. Some received 'gaps' funding to provide services in areas where there were gaps in coverage. The amount of additional funding for providers varied. The difference MSD funding made for providers needs to be considered in the context of SHCSS providers who received funding from multiple government contracts, with one provider describing as many as 35 different contracts.

Some providers described how they used the additional funding. For example, to fill new roles, such as social workers, or to increase their capacity for counselling sessions. However, many providers pooled their funding from multiple sources and used this pooled funding as 'core' funding to deliver the breadth of services they required to support clients. Many staff did not work exclusively on one contract. This was particularly the case for smaller providers and in rural locations.

Although new funding and extended contracts had made a positive difference for many providers, most described continuing funding shortfalls. Funding shortfalls included:

- managing requirements for 24-hour cover in localities where the 'gaps' funding is for less than 1 FTE and more than one person is required to cover the time period.

  "[Funding] is not enough when it's professionals and you've got multiple part-time people and it's trauma work…you have to provide really good supervision and support…[We're] expected to run 12 positions when it's a 24/7 service…'Safe to talk - He pai ki te kōrero ' worked out it takes five full-time people to cover one position…so if you give us 12 FTEs, we've got two and a bit…The financial underpinnings were errors from our perspective…" – Tauiwi provider

- funding models not adequately reflecting inherent differences in the way kaupapa Māori providers supported whānau. Whanaungatanga and manaakitanga were integral to kaupapa Māori services and may take longer than tauiwi approaches. Kaupapa Māori services were also accountable to their wider communities and funding based on individuals did not recognise the whānau obligations of these services.

- some parts of client pathways that were not funded by government and these included:

  - the 'holding time' and kaiāwhina support while clients waited for ACC counselling

    "We manage our waiting list quite closely and robustly…we refer so people don't wait very long on that…They can wait a few weeks sometimes, but they are offered other support so if they need a social worker…or if they need a counsellor to hold them that's not ACC registered…" - Tauiwi provider

  - travel time to support clients in locations, mostly rural, at a distance from the SHCSS location. However, travel time could also be a challenge in Auckland.

"We can travel from here to Albany…when it's a booked appointment but for those initial interviews which are critical…there's a window in the day and the night where we can make that journey in 20 minutes…the rest of the day it's impossible…" -Tauiwi provider

- longer-term counselling for people not eligible for ACC counselling.

- a lack of government funding for children and young people affected by sexual violence and their whānau. The long-term impacts of sexual violence on education and employment and the potential for life long impacts for this group represent substantial personal and public costs (lack of engagement in employment and long-term benefit receipt).

  "…Another major impact on the new contract is [that it is] for adults 18 [years] and up…when there has been a child that's been harmed…it's the family that we deal with…The best way to support the child is to support the parents because they're going to be there for the child, so we're not funded to do that but there's no way we would not do it…" – Tauiwi provider

  "Better communication between Oranga Tamariki and MSD so that there is no "grey" area about who we can and can't help in terms of age." – Survey responder

SHCSS providers' policies of not turning people away and their motivation to make a difference for clients meant they needed additional funding to complement that provided by government agencies. Providers accessed additional funding through grant applications to funders such as lotteries and charitable organisations. Completing applications for funding also used considerable provider resources.

The integrated and holistic support provided to individuals and whānau where people were moved from one contract to another made it time consuming for SHCSS providers to separate out what services they provided to whom and under what contracts. Multiple contracts required multiple performance management reporting to agencies and considerable resource to develop different reports for different agencies.

Providers described funding their organisations as "*a delicate balance"* like "*walking a tight rope"* where they were never sure about their funding shortfall. They were anxious about the impact any funding changes might have on their viability. A few providers also said they were worried MSD might pull out of funding the sector. This concern may have arisen because of the funding gap for young people that appeared when MSD and Oranga Tamariki separated.

The SHCSS workforce

The survey provided information about the workforce profile (Table 2) that was consistent with qualitative information from providers. The SHCSS workforce:

- is primarily female – we spoke with some male practitioners in SHCSS but none responded to the survey
- is an older workforce – with 70% aged over 50 (Figure 6)
- includes a higher proportion (36%) of Māori than in the population but may not reflect the profile of victims/survivors
- includes a small Pacific workforce all working in tauiwi organisations
- is a long serving workforce with 54% working in the sector for more than six years.

Table 2. Profile of the SHCSS workforce (Source: Workforce survey)[18]

Characteristic		Survey respondents
Gender	Wāhine / Female Tāne / Male Gender diverse / Momo rerekē o te ira tāngata	80 (93%) 3 (3%) 3 (3%)
Age	Under 39 40-49 50 or older	12 (14%) 14 (16%) 60 (70%)
Ethnicity[19] (total count)	Māori Pacific European/Pākehā Other ethnic group	31 (36%) 8 (9%) 64 (74%) 7 (8%)
Time in workforce	Less than one year One to two years Three to five years Six to ten years More than ten years	8 (8%) 13 (13%) 26 (25%) 26 (25%) 30 (29%)
Full time	Full-time Part-time	56 (54%) 47 (46%)
Role type	Paid role fixed term Paid role permanent Paid role contractor Volunteer	14 (14%) 80 (80%) 9 (9%) 10 (10%)
Specialised training or experience	Lived experience Specialist training Both lived experience and specialist training Neither	7 (7%) 41 (41%) 46 (46%) 9 (9%)
Training	Related undergraduate Related post-graduate degree Related non-degree training Unrelated or no tertiary education	32 (31%) 32 (31%) 29 (28%) 29 (28%)

[18] The numbers of survey responses were highest for Auckland, Wellington, Canterbury and Manawatu-Whanganui

[19] Unless otherwise stated, we used a total count approach to analysis of ethnicity where people were counted in all the ethnic groups they identified with.

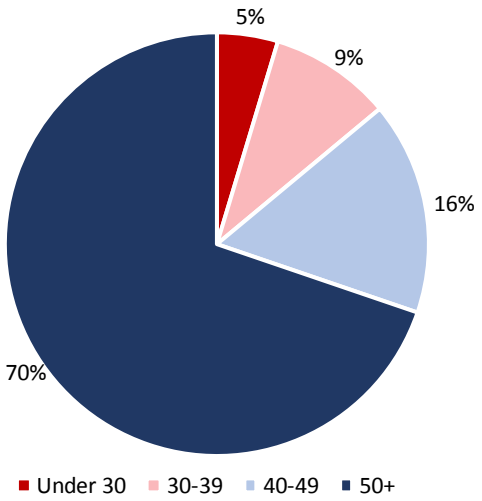

Figure 6. The age profile of the SHCSS workforce (N=60)

Most of the survey respondents were in permanent paid roles. SHCSS managers explained that even though they had fixed-term funding contracts with government, New Zealand employment law required them to roll fixed-term contracts into permanent contracts after 12 months. Funding reductions required adherence to redundancy processes.

Just under half the survey respondents worked part-time. Those we interviewed thought that part-time work helped staff to manage the stress levels associated with their roles. Some contracted staff such as ACC counsellors worked part-time for an organisation and part-time as self-employed counsellors. There were some advantages in this combination as working for a provider organisation provided them with professional support and collegial contact.

> *"Full-time trauma work is difficult, and there are better opportunities elsewhere." – Tauiwi provider*

Many in the workforce had relevant specialist training (41%) or specialist training alongside lived experience (46%). However, SHCSS managers described a lack of training specific to the sexual violence sector and many developed staff through on the job mentorship.

Workloads were high. In response to the workforce survey, 35% of all SHCSS staff, 32% of frontline staff and 41% of non-frontline staff considered their workloads to be too high.

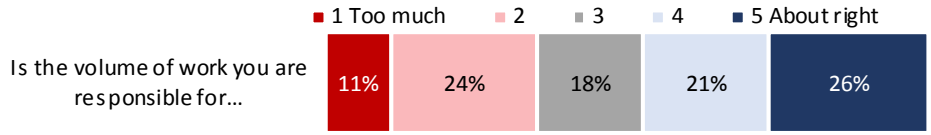

Figure 7. SHCSS staff views on their workloads (Source: Workforce survey n= 491)

In the week preceding the workforce survey, full-time staff had worked an average of 37 hours and part-time staff an average of 22 hours (Table 3).

Table 3. Hours worked in the week preceding the workforce survey (Source: workforce survey n=103)

Hours worked in last week	All respondents (n=103)	Part-time workforce (n=47)	Full-time workforce (n=56)
Over 45 hours	9%	4%	13%
40-45	22%	2%	39%
30-39	32%	28%	36%
20-29	17%	30%	5%
10-19	15%	30%	2%
Less than 10	6%	6%	5%

Survey respondents were asked to estimate what they spent their time doing in the week preceding the survey. Responses indicated frontline staff spent approximately one-quarter of their time of their time on administrative activities and paperwork.

Table 4. Distribution of activities in the week preceding the workforce survey (Source: workforce survey n=103) Note: this table provides estimates only

	Average hours spent					
	Staff only working in frontline roles[20] (n=46)		Staff in mixed roles (mainly managers) (n=21)		Administration only staff (n=11)	
Average total hours worked	27	100%	30	100%	28	100%
Time with clients/ whānau – funded time in MSD contract	9	31%	3	13%	1	3%

[20] Frontline roles include: Counsellor/ other clinical role, Kairuruku / Social worker, Kaiāwhina / Support role and Peer support.

Time with clients/ whānau – funded time in another contract	6	20%	1	2%	0	1%
Time with clients/ whānau – not funded	2	6%	0	2%	0	1%
Travelling time	2	8%	2	7%	1	4%
Activities to prevent sexual harm/violence	1	4%	4	16%	1	2%
Administration, paperwork	7	23%	14	52%	24	86%
Other/ not recorded	2	8%	2	8%	1	4%

The SHCSS workforce were a generally satisfied workforce despite the demands of their jobs and their workloads, with 43% rating satisfaction as high as possible and a further 53% rating satisfaction as 4 out of 5 on a 5-point scale (Figure 8).

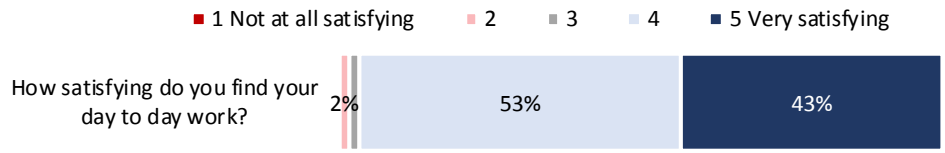

Figure 8. Satisfaction with work (Source: Workforce survey n=99)

When asked in the survey to comment about what they found satisfying about their work comments included:

- Satisfaction with the team, the organisation they worked in and other organisations with whom they worked

  "Our supportive team of staff where every team member is valued and staff self-care is actively encouraged. I know I can have some time off and that my clients will be supported and looked after by other team members." – Survey responder

  "Supporting team members in ensuring we get the best outcomes for our clients. Interaction with other agencies who have a desire to make a positive difference in the lives of our clients - Police, WINZ, Oranga Tamariki, Salvation Army, SAATs, Safeguarding Children, Schools." – Survey responder

- Working with clients

  "Connecting with people who might otherwise not have the chance to speak about their experience. It is satisfying to be able to provide a space where those people can talk about their

experiences in a non-judgmental environment and know that from their feedback they feel cared for and believed!" – Survey responder

"Empowering and reassuring whānau of their capacity to successfully cope with the effects of sexual violence. Empowering and informing people so that their resilience and safety from experiencing sexual harm is enhanced." – Survey responder

- The changes they saw in clients and whānau

  "Seeing change/growth in clients. People taking responsibility, being accountable. Increasing well-being, happiness." – Survey responder

  "Supporting healing from trauma. Seeing clients discover healthy power and freedom from self-blame, shame." – Survey responder

Managers were mindful of the need to keep their staff safe. Safety for staff includes physical, emotional and spiritual safety. Karakia provided a critical role in process and safety for Māori and some tauiwi providers. The importance of support from kaumātua was also emphasised.

> *"Within our community there's always somebody you can go to – some Kuia, some Kaumātua, another agency – I'll often ring up … and say, 'Hey, what do you do with this?' so there's also that invisible network." – Kaupapa Māori provider Source*

Kaiwhakahaere of kaupapa Māori services said they also made sure kaimahi took days off, or spent an afternoon at the beach. Transparency was important within teams, and managers described open communication with staff.

> *"That's how you keep your long-term staff and your long-term volunteers is like I said – looking after them." – Kaupapa Māori provider*

Kaupapa Māori organisations live and breathe aspects of wellbeing that are critical in supporting whānau in the service, but also enable the organisation to properly care for staff.

> *"We talk to our kaimahi that wairua isn't just about getting up in the morning, having a karakia session, it's actually a whole being, a living thing and you have to personify that to be able to allow that person to receive it so they understand where you are at. When your wairua is not in check, they'll feel it. There's no point having the session that day." – Kaupapa Māori provider*

Managers described internal, group and external professional supervision. All staff with frontline roles and most non-frontline staff received professional supervision. Supervision was provided internally within

organisations and by external supervisors. Most staff were satisfied with the supervision they received.

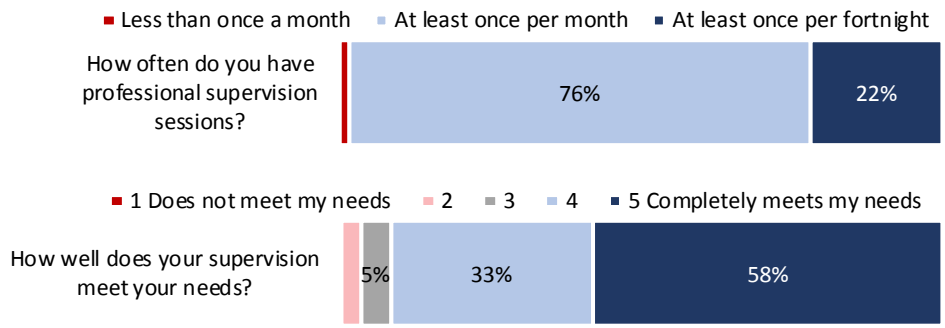

Figure 9. Staff supervision and satisfaction with supervision (Source: Workforce survey n=91)

Most (80%) frontline staff said they had a professional development plan. Professional development was available, and one-third of survey respondents said there were many opportunities available (Figure 10).

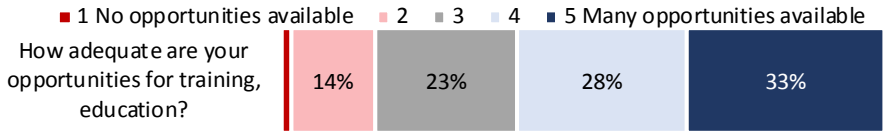

Figure 10. Adequacy of opportunities for training and education (Source: workforce survey n=91).

Cost was identified as the main barrier to accessing education, training and other forms of professional development. Travel time and distance, suitable courses not available and not being able to take time off work to attend courses were also identified as barriers by approximately one-third of survey respondents.

> *"Not so much that suitable courses are available as much as very specific in-depth courses. – Survey*
>
> *Because of the specialised nature of the work there is not a lot of training - but when there is we utilise it." – Survey responder*

Table 5. Barriers to accessing education, training and other forms of professional development. (Source: workforce survey n=95)

Reason	Count	Percent
Cost	62	65%
Travel time and distance	40	42%
Suitable courses are not available	33	35%

Not able to take time off work to attend courses	23	24%
Personal/family reasons	12	13%
Not liking online courses	10	11%
Difficulty accessing online courses	9	9%
Other - please describe	9	9%
No issues reported	8	8%

To overcome some of the barriers to training and geographical isolation the workforce agencies shared information. Managers we interviewed suggested an educational website, annual meetings to share learnings, and more online training. TOAH-NNEST has been funded by MSD to develop online training material for tauiwi SSHS providers. A recent series of workshops with providers introduced the educational resources and was very positively received by providers.

The SHCSS workforce was stable and most staff planned to stay in their roles for the coming year (Figure 11). The main reasons for leaving given by those who said they might leave were frustration, not enough pay and stress. Approximately half of those planning to leave said they would leave the specialist sexual violence sector.

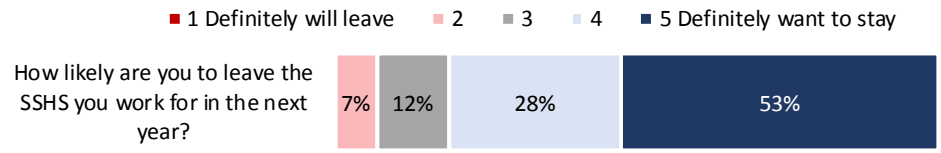

Figure 11. Staff plans to stay in their roles. (Source workforce survey n=103)

Recruiting specialist staff was challenging for all providers.

> *"There aren't enough people with those specialist skills…we've had lots of applicants [but] the percentage who have previous experience in this field is very small…you've got to have the right kind of personality to be able to deal with it…it's not for everybody." – Tauiwi provider*

> *"They need to be a mature person to be able to deal with families." – Tauiwi provider*

> *"Skills around being able to sit with and support somebody who's been through [a crisis], at the same time being able to work alongside Police and medical staff but also be able to stand up to those people should they feel the need to advocate for the clients." – Tauiwi provider*

The characteristics providers wanted for staff included a non-judgemental approach, maturity and experience, an ability to provide specialist support to clients in crisis as well as confidently work alongside the Police and medical staff.

> *"… actually able to be open and non-judgemental…., it's those core things that enable you to look at yourself and not perpetrate a rape myth when you're sitting with someone, or speaking to a group. You can't learn that, or you can but it's very hard to unlearn default unconscious biases. And, in our workload it's easy for those defaults to come out." – Tauiwi provider*

Whakapapa links to the community were also important for some kaupapa Māori services. Tauiwi services also noted the importance of cultural representation.

> *"…because then we know they have innate responsibility to look after our people." – Kaupapa Māori provider*

> *"From the new contract they've allowed for a social worker so that's really fantastic…unfortunately I still haven't got that person…we really want Pacific or Māori." – Tauiwi provider*

Providers talked about difficulty competing for specialist staff with ACC funded organisations and more recently with Homecare Medical who were recruiting for the helpline. Providers reported ACC and Homecare Medical both paid staff at higher rates than NGO providers were funded to pay.

Providers described specific workforce shortages as:

- limited workforce capacity/service provision in Auckland for Māori, Pacific, Asian, Muslim
- small specialist workforce and even smaller Pacific workforce
- limited workforce capacity/services and integration for immigration-refugees
- shortage of counsellors to work with people with disabilities
- shortage of people who can work with transgender people.

Cultural safety

Culturally safe practice places accountability with the counsellor, social worker or other practitioner to recognise their own culture, and how this might affect whānau with whom they are working.

Good practice, as outlined in the TOAH-NNEST guidelines, and in other organisations such as Women's Refuge, guides services to automatically link Māori clients to kaupapa Māori services where they were available in the locality. Many providers understood this and described the importance

of the trust, inherent understanding and advantages for recovery for Māori clients linked with kaupapa Māori services.

> *"… our priority is to provide accessibility for Māori to kaupapa Māori services as our organisation believes and is supported by most other services that although the incidence of sexual harm is universal, the healing pathway is cultural." – Survey responder*

There were two factors that influenced whether Māori clients were able to access kaupapa Māori services:

- Client preference of who they went to for support.

  > *"This is a case by case issue and I would always ask the client and seek additional support if needed." – Survey responder*

- Access - as there were only seven Kaupapa Māori SHCSS in Aotearoa, many Māori who need support inevitably had to access tauiwi services.

In the survey, respondents were asked about their confidence in working with Māori and other ethnic groups (Figure 12). Staff perceptions of their confidence was markedly lower for working with Pacific clients and aiga.

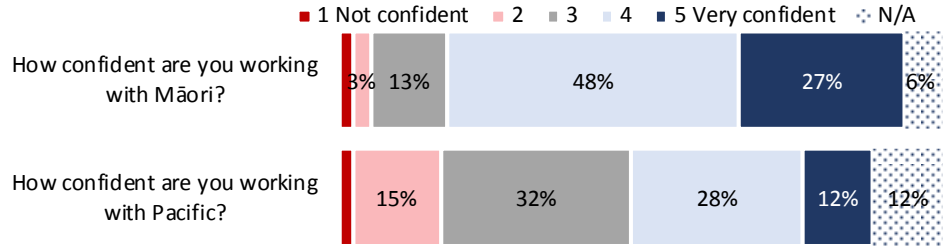

Figure 12. Confidence of all staff in working with Māori and Pacific people (n=95)

A few tauiwi providers had Pacific staff who provided specialist, holistic and cultural support and services for Pacific clients and families.

> *"You just have that connection and then they open up amazingly and I think that is priceless that [Pacific client] will talk and get the help and feels so much better about the process…feels that [they] can say a lot of things that probably you wouldn't say to Police because it's about family, it's about connections, it's about the whole cultural understanding…whereas to the Police she's reserved and withdrawn and really shy." – Tauiwi provider*

When asked to note any other ethnic groups they would like to know more about how to work with, the most commonly noted groups were Asian, Indian and other Middle Eastern cultures. Providers who worked in localities with refugee populations said they lacked confidence in working with these communities.

> *"We had identified a number of gaps…specialist staff…Māori, Pacific and Asian. Those groups aren't necessarily the same across the country but certainly in our CBD area…Asian students…there are particular challenges for Muslim women…and we have large disability communities…another big one for us is immigration…people will apply for refugee status based on sexual violence in their home country… [immigration officers] are interviewing them in the way Police used to 30 years ago…" – Tauiwi provider*

SHCSS teams described the ways they supported Māori and other cultural groups. Many emphasised the importance of the receptionist in making people feel welcome

> *"As the receptionist/administration officer at the organisation I deal with all cultures and ethnicities on the telephone and at the reception desk ... I treat all clients with respect and understanding." – Receptionist – survey*

> *"I am always seeking to know more about other cultures and working effectively and with cultural sensitivity" – Survey responder*

Staff described courses and training including cultural training and/or supervision they had received.

> *"We have adopted the TOAH-NNEST guidelines, particularly the cultural diverse ones…everybody has $1000 training grant a year…opportunities for training and for cultural supervision…" – Tauiwi provider*

Some staff asked for more professional development.

> *"There is certainly room for development in the kaupapa Māori area…we have a diverse staff but we also have extremely diverse community so it's catering to those needs…we do the best we can but I do think there is room for growth and development in that area of providing appropriate services." – Tauiwi provider*

Connecting and collaborating with Pacific cultural advisors and/or health and social service providers was also a way to ensure the needs of clients are met.

> *"Try and be culturally appropriate or if we can't be we will try and get somebody to help us in that area…we do have a cultural advisor…" – Tauiwi provider*

> *"I have been doing some talking with people from different [organisations], particularly the Pacific Island [ones]…in terms of ensuring we are meeting the needs of the individuals here…a more collaborative approach…work together in supporting that person holistically…" – Tauiwi provider*

Many Auckland providers have ethnically diverse members of staff that reflect the diverse range of clients and families. However, there remains a need to increase and develop the Māori and Pacific workforce.

> *"We have Māori, Pacific, Indian, Malaysian, Fijian Indian…quite a diverse team and what I see best working here is when we do have a whānau approach and we have the capability when there are children involved…all the counsellors take a child each…" – Tauiwi provider*

> *"Just look at the statistics, this is where Pacific people live in this country. There's a few other places but not that many and if we can't do it well in Auckland what is that about?" – Tauiwi provider*

Collaborations and networks

Local networks were very important in client entry to services and for SHCSS to refer clients for additional support. SHCSS seemed to have very good networks with Police and referrals from Police were a common entry point to services.

Some interfaces were more challenging with some providers describing tensions between their holistic social support service and 'medicalised' models of care.

Some collaborations were in place amongst providers who saw advantages in working together.

> *"Support services would work better as a connected service with central administration, that can meet the specific and wider needs of a client within a hub. In many respects many agencies are already moving closer to this model." – Survey*

Examples included:

- supporting each other to provide 24/7 cover
- spreading the workload when services were at capacity. For example, in Auckland there is an on-call system and service providers communicate with each other to transfer clients to the provider most appropriate for them – often the provider closest to where they lived.

> *"Three [providers] are working on a MOU at the moment and in alliance so that we provide consistent services across Auckland…we're also aware that there are pressure points so there will be times when one person can't cover for another…we covered for one that was a South Auckland client…that actual specialist part we rely on [other providers] and it's nice that we've been able to give [them] some support as well…" – Tauiwi provider*

- working strategically rather than competing for funding -as exemplified by a group of kaupapa Māori providers in Northland.

  "We don't compete for contracts. We discuss what contracts are coming in and where they will be specialised." – Kaupapa Māori provider

The Pacific Counsellor's Collective (PCC) is currently being established to build the capacity and capabilities of a qualified, trained and experienced Pacific practitioner workforce, and to provide advice to other providers about how to support their Pacific clients.

> *"…connecting the Pacific people in the sexual violence sector…have connections with the students coming through…help them through pathways like ACC…" – Tauiwi provider*
>
> *"This group for me is in a way what [name deleted] was trying to get going all those years ago…things have their time…the need is huge…if Auckland can't do it then where?" – Tauiwi provider*

In the workforce survey, staff were asked about ways to strengthen how specialist sexual harm services work together and with other agencies. The most frequently made suggestions were:

- opportunities for regular meetings, networking and talking to each other

  "Meetings to connect the different services which allows them to each share knowledge of who they are and how they work and possibly workshops together." – Survey responder

  "Time to be able to network and train together. We are so short of resources (i.e. money) that we don't have adequate staffing levels. This means it is almost impossible to dedicate time to training and to connect with other service providers." – Survey responder

  "Having a get together every so many months, to talk about their work. There may be trends happening etc." – Survey responder

- funding to enable meetings and networks

  "Funding providers encouraging partnerships and providing funding for staff to work in partnership." – Survey responder

  "Relationships, relationships, relationships! To achieve successful collaborative approaches time and resources must be allocated to the development of respectful professional relationships." – Survey responder

Competitive funding models were described as a barrier to networking and collaboration

"Yes, by understanding each other's services we can find what is more suitable for the client. But it all comes down to the fight for the funding, so no-one wants to lose. Unfortunately, there is the client that can miss out on what can work for him while we compete for the funding." – Survey responder

Interface between Safe to talk - He pai ki te kōrero and other SSHS

MSD has funded a new national helpline Safe to talk - He pai ki te kōrero. The helpline provides support everywhere in New Zealand for all people affected by sexual harm including victims/survivors as well as perpetrators, or those with concerns about others regardless of age, gender, sexual orientation, special needs, or ethnicity.

The Ministry expects that SHCSS providers will interact with Safe to talk - He pai ki te kōrero. SSCHS providers had mixed views about the advantages and challenges of Safe to talk - He pai ki te kōrero. The main advantage of a national helpline was recognition of the potential to improve access for victims/survivors and whānau and take pressure off SHCSS:

- Some SHCSS considered that the 24/7 availability would give some people more privacy to call at night.

  "I think it would be a great support or tool for us … because we've not got our own line … (name of service) phoneline does have a lot of clients who are waking up in the night having traumas and night terrors and feeling like they need to talk to somebody or it can be … something's happened we need you to come." - Tauiwi provider

- Some thought that online contact would appeal to some people more than other ways of contacting services.

  "Reporting may also increase when community-based programmes known to deliver high-quality, trauma-informed, confidential survivor services become accessible online. For a variety of reasons, people who have experiences sexual assault initially are more likely to seek confidential services online rather than in person." – Survey responder

The main concern for those who were positive about Safe to talk - He pai ki te kōrero was the unknown level of demand and the impacts on specialist services of the volume of people referred to them.

Generalist providers who supported victims/survivors and whānau with holistic responses seemed more likely to be concerned about how well Safe to talk - He pai ki te kōrero would support people seeking help. They saw

crisis support for sexual harm as part of a spectrum of support that considered all the needs of people who contacted their services.

Kaupapa Māori providers had mixed views on the effectiveness of the Safe to talk - He pai ki te kōrero helpline service in effectively engaging with Māori. Some providers had been involved in training staff for the telephone counselling arm of the service. Others were not confident that Safe to talk - He pai ki te kōrero would refer Māori clients to a kaupapa Māori service. Most kaupapa Māori providers had not had any referrals from Safe to talk - He pai ki te kōrero after the service was launched. There was a strong voice from Kaupapa Māori services regarding the Safe to talk - He pai ki te kōrero referral process. They hoped that every person who answered a helpline call would confidently ask for the ethnicity of the caller and refer Māori to a kaupapa Māori provider. To ask Māori clients if they wanted a Māori service positioned tauiwi services as the main service and kaupapa Māori services as 'other'. It was pointed out by one provider that tauiwi clients were not asked if they wanted a tauiwi service.

Overview of crisis support services

Evidence shows that specialist first response services are very important. A lack of these services, or insufficient or poor-quality services, may exacerbate the harm or, at the very least, mean recovery takes longer[21].

Government's Budget 16 investment in SHCSS

- A move to three-year contracts to provide more certainty to providers and enable investment in workforce development and infrastructure
- Consultation with the sector to develop service guidelines and a results measurement framework
- Development of a funding allocation model to ensure a consistent and strategic approach to the distribution of funding across the country. The funding allocation model was developed using a social investment approach. It is based on three key principles:
    - using a client-centric approach – understanding who clients are and where they are located
    - using an evidence-based approach – using 50+ datasets to build the model
    - applying specialist knowledge and expertise to the data.

[21] Report of the Social Services Committee (Dec 2015). Inquiry into the funding of specialist sexual violence social services.

- A two-phase procurement process to fill identified geographical gaps in SHCSS services around the country
- Commitment to continuous improvements by reviewing the guidelines with the sector.

The impact of government's investment in SHCSS

Government's initial investment through Budget 16 has had a positive impact on the sector that has contributed to:

- **Increased sector stability**: The challenges of short-term contracts for providers have been widely reported as barriers to workforce development. Extended contracts are helping to provide stability in the sector.
- **Building service capacity**: Additional funding has enabled some providers to extend their workforce, for example to employ other roles such as social workers to provide holistic support for clients.
- **Improved service capability**: Consultation and the development of service guidelines, alongside funding for TOAH-NNEST's online learning platform are likely to contribute to building sector capability.
- **An integrated service network with improved geographical coverage, availability and accessibility:** Gaps funding for some providers and the establishment of the national helpline Safe to talk - He pai ki te kōrero are progress towards an integrated service network. However, there are remaining gaps in the geographical coverage of SHCSS.

Meeting the needs of clients

SHCSS have a dedicated and mainly stable workforce who work in the sector because of the satisfaction they receive from the changes they make to people's lives. Changes for clients were mainly described as changes in wellbeing, mana and wairua. These changes contributed to clients and whānau having increased ability to engage with life.

SHCSS provide client focussed support that ranges from support during the crisis event only to 'wrap-around' support that may extend over a much longer period. Support can include ensuring clients and whānau have their basic needs met, advocacy with other agencies (especially Work and Income), and specialist social work and trauma counselling. The breadth of services different SHCSS provide is influenced by what other services are available in the locality. For example, in some rural locations, the SHCSS may have to provide the full breadth of support for

whānau because there is no-one they can refer to.

MSD funds support during the crisis period and ACC funds long-term care and recovery services. There are constant challenges for providers in accessing ACC services for their clients. Some providers noted that perceived financial incentives for clients to access ACC counselling may contribute to some clients seeking ACC counselling when other forms of support may be more appropriate for them. SHCSS also support clients and whānau who are not eligible for ACC services or do not want ACC them.

SHCSS providers described themselves as working at or over capacity. Despite being at capacity, providers said they did not turn anyone away. They drew on resources to ensure clients had basic resources and were safe. Awareness that SHCSS will not turn clients away contributed to some other local agencies referring people to SHCSS for support who do not strictly meet the eligibility criteria.

Good information about client outcomes will be part of later evaluation reports. A current lack of consistent outcome measures and computerised case management systems limits the extent client outcomes can be objectively reported.

Opportunities to further strengthen SHCSS

Budget 16 was the start of funding to support changes in the sector. There are some remaining challenges for the sector:

- Unfunded components of the support SHCSS provision that include 'holding time' while waiting for specialist counselling, funding for people not eligible for ACC services, funding for those under 18 (currently being addressed by Oranga Tamariki).
- Insufficient funding for travelling time and challenges for smaller providers to provide 24/7 cover. For example, funding may be for 1 FTE but it can be logistically difficult for smaller providers to provide 24 hour cover within 1 FTE.
- Funding that does not adequately recognise differences in the way kaupapa Māori providers support clients where additional time may be required for whakawhanaungatanga and manaakitanga and accountability is to whānau, hapū and iwi.
- How to adequately fund support for victim/survivors and whānau who have complex needs that extend beyond crisis support.
- Further funding to continue to build the capacity of the sector to meet demands: SHCSS are managing multiple contracts with different agencies and spending time and resources in fundraising

to cover funding shortfalls. An integrated sector may require reviewing and simplifying funding algorithms and contracts.

- Capability building: considering workforce development opportunities and ways to fund meetings and networking for providers to share learnings as part of a continuous improvement process.
- Resourcing infrastructure through guidance about effective case management systems, co-designing outcomes measures and resourcing computerised record keeping.

Safe to talk - He pai ki te kōrero

New funding in Budget 2016 sought to implement a national 24/7 helpline providing counselling, social work support, and referral services. The aim was to

- Provide support for all victim/survivors - everywhere in New Zealand - regardless of age, gender, sexual orientation, special needs, or ethnicity
- Provide counselling and social work services through multiple modes of communication, including social media, texting, and web-based services
- Service a proportion of latent demand.

Homecare Medical was selected as the provider of the Helpline. Homecare Medical is a social enterprise which is owned by the primary health organisations ProCare and Pegasus Health. It runs the National Telehealth Service which delivers free health and mental health advice, support and information including Healthline, Need to talk? 1737, Quitline and other specialist services.

MSD facilitated extensive consultation with the sector in planning the Helpline which has been called Safe to talk - He pai ki te kōrero. The helpline is a multi-channel national sexual harm helpline which clients can contact by telephone, webchat, social media and text.

Safe to talk - He pai ki te kōrero was implemented in Christchurch as a pilot in February 2018 and nationally on April 16, 2018. Implementation was not widely promoted as there was a need to track responses and to align them with sector capacity to respond.

Introduction of the helpline is not intended to inhibit a client's ability to connect with regional services via current local numbers already in operation. A client's trust and relationship with the provider is vital and should not be compromised by the introduction of the helpline.

How Safe to talk - He pai ki te kōrero supports clients and whānau

Safe to talk - He pai ki te kōrero promotes the following services for people:[22]

- contact with a trained specialist at any time, day or night, seven days a week.
- answers to questions about sexual harm.
- information about medical, emotional, and behavioural issues related to harmful experiences.
- explanations of what you might expect if you report to the police.
- referral to specialists in your area.
- information for family and friends wanting to help someone.
- information and contact with a specialist if you are worried about your own sexually harmful thoughts or behaviour.
- information on or connection/referral to medical practitioners for medical care or forensic medical examination. this can happen without police involvement or while they are making up their minds about whether to contact police.

MSD expects that providers will interact with Safe to talk - He pai ki te kōrero, which will include:

- receiving referrals from the helpline
- making referrals through the helpline to access and align with other available services
- providing information to clients, family and whānau about the helpline
- using the helpline for information and/or support.

Awareness of Safe to talk - He pai ki te kōrero

MSD and Homecare Medical facilitated eight roadshows to discuss Safe to talk - He pai ki te kōrero with sector providers. We interviewed providers during the pilot and just after the national implementation. At that time, some of the providers we interviewed were not aware of Safe to talk - He pai ki te kōrero and many of those that were aware wondered what was happening and when it would be rolled out.

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22 https://www.safetotalk.nz/?gclid=Cj0KCQjwxN_XBRCFARIsAIufy1aJIpW60jWbnuAaVVAdhdsaSSmF9tYRoKQh8KN4HFvLt5RRchSfE-YaAsAoEALw_wcB

The evaluation focus for Safe to talk - He pai ki te kōrero

The purpose of the evaluation of Safe to talk - He pai ki te kōrero is to:

- describe the implementation of Safe to talk - He pai ki te kōrero and provide information to inform its ongoing development
- understand what is working well, what challenges have been encountered
- describe client experiences
- understand how effective Safe to talk - He pai ki te kōrero has been in increasing access to specialist services and connecting all people, particularly Māori and Pacific peoples, to the services they need (both in-house and external services).

The focus of the evaluation is not on the technical aspects of helpline delivery.

Safe to talk - He pai ki te kōrero is not a focus of the formative evaluation because of the early stage of implementation. At the time of the evaluation, none of the providers we interviewed or who responded to the workforce survey had received referrals from Safe to talk - He pai ki te kōrero. Subsequent process evaluations and workforce surveys will explore the interface between Safe to talk - He pai ki te kōrero and other specialist providers.

Early findings about the use of Safe to talk - He pai ki te kōrero

Preliminary data provided by Homecare Medical indicates that Safe to talk - He pai ki te kōrero is not having a large demand on frontline services. To the end of June 2018, the majority of service users of the helpline required service in the moment, but once they had been listened to and de-escalated, did not want to be referred onto another service at that time. Clients were more open to being signposted to other services so that they can choose when to engage.

In the reporting period (December 2017 – June 2018) there were 11 referrals to other services, and 70 people were signposted to other services.

Overview of Safe to talk – He pai ke to kōrero

Government's Budget 16 investment in a national sexual harm helpline
Budget 16 funded the establishment of a new national 24/7 multi-

channel sexual harm helpline to:

- provide support for anyone affected by sexual violence - everywhere in New Zealand - regardless of age, gender, sexual orientation, special needs, or ethnicity
- provide counselling and social work services through multiple modes of communication, including phone, social media, texting, and web-based services
- service a proportion of latent demand.

What changed following government's investment in Safe to talk - He pai ki te kōrero

Homecare Medical is the helpline provider. A series of workshops introduced the service to providers and provided opportunities for consultation and discussion.

Safe to talk - He pai ki te kōrero was implemented in Christchurch as a pilot in February 2018 and nationally on April 16, 2018.

Safe to talk - He pai ki te kōrero was released across New Zealand from 16 April 2018 increasing the availability of 24/7 contact for people who want to talk about sexual harm. Although some providers already had a 24-hour phone line in place, the new helpline provides increased resources and a standardised approach.

Providers saw some areas of Safe to talk - He pai ki te kōrero as potentially highly beneficial to clients. The option to contact services online was considered particularly useful for clients who may be nervous about disclosing in-person.

As Safe to talk - He pai ki te kōrero is rolled out the evaluation will focus on the reach of the service, the interface with other providers and the outcomes for clients.

Male Survivors of Sexual Abuse

The Male Survivors of Sexual Abuse (MSSA) are organisations that support male victims/survivors of sexual abuse. All MSSA services are different and provide a range of support for people but the primary basis of all services is one-on-one and group peer support. MSSA services offer free support that may be additional to other free and paid models of care, such as: crisis support services, ACC services and other clinical and non-specialist support.

MSD funds the continuation of male survivor services to help them deliver the peer support currently offered, as well as funding a national organisation, the Male Survivors Aotearoa (a trust set up to represent the majority of MSSA services).

The evaluation focus for male survivors of sexual abuse

The primary purpose of the evaluation is to assess the implementation and outcomes of MSSA services. The focus of the new investment has been on identifying 'good practice', service development to consistent 'good practice' standards and establishing data collection to understand client outcomes.

Where MSSA support is located

There are seven MSSA services in New Zealand (Invercargill and Dunedin services are run as one service) with most having fewer than five staff (Figure 13). Much of New Zealand is not covered by MSSA services, especially rural areas.

MSSA staff are mostly unable to provide peer support for people outside their area within the limited time and funding available. However, some practitioners travelled to a limited extent to facilitate peer support groups in smaller areas. Establishing and maintaining peer support groups in other locations took a lot of time and effort to promote the service, connect with local services and the associated travel time.

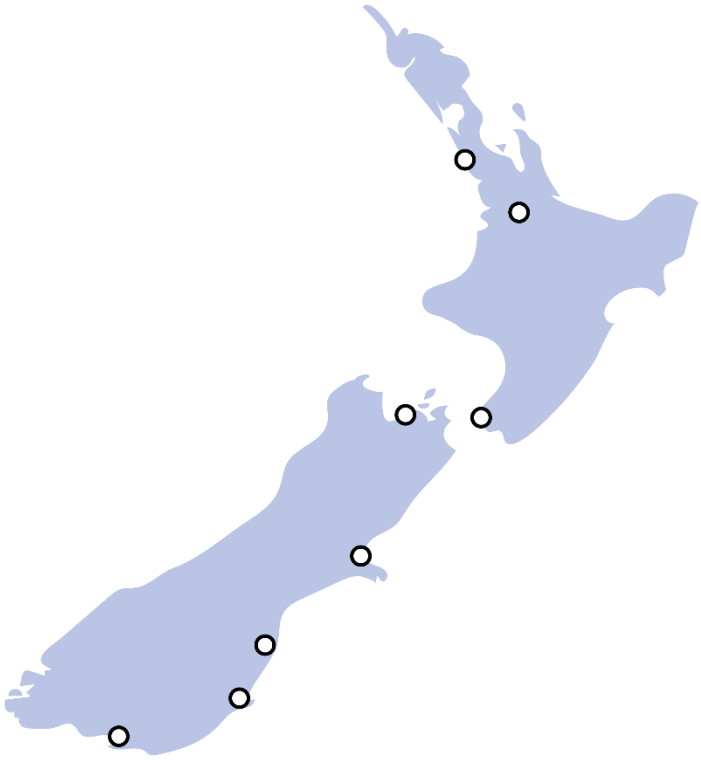

Figure 13: The location of MSD funded male survivors of sexual abuse services

Clients and whānau

MSSA providers explained that most male clients take many years to disclose sexual abuse and to seek help and support, meaning that client ages extend from the twenties and onwards. Most clients were described by MSSA providers as the "*underserved in the community*". Childhood trauma with delays in disclosure contributed to a variety of unaddressed issues that were symptomatic of the underlying harm caused by sexual abuse (usually experienced by these men in their childhoods). For example, many clients who accessed MSSA services were dealing with issues such as: relationship breakdowns, separation/divorce, crime and going to prison, drugs and alcohol and other mental health issues. They had high rates of homelessness, benefit receipt, and gang connections.

> *"You don't often get a middle-class guy walking in the door who has a good job and has his life together, we are dealing with the bottom of the bottom." – MSSA provider*

MSSA referral sources varied by provider. Most clients were self-referred. MSSA services also often received phone calls from partners asking for help for men. MSSA services gave whānau advice and support but they all

thought it was best to wait until the male survivor was ready to get in touch with them.

Other referrers commonly included Police, Corrections, ACC, mental health services, sexual harm NGOs, and self-referrals. Some MSSA peer supporters were part of larger organisations that provided support services for a broader range of issues than sexual abuse, resulting in referrals from a wider range of sources.

Several barriers to client entry were identified including:

- clients who had very little trust in the establishment. Childhood abuse of MSSA clients while they were in institutional care has led to mistrust of government and other bureaucratic services. MSSA services developed as peer supporters so they were not seen as being part of the establishment.
- stigma associated with being a male survivor. MSSA practitioners considered that current ideas of masculinity portrayed men as being dominant and aggressive, meaning that they were usually viewed as the perpetrators of violence rather than as the victims. Therefore, being a victim could be stigmatising because it contradicted stereotypes and expectations of male strength and dominance. Admitting that they had experienced sexual violence may, therefore, open up feelings of shame. One provider pointed out that:

  "There's huge shame and guilt that goes with being a male survivor in a patriarchal society where we're supposed to be tough and staunch. So, we become tough and staunch and when it comes to dealing with the emotions that have been shut up inside us for so long, we don't know how to do that." – MSSA provider

- a lack of awareness of MSSA services. Some of the MSSA client population were not connected with any media or other services, meaning they were potentially unaware of the available services. One provider worked largely with homeless men and pointed out that those who could or did not read were unable to learn what services were available.

  "The public is not aware of the prevalence of sexual harm against males. We need widespread public education initiatives. These are key messages - 'One in six males has been sexually abused. ' 'Services exist to help males who have been sexually abused'" – Survey

  "That males are victims too and the lack of publicity around this. There is not enough discussion and advertising from government agencies." - Survey

- cultural barriers to disclosure, particularly for Māori and Pacific men. Lack of disclosure may be affected for these groups by the sense of bringing shame to their families, and the sense of not being able to find support within their families and communities.

Some MSSA also held contracts with the Department of Corrections for work in prisons and to support male offenders and parolees who had been sexually abused. It was rare for MSSA providers to work with male sex offenders; only one MSSA provider identified working with male sex offenders in addition to male survivors. These two groups never met.

How MSSA support clients and whānau

All MSSA classified themselves as crisis support services and all had 24/7 telephone lines that people could call for support. A few allowed calls to go to voicemail outside of working hours but checked messages and responded to crisis calls.

All MSSA providers reported that men were reactive and not likely to seek support until they were experiencing a crisis. Crisis support was described as responding to a client who had experienced re-traumatisation and had found themselves in need of urgent support, or clients who may or might have harmed themselves or others.

The primary types of support offered by MSSA services were one-on-one and group peer support. The structure of these types of support often varied according to location. MSSA providers felt it was important to provide holistic services that encompassed emotional, physical, and domestic abuse for male victims. Several also offered support for whānau of male survivors.

MSSA services linked their clients to the specialist services they required and continued to support their client, sometimes helping to advocate with other services.

Figure 14 shows the potential service journey of male survivors and where they may disengage. It is important to note that disclosure may be 20 to 30 years after the sexual abuse event.

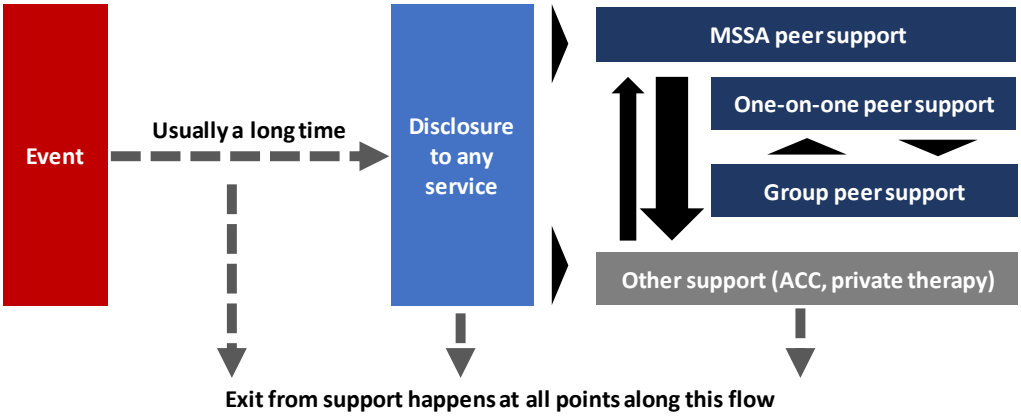

Figure 14. Client journey for male survivors

One-on-one support

One-on-one support included formal and informal support. In some cases, it involved talking over the phone, going for a walk and a chat, meeting up for coffee, one-on-one coaching, or advocating with the social, health and/or justice system. This support was provided both in response to crisis as well as for regular catch-up meetings.

Support might start with providing a client with a warm drink and finding them somewhere to live, encouraging someone to put a shirt on in the morning, through to reconnection with whānau. One example of support involved a client's eviction from his accommodation, resulting in his MSSA provider helping to find him new accommodation and setting him up with some necessities. Support might move to clients setting goals and peer supporters helping them to achieve their goals and monitoring their progress.

Services which had appropriate office space available tried to create a friendly environment where clients both new and old could feel comfortable, clients could come in and make their own cup of tea or coffee and get a snack.

Examples of one-on-one support included:

Gardening therapy

One of the peer supporters works in a wide range of ways with his clients. If he thinks it is appropriate, he invites them to garden with him as a way to provide a physical outlet in a calm environment.

Going for a walk

One of the smaller MSSA services does not have access to a permanent office so the peer supporter meets his clients and goes for a walk. This helps to create a casual interaction which is not intimidating and removes any stigma of walking through doors which might say survivors of sexual abuse.

Peer support groups

Peer support groups are not provided by all MSSA services. All services reported that group peer support is extremely helpful, but it can be very intimidating to come to a group session. Clients are screened before being invited to come along to group sessions to make sure they are ready and that the group is ready.

However, all services said that male clients who were part of peer support groups found it useful to meet and support their peers and that group dynamics were therapeutic. Some providers trained facilitators (who were current peer support group members) to go into their communities to work with male survivors. Outreach services were important because many clients could not travel to access services.

> *"Peer support groups are quite amazing… it really, really works… the changes you see in guys, it is powerful stuff." – MSSA provider*

Advocacy

MSSA providers frequently supported male survivors to engage with other services. For example, they often supported clients in their engagement with the police and the courts, and they accompanied clients to doctors and emergency mental health services.

Education and prevention

Education about male survivors and sexual harm was another service offered by some MSSA providers. Some services wanted to educate young people in schools and raise awareness of the impact for younger people and the services available. Others generally worked on improving public awareness of MSSA services through various speaking engagements within the community.

Service exits

Providers agreed that sexual trauma is permanent and ongoing and could never be resolved. Therefore, there was no such thing as a service exit. Client engagement with their services were often intermittent but ongoing. Although male survivors may stop attending peer support groups or one-on-one sessions, they were always able to get in touch for support whenever necessary.

Client outcomes

Peer support is widely used in many areas including weight loss, addiction, mental health and chronic conditions. Research has demonstrated the benefits of peer support in many areas, although there is very little research on the effectiveness of peer support for survivors of sexual violence.

MSSA services aim to address the multiple disadvantage in men's lives that have resulted from sexual abuse. Outcomes for clients therefore relate to improved wellbeing and a reduction in outcomes such as suicide and self-harm. MSSA practitioners suggested a qualitative measure of the effectiveness of MSSA was whether men continued to come to the service. Continuing to engage with MSSA reflected men were getting something from the peer support.

None of the MSSA services were objectively measuring client outcomes. However, MSD has been working with MSSA providers to develop performance reporting measures. Potential approaches might include:

- monitoring progress towards achieving goals.
- tools that measure changes in wellbeing. Because of the wide range of outcomes and what would be considered success for different people, MSSA services agreed it was challenging to report on client outcomes with a valid measure across all clients.

Infrastructure

All MSSA services were individual services that ran independently. Each service had a Board of Trustees, and three of the services shared a Board (Oamaru, Dunedin and Invercargill). All services aimed for good clinical representation on their Boards to help promote and maintain their services.

Each service had a manager who organised the service and applied for funding; however, their roles extended well beyond these functions. Managers saw themselves primarily as peer supporters and peer support

facilitators who were forced into management positions due to a lack of others available and/or willing to fill these positions.

In 2017, MSSA services started using PAUA: an online client management system. Licensing for this comes from the national body, Male Survivors Aotearoa. PAUA tracks clients' engagements and details and can be accessed through an online portal. It can be customised for each service's needs to allow for different care streams. PAUA has the capability to track extra variables that services wished to incorporate.

All MSSA services had computers but funding limitations made keeping up to date with technology difficult. In response to the survey, most staff reported they had an adequate work computer even if it was their own personal computer.

Funding

Budget 16 changes provided some funding certainty to the sector through one-year contracts. In the past MSSA had been funded through grant funding.

Despite new funding to the services, adequate funding to meet demand was an ongoing challenge for MSSA services. MSSA services often relied on funding from other sources such as other contracts or private donations to continue providing support.

Providers said lack of funding limited access to resources to provide services for male survivors and limited staff engagement with professional development opportunities. For example, one provider was limited to holding only one regular peer support group, even though it would like to be able to provide more.

One of the aims of Budget 16 funding was to develop service guidelines and consistent practices throughout the sector. One of the aims of the evaluation is to explore the effectiveness of MSSA in improving outcomes for clients.

The MSSA workforce

MSSA services required peer supporters to be men who were survivors of sexual abuse. Eleven men responded to the workforce survey. Their profile is summarised in Table 6 and characterised by:

- an older workforce – 64% aged 50 or older with managers describing difficulty in attracting younger men
- a mainly Pākehā workforce (91%).

Table 6. Profile of the MSSA workforce (Source: Workforce survey n=11)

Characteristic		Survey respondents
Gender	Tāne / Male	11 (100%)
Age	Under 39 40-49 50 or older	2 (18%) 2 (18%) 7 (64%)
Ethnicity[23]	Māori Pacific European/Pākehā Other ethnic group	- - 10 (91%) 3 (27%)

Roles in the workforce

All MSSA services had a manager. These managers filled nearly every role in their service, including: managing the service, answering the 24/7 phonelines, one-on-one peer-support, peer group facilitation, promoter, administrator, applying for funding, and advocacy. Additionally, they were also responsible for the multitude of other tasks involved in running a small service. Many of the managers had worked in their roles for over five years.

Other staff roles differed across the services. Smaller services sometimes had peer support facilitators, co-ordinators, and social workers. MSSA who were part of larger services had access to a range of contractors such as social workers, counsellors, psychologists, and administrative staff.

Most MSSA staff worked part-time. The larger organisations were more likely to have full-time staff. Everyone working for MSSA services reported that the administrative part of their role took up a lot of their time. Importantly, nearly all services had staff who were working more hours than they were paid to work.

Workforce challenges included finding people trained to work with male survivors of sexual trauma and to provide the holistic support required for survivors. Young men were under-represented in training courses for helping professions like social work, counselling. Expanding or creating new services was often challenging as it required finding a male survivor in a new location who was willing to start their own service.

[23] Unless otherwise stated, we used a total count approach to analysis of ethnicity where people were counted in all the ethnic groups they identified with.

Workforce satisfaction

People who responded to the workforce survey found their day to day work satisfying and most intended to remain in their roles for the next year (Figure 15). Those who said they might leave in the next year reported reasons that had nothing to do with the satisfaction of the job.

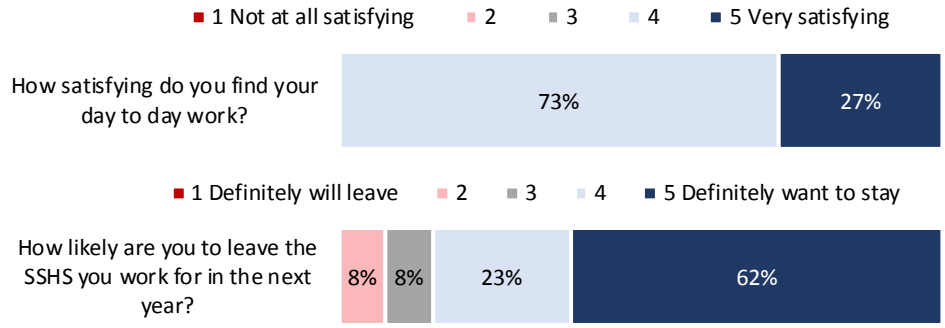

Figure 15. Workforce satisfaction for all staff (n=13)

MSSA peer supporters explained the reasons for their satisfaction as:

- the privilege of working with male survivors and whānau

  "Connecting with and validating men through a shared experience. Challenging misconceptions around male sexual abuse and the feeling of making positive change." – Survey responder

  "Giving people hope." – Survey responder

- building a therapeutic relationship

  "The opportunity to support my clients as they consider an alternate or preferred way of being." – Survey responder

  "Connecting with people who might otherwise not have the chance to speak about their experience. It is satisfying to be able to provide a space where those people can talk about their experiences in a non-judgmental environment and know that from their feedback they feel cared for and believed!" – Survey responder

- the changes they saw their clients achieve

  "The most satisfying part of my job is seeing the relief on a man's face when he realises he is not responsible for what was done to him and that he is not alone. When he sees a man who is not ashamed to share his story and the feelings experienced are similar. Seeing the man's thoughts about self-change as he moves through his journey." – Survey responder

- changing societal attitudes

"Changing the way this country sees male victims of sexual trauma, satisfaction the males we support getting the support they need. Being part of a movement to help male survivors of sexual trauma." – Survey responder

Support for staff

All MSSA survey respondents had external professional supervision which mostly met staff needs (Figure 16). External contractors working with MSSA services had their own formal supervision. Professional supervision was generally funded by the national body so monetary barriers to supervision did not seem to exist.

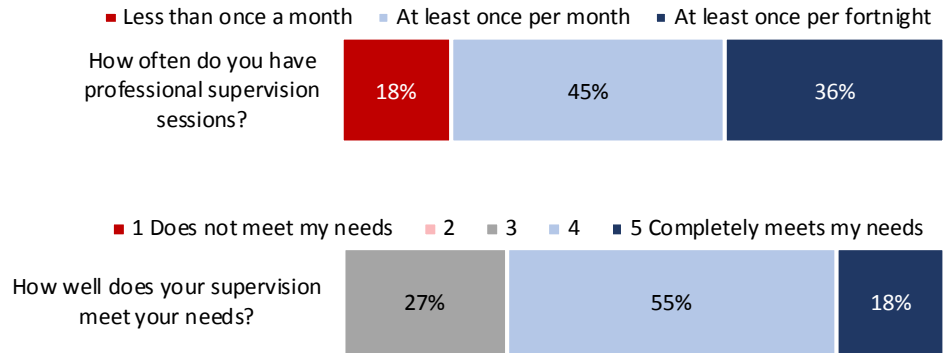

Figure 16. Supervision timeframes and satisfaction for all staff who receive supervision (n=11)

Cultural safety

MSSA services were committed to developing personal relationships within their communities and to providing culturally-appropriate services for all their clients. MSSA services tried to engage with different cultural groups wherever possible to provide culturally safe services. For example, several providers were worked with local iwi and had culturally-appropriate facilitators to run ethnic-specific support groups. MSSA services had few or no Pacific clients.

"We have a Kaumātua for advice. We don't have specific systems apart from that all cultures are respected, and we strive to meet all needs." – Survey responder

"Making sure my Māori client needs are met. Working within a Māori worldview and understanding the differences." – Survey responder

"I deal with all clients in a respectful way, but I always clarify a client's cultural needs." – Survey responder

Many providers expressed a preference for more Māori and Pacific staff but being a peer (a fellow survivor of sexual abuse) was considered the most important attribute for supporting clients.

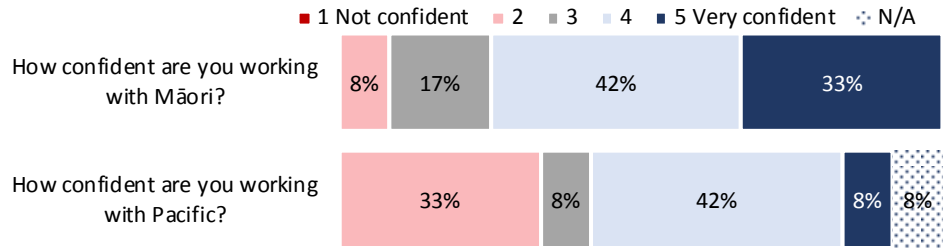

Figure 17. Confidence in working with Māori and Pacific people (n=12)

Collaborations and networks

MSSA services were not clinical services but provided peer support services to assist clients with the issues they were experiencing. MSSA providers were increasingly building networks to engage with other services to link their clients with the support they needed. MSSA services varied in their engagement with services for female survivors. Ideological differences could inhibit collaboration. Other services that MSSA providers engaged with included ACC. MSSA services also often worked with the justice system – with the police, corrections, and probation.

Budget 16 funding supported the development of a national body: Male Survivors Aotearoa. All but one MSSA service belonged to the national body.

Male Survivors Aotearoa

MSA was a trust set up to represent the various MSSA services around to country. Its goals were to help align the services delivered and help to promote the need for continued funding and awareness of male survivors and the services supporting them.

All participating members of the national body valued its contribution. They felt the national body legitimised their services and increased their credibility. Additionally, it provided the backbone for expanding their services, helped provide consistency, and helped organise the wider direction of MSSA services.

Overview of services for male survivors of sexual abuse

Government's Budget 16 investment in MSSA
The focus of government's Budget 16 investment in MSSA was on identifying 'good practice', service development to consistent 'good practice' standards and establishing data collection to understand client outcomes.
The impact of government's investment in MSSA
MSSA are provided by the same providers and at the same capacity as prior to Budget 16 changes. However, services now have some funding certainty through one-year contracts. There is a focus on identifying 'good practice', service development to consistent 'good practice' standards and establishing data collection to understand client outcomes. A national body, MSA have been resourced by MSD to provide sector leadership. MSA has taken some time to become effective. However, the participating members now feel that it is an effective and organised national voice for male survivors. All MSSA services now use the client management system PAUA to help track and manage their clients. Use of PAUA provides opportunities for robust information about how MSSA support clients. Later stages of the evaluation will draw on client interviews and data from PAUA to track client journeys and outcomes.
Meeting the needs of clients
MSSA provide holistic support for clients and help to build trust and link their clients to the specialist and treatment services they need. Their peer support facilitated client engagement with other specialist support to improve outcomes. No objective data were available about client outcomes. However, MSSA services believed that they were providing effective support for their clients. Later stages of the evaluation will draw on client interviews and data from PAUA to track client journeys and outcomes.
Opportunities to further strengthen MSSA
MSSA services considered that a lack of funding limited their reach and capacity of what they could achieve for their clients. MSSA services requested clearer direction from MSD on how to record outcomes for

clients, and what type of data they could collect to help them grow and develop their services.

Harmful sexual behaviour services for non-mandated adults

Harmful sexual behaviour or sexually abusive behaviour is a descriptor for sexual behaviours that involve elements of force, coercion and/or power by one person over another for sexual gratification and control. These behaviours can include both contact and non-contact behaviour. Concerning sexual ideation (CSI) is a descriptor for people who have harmful sexual thoughts or fantasies, but who have not yet acted on them.

The MSD-funded specialist services to address harmful sexual behaviour that are included in the evaluation provide information, assessment and treatment for non-mandated adults who have engaged in concerning or harmful sexual behaviour.

The cohort includes those who:

- refer themselves (of their own volition or on the advice of lawyers or are referred by family or whānau) or are referred by other counselling and social work services to HSB assessment and treatment services
- have been tried for a sexual offence but have not been convicted
- are on probation, or who have received a community sentence for a sexual offence, typically referred directly to treatment services by Police.

MSD purchases the provision of clinical assessment and intervention places for non-mandated adults who have engaged in HSB from three specialist services. MSD-funded harmful sexual behaviour services represent a small proportion of the work of the three specialist providers. These providers also have contracts with Department of Corrections, the Ministry of Health (Health), and Oranga Tamariki to deliver HSBS to other population groups.

Changes in funding in Budget 2016 for HSBS aimed to:

- increase available places in assessment and in existing treatment programmes, thereby clearing current waiting lists and meeting some additional latent demand.
- improve the geographic coverage and tailoring of services to minority groups.

- define and incorporate best practice recommendations from recent and future research on effective delivery of HSB assessment and treatment services. A design sprint, facilitated by PwC, was held end of 2016 to define the harmful sexual behaviour service. The HSB non-mandated service guidelines were created from the meeting.
- improve stability through a move to two-year contracts.

The evaluation focus for HSBS

The primary purpose of the evaluation is to assess the response to the increased funding to increase the capacity of HSBS. The evaluation aims to highlight facilitators and barriers to increasing the capacity of HSBS and maintenance of the quality of service provision. Information will inform the case for the budget bid for 2019 to secure funding for future years.

Where HSBS for non-mandated adults are located

Three specialist services providing MSD-funded services for non-mandated adults with harmful sexual behaviour – Safe Network, Wellstop, and STOP Christchurch – are the focus of the evaluation[24]. Although their primary locations are Auckland, Wellington, and Christchurch, they provide services across the upper North Island, lower North Island, and South Island respectively to cover all of New Zealand. Each provider covers a large geographical area.

[24] An MSD funded pilot kaupapa Māori HSB service is not included in the evaluation.

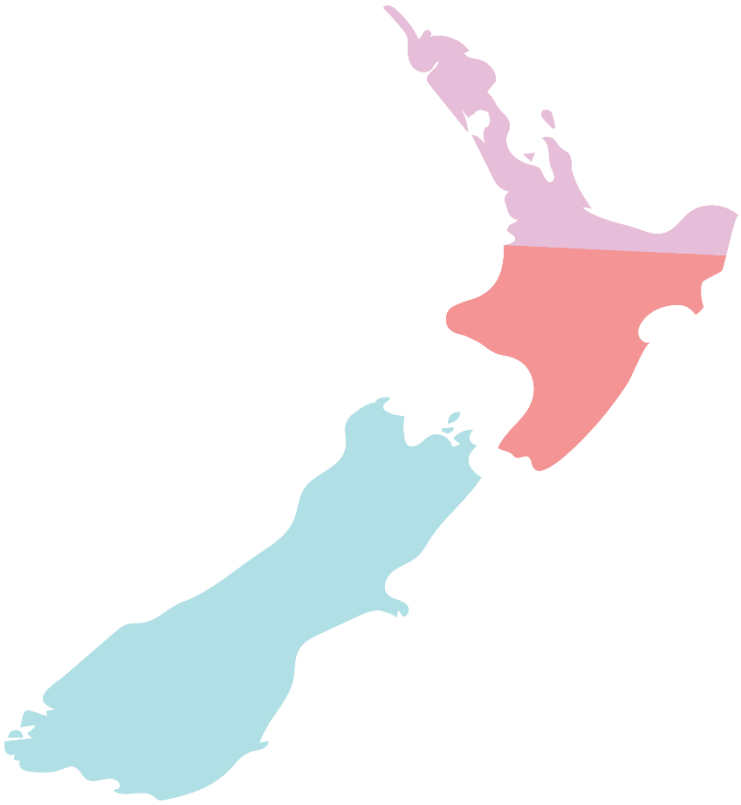

Figure 18: The location of MSD funded harmful sexual behaviour services

There are approximately 120 staff across the three HSBS providers. The number of staff at each provider that work with non-mandated adults is a smaller subset of total staff numbers. Depending on the location, staff may work across multiple client groups but only dedicate part of their time to each group or may work with a dedicated group full-time. Each HSBS has some staff who work remotely to cover a greater geographic area. In rural locations or for staff working remotely from the main office of the service, the likelihood of having to work with different groups, such as adults and children, is increased.

In addition to these three providers, 22 people who responded to the survey said they also provided harmful sexual behaviour services. Most were providers who also provided crisis support. HSBS providers stressed the importance of having an evidence-based co-ordinated approach. They were concerned that if smaller services were to begin to offer HSB treatment, their size and limited resource would mean that HSBS clients would not receive best-practice care.

> *"It's hard to see a generalist provider providing an evidence-based intervention. Because it is complex, the field has changed so dramatically, and a generalist provider – what is seen as intuitive*

doesn't necessarily match research. What you think is the way you should go about this is not what the evidence shows …. One thing, for example – there used to be a lot of the AA sort of approach, 'I'm a sex offender and these are all the terrible things I've done", and expecting clients to pour out in detail all the horrendous things they've done…' - HSBS provider

"There are small counselling practices out there trying to do the stuff we're doing… I don't see how they have the critical mass to deliver the quality of service we have." – HSBS provider

Clients and whānau

HSBS clients are predominantly males. They have a very mixed socio-demographic profile and include internet offenders, clients with mental health issues, those with intellectual disability, low cognitive function, those who are isolated and struggle to maintain relationships, and/or are involved with drugs and alcohol. They may also be victims/survivors of sexual abuse.

HSBS funded by MSD are focussed on assessments and treatments. Many clients also required support across other aspects of their lives, such as social needs, mental health, and alcohol and other drug use. One HSBS provider also provided 'wrap around' support but the other two providers focussed on treatment.

"The clients we're dealing with will probably be the same clients that are being dealt with by other agencies as well." – HSBS provider

HSBS were working at capacity and had waiting lists for non-mandated services. Clinicians worked closely with referrers to help them manage clients while they were waiting for assessment by the HSBS provider. During the waiting period, clients were supported by the initial referrer, not the HSBS, although the HSBS supported referrers to provide appropriate care.

The limit on assessment places meant any increased awareness posed a risk to increasing waitlists without being able to provide the advertised service in a timely manner.

How HSBS support clients and whānau

The three MSD funded HSBS were specialist services. Providers saw this level of specialisation as highly important to effectively engaging with clients to engender the necessary behavioural changes.

"We need to recognise the value of specialist organisations. Even with our own staff, people are really nervous around asking people about what nasty things they've experienced in terms of sexual harm and what they've done to others." – HSBS provider

The guidelines for HSBS interventions for non-mandated adults state the following components must be included:

- gather and review background information and collateral reports about the client and keep records of consultation with relevant persons/agencies involved.
- employ a motivational interviewing technique designed to increase the client's motivation to participate in intervention.
- engage and build rapport with the client's support network in a non-threatening and professional way.
- use psychometric assessment tools to assess the client's static and dynamic risk factors to reach an estimate about the client's overall level of risk and need, and level of protective factors.
- develop a working formulation/hypothesis about why the client's harmful sexual behaviour occurred.
- identify actual or potential risks to safety and well-being, particularly in respect to the client/victim/children.
- prepare an assessment report documenting the client's level of risk, as well as needs, strengths and responsivity issues, and the clinician's intervention recommendations as to how those issues can be addressed.
- obtain written and informed consent from client and client's support network to the assessment and intervention recommendations.
- refer the client to other services if they have outstanding health or social needs that need addressing before assessment and/or intervention can occur.
- keep accurate and secure records of all client data, reports and recommendations.

The figure below shows potential pathways for clients who engaged with HSBS.

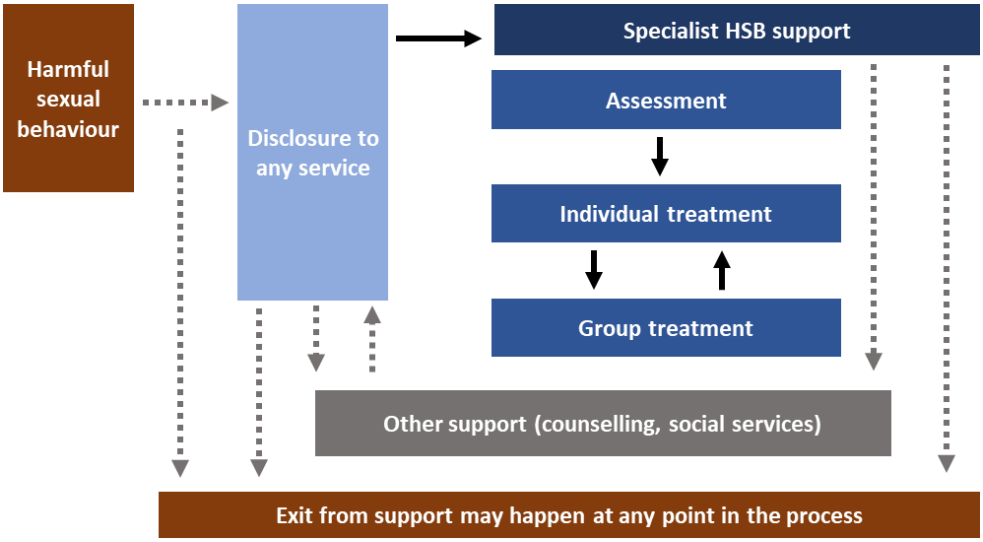

Figure 19: Client journey for HSBS clients

Referral

Non-mandated adults reach HSBS through self-referral, family or whānau referral or through referrals from other agencies including Oranga Tamariki, their GP, non-SSHS counsellors, university health clinics, and mental health services.

Disclosure may be through the client volunteering information, for example to a counsellor or GP, through self-disclosure to the HSBS, or through a service discovering the harmful sexual behaviour and recommending treatment.

Screening

People referred to HSBS are screened prior to the referral being accepted but before the formal assessment process begins. HSBS providers screen clients to:

- ensure they are suitable candidates for treatment and the behaviour the potential client is presenting with is aligned with the treatment provided
- ensure there are no barriers to treatment. Barriers to engagement may include drug and alcohol use, poor mental health, or inability to travel to the HSBS provider's premises for treatment. If such barriers are present, HSBS will refer the client back to the initial referrer. The HSBS then supports the referrer to work with the client to facilitate future engagement.

The screening helps to ensure clients will be able to fully engage with the formal assessment and treatment process or the referral will not be accepted. The screening process can take time and this time is not currently funded.

Assessment

At entry into the service, clients undertake a structured assessment using formal risk assessment tools. Assessments typically comprise several sessions over several days – however, for remotely located clients who need to travel for assessment, sessions are compressed to take place over one day to streamline the process and reduce the cost to clients, both travel costs and lost time from work.

Assessments analyse the client's level of risk of future offending/reoffending and informs the level of intervention they will receive. It also helps to create the formalised treatment plan between providers and clients, which details what treatment will involve, and the expected end date for treatment. Low-risk clients will receive less intensive treatment than medium or high-risk clients.

> *"Every client that comes in there's a treatment plan developed and the treatment plan will have a treatment expected end date." – HSBS provider*

HSBS providers pointed out that the assessment needs to be rigorous and manualised. Although clinicians may come from various backgrounds or schools of thought, they undergo specialised in-house training with the HSBS providers to ensure consistency of care. In some cases, providers will use contractors for the assessment component of their service to ensure their own clinicians are available for the longer-term work involved in treatment.

As well as the risk assessment, initial assessments include the use of psychometric tools, motivational interviews, and the preparation of a written assessment report by the assessing clinician. These components all inform the treatment plan developed between the clinician and client.

Interventions

HSBS provide specialist behaviour change interventions consistent with international best practice. HSBS interventions are client centred, manualised, and make heavy use of structured assessment tools such as psychometrics and risk assessment.

> *"It takes a lot of time to keep up with the field and all the research that is coming out." – HSBS provider*

The aim of intervention is to reduce or minimise the risk factors linked to the client's harmful sexual behaviours and to increase the client's protective factors. Treatment must be evidence based, responsive, client centred, and integrated across the social services sector.

Treatment plans are created at assessment and followed closely, including time frames set up at the beginning of treatment. Treatment plans include a set end date, which can be reviewed if necessary.

> *"We are standardising our psychometrics and our clinical demographics with the other two agencies, so we can do national reporting to stakeholders and national benchmarking." – HSBS provider*

Providers can refer clients with related issues, such as addiction, mental health, or social needs to other services. Two of the HSBS providers had a specific focus of treatment on harmful sexual behaviours and relied on external agencies to provide any social support clients might require. As holistic support is key to a client's success, having other agencies commit to providing social support is important.

> *"I think there's challenges around the social work. We're not really funded to provide social work support for our clients – it's supposed to come, if you take Oranga Tamariki, that's supposed to come from their social workers but there's a tendency for them to, as soon as the client comes to us, close the file and just kind of wash their hands of it cos they've got huge workloads and so on and then we're left holding the client and yet the research shows that a pro-social system is one of the key factors to protect the factors in preventing recidivism and that's kind of the KPI for us." – HSBS provider*

In some cases, clients can access ACC sensitive claims funding if their harmful sexual behaviour can be directly linked to past sexual harm. If they are eligible for ACC treatment, they can be referred externally to an ACC accredited counsellor or see an ACC counsellor through the HSBS if there is one available.

> *"Without intervention – clients get through life but have constant challenges to trust and worthiness." – HSBS provider*

Group support

Some providers offered group services for non-mandated adults in their larger centres. This was dependent on location, as there must be enough clients in the area who can and will attend the group. In rural areas, travel time and timing were barriers group to work, and providers typically worked one-on-one with clients.

Service exits

Treatment ends at a set end date which is listed in the client's individual treatment plan. If clients require more time in treatment, this is discussed with the treatment team and the end date reviewed. There are protocols in place around extending treatment end dates because of the impact on waiting lists.

> *"There's some flexibility for the manager to sign it off after that the clinical practice advisor who's like our chief medical officer has to sign it off because every client that stays longer is taking a place for another client that's waiting to come through." – HSBS provider*

At the end of treatment, clients complete a system review with their clinical team. Best practice guidelines suggest that providers only report on client results and service delivery measures in respect to clinical assessment and intervention.

If clients exit the service before completing their treatment, providers are required to make any necessary recommendations to the referrer and the client's support network to support the client's and others safety. HSBS providers noted the potential of early exits to increase the risk of recidivism.

> *"One of the things we measure is clients' exit and complete because the research shows that there can be elevated risk of recidivism if someone exits your programme incomplete." – HSBS provider*

If clients exit the service without completing their treatment, their place is made available to the next client on the waiting list and the client may re-enter the service at a later date through the standard referral pathways.[25]

Client outcomes

Throughout clients' engagement with HSBS, providers used Feedback Informed Treatment comprising Session Rating Scales (SRS) and Outcome Rating Scales (ORS) to assess the effectiveness of the treatments for clients. The SRS is used at the end of each session with a clinician to measure the extent to which the client felt the session went well, the clinician is a good fit, and the session covered their goals. The ORS is used periodically throughout treatment to assist clients in tracking progress towards their goals and measure how that fits their expectations.

Conclusions about client outcomes can be drawn by comparing changes to client risk levels before and after treatment. Risk factors at the end of

[25] Harmful Sexual Behaviour Services for Non-mandated Adults: Service Guidelines

treatment are compared to risk factor scores taken at initial assessment. This gives an indication of the effectiveness of treatment. HSBS use standardised psychometric risk assessment tools.

Services were also required to measure and report on client outcomes using a RMF developed by MSD that was specific to HSBS. Outcomes tracked on the RMF included clients who exited the service before completing intervention, clients who completed intervention and exited, client satisfaction data, and recidivism rates during intervention. However, providers noted that their reporting did not include waiting lists and enquiry levels, so the level of demand was not fully captured.

All providers described low recidivism rates. Data from providers suggested their recidivism rates were less than 15%. However, these were mostly based on recidivism rates in international studies of clients completing the same manualised interventions.

> *"Our recidivism rates are really, really low." – HSBS provider*

> *"We don't have access to criminal justice records so, and I guess the other challenge with measuring recidivism is that unless it's behaviour that's at that threshold that gets noticed or they get caught then you don't really know." – HSBS provider*

Infrastructure

All three HSBS providers had a formal management structure. HSBS reported to a board and had a head manager or CEO.

Because of the scope of work, some services had different teams for different areas of work such as child services, non-mandated adults, and mandated adults. These teams had their own line managers. Line managers may be responsible for a region or an area of work. For example, some services had an adult services manager and a child services manager, whereas some assigned a manager to all services in a geographical area.

All three providers had computer-based client management programmes. They were working together to create a standardised national database which will be shared between the services to allow better sharing and comparison of data.

> *"The system's not great at the moment but the three agencies are working together on a single national database… we'll have the standardised, clinical demographics and standardised psychometrics and that'll enable us to compare data and benchmark data and report on it nationally … and data on client volumes and where clients sit in the process." - HSBS provider*

Funding

HSBS providers had multiple contracts with a range of agencies including Oranga Tamariki, Department of Corrections and Ministry of Social Development. Providers found the wide range of contracts to be both useful and challenging. On one hand, it significantly increased the amount of reporting required to agencies providing funding. However, having a variety of contracts meant providers could often continue to offer services to clients after they were no longer eligible for treatment through the contract they were originally referred through.

> *"We've got a 17-year-old youth, under Oranga Tamariki. Funding for that stops when they turn 19, but they still need intervention. We can move them on to [another contract]. Another provider who's just got one little contract couldn't do that. So that provides much more in terms of continuity, workforce capability." - HSBS provider*

Funding challenges included lack of funding for travel time for providers and for clients. Providers require clients to travel in for their treatment to maximise specialist time for client contact.

> *"It's actually good for clients to travel… it's them stepping out and there is a sense of… that person's demonstrating their motivation… this is a commitment, this isn't going to be an easy journey but you're going to do whatever you need to do to move forward and make some changes." -HSBS provider*

There were some locality funding gaps which appeared to be historical anomalies.

> *"…I haven't got a contract for Bay of Plenty for non-mandated adults – so there's not a consistency of delivery." – HSBS provider*

Providers also reported working at capacity and managing waiting lists. There was a demand for additional funding for assessment and intervention places. Providers were funded for more assessment places than intervention places as some clients did not progress from assessment to intervention. However, the numbers did not always align, and providers did not have flexibility to shift funding from assessment to intervention.

Seeking external funding from grants and charitable groups was less feasible for HSBS than for other organisations in the sector.

> *"We work with a client group that no one likes – they're probably a lot more sympathetic to kids than they are to adults, but you only have to look at today's paper to see the stuff around people with convictions for sex offenders living in the community." – HSBS provider*

The HSBS workforce

Two of the three HSBS providers did not participate in the workforce survey and will provide information about their workforce later.

Clinical staff in the HSBS sector included psychologists, counsellors, social workers, and people who have previously worked in probation services. Providers reported difficulty hiring people with the necessary skills and competencies as the field is highly specialised. Staff received in-house training including:

- Use of risk assessment tools, taught by a licensed facilitator
- The manualised assessment and treatment processes used by the services.

The training aimed to ensure consistent delivery of therapeutic interventions regardless of the clinician's professional background.

> *"It's pretty hard to get experience working with this client base if you're not, if you haven't worked here before – it's quite a challenging client group so even if you get fairly experienced staff, they effectively start from scratch – it can take about three years probably for them to become sort of fully competent." – HSSB provider*

HSBS staff had internal support through line managers and peer support sessions. Internal support included peer supervision, cultural supervision, training, and group review of clients. External supervision was available at different stages and frequencies. External clinical supervision was typically provided either monthly or on an as-needed basis for staff. Group supervision facilitated by an external clinicial was also available.

> *"[Staff] get internal supervision with a manager around their clinical work, they get external supervision with an external person so if they're a psychologist it's got to be another psychologist, they get that once a month… A lot of our work is group work so monthly an external person comes in and talks to them about group work… Quarterly we have someone to come in and do work around cultural competencies for Māori." – HSBS provider*

There is a professional body for sexual abuse treatment providers.

> *"All our staff are professionally registered. They all belong to ANZATSA (Australia and New Zealand Association for the Treatment of Sexual Abuse)." – HSBS provider*

With recent increases to funding, the client capacity of HSBS providers has increased, resulting in a need for more staff. However, the challenge for HSBS managers was that if the funding increase was not permanent, staff who had been hired to manage the increased client numbers would have

to be made redundant. Because of this, providers have been using contracted staff to fill some roles.

> *"It's a little bit tricky 'cos you don't know if it's ongoing so I don't want to staff up and then making people redundant so we brought in – we tend to use contractors to get the assessments done cos that's a discreet block of work and reserve our staff to do the treatment and intervention stuff which is ongoing." – HSBS provider*

Cultural safety

Services received cultural support from local marae, iwi, and Māori staff members to work with Māori clients. Cultural supervision was in place across all three providers. Providers also had access to cultural supervision for other groups – Taeaomanino Trust supports one provider to work with Pacific clients, and services like Shakti also provide advice.

> *"We have a Māori programme and a Pacific programme and so those services are delivered within those cultural frameworks. We're currently developing a short intervention programme for our adult clients and we have consulted with (Kaumatua) - and then we'll talk to (iwi name) and we've got a relationship with (iwi name), we'll talk to them as well but as we roll it out we'll talk to local Iwi and get their input into the design and we can tailor the service." - HSBS provider.*

There was one kaupapa Māori HSBS provider in Aotearoa but this service was part of a separate evaluation and out of scope to be reported here. The three current HSBS providers believed there is a space in the sector for kaupapa Māori services, as long as the client volume was there to support it.

Collaborations and networks

The three HSBS have worked in partnership since the formation of each service. Together they share best practice guidelines, training, and participate in research to advance the field.

> *"There's a considerable focus on clinical best practice, sharing information and supporting research and trying to support Government through ensuring that there's consistency of service delivered across the country." – HSBS provider*

The three providers also collaborated with the University of Canterbury and the University of Auckland to develop guidelines around best practice in the field. They participated in research about the treatment of harmful

sexual behaviour through these local universities and at an international level.

At least one HSBS provider was a member of the TOAH-NNEST collective, providing opportunities to share knowledge and best practice with crisis support services across New Zealand. In some areas there were collaborations in place between HSBS and crisis support services. In the most successful instances, there were formal collaborations between HSBS and crisis support services to deliver education and prevention initiatives. In the least successful, there was significant tension and relationships between providers offering crisis support and HSBS providers are strained.

> *"Most [abuse] is intra-familial stuff and so that can make it quite tricky actually, working with victim's agencies cos …they're working with the people who have been victimised by the behaviours that our clients have so that's naturally [difficult] – most of our clients are male and most of their clients are female so there's kind of gender issues in there." - HSBS provider*

Overview of harmful sexual behaviour services for non-mandated adults

Government's Budget 16 investment in HSBS
Changes in funding in Budget 2016 for HSBS aimed to: • Increase available places in assessment and in existing treatment programmes, thereby clearing current waiting lists and meeting some additional latent demand • Improve the geographic coverage and tailoring of services to minority groups • Define and incorporate best practice recommendations from recent and future research on effective delivery of HSB assessment and treatment services. • Improve stability through a move to two-year contracts.
The impact of government's investment in HSBS
A design sprint, facilitated by PwC, was held at the end of 2016 with the aim of defining and incorporating best practice recommendations from recent and future research on effective delivery of HSB assessment and treatment services. The HSB non-mandated service guidelines were created from the sprint. Government investment increased the capacity of assessment and treatment places. One service has increased from a total of 11 yearly

places to 30 for assessment and 24 for treatment. Another has moved from 10 treatment places to 29. However, demand had also increased, and providers reported they were still managing waiting lists. The level of unmet need is not known.

The evidence base for HSBS is substantially drawn from international evidence. A kaupapa Māori pilot has been funded to develop evidence about what works for Māori in a New Zealand context. Evaluation of this new service is out of scope for this evaluation.

New client management systems will provide good information about client volumes, demographic profiles and completion rates.

Meeting the needs of clients

Client interventions are based on evidence-based programmes. Providers estimated their recidivism rates for clients who completed the intervention at 15% for non-mandated adults through STOP Christchurch and less than 10% at Safe Network.

New client management systems will provide good information about client volumes, demographic profiles and completion rates.

HSBS offer very specialised services and providers discussed/debated whether they should expand the core three services or provide training and resources to existing generalist services to allow them to develop skills to support HSBS clients.

The evaluation will explore further the way other specialist services provide treatment for harmful sexual behaviours.

Opportunities to further strengthen HSBS

Funding gaps remain including funding for pre-assessment screening, treatment for concerning sexual ideation, funding to meet demand and to support client and provider travel. HSBS providers also face challenges in managing the balance between assessment and intervention places. Providers also noted they are about 20% underfunded since the cost of living adjustments stopped being applied to funding.

There are opportunities to compare recidivism between HSBS clients and a comparison group using information in the integrated data infrastructure.

Overview of specialist sexual harm services

This formative evaluation report provides information to describe the current status of the sector, changes to the sector in response to additional funding from Budget 16. The report will act as a baseline to track changes to June 2021.

Overview of the sector

New Zealand research[26] has shown that the following groups are over-represented in those needing sexual harm crisis support services:

- women
- those aged under 29
- Māori and Pacific peoples
- people with mental health disabilities.

Service providers also identify that women at higher risk may include those who have low educational achievement or employment status, face a mix of social changes and have become socially isolated, use drugs and alcohol, identify as a sexual minority group.

Poverty, racism and harmful state interventions over multiple generations have placed Māori communities at a higher risk of vulnerability to all forms of violence including sexual harm. Additionally, kaupapa Māori services described the violence, including sexual violence, that has stemmed from colonisation and has permeated multiple generations for some whānau. Healing for these whānau explores the historical abuses that took place over hundreds of years and can relate back to an incident or incidents at the time of early contact with Europeans.

Stable and effective SSHS have the potential to significantly reduce the costs of sexual violence—both to society and to individuals[27].

Since the 1980s, the specialist sexual violence social services sector has grown from grassroots community organisations. Most services were local and without formal nationwide infrastructure or permanent funding. They were often staffed by volunteers. Limited, unstable funding, a large

[26] Ministry of Women's Affairs (2009). Restoring Soul: Effective interventions for adult victims/survivors of sexual violence.
[27] Report of the Social Services Committee (Dec 2015). Inquiry into the funding of specialist sexual violence social services.

volunteer workforce, variable quality guidelines, and a lack of training were all issues that affected the sector.

In December 2015, an enquiry by the Social Services Select Committee into the funding of specialist sexual harm services confirmed that current services did not provide consistent, effective cover and that current funding approaches were insufficient. The Social Services Select Committee enquiry provided 32 recommendations to government to improve the integration, coverage and practice standards of these services. Recommendations emphasised the importance of whānau centred, culturally competent and responsive services for all client groups and in particular Māori. A further recommendation was support for mainstream service providers to become whānau-centred and culturally competent and work towards integrating tikanga into practice.

Developing an integrated national system

New funding from Budget 16 aimed to first stabilise the sector and then to build an integrated national sector that provided the right support and services to reach more of the people who need them.

The overarching logic model developed with MSD (Appendix 1) summarises the foundations for developing an integrated national system as:

- sector leadership, management and governance
- developing the workforce
- enabling systems and tools
- collaborations and partnership.

Sector leadership, management and governance

Developing an integrated national system requires national leadership through government and national service provider organisations.

Government leadership is important to:

- develop the overarching strategic approach to SSHS and ensure alignment with other government initiatives
- provide strategic leadership to identify service models and mix required and geographical locations to meet the needs of clients
- provide effective project management to support SSHS sector wide changes, lead SSHS sector consultation (with national bodies and service providers).

MSD has resourced an expanded team to support changes to SSHS. A multi-agency advisory group is in place to align government initiatives and examine workforce development. MSD completed work to develop funding algorithms and used these to extend contracts with some providers, to provide more funding certainty and to provide additional funding to fill geographic gaps. A new helpline has been funded to complement existing services and provide an additional avenue through which people can seek support.

The formative evaluation identified areas where government leadership is required to strengthen the sector to:

- further refine and specify service models and mix and consider how they align with funding algorithms. While some SSHS focused on providing specialist 'treatment', many provided 'wrap-around' support to respond to the complex needs of clients. 'Wrap-around' support was integral to kaupapa Māori service delivery. Some SSHS providers offered 'wrap-around' support because there were no or limited services in their localities to support the wider social needs of clients and whānau.
- consider the interface between crisis support services and ACC services – some providers described perceived financial incentives for clients to try to access ACC services when ACC counselling may not be the most effective support for them.
- address funding gaps which many services are filling because they do not turn clients away. Funding gaps include:
    - supporting adolescents – not currently funded by any government agency. This need is being met by the goodwill of SSHS providers
    - holding people on waiting lists for specialist ACC services – waiting times exist in all localities and SSHS providers support people while they are waiting. The waiting time is not necessarily a problem for some clients as it provides a space where clients can be helped with urgent social needs such as food and housing. However, holding clients while they wait for specialist services is not funded. Although no data were available, the need to provide 'wrap-around' support is likely to disproportionately affect services in rural and lower socio-economic localities
    - supporting people not reaching ACC threshold, not eligible for ACC support or not wanting ACC services
    - travel time – SSHS in some rural localities spend a significant amount of time travelling to clients

- services to treat concerning sexual ideation.

The current workforce

Providers are regarded as "specialist" if their service provision focuses mainly on sexual violence and if their staff have specialised knowledge and skills about issues stemming from sexual harm. The workforce also includes people working within generalist scopes of practice such as nursing, social work, kaiāwhina.

Provider teams comprised of a mix of professional groups. Multi-disciplinary teams have the advantage of bringing different perspectives and skills to supporting clients. However, within multi-disciplinary teams, different training and professional boundaries can be problematic. Managing a multi-disciplinary team to work as whole can require experienced managers.

There were high levels of job satisfaction. SSHS practitioners valued the difference they could make for clients. Many who responded to the workforce survey specifically noted teamwork and the people they worked with as one of the reasons for their satisfaction with their jobs.

Based on responses to the workforce survey, the SSHS workforce is an older and stable workforce. The inflow of new staff approximately matches the numbers who reported they may leave in the next 12 months.

Figure 20. In and outflow of all SSHS staff (n=132)

Practitioners responding to the survey felt well supported with professional supervision. However, access to professional development was limited primarily by cost, but also by time and funding.

Challenges to the SSHS workforce included:

- a lack of specialist training applicable to the sector – as a result staff were frequently developed using an apprenticeship model of on the job training
- workforce shortages, especially shortages of Māori and Pacific counsellors which limited access for clients
- competition to recruit specialist staff.

Further developing kaupapa Māori services sits across all aspects of an integrated national system. Kaupapa Māori providers interviewed for this evaluation considered building the cultural competence of tauiwi providers was not sufficient to meet the needs of Māori. Good practice guidelines such as the TOAH-NNEST guidelines encourage Māori services for Māori.

Where kaupapa Māori services are not available in the locality, cultural safety provides a robust framework for providers to better reach and serve Māori. Cultural safety places responsibility with the practitioner to understand their own culture and recognise the assumptions that they might inadvertently impose on the whānau with whom they are working. Cultural safety also places power with the client to decide whether the service meets their needs.

Tauiwi SSHS are also actively working to reject negative stereotypes and work effectively with Māori and other groups.

Considerations for government include:

- supporting the development of kaupapa Māori services
- considering the composition of the workforce needed to provide the different types of support for people affected by sexual harm. e.g. the role of specialist practitioners and peer supporters
- establishing workforce competencies – The family violence, sexual violence and violence within whānau workforce capability framework recognises the limitations of a competency framework and instead shifts to capability of the SSHS and family violence services in Aotearoa.[28] The framework aims to give the workforce a common understanding of SSHS and family violence, enabling the workforce to provide a consistent, effective and integrated response to victims, perpetrators, their families and whānau.

Enabling systems and tools

Providers held multiple contracts with different agencies. Providers were largely positive about the support provided to them by their MSD contract managers.

> *"We have a good relationship with our MSD guy. We've known him for a long time now, he's always happy to come and see us, and explain things. It was always good, and he celebrates our work with*

[28]Ministerial Group on Family Violence and Sexual Violence (2017): Family violence, sexual violence and violence within whānau workforce capability framework. Ministry of Social Development

us. We've got that extra time, and we can do so much more with that." – Tauiwi provider

"We've got an amazing funding advisor with MSD –it makes me feel safe and I know I'm not cheating anyone out of the dollar and especially not the Government … she's brilliant and we've always had good funding advisors out there." – Tauiwi provider

However, managing reporting requirements against the different contracts was time consuming. MSD performance reporting requirements set out the content of the information required but do not specify how the information should be collected. Changes to reporting requirements and alignment across government had the potential to provide useful and usable data for policy and service delivery and reduce the reporting burden for providers.

There were no consistent measures of client outcomes for MSD funded services and client case management systems varied with some being hard copy. Developing consistent ways of recording client information and measuring client outcomes would provide much needed information about who is being reached, changes over time and enable estimates of unmet need

Current reporting requirements may not align well with kaupapa Māori providers' approaches. Kaupapa Māori providers primary accountability lies with their communities and they support whānau, so individual measures do not adequately capture their work.

There can be conflict between 'good practice' guidelines and tikanga Māori. Being accountable to the community can mean working long hours. Working with whānau is critical and not sufficiently recognised.

"We work all hours of the day and night, we'll come in in the weekends so that's the difference – we can see people relatively, we aim to see people within 24 hours" – Kaupapa Māori provider

Collaboration and partnerships

Specialist sexual violence social services exist within a system that includes other health, justice, and social sector responses, such as medical forensic, general practice, emergency department, mental health, and social services.

At agency level, service providers are funded through separate contracts with multiple government agencies: ACC, the Police, Department of Corrections, and the Ministries of Health, Justice, and Social Development. Building an integrated national system would be facilitated by an integrated approach to contracting.

The main national organisation in the sector is TOAH-NNEST but national organisations also provide leadership for MSSA services and HSBS have a

national accreditation system. The role and potential of national organisations is still developing. MSD is working with the organisations to discuss roles and co-design service guidelines.

Within the sector, there are various partnerships, collectives and collaborations between providers that are helping to strengthen the sector. A Pacific Collective has been established in Auckland to build Pacific practitioner capacity.

Service providers welcome opportunities to network and share information and learnings. Some services were connected into local advisory groups and local organisations and this helped provide a seamless system for clients.

When asked in the survey about ways to strengthen how specialist sexual harm services work together and with other agencies, most responses related to improving opportunities for service providers to meet, network and get to know each other to improve collaboration. Working together would be supported by non-competitive funding models, co-location, MDT meetings and joint training opportunities. One respondent suggested shared infrastructure and a hub and spoke model.

Reducing the impact of sexual harm and improving outcomes

Reducing the impact of harm requires:

- reaching the people who need to be supported
- minimising any barriers for them to accessing support
- providing them with the 'right' support to meet their needs.

Services provided by Māori for Māori have been successful across health and social services in identifying and meeting the needs of community, whānau and individuals in ways that tauiwi services cannot. Minimising harm from sexual violence for Māori is best undertaken by kaupapa Māori providers who hold positive Māori development at their core, and are accountable to iwi, hapū and whānau. Kaupapa Māori SSHS providers are able to facilitate meaningful connection with whānau and provide them with specialist tools and support to begin their healing.

Reducing the impact of harm	Current status	Actions to strengthen the system
Reaching people People who need support must be aware of services and how to access them	• Budget 16 funding increased the capacity of some services and provided some funding to fill gaps. However, large geographical gaps remain. • Specialist services, especially HSBS and SHCSS in provincial towns and rural localities are covering large geographical areas. • A national helpline - Safe to talk - has been funded to fill gaps and service latent demand but there is concern in the sector about the capacity to respond and increased pressure on services. • The reach of specialist providers is limited by availability of workforce with the skills required • Kaupapa Māori services are sparsely spread geographically. • Safe to talk and HealthPoint may raise awareness of sexual harm and where to go to seek help but taking the next step to disclosure may take time. • MSSA providers emphasised the need to change the dominant discourse around what it is to be a man.	• Many providers noted the importance of raising awareness of specialist sexual harm services and removing the stigma associated with sexual abuse. • Raising awareness also included raising awareness amongst wider health and social services of the specialist support available in their localities. Awareness was high amongst Police but primary care providers such as GPs and mental health providers were not all aware of what specialist services provided. • Services must have the capacity to service the increase in clients expected from increased awareness.
Enabling them to access support Minimising barriers to accessing services	• Geographic distance is a barrier for many clients. Many specialists service providers traveled to clients to minimise the distance barrier. Funding for specialist services does not recognise the time and other costs of travel or provide funding for clients to travel. Specialist providers have tried electronic communication with providers but have found it does not meet the needs of many and clients may disengage. • Cultural barriers also exist and in localities where there are no kaupapa Māori services, Māori may consider tauiwi services. Some service address this barrier with Māori staff. • Long waiting times for ACC counselling is a challenge in many localities. • Some Providers outside of the specialist sexual harm sector may not encourage disclosures which may result in delays on people reaching support. • There are fewer male ACC counsellors and Māori ACC counsellors limiting choice for people to find the 'right' fit for them.	• Waiting lists represent a substantial barrier to specialist counselling services. • There are financial incentives for clients to access ACC counselling. ACC counselling may not be required or the most appropriate support for all. Some clients are not eligible for ACC support. There is a need to review the interface between ACC counselling and non-ACC specialist counselling. • Consider funding models that address the growing two-tier system.
Providing the 'right' support Client focussed support - culturally safe support that meets victim/survivor and whānau needs	• Appropriate support is different for each client's situation - highlighting the importance of assessment. • Some clients require only crisis support but may return later to receive additional support to respond to trauma. • Clients who did not receive support at the time of the acute event may have complex needs arising from their trauma including health needs such as mental health and addiction issues and social needs arising from poverty and limited engagement with employment e.g. homelessness. • Some providers focus on specialist treatment, others provide holistic support as well as linking people to specialist treatment. • Culturally safe support for clients is essential. Many providers felt confident and well supported in their work with Māori but were less confident in working with other population groups. • Kaupapa Māori and some tauiwi providers emphasised the importance of providing support to whanau as intergenerational abuse and long-term recovery requires a whānau centred approach. • The extent SSHS providers could link people to other social services they needed was influenced by what, if anything, is available in their localities and accessible for their clients. • Many providers managed 'wrap-around' support by moving clients into and out of different contracts they hold with different agencies. While this provided seamless support from the client's perspective, accessing funding from multiple sources and reporting against many contracts was resource intensive for providers and took time away from client care.	• Long-term recovery requires all of client/whanau needs to be assessed and responded to. • Including holistic or 'wrap around' support as part of specialist sexual harm services is an important step in improving long-term outcomes. • Review the current funding approach to more adequately include holistic or 'wrap around' support - support for social needs while clients are waiting for specialist counselling. • Recognise that 'wrap around' support in some localities may need to be provided by the SSHS provider. • Integrated client focussed care means a seamless transition for clients through the different types of support they need.

Evaluation next steps

This report includes primarily descriptive information to be used to track changes as MSD continues to respond to Select Committee recommendations to strengthen support for people who have experienced sexual harm.

Process evaluation reports will be provided six-monthly. The next report will include:

- analysis of provider administrative data from providers who can export electronic data. Analysis of the data will provide information about client numbers, profiles and service engagement
- client case studies to demonstrate the different client pathways through the services
- interviews with clients to hear from them about their experiences of support.

Appendix 1: Logic model