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Tauiwi Responses to Sexual Violence

Mainstream crisis support and recovery and support services and Pacific services

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This report was prepared by Te Ohaaki a Hine: National Network Ending Sexual Violence Together – Tau Iwi Caucus (TOAH-NNEST - TC). TOAH-NNEST is a national network of organisations and individuals involved in responding to sexual violence and committed to promoting the changes necessary to enable all people to live free of sexual violence and its effects. It consists of two "houses" working within the Treaty relationship: Nga Kaitiaki Maori o Te Ohaaki a Hine is the tikanga Maori house, and Te Ohaaki a Hine – National Network Ending Sexual Violence Together – Tau Iwi Caucus is the other house.

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Vision

Communities are well-served by comprehensive specialist sexual assault services in order to provide for acute and on-going needs of survivors and those supporting them. Where possible, services are provided by culturally appropriate service providers. Where culturally appropriate services are not available, mainstream *services are well connected to cultural communities to enable culturally safe services and referrals.*

The Project

This stocktake of Tauiwi specialist sexual assault services was completed as part of the Taskforce for Action on Sexual Violence working groups addressing Terms of Reference 2 - Crisis Support and Early Intervention and 3 - Support and Recovery Services . Its primary purposes are to answer the questions "*who is doing what, where, when and for whom" in terms of crisis support services?* Further, *how are support and recovery services configured within organisations providing specialist sexual assault services?* These questions relate to services for adult survivors.

All *mainstream*[1] sexual assault services (n=30) for adults as were commonly known in the field in late 2008 were invited to participate and a total of 28 specialist services actively responded. In an associated project nine national, though primarily Auckland based, Pacific services used a fono meeting to discuss what Pacific people need in response to sexual violence.

A separate stocktake is being undertaken on kaupapa Maori services by Nga Kaitiaki Mauri in conjunction with Te Puni Kokiri.

Key findings

Across both the *mainstream* service stocktake and the Pacific fono and stocktake a number of key themes have emerged. While there are some common themes and issues, the services bring different cultural contexts to the problem of sexual violence, including different models of recovery. In common is the desire to respond fully to the problem of sexual violence, but constraint from lack of resources to do so.

Mainstream Services

While there is wide support for provision of specialist sexual violence services, how these services are delivered differs across the country. The ability to provide a crisis service 24/7,and the model and structure of services differ between urban and other

[1] *The word mainstream appears in italics to denote the way that its use is problematic due to the hegemonic assumptions which such a word can imply.*

geographical areas and is most often determined by access to workers, resources, demand for service and the relationship between points of referral within the community. What is evident is that organisations aim where possible, to provide specialist, holistic, wrap around, and client-centred services.

A list of services recorded includes:

- Support during police interviews
- Support during medical forensic examinations
- Court preparation and/ or support
- Telephone information/referral and crisis line
- Emergency face to face crisis counselling/support
- On-going counselling and support
- Social work
- Prevention education and community consultation

Geographically there are areas of the country without access to such services, but approximately 70% of the population (less for males) has access to 24/7 specialist crisis support services.

Core crisis support services are defined as telephone crisis or support line, support at police interviews and forensic medical examinations, and face to face emergency sessions. Due to the nature of rape and its impacts, ideally these services would be available on a 24/7 basis. Thirteen of the 28 respondents reported providing the first two of these services 24/7, with one service also able to provide emergency sessions 24/7. Many organisations also reported that they see court support as a further key component of service but few services are able to provide this.

Perhaps reflecting funding and capacity issues many crisis services are not available on a 24/7 basis, in spite of nights and weekends being the time that much sexual assault occurs. Further the tripartite relationships between specialist services and the police, which are critical to the successful delivery of crisis services, are in some areas not working well (if at all) due to a break down or lack of development of relationship.

Services report a range of strategies and challenges meeting the needs of diverse client groups. In particular challenges and gaps were identified in the provision of appropriate services for male victims, children and families and young people. Most services are active in finding ways to serve Maori clients through referral to kaupapa

Maori services, provision of bi-cultural services or staff training and supervision. Mainstream organisations appeared less confident in their strategies to meet the needs of Pacific peoples and those of other cultures. Clients with needs relating to non-ethnic cultures were generally not identified.

Government funding of crisis support services is primarily via MSD or its service line CYF, with 3 services holding contracts instead with DHBs and one service having a contract with ACC for some of the work until the end of July 2009. Most services also rely on community funding, philanthropic trust funding and the use of unpaid staff.

Similarly Support and Recovery Services are funded primarily through MSD or its service line CYF, and/or ACC, along with the range of community funding options listed above and unpaid staff time. Of interest for support and recovery is the response of a significant number of services who actively choose not to access ACC funding for counselling due to barriers inherent in that ACC funding model for both service providers and the client.

From a service delivery perspective the ACC funding model is not a good match to the nature of the services required as it can at times actively undermine holistic service delivery. Treatment of sexual violence can be a complex issue requiring multiple levels of intervention and counselling is, at times, only part of the support and recovery services clients need. Other needs may include liaison and advocacy; additional contact outside of session; support and/or counselling and/or education of family members; and, social work support.

Sustainable funding models for specialist services is a critical issue and while most groups have benefited from Pathway to Partnership funding, some either haven't, or reported that rather than improving their service capacity, it has allowed them to remain in a status quo position, often due to prior operating deficits. Funding to enable development of services and to ensure ongoing best practice is still elusive for most groups. Few services describe themselves as having adequate funding to do the work. Organisations manage this lack of funds through limiting hours of service provision, not paying for some hours of service provision, and/or paying low wages.

There were many community needs which organisations identified as not currently being met. These include Maori for Maori services; services for male survivors, children and their families and young people; court support; education and prevention; collaboration and networking and to reduce waiting lists and call outs missed due to insufficient staff.

While lack of funding was indicated as the predominant issue that services faced, including its impacts on service availability, recruitment, retention and training of staff, a number of other barriers and issues were also identified by some organisations including

lack of profile in the community and lack of referral by police and other community agencies.

Barriers for survivors were identified as accessibility and awareness of the service; lack of transport; phone coverage and expense; the impact of societal attitudes on victims/survivors which can result in shame and prejudice leading to social isolation and little access to practical and emotional support.

When asked what people valued about their services, a group of similar values were reported. These included quality, independence, integration, accessibility, political, client focused, having good community relationships, providing local services, good work culture, and a dedication to supporting women and children no matter what. There is a strong determination to keep specialist sexual violence services available for those who need them.

Such commonality of problem identification, purpose and values suggests that in spite of different beginnings and varying paths, the group of organisations in this sector have much that is shared, enough to move forward with developing a vision for services that can bring comprehensive specialist service provision back to the people of Aotearoa/New Zealand.

An output of the project was to develop a vision for the provision of crisis support services. The vision is:

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

Such services would include: 24/7 telephone and internet communication service, 24/7 call-out service for advocacy and support, emergency sessions provided in day-time, follow-up services, case tracking, court services, information bank, resource bank, and social work support. These services would be integrated with recovery and support services, education and prevention services and advocacy, along with other services as locally determined. Services would need to develop capacity to work well with all populations, and would be supported by national infrastructures to do this, for example, through the provision of consultancy services. A consultation process would occur with communities currently without services in order to establish the optimum structure for establishment of such service in that community.

Key issues in the successful implementation of this vision would be the establishment of responsibility for the funding of such services, and on-going development of the

relationships involved in the tri-partite response to sexual violence – crisis support services, police, and DSAC trained doctors.

While a similar vision was not developed for recovery and support services, this stocktake highlights the need for a review of the most appropriate model for service funding, as well as the levels of that funding.

Pacific Services

In turning to past conversations between Pacific communities and government agencies that span over two decades, central questions from those discussion return through the participant voices in this document. These are, 'Who is defining the problems for Pacific people?' 'Who is defining the solutions for Pacific people?' 'Whose values and beliefs have primary place in the lives of Pacific people?'

The discussion from the Pacific fono covers the range of work areas which participants have identified as presenting barriers to effective service delivery. Enablers have been proposed as strengthening and taking on new ways of thinking and working forward in a way which has positive implications for Pacific survivors of sexual violence as well as families and perpetrators.

The discussions are not the final voice and ongoing dialogue needs to be continued with all providers and key stakeholders.

The key themes identified focused on

- Models of Practice
- Assessments
- Responsibilities towards Victims
- Strengthening Pacific Provider Responsibilities
- Workforce Development
- Qualifications and Skills
- Funders

Overarching themes arising in the discussion of enablers for ways forward was the need to recognise the ethnic-specific needs and responses within the Pacific communities. Participants highlighted the inappropriateness of the *"one size fits all"* approach which is common among funders and policy makers. A central theme was the importance of holistic services which places family wellbeing at the centre of practice. Further as with *mainstream* services, challenges include the critical issues of workforce capacity and capability, the lack of suitably qualified support workers and, most importantly culturally appropriate professionals.

The Pacific voices are not seeking exclusive domains for working. They continue to advocate for collaboration, partnership, and an inclusive place for the values, practices, and beliefs of ethnic specific groups within policy writing and funding allocation. For the group of participants who attended the fono, there is an awareness

that respect for other ways of seeing and understanding the environments which Pacific and non-Pacific people share will keep the dialogue and discussions open and debates constructive.

Pacific families now live in extremely demanding times. There is no doubt that violence in all its forms will continue to impact on the lives of the most vulnerable in communities. The barriers and enablers within this report will form part of ongoing discussions and debate within the Pacific sexual violence sector. It will hopefully be a springboard to galvanising practical and innovative ways to creating violence free environments within Pacific families, communities and our society.

Conclusion

Though coming from very different cultural positions both *mainstream* and Pacific views come together in recognition of the current position of sexual violence service provision which though under-resourced, continues to provide much needed services for survivors of sexual violence and their families. A vision for the future is one which encompasses and embraces the rich diversity of our communities while addressing the shared problem of sexual violence. It is with this shared idea that the Vision at the beginning of this summary was developed.

Section 1: General Introduction

Focus on Tauiwi services

Both as an expression of a Te Tiriti based partnership and in reflection of the realities that responses to sexual violence operate best when they are culturally based, the stocktake process was divided into two projects – a Maori led project working with kaupapa Maori providers, and a Tauiwi (other people) project. This, the Tauiwi project looks at both *mainstream* specialist sexual violence services working with victims/survivors of adult sexual assault (Section 2) and services for Pacific peoples which includes services working not only with survivors of sexual violence, but also families and perpetrators (see Section 3)[2]. The two projects will reconnect in the report *Mata Hereherenga Tukino – A Shared Vision for Responding to Sexual Violence*, which will outline the ways that the recommendations and visions arising separately from the two projects are envisioned to work together.

While a true Tauiwiview would have explored services for all non-Maori ethnic and cultural populations in New Zealand, limited resources led to an initial focus on *mainstream* and Pacific. Pacific peoples represent 6.9 % (i.e. 265,974 people) of the total New Zealand population. Samoans are the largest ethnic group and make up 49% of the Pacific population, followed by Cook Island Maori and peoples from Tonga, Niue, Fiji, Tokelau and Tuvalu (Statistics New Zealand, 2006). The Pacific population is one of the fastest growing ethnicities in New Zealand and is projected to grow from 260,000 people in 2001 to 420,000 in 2021 (Statistics New Zealand, 2005).

It is hoped that there will be further research opportunities to explore the needs of other groups, and that awareness raised through this project will in the meantime also be brought to relationships with members of those other groups.

The word *mainstream* appears here in italics or quotation marks to denote the way that its use is problematic. For much of the duration of the data gathering process, we have avoided its use completely due to the hegemonic assumptions which such a word can imply. However, in so doing we have often tied ourselves in knots looking for more appropriate language, but failed to find alternatives which did not cause other difficulties. Furthermore, the word can be seen to imply that these services have more systemic cultural power than other services. While most services tend not to feel such

[2] A full report of the research with Pacific providers has also been separately submitted to Ministry of Pacific Island Affairs.

power being to some degree counter-cultural themselves, it is nonetheless an implication which is probably true when comparing with other ethnic specific services.

Services for survivors of sexual assault

Services for survivors of sexual assault were initially established in the 1970s as "grass root" responses to the experiences of women being raped. It was seen that women needed immediate practical and emotional assistance following such events which were frequently traumatic and could have long lasting negative impacts. Groups of women established collectives of volunteers to provide this support, usually as a Rape Crisis group. Some of these groups came together to form the National Collective of Rape Crisis in the early 1980s. At the same time, a network of Maori providers were spread through the country – Te Kakano o Te Whanau. Some police districts came on board in the 1980s with the recognition that the processes that women were required to undergo as a part of the police response to rape could cause further harm to survivors, so calls went to the community to establish services which could provide support and advocacy and trained female medical providers. These tended to be established as the HELP groups. Many of the Rape Crisis groups and at least one of the HELP groups were established as or developed into bi-cultural groups. Over time some groups stayed as one, while others separated into cultural units. Some organisations also had Pacific units, and a few Pacific services developed to respond to violence against women and children.

Over the past few decades, services have grown, split, opened and closed. Most added recovery and support services to their core business early on. What has not changed is the high incidence of rape in our communities and the needs of survivors for immediate support. This need has now been validated by research which has confirmed many of the ideas of the early grass roots movement, both about the psychological significance of rape and the kinds of responses and services needed to minimize its negative impacts.

With such active beginnings, and the more recent scientific validation, it might be expected that in 2009 we would be seeing a well organized sector with services available to everyone when needed and good working relationships between police, medical service providers and services providing psycho-social and cultural support. However, this is not the case. Instead, the past few decades have seen services struggle to survive, significant proportions of the population without access to any specialist service and inconsistent police responses to sexual violence and survivor support services. A report from 1983 on Maori and Pacific Island perspectives of sexual

violence to women and children suggests that these issues have changed little over the past 26 years[3].

One of the key areas of focus of the Taskforce for Action on Sexual Violence is to address these difficulties. To determine what needs to be done, we need to understand the current situation – what is being done, by what service and where? And, the flip side of this, what population groups in what areas do not have access to what services? From a Pacific perspective it is also necessary to understand and contextualise the current situation through understanding what has happened in the past.

[3] Pacific Island workshop in YWCA Conference on Sexual Violence to Women and Children, Wellington

Section 2: *Mainstream* responses to sexual violence[4]

Introduction

We begin this chapter with a discussion about the culture or world views that underpin *mainstream* responses to sexual violence. We do so at the request of our Maori colleagues who reminded us that one of the ways in which *mainstream* anything is harmful to other cultures is in its assumptions that it is the "normal" way of being or doing so it does not need to articulate the world view upon which it sits. This positions other ways of being or doing as "alternative" rather than "co-existent".

The culture in which *mainstream* sexual violence services developed and operate is a New Zealand culture derived from European, particularly English, views about sex, violence, gender and justice. Looking at both formal structures and the expressions of general sentiment conveyed by media, this culture seems to be at best ambivalent about sexual violence perpetrated against adults. This is evident in a number of phenomena. For example, the relatively recent repudiation of the right of a man to rape his wife, so recent that many older people maintain a belief that a woman gave away her right to a process of consent as a part of her marriage vows. It is also evident in the high penalty for perpetration of rape (maximum sentence 20 years imprisonment), but low conviction rate of approximately 1%. Ambivalence is evident in the laws of consent which both say that the victim/survivor does not have to have protested to indicate non-consent, but also provide an automatic defence of "reasonable belief" which, when the victim/survivor did not protest, is difficult to repudiate due to the gendered assumptions of male initiation and female sexual passivity.

Lack of support for women is evident in the media reports of community outrage about the idea of a woman making a false complaint of rape against a man. In spite of the fact that research suggests that this happens infrequently, media reports suggest that it happens often (for example, NZ Herald reported that senior police "investigators estimate that between 60 and 80 per cent of rape complaints made by women are false" 08/08/05) and that the impact of this on the falsely accused man is extreme. This sits in clear contrast to the research which shows that rape happens often, that it can have significant impacts on the victim's/survivor's mental health and that there is very little formal justice. Media does not show us public outrage about those facts. See

[4] The discussion and information presented in this section does not include that for services offered by Pacific providers. See Section 3 for information about Pacific responses to sexual violence.

Gavey and Gow (2001)and Jordan (2004) for further discussion of this media representation and the cultural contexts of such disbelief and minimisation.

Cultural exposés from other European derived cultures attribute ambivalence about sexual violence to a history of profound misogyny sitting as a core of the culture, leading in effect to a "rape supportive culture". While this could not be said to be uniformly true across all people and institutions of this culture, it could be seen to be true in as much as the high incidence and low conviction rates do mean that we have a culture of ineffective sanction against rape.

Further, our media is saturated with images of the sexual objectification of women, along with the portrayal of women being hunted and hurt by men shown for general entertainment. While our culture is described as in denial of "the existence, extent and effects of sexual violence" (Jordan, 2004, p6), its ambivalence about this subject matter is also evident in this publically obvious (television, magazines and billboards) and personally private (internet pornography) apparent obsession with sexual objectification and violence as entertainment.

World view of services

Sexual violence services grew in reaction to this cultural ambivalence - the way that dominant ideas about rape provided more support for the alleged offender than for the victim/survivor, blamed the victim/survivor, and minimized the incidence and impacts of sexual violence on survivors and women in general. Initially services tended to come from, or adopted, a feminist platform as a group of coherent ideas and practices which came from the woman's side of this issue and resisted dominant interpretations of women's behaviour. As these services and other campaigners have been successful in offering alternative ideas about the nature of sexual violence, *mainstream* culture has shifted a bit, for example, removing immunity for spousal rape and providing special conditions for survivors in court. This shift in culture, along with a general backlash to feminism, has seen a shift in specialist sexual violence groups and the individuals in them – some have retained a clear feminist platform, while others have moved more to a liberal humanist understanding of sexual violence – that anyone can do it or be a victim of it, and that such victimization is equally awful regardless of who you are.

While every service is different having had its own journey of growth within its own local community, there are some generalities that can be said to apply to many services due to their counter-cultural roots and on-going exposure to the realities of sexual violence. These include:

- belief in the value of specialization of response to sexual violence

- the intertwining of service delivery and political advocacy inherent in the recognition that "the personal is political"
- victim/survivor centred practices
- beliefs that the causes of sexual violence lie in a combination of individual and societal factors, and that healing from the impact of sexual violence is also both an individual and a social matter; and
- commitment to practices which oppose the "power over" dynamics inherent in sexual violence – practices such as processes of cooperation and consensus.

Our commitment to responding to sexual violence

Sexual violence can have significant levels of impact, often leading to high levels of anxiety, avoidance, depressed mood, lowered self-esteem, reduced trust, emotional numbing, withdrawal from the world and from intimacy, lack of sexual arousal and fear of sexual interactions. These impacts can themselves lead to further negative life impact as the victim/survivor tries to cope with them – being not able to work or parent as well as usual, having difficulties maintaining friendships, and/or coming to rely on the self-medication of alcohol, other drugs or self-harming behaviours.

Impacts of sexual violence can be high due to factors such as: it is the occurrence of the event that we have been warned is so dangerous that we should have restricted our public activities all of our lives, it is intentional harm caused by another human being, it takes fundamental control of a person's body away, it often involves a direct or implied threat of murder, it is a violation of those parts of our bodies and selves which can be considered most private or for some sacred, and survivors are exposed to constant reminders of its dynamics through the daily portrayal and experiences of the sexual objectification of women.

For some it can be difficult to manage the impacts without assistance as in general our usual cure for trauma – to tell and retell of our experience – is not available to the survivor due to a culture which makes it unacceptable to talk about it and/or blames her for the event. Furthermore, some survivors instinctively know that they cannot tolerate talking about it, a wise move when lack of capacity to moderate arousal can mean that talking about it could cause further damage to the neural pathways activated by the trauma. Both associated and added to this is the capacity of medical, legal and community responses to sexual violence to inadvertently further traumatise the victim/survivor (Campbell et al, 1999).

However, the impacts can reduce or increase over time, depending on the internal and external resources the survivor has to process the experience and deal with the impact. Provision of appropriate psycho-social services can assist in providing the

external resources and facilitate development of the internal resources necessary to recovery. When services are provided during those medical and legal processes which can cause further traumatisation, the risk of this can be significantly reduced. While there is not yet New Zealand research to demonstrate the effectiveness of this, international research suggests that provision of support services can:

- provide support, increase victim's/survivor's information and knowledge and help them to understand options and make decisions (US - Wasco, et al 2004)
- assist victims/survivors to get a better deal in medical and legal systems and feel less distressed by them (US – Campbell, 2006); and
- mean that victims/survivors are less likely to withdraw from the legal system if they have a support worker present at the police interview and receive follow-up support (UK - Lovett, Regan and Kelly, 2004).

Studies of user satisfaction also rate specialist psycho-social support services well (Aus – Lievore, 2005; US – Fry, 2007).

Commitment to specialisation in responding to sexual violence

Within the sector, there is on-going commitment to specialist services responding to sexual violence for the following reasons:

- The potentially high negative impact of sexual violence on quality of life, psychological functioning, and relationships. E.g. DSM IV lists survivors of rape as having one of the highest prevalences of Post Traumatic Stress Disorder.
- The importance of early intervention as the difficulties arising from sexual violence can have a deteriorating course due to both the physiological factors associated with trauma responses – the "kindling" effect whereby there is increasing hyper arousal at lower trigger thresholds – and the interplays of psychological and social factors e.g. social withdrawal due to lack of sense of safety in the world leads to less positive experiences of the world, which, along with emotional numbing, can lead to depression.
- The importance of informed and appropriate early intervention – ill-conceived early intervention, such as some models of Critical Stress Debriefing, has been shown to have the potential to cause further harm following trauma.
- Cultural ambivalence about sexual violence can play out in the responses of service providers. When such responses occur at a time of high vulnerability, a person has little resilience so they can be easily harmed by such ambivalence. For example, the service provider who idly wonders "what were you doing there anyway?" can inadvertently reinforce a process of self-blame, or the service provider who thinks that 80% of complaints of sexual violence are false brings this filter to their normal processes of selective attention when listening to the survivor's disclosure.
- Cultural ambivalence also plays out in families so it is helpful to have specialist guidance available for them as well.
- There are specific legal and court procedures which relate to sexual violence so it is in the interests of survivors and their supporters to receive accurate information.
- Survivors rate the services provided by specialist services highly for both the specialist knowledge brought and the way that it is offered with an emphasis on emotional care and support (Lievore, 2005).
- Specialist sexual violence services tend to provide a range of services, being almost a one-stop shop for sexual violence (excluding police and most medical responses). This is helpful not only for survivors and their families, but also for

communities. When the local school teacher or youth group leader suspects sexual violence but needs to consult, there is a place to go. Cultural ambivalence means that in general people seem to make disclosures when the environment has told them it is safe to do so. For example, in mental health assessment interviews much work has gone into teaching clinicians how to ask about sexual violence in a way that assists people to feel safe enough to disclose (Read, Hammersley and Rudegair, 2007). At the level of community, it is easier for people and services to acknowledge an incident of sexual violence if it is already regularly talked about in that community.

What is a *mainstream* sexual assault service ?

Mainstream sexual assault services tend to be based at least in part on NZ Euro-derived cultural or counter-cultural models of abuse, recovery and service delivery, though they may also provide services from a kaupapa or tikanga Maori perspective. In addition, they tend to act as a backstop, providing services to those who either have no access to a culturally appropriate service, or those who choose not to use culturally appropriate services.

Early intervention or crisis support services

Mainstream crisis support services provide emergency psychosocial support following sexual assault. This is a client centred definition in the sense that, the "emergency" is when the client defines it rather than how long ago the assault occurred. This is due to the nature of people's emotional and psychological responses to sexual assault which mean that the point at which a person requires service may not be immediately after the assault. This can be a difference between psychosocial service providers and other providers for whom the nature of "emergency" with regard to the survivor can be defined by the nature of their work– medical care and evidence gathering. Inrelation to evidence gathering, "emergency" services tend to be defined in relation to the time elapsed from the event.

Emergency psychosocial support tends to be primarily provided through three service components. The converging of grass roots and professional groups and models in this area mean that service providers can use widely varying language to describe the content of what they actually do within the services provided, so for ease of communication at this point we will stick tosimple service descriptions.

1. Telephone service to respond to people when they or someone they know has experienced sexual assault.
2. Call-out service to provide psycho-social support at police interviews and medical examinations.

3. Support sessions – emergency face-to-face sessions when needed e.g. to respond to high levels of distress, safety concerns, or the need for quick decisions to be made about proceeding legally.

Arguably, in the current environment, to more fully serve the young and the hearing impaired, a further service would be added, one which allows for real-time written electronic communications. This was not canvassed in this research, but there are known to be some day-time e-mail services operating, though none guaranteeing a real-time response. Response times range from "daily office hours" through to weekly responses from those services which have just the one phone line and dial-up internet services so only check their e-mails once a week and do so quickly to keep the phone line free. A further restraint on such services is the limit to confidentiality of e-mail communications.

Whatever the component of service delivery, within all of these services what is provided will be some combination of humane emotional and practical support, acute counselling including assessment of safety and other needs, advocacy, information, and referral.

There are four factors which mean that the provision of a 24/7 service in this field is considered to be desirable or necessary.

1. Rape – can happen anytime, but mostly happens at night.
2. Flashbacks and nightmares following rape – can happen anytime, but often happen at night.
3. Disabling terror following rape – can happen anytime, but mostly happens at night.
4. Privacy to talk on the phone about something that you feel ashamed and distressed about when you do talk about it – can happen anytime, but often happens at night.

So, a full crisis service as they are currently conceived, would provide all three services, (telephone, call-out and support sessions) on a 24/7 basis. There is currently only one service in this country that can provide all three on a 24/7 basis so the following categorization table provides definitions for full and partial services for each component of service

Table 1: Categorization table

Telephone Crisis service	Full - 24/7	Partial – some service	none

Emergency call-out service	Full - 24/7	Partial - day-time only	none
Face to Face Crisis Support sessions	Full – 24/7	Partial – day-time only	none

Support and recovery services

A "*mainstream*" support and recovery service is one which provides ongoing and possibly long term support and or therapeutic services for survivors of sexual assault. Typically such services provide counselling, one to one support sessions, telephone support and social work intervention to ensure a holistic or wrap around service for clients using the service. As the results below will show, a common theme across services is, as with crisis services, a model of service delivery which places the needs of the client firmly at the centre.

Methodology

Material informing this chapter has been gathered by a combination of telephone interviews, written questionnaires, follow-up emails, face to face interviews and from the public domain through web searches. Information was also collected through a Vision workshop held during the TOAH-NNEST National Hui in November 2008.[5] The stocktake questionnaire combines both a qualitative and quantitative approach (see Appendix 1).

Initial pilot interviews conducted by staff at Auckland Sexual Abuse HELP shaped the questionnaire guide used for telephone interviews. As a response to those services under pressure of time, and for those whose governance structure held a preference for collective input, the survey was reformatted to allow services time for discussion and to fill in the questionnaire and return by mail or email.

Services were also asked to submit statistics from the last year of service provision to give further information about what services were being delivered to whom.

A draft report was sent out to participants for feedback about accuracy of representation and the meanings made and analyses drawn.

Quantifiable Information

A data base was designed to capture the singular Yes/No or numerical answers. These have been compiled using an Excel spreadsheet and are mostly presented in table form.

Statistical reports supplied by services have given a limited sense of the amount of crisis intervention and recovery and support work being carried out across parts of the country. Analysis of this material has not been able to be managed in any significantly quantifiable way. This is due to a lack of comprehensive statistical information available across the board, and the different criteria, definitions, and meaning attached to the statistics as they are captured by different services. It could be of immense value to organisations and to future research to support the creation of a standard national database available to all services, to be utilised for statistical collection and analysis.

Descriptive Information

All comments and descriptions have been recorded as close to quote form as feasible through note taking on the phone. Any identified ambiguity has been checked back

[5] See Report submitted to MSD December 2008 titled "Tau Iwi Caucus TOAH NNEST Hui 5-6th November 2008"

with the service for clarification. The open ended questions have been grouped into table form to look for similarities and differences in perspective. Some services were able to offer more in-depth feedback to the open ended questions while others were limited in their description due to time, knowledge and information constraints.

Participation

This chapter draws on the information gathered from 30 specialist sexual assault services across the country. The list of potential participants was drawn from TOAH-NNEST contact lists. Twenty five of the thirty services participated fully in the stocktake process. Two services partially participated including offering information about service provision at the community feedback stage of the report. A further three services were unavailable to engage in the stocktake. Data relating to these service details have been drawn from publically av ailable community web-based information and from information contributed by their colleagues from Nga Whiitiki Whanau Ahuru Mowai O Aotearoa National Collective of Rape Crisis and Related Groups of Aotearoa. Interviews were also conducted with individuals and generic service providers in areas where specialist sexual assault services have closed in the last 5 years (to include Levin, Tauranga, Ohope/Whakatane, and Waihi). These broadly informing interviews do not numerically count within the thirty services reported in the stocktake.

A further consideration to be noted when reading this report is that the focus of the research was in line with that of the Taskforce for Action on Sexual Violence, on services for survivors of adult sexual violence. Consequently, several agencies which specialize in providing support and recovery services for children and their families were not interviewed for this stocktake. At the time that the stocktake was initiated, there were no identifiable specialist sexual assault agencies working solely with men who were survivors of adult sexual violence. Further, the considerable number of private practice counsellors who specialize in sexual abuse counselling have not been interviewed and nor have sexual violence specialists working within more generic services

What is apparent in some of the responses is that service providers view their services holistically and do not necessarily differentiate between services for adult sexual assault, adults dealing with historical childhood sexual abuse and children and families. Where it is appropriate and possible information pertinent to adult survivors of sexual assault will be highlighted.

In providing a stocktake of services, what is not taken account of is the needs of communities without access to such services. A fully comprehensive look at this issue nationwide would have worked with such communities to look at how they respond to sexual violence and what needs they might have. Resource constraints in the research precluded such an approach, though one participant in the Vision workshop was there

to represent her community's needs in this way. This is reported Section 2.3 Improving Services.

Geographic Areas

As with many social services, differences between urban and rural needs and service delivery can sometimes be significant in this field. This report attempts to convey the complexity of difference by maintaining the distinction where relevant to the rural urban dynamic.

Geographic areas have been defined with reference to Statistics New Zealand Urban/Rural Profile Classification Categories. These are determined by population bases. Urban areas include Whangarei, Auckland, Hamilton, Tauranga, Rotorua, Gisborne, Napier-Hastings, New Plymouth, Wanganui, Palmerston North, Kapiti, Wellington, Nelson, Christchurch, Dunedin and Invercargill.

Other areas are defined in relation to their access to these main urban centres. These areas are defined in relation to movement between place of residency and place of employment. Statistics NZ use six variable definitions for areas that range from satellite or independent urban to rural areas with high, moderate or low urban influence, and, highly rural or remote. Statistics NZ geographically defined areas can be seen on the following map (See Appendix 2)[6]

Aside from Auckland and Wellington services, all other services support an urban and satellite urban and/or satellite urban/rural coverage.

Limitations

The time frame for the stocktake limited the ease of participation both in terms of the months available to collect information (November - January) and leaving enough time for the report to go back to the community for feedback prior to final submission. Many services found the pressure of end of year work restricted their availability to fully engage with the research and key people in some agencies were unavailable due to summer vacation time.

Some interviewees commented on how refreshing it was to be able to reflect and be heard on the key questions affecting their services, but many found the demands of participation burdensome. This was understandable given the already over stretched capacity of many organisations for meeting core business and their need to keep

[6] Also see Appendix 2 for map reference. www.stats.govt.nz/statistics-by-area/urban-rural-profiles

phone lines open to crisis calls. Responses to the draft report ranged from silence, to technical corrections through to enthusiasm at having such information available to the sector.

2.1: The what, how, where and with whom?

What services are provided?

In order to determine what specialist sexual assault services are available to the population, organisations were asked to describe the work they do and the types of services they provide. A list of services available has been drawn out of the conversations and the questionnaire.

There is a range of models for service provision across the country. The ability to provide a crisis service 24/7 and the model and structure of these services differ between urban and other geographical areas and is most often determined by access to workers, resources, demand for service and the relationship between points of referral within the community – particularly the tri-partite arrangement between such services, police and the DSAC trained or other doctors providing medical care and collection of evidence.

A list of services recorded includes:

- Support during police interviews
- Support during medical forensic examinations
- Court preparation or support
- Telephone information/referral and crisis line
- Emergency face to face crisis counselling/support
- On-going counselling and support
- Social work
- Prevention education and community consultation
- Other specialist sexual violence services
- Other services

Each of these services is presented in table form and description with a breakdown by geographic area. Services with an urban base are recorded as urban, although many of these services cover satellite/rural areas as well as their urban base. Those services which are counted as satellite urban/rural work only within that context and are not sited in an urban centre.

Support during Police Interviews

To more fully understand the context of this work a description of the role of the crisis support worker is attached as Appendix 3.

Twenty eight of thirty services answered questions that relate to their capacity to provide support during police interviews. Analysis of the answers to this question highlight the difference between services able to provide support for police interviews during working hours (partial support) and those able to provide 24/7 support during police interviews. Table 1 below reflects this breakdown.

Table 2: Support during Police Interviews

	Total	%	Urban Centre	Satellite Urban or Rural
24/7 support at police interview	13	46%	8	5
Partial support at police interview	23	82%	15	8

Total number responses = 28

Thirteen of twenty-eight services provide support at police interviews in a 24/7 capacity. An analysis of the relationship between service availability and call out referrals from police is found in the *How* section of the report under the title *Tri-partite relationship.*

All thirteen of these services are the primary support agency called by police to support survivors of sexual violence, however many are aware that despite their availably, referrals or 'call outs' do not always transpire. With the exception of one service, most partial support services are not considered to be the primary point of contact/referral for the police in their area.

Twenty-three of the twenty-eight services describe being available to provide support at police interviews in the context of meeting the needs and wants of women/survivors as they present to their service. This was described mainly as survivors presenting to the service for counselling or support due to the impacts of historical abuse who, in the process of receiving these services, go on to make a statement to the police. This is made at an arranged time managed between the survivor, the service and the police and is not considered a crisis service.

"If we are asked to support at police statements then we will support that process".

Support at Forensic Medical Examinations

Providing support during forensic medical examinations correlates with the provision of support at police interviews.

Table 3: Support at Forensic Medical Examinations

	#	%	Urban Centre	Satellite Urban or Rural
24/7 support at medicals	13	46%	8	5
Partial support at medicals	19	68%	12	7

Total number responses =28

Thirteen services provide support at forensic medical examinations on a 24/7 basis, along with supporting survivors through a police interview. A further six services will do so on request from a survivor/victim.

Usually the provision of support at a police interview and a forensic medical examination are linked, although at times women do present to a DSAC[7] trained doctor and connect with specialist sexual assault services independently of making a complaint to police.

Four services registered that they offer support at police interviews during office hours but do not provide support at forensic medical examinations, as they work only with survivors presenting with historical complaints.

Court Preparation

A critical aspect of service is the provision of support during the preparation for and the attendance at court.

Table 4: Court Preparation

	Total	%	Urban Centre	Satellite Urban or Rural
Support for court preparation	23	92%	17	6

Total number responses =25

Twenty-three of twenty-five services responded that they support clients through court preparation. In discussion on what this actually means, services related that due to lack of funding for support at court, they were more able to assist the client prior to the court case than to provide support through the trial itself. Such preparation includes familiarization with court processes and development of strategies for managing their emotional responses to court processes and content.

[7] Doctors for Sexual Abuse Care

The actual need for support during the daily demands of a criminal trial can be high. The presence of the offender, the need to explain a difficult experience to a group of strangers in an unfamiliar and formal environment and the current emphasis in rape trials on her lack of credibility and blame for what happened, along with the low rate of "guilty" verdicts, lead some victims/survivors to describe such experiences as "a second rape". The psychological and emotional impacts of this experience can be lessened with specialist support available through the trial itself, yet there is no funding for such service provision to survivors during this difficult time. Some services do this critical work any way they can within the limited capacity of worker resources. It is not uncommon for services to extend to survivors in an unpaid capacity in order to provide court support.

Telephone information/referral and crisis line

Telephone services typically provide crisis support, information and referrals for survivors of sexual violence and their communities of support.

Table 5: Telephone information/referral and crisis line

	Total	%	Urban Centre	Satellite Urban or Rural
Telephone Information	30	100%	18	8
Telephone referral	30	100%	18	8
Telephone Crisis Support	28	93%	18	10
Telephone Crisis Support 24/7	16	53%	9	7
Telephone Crisis Support Paid	5			
Telephone Crisis Support Unpaid	11			

Total number responses = 30

All services checked the telephone information and referral service as a key aspect of their service provision. However, not all phone information and referral calls relate to crisis or intervention. Services provide information to media, community and other services in their area. Such a service includes being available to general enquiries from the public as well as to non specialist services for information on rape and sexual assault, education, prevention, and referral to support and recovery services. Mostly these telephone information and referral services are limited to office hours.

Some services have website details available which broadens their capacity to provide information.

From a crisis perspective, the availability of a telephone support service is a critical element of service provision. Twenty eight of thirty services offer a partial crisis line service[8], responding to survivors looking for an urgent telephone intervention during office hours. Only sixteen of these services are able to provide this service on a 24/7 basis.

Eleven services have trained volunteer workers on the phones providing an afterhours service, while five employ trained or training counsellors or social workers in this role. In several interviews, services wanted to be clear that volunteers are not always trained counsellors and did not offer phone counselling per se but were trained to offer support and referral.

Four services, working within limited hours of service delivery, mentioned that they offer telephone information and referrals within set times and then utilize a telephone answer machine to refer to other specialist services in the area or organisations such as Lifeline, Victim Support, and the Mental Health crisis team if requiring immediate intervention.

Some services have no referral to an after hour's service but encourage people to leave a message which will be picked up either during office hours, or by a dedicated worker who "*checks the phones regularly".* Several workers described how their dedication to the work included checking the phone hourly up till 10pm at night and over the weekend when they were not officially at work in case someone calls. This is an attempt to stay as available as possible to a 24/7 emergency information / referral and support service with limited resources.

Face to face emergency sessions

Such sessions are used to respond to high levels of distress, safety concerns, or the need for quick decisions to be made about proceeding legally when these issues are better addressed face to face than over the phone.

Table 6: Face to face emergency sessions

	#	%	Urban Centre	Satellite Urban or Rural
Partial emergency support	27	90%	17	10
24/7 emergency support	1	3%	1	0

Total number responses = 30

[8] Those services not providing a crisis line tend to be located in geographic areas where another service carries this function.

One service has the capacity to provide emergency face to face support in a 24/7 or as an out of hour's service. All other clients accessing an after-hours crisis service are maintained through phone contact until office hours allow an emergency face to face counselling or support session to be established.

The capacity of services to respond to this need within office hours is variable. Twenty eight services provide such face to face emergency support/counselling. Some services have duty counsellors who respond to these appointments urgently as required, while others work in a more organic way supporting as best as possible within their capacity the needs of survivors and their supporters as they present.

Ongoing support/counselling

Ongoing support or counselling is the ability of the service to provide longer term face to face counselling and support to survivors. The detail of the type and structure of the service provided was not quantitatively explored. Descriptive reporting on service structure is found in later sections of the *mainstream* report and explores the use of ACC or non ACC registered counsellors, funding, values and issues.

Table 7: Ongoing support/counselling

	#	%	Urban Centre	Satellite Urban or Rural
Ongoing support/ counselling	28	93%	18	10

Total number responses = 30

Most, but not all services offer ongoing counselling as an aspect of their service. Of the two which do not, one is focused on prevention and education work only and the other urban based centre currently refers all ongoing counselling work to external independent counselling services (ACC registered or specialist sexual abuse counsellors). This service is hopeful that they will soon be able to provide an in house counselling service.

> *Currently we refer counselling services externally as well, but we are looking to employ an in house counsellor in the next month who will be able to provide this service*

Social Work

Services were asked to comment on their ability to provide *social work* level intervention as part of their service provision.

Table 8: Social Work

	#	%	Urban Centre	Satellite Urban or Rural

Social Work	20	77%	13	7

Total number responses =26

Not all services employ a social worker per se, but 20 report that they provide a social work function as part of their support to survivors. Social work support and intervention provides an opportunity for services to place the client in a wider context beyond the individual client, counsellor/support worker relationship. For individual clients this can take the form of advocacy and support for dealing with WINZ, Housing NZ, health services, communications with schools and childcare etc. At an organisational level social work can enhance the development and maintenance of collaboration and relationships with others in the client's networks and the wider community.

Some services talked about the idea of being a "wrap-around" service and responding in any way possible to assist survivors to stabilize their lives while they are dealing with the trauma of rape and abuse.

> *Our collective workers aim to meet the needs as they are presented by the client – so that means we will try to support women in any way we can- as in the above list – it could be referral or more direct support for example, from going shopping with someone to helping them through support and recovery in counselling*

Social work support is an example of where services straddle both crisis and support and recovery services. Often a service will respond to a critical social work based intervention required for the immediate functioning of a survivor after an acute crisis. Social work services might also be a part of longer-term recovery work when identified as necessary or helpful during established counselling sessions.

Mobile services – multiple sites, outreach and home visits

Organisations were asked about how they physically provide services – whether they work from one site, or provide outreach or home visits also. Table 9 reports the way in which services physically present their services in order to build maximum accessibility to clients.

To define the terms, one site means that the service has an office base and has limited the work with clients to this space alone. Multiple sites includes providing outreach services to smaller rural/satellite urban centres, provide counselling/support in schools, or more than one office space within the urban area. One site plus home visits or multiple site plus home visits reflects those services which also include home visits as part of the service delivery and the base from which they work.

There were a number of combinations of answers to this question with evident rural/urban geographical differences. For example there are no reported Satellite Urban/ Rural services providing a multiple site service other than home visits, yet it is the way that the majority of urban services work - providing outreach to another service, prevention programmes, or working in schools.

Table 9: Mobile services multiple sites, outreach and home visits

Site Type	Urban	Satellite Urban/ Rural
One site (includes stand alone or community house)	4	2
Multiple sites i.e. schools, outreach or other office space	7	0
One site plus home visits	5	4
Multiple sites plus home visits	2	2

Total no responses = 26

Six of the twenty six responding services work from one site only and do not do home visits. Two of these services have a satellite urban/rural base and four are urban centres. Seven urban services work across multiple sites not including home visits.

Five urban one site services reported that they do home visits as part of their service, however the additional comment made was most often that this was an occasional event. One service noted, "we *work mainly from one site, occasional home visits, but mainly office based with therapy rooms".* The reluctance to do home visits related mostly to requiring more than one worker for worker safety issues and the resources required to travel.

Satellite urban/rural based services talked more about working with clients at home in order to accommodate some of the structural barriers experienced through rural isolation. Issues of worker safety were not raised.

> *We do go to homes as we have a rural and transport issue here for women*
>
> *We have rental space which we work from in town but do home visits and go to where the need is as much as possible.*

The willingness to accommodate clients with transport barriers was not limited to the rural context with an urban service stating that "we c*an access rooms in Upper Hutt for clients with no transport to get to the main centre".*

Some services talked about either using an urban based specialist sexual assault service/counsellor to provide an outreach service into their rural area or of being the provider of an outreach service to meet the needs of rural/satellite urban communities. At least three services are actively providing this level of services.

Three urban services (multiple sites only) plus one rural service (who also does home visits) described their use of multiple sites to include the provision of school counselling or the delivery of prevention/education programmes. One service talked about the home visits by a social worker to include the delivery of parenting programs. Another distinguished the home based support service as social work/advocacy but not as a counselling service which is based on site only (with the occasional exception).

Comment was made about requiring a separate site in order to accommodate a provision for men to use the service.

> *We hold women only space as an important feature of providing service but find more and more that this impacts on our ability to provide effective services to male survivors and male support people. Seeing male clients off site has raised some safety issues for our female workers which we are currently addressing.*

Prevention Education/Community Consultation

Organisations were asked to identify if they had an active prevention education programme or if they played a part in community advisory matters or consultations as a specialist sexual assault service.

Table 10: Prevention Education/Community Consultation

	Total	%	Urban Centre	Satellite Urban or Rural
Prevention Education	22	82%	15	7
Community Consultation	26	96%	18	8

Total number responses = 27

Twenty-two organisations are running some form of prevention education programme. Again the scope and delivery of these services varies.

Some programmes are provided for children and young people of varying ages, while others involve the training of staff to receive disclosures and limiting sexual harassment in the workplace. Organisations described common foci of prevention education (for

young people and adults) being addressing rape myths and promoting empowering models of sexual practice.

Some organisations talked of the difficulties in gaining access to present prevention education programmes due to the reluctance of some schools to confront sexual violence issues.

> *Community lack of knowledge, [rape and sexual abuse is] still a tapu subject and denied in society. It doesn't affect how we do the work but has an impact on our education programme (can't get into some schools) Society needs to open its eyes.*

Satellite urban or rural based organisations also mentioned how they are limited in the frequency that they can deliver some programmes as they require critical numbers of people to participate, and in smaller communities, getting enough people at the same time can prove difficult.

Never the less, most organisations talked of the importance of education and prevention work as playing a role that supports the crisis and support and recovery work – both in terms of its potential to reduce risk and vulnerability in the population and also as a balance which helps to hold up the morale of the organisation in the face of the traumatic nature of much of the other work.

Other specialist sexual assault services

Organisations were invited to add other specialist sexual assault services that they provide.

Table 11: Other specialist sexual assault services

	Total	%	Urban Centre	Satellite Urban or Rural
Other services	20	77%	14	6

Total number responses =26

Twenty of the twenty-six organisations who responded to this part of the questionnaire took the opportunity to describe a variety of services not listed already in the tables above. These were considered to be important aspects of the specialist sexual assault service and include:

- running a safe house,
- providing emergency money for food and bills,
- providing a library and resource centre,

- group and empowerment work,
- media statements,
- restorative justice,
- providing training for receiving disclosures,
- political lobbying and advocacy,
- email answering service,
- phone service referral for offenders,
- work with adolescents – resilience and recovery for girls,
- early intervention offender program for young men,
- support for family and partners, and
- training for dealing with sexual harassment in the workplace.

Other services

Organisations were also asked to describe any services that they provided other than specialist sexual assault services.

Some organisations have diversified away from focusing exclusively on sexual violence services due to meeting other needs within their communities.

> *When we first started we were initially Sexual Assault for women and children and then we noticed the gaps in our community these were also gaps for survivors – so we broadened our kaupapa – include budgeting and support – a social work focus as well.*

> *Has changed over the last 5 years. Because we are a small town we had few services – grown to meet the need of the community. Values driven with Sexual Violence as our core work but other needs are met as well.*

Several organisations commented that they now also provide Family Violence support and more generic counselling work as part of their service provision, but that the drive for this was largely a result of the need to seek more funding.

> *The only issue we have is funding which constrains what we want to do…. This has forced us to go into other areas like family violence because this is where the money is…. taking us away from our core work.*

In the last few years we have expanded from sexual assault service only to a broader range of services including self esteem and parenting courses. This is in part due to funding – as it is easier to find the money to run these courses then provide crisis care

Some organisations have widened their scope but maintain a specialist interest and focus on sexual violence, while others have integrated other work (mainly family violence responses) into their core business. Over half (51%) of organisations who answered this question (n=27) have other non sexual assault services attached to their organisation/agency. Descriptions of the wider work include budgeting services, family/domestic violence response, youth work, self esteem and body work massage.

Summary – Service Provision within Specialist Sexual Assault Services

Specialist sexual assault services offer a range of services from crisis intervention support in person to telephone referral, support, social work, on-going counselling and community prevention programmes and consultation. As the tables have illustrated, most services are attempting to provide as many of the above services as possible. Illustrations of the intent of services can be found throughout the conversation with services -

We provide a wrap around service whenever we can – client focused – they identify what they need and we meet them where we can. So although we can do all these things (police, DSAC, court etc) we don't always do it all.

We do whatever we need to do for the client if they need us there we go. If we can't do it we refer on. We are beginning to get the Education work together

Although twenty-three services indicated that they would provide support at police interviews, only thirteen can do so covering a 24/7 period. Other services acknowledged that their support at police interviews and/or medical forensic support were most often limited to historical abuse when women were self referring through these agencies rather than picking up referrals coming from the police/ medical forensic services.

All services are focused on being able to provide multiple levels of service for survivors: emotional and practical support, ongoing therapeutic support, referrals and education, acceptance and empowerment. All services talked about working from models of providing survivor centred care.

The thirteen services capable of providing 24/7 support at crisis intervention within the tri-partite relationship (with Police and DSAC) also provide telephone crisis support, face to face crisis counselling, ongoing counselling services, and some form of prevention

education or community consultation about rape and sexual assault. In addition, many of these services also offer social work and/or court preparation and support work.

Specialist sexual assault crisis support services are generally well-integrated services which respond to sexual violence as a whole. Where available, survivors, their support networks, and the local community, are all able to access a comprehensive range of services to meet both their acute and on-going needs.

How services work?

Tri-partite Relationship

This section explores the relationships between members of the tri-partite response to sexual violence – crisis support services, police, and medical providers, usually DSAC trained doctors. Interviewees were invited to check "support at police statement" and "support through medicals" as options by which to describe an aspect of their service provision and then at a later stage, to answer if they are the primary contact point for police? If yes, do they have a signed agreement? If not, who is the primary contact point for police in their area? And, is this who they think it should be? A question on the primary contact point for Medical Doctors (DSAC) was also included.

The table below shows the number and percentage result of the stocktake and again includes a cross reference with the geographic area of the service provision.

Table 12: Police & Medical Support

	#	%	Urban	Satellite Urban & Rural
Support at police interviews	23	82%	15	6
24/7 support at police interviews	13	46%	9	4
Primary contact police	14	50%	9	5
MOU with police	4	14%	3	1
Support at medical examinations	19	68%	13	6
24/7 support at medical examinations	13	46%	9	4
Primary contact forensic doctors	12	43%	9	3

Total number responses = 28

Local agreements & relationship building

The fourteen services which considered themselves the primary police contact in their area for providing acute victim/survivor support are all 24/7 call-out services bar one rural service which operates as a partial service. Only 4 services have a formalized local agreement or Memorandum of Understanding (MOU) with the police. Several services talked of having established a good relationship with local police (more so the Detectives than front line staff) and were working towards creating a more formal MOU as a next step. Others did not have a formal agreement or MOU and were aware that at times they were not being referred to as the primary contact despite their 24/7 availability and the Policy commitment from police to call specialist services.[9]

Services acknowledged that a mutually respectful professional relationship of trust and understanding with police is necessary in order to be considered the primary contact organisation. This can take time to build and is limited by a lack of resources and capacity to extend beyond the core work in order to adequately network.

Police staff turnover and a lack of commitment from the police to work with specialist sexual assault services was often cited as having led to the breakdown of services being called to support survivors presenting to police with a complaint. Equally, the service's own high staff turnover (often driven by poor pay, lack of service stability through unreliable funding and high demands of the work), was seen as playing a part in limiting the building of good networks.

> *At present [one of our biggest issues] is gaining the trust of the police – they should be our main referrers – although we get referrals from other districts but not here. There is a history of mistrust which we have to undo. Does take time to rebuild the relationships*

Several services talked about having regular meetings of the tri-partite members - crisis support service, local police sexual assault coordinator, and medical services - where client issues and follow-up are discussed and any issues arising in the relationship between the parties are also discussed. These meetings were considered to be highly effective and crucial in the smooth working of the tri-partite relationship. Several other services talked about being part of regular meetings between police and a number of social service providers where referrals took place, and issues of concern within the community could be reported back and addressed. These meetings were seen as important for relationship building and for visibility between agencies and as an opportunity for education around the prevalence of rape myths.

[9] Since 1998, this commitment has been embodied in the NZ Police Adult Sexual Assault Policy. The policy requires police to call the local specialist sexual assault service, and to have an agreement with that service.

Some services talked of a sense of judgment made in the community about who they were and what they did. The basis of the judgment is the stereotype that the group is made up of "men hating lesbians". This has seen groups isolated and without an invitation to be part of a local network. Comment was conveyed that misunderstanding or myths about the work that specialist sexual assault services provide can serve the purpose of distracting a community from dealing with the real issue of sexual violence and act to invalidate and minimize the visibility of the work.

Clearly, the importance of relationship building, of visibility of services and the nature of the work being understood (both in a rural and urban context) is important ground work for signing a meaningful Memorandum of Understanding between services and police.

Primary Points of Contact

In some areas, although the specialist sexual assault service is providing all of the other sexual violence related services to their local community and they may have been called by police in the past, they reported that the police now call Victim Support in response to complaints of sexual assault.

One service expressed confidence in Victim Support doing the work in their area as they had trained them in supporting survivors of sexual assault. Another service spoke positively of the informal relationship that existed between the specialist sexual assault service, Victim Support and the police –

> *Yes – but not formal – we have a good active relationship – attend weekly crisis meetings with police and other agencies. Collaboration is good….. Victim Support always refers onto us.*

With regard to who was primary contact for police and the further question "is this who you think it should be?" all except the one service previously mentioned felt that a recently sexually assaulted rape survivor should have access to independent specialist crisis support. Mostly, services did not feel that it was appropriate for Police to call Victim Support as the support service for rape and sexual assault. It was believed that the training and understanding held by such generic supportservices was often inadequate which could increase the risk to the survivor's future well-being. Other concerns related to a lack of independence from police among Victim Support staff – this ranged from concerns about the close working arrangements, through to concerns about the marital relationships between police and Victim Support workers in one area.

> *Victim Support has the contract with police. It should be us and we should receive referrals directly from the police or at least from Victim Support. Attempts to forge a relationship with Victim Support have been disappointing. [Victim Support] say they need a National MOU before they will refer to us. Police think*

they don't need us in emergency/crisis situations as they have a female constable that they use who is very good with victims

We would like to say yes [we are the primary point of contact] but this is not the case at the moment. Survivors often get referred to Victim Support or Women's Refuge. We have the capacity just not the referrals. We need to build our relationship and network with police. Police staffing changes is also an issue.

Forensic Medical Examinations

Access to medical services where practitioners have an understanding and context for service provision after a sexual assault is considered to be critical to the healing journey of the survivor. The ability for survivors to access medical services at the time of assault and for this to be well supported to limit experiences of re-traumatisation is a key understanding and focus of the work of sexual assault services. Not being able to find doctors to assist with this work is a source of deep frustration and concern to services.

Mostly the sexual assault services make a connection with medical forensic services via the police when a forensic examination is required as part of the process of reporting rape.

At times survivors not wishing to report to the police may require medical intervention and will approach a specialist service for support and advice about accessing a local DSAC doctor. Occasionally, survivors will seek out a DSAC doctor themselves, and specialist support and recovery services are then referred to the survivor via the doctor.

Nineteen services reported offering support at medical forensics as part of their service. Generally, relationships between support services and DSAC trained doctors were good. However, services which face high staff turnover resulting in the loss of grass roots knowledge, plus a limited number of DSAC trained doctors in an area report a more confused state of affairs. One service responded that the point of contact with local DSAC was "*unknown, but we think we are registered as a point of contact. The forensic process is usually organized via the police".*

Many satellite urban/rural services face having no trained DSAC doctors in the area and therefore face the additional expense of travel to support survivors to seek specialist medical services in urban centres. Rural and urban satellite services most commonly reported that a lack of service availability resulted in no point of contact.

No current DSAC trained doctor in area – we have to go to Hamilton for this.

No – all the DSAC doctors are based in New Plymouth

We take women to DSAC – we actively go to support clients in the process, but we have to go to Whangarei for this.

I think the closest DSAC doctor is in Whangarei. We are trying to convince doctors to train in the area.

Services and survivors are being confronted with the expense and time required to travel to a trained DSAC doctor outside of their local context. In some situations, this involves considerable distances of car or plane travel. None of this level of support for service is funded so survivors are often making these journeys without support. In one instance described, within hours of being raped a woman was required to travel alone by public plane to another city for a forensic medical examination. Given prohibitions on washing and what we know about many survivors' experiences in these early hours of feeling exposed as having been raped, such an experience could add significantly to any trauma from a rape.

What happens for survivors when forced to use doctors untrained in working specifically with survivors of sexual violence for medical forensic or follow up examinations after an assault or rape (STD, pregnancy, medical certificates for time off work etc) when there are no DSAC doctors in the area and travel is prohibitive?

The service on the West Coast of the South Island conveyed their concern in this respect:

The doctors in the area are predominantly locum – only here for 3 months – have had some concerning situation with the locum doctors - no opportunity to establish relationship and understanding. The locum / transitory nature of the doctors add risk and vulnerability to women – both from professional misconduct point of view and also no reliable medical practitioner to build an understanding relationship with our service. Presently we have no DSAC service on the West Coast. Clients have to travel either to Nelson or Christchurch to see a DSAC trained doctor.

Summary

In some areas, the tri-partite relationship is working well from the point of view of crisis support agencies. Each party knows their own role and respects that of the other parties, and regular meetings occur for mutual feedback and case management. However, in other areas a lack of cohesion, resources and shared understanding means that the tri-partite relationship is not functioning well. While this is stressful for services involved, it could be suggested that those who could suffer most impact of this would be those making complaints of sexual violence.

Where?

Table 13 shows the core crisis support services and support and recovery /counselling services and their availability within each Police District. A map of Police District boundaries can be found as Appendix 4.

A geographical description of the district has been sourced from the police website and 2007/08 population figures in each district have been drawn from 2001/2006 census data. All information has been sourced from Police District Annual Reports available on their website.[10]

This table brings a focus to the crisis or acute response available across the country. The three acute responses are described as a telephone crisis line (telephone crisis service), call-out response to support at police/forensics (emergency call out), and face to face support sessions– client being able to immediately access a counsellor/support worker.

Further reference within the table is made to the availability of each of these services as either 24/7, partial (as in during the day but not at nights) or as none.

A star (*) has been added to service columns where although the service is available in either a full capacity (24/7) or partially available, these services are not the primary point of contact for crisis referral by the police and have no MOUor other formal agreement to ensure their participation.

[10] http://www.police.govt.nz/

Table 13: Crisis intervention and support and recovery services available within Police Districts

Police District	Geographic Description of District	Service/s	Telephone Crisis Service	Emergency call out	Face to Face Crisis Support	Support and Recovery Services
Northland District	Northland covers an area of 12,844 square km between Kaiwaka and Cape Reinga. The Whangarei/Kaipara area stretches from Whangarei to Kaiwaka, across to Dargaville and Kawakawa. The Mid/Far North area starts at Kawakawa and stretches along both coastlines to Cape Reinga. Population: 152,510	Kaitaia Women and Children Fresh Start Support Group	24/7	Partial	Partial	Y
		Mid North Family Support	Partial	Partial *	Partial	Y
		Support of Sexually Abused (Rape Crisis) Dargaville	24/7	24/7 *	Partial	Y
		Whangarei Rape Crisis	24/7	24/7*	Partial	Y
		Miriam Centre	None	None	None	Y
Auckland City	Auckland City District covers all the places between Herne Bay and Freeman's Bay to the north, St Heliers to the East, Onehunga in the south and Avondale in the west. Population: 416,675	Rape Prevention Education	Partial	None	None	N
		Auckland Sexual Abuse HELP Foundation	24/7	24/7	Partial	Y
Waitemata District	Covers the North Shore of Auckland, up to Mangawhai, across to Helensville and Waitakere and through to New Lynn. It also encompasses the entire 106 kilometre stretch of motorway from the Bombay Hills north to Orewa. Population: 519,745	Auckland Sexual Abuse HELP Foundation	24/7	24/7	Partial	Y
		Waitakere Abuse and Trauma Counselling Service	None	None	Partial	Y
Counties Manukau	The district covers an area from Pokeno over the Bombay hills to Otahuhu and from the coastline of Maraetai in the east to Port	Counselling Services Centre	24/7	24/7	Partial	Y

	Waikato on the west coast. *Population: 488,875*					
Police District	*Geographic Description of District*	*Service/s*	*Telephone Crisis Service*	*Emergency call out*	*Face to Face Crisis Support*	*Support and Recovery Services*
Waikato District	*This district covers an area of more than 15,000 square kilometres - spreading to Te Kauwhata in the north, Benneydale in the south, Raglan to the west and includes the Coromandel Peninsula to the east.* *Population: 325,745*	*Ngaruawahia Community Care and Crisis Centre*	*Partial*	*None*	*Partial*	*Y*
		Hamilton Rape and Sexual Abuse Healing Centre	*Partial*	*None*	*Partial*	*Y*
		Healing and Rape Crisis Centre Te Awamutu	*24/7*	*Partial**	*Partial*	*Y*
Bay of Plenty District	*Cover the area from Katikati in the north; through to the northernmost tip of the Bay of Plenty in the east; reaching into the central North Island south of Turangi.* *Population: 325, 745*	*Sexual Abuse Centre (Rotorua)*	*Partial*	*Partial**	*Partial*	*Y*
Eastern District	*Covering an area that extends from near the tip of East Cape through to southern Hawkes Bay.* *Population: 198, 605*	*Rape Crisis Gisborne*	*24/7*	*Partial**	*Partial*	*Y*
Central District	*Stretches from North Taranaki across to the Ruapehu District, south to Otaki in the west and across to the Tararua ranges in the east.* *Population: 344,390*	*Taranaki SAFER Centre*	*Partial*	*None*	*Partial*	*Y*
		Hawera Rape Crisis	*24/7*		*Partial*	*Y*

		Manawatu Rape and Sexual Abuse Centre	*Partial*	*Partial**	*Partial*	*Y*
		Wanganui Sexual Abuse Healing Centre	*Partial*	*Partial**	*Partial*	*Y*
Police District	*Geographic Description of District*	*Service/s*	*Telephone Crisis Service*	*Emergency call out*	*Face to Face Crisis Support*	*Recovery and Support Services*
Wellington District	*The Wellington district covers 497 kilometres of coastline, encompassing the southern portion of New Zealand's North Island. The northern boundary is Peka Peka, just north of Waikanae on Kapiti Coast, and spreads east across the Tararua Ranges to the Wairarapa. Mt Bruce is the northern most point and we stretch south from the Wairarapa, to the Hutt Valley, the Porirua Basin and Wellington city.* *Population: 464,810*	*Rape Crisis Wairarapa*	*24/7*	*24/7*	*Partial*	*Y*
		Hutt Rape Counselling Network Incorporated	*24/7*	*24/7*	*Partial*	*Y*
		Wellington Rape Crisis	*Partial*	*None*	*Partial*	*Y*
		Wellington Sexual Abuse HELP Foundation	*24/7*	*24/7*	*Partial*	*Y*
Tasman District	*The Tasman Police District covers 70,000 km. If you were to drive from one end of the Tasman District to the other, from Haast on the West Coast to Kaikoura in the east, it would take 12 hours. From the Glaciers of South Westland to the isolated bays of the Marlborough the district takes in the Nelson Bays, West Coast, and Marlborough.* *Population: 171,110*	*Nelson Rape and Sexual Abuse Network Inc*	*24/7*	*24/7*	*Partial*	*Y*
		Marlborough Women's Refuge & Sexual Assault Resource Centre Marlborough Inc	*24/7*	*24/7*	*Partial*	*Y*
		Rape and Sexual Abuse Support (West Coast)	*Partial*	*Partial**	*Partial*	*Y*

Canterbury District	*From east to west, the district traverses from the coastal plains though the foothills, to high in the Southern Alps. From north to south, you travel from the Conway River, (just south of Kaikoura), to the Waitaki River, south of Timaru.* *Population: 544,725*	*Monarch Centre*	*24/7*	*24/7*	*Partial*	*Y*
		The Sexual Abuse Centre	*Partial*	*None*	*Partial*	*Y*
Police District	*Geographic Description of District*	*Service/s*	*Telephone Crisis Service*	*Emergency call out*	*Face to Face Crisis Support*	*Recovery and Support Services*
Southern District	*Southern District spans from Oamaru in the North through to Stewart Island in the far South of the South Island. Central Otago, Queenstown, Wanaka, Fiordland and the lakes of the McKenzie Basin in Otago/Southland and Dunedin city.* *Population: 297,130*	*Rape Crisis Dunedin Inc*	*24/7*	*24/7*	*24/7*	*Y*
		Wakatipu Abuse Prevention Network	*24/7*	*24/7*	*Partial*	*Y*
		Rape and Abuse Centre Southland.	*Partial*	*Partial**	*Partial*	*Y*

While we cannot make precise extrapolations from this table, it does suggest that approximately 67% of the population, (less for males) plus those served by providers in Hawera, Te Awamutu and Nelson, have access to 24/7 support by specialist sexual assault services at police interview and/or forensic medical examination.

With whom?

Introduction

Although organisations hold a common purpose in the work, the structure and models of service provision differ. Across the country there are two main blocks of service providers, those affiliated to Nga Whiitiki Whanau Ahuru Mowai O Aotearoa National Collective of Rape Crisis and Related Groups of Aotearoa whose work is informed by a constitution which places the focus on services for women and children; and, those that are independent Trusts and Incorporated Societies which work within a local and independent context.

The establishment of most specialist sexual violence crisis and counselling services occurred at a time when sexual violence was understood to be a product of a patriarchal society and almost universally perpetrated by adult males against women and children.

In response to this, and the lack of *mainstream* acknowledgement of male violence against women and children, most groups were established by women for women, on a feminist platform, and running on the good will of a group of female volunteers. It is now understood that males are also sometimes the victims of sexual violence perpetrated by men, or less often, by women.

Some services responded to male need by offering services to victims/survivors of sexual violence regardless of gender. Others maintained a focus on directing their still meagre resources to women and children for any of a variety of reasons such as;

- the gender inequity of access to resources in our society
- the problem of sexual violence primarily remains one which is perpetrated by men on women and children
- a wish to direct their personal (often fully or partially unpaid) energies to supporting women and children
- a belief that men need to step up to support men and that for women to do so instead would block the development of this aspect of male culture, and
- a belief that experiences of sexual violence are culturally situated and that therefore they are fundamentally different for men and women so men deserve a specialist response to their needs in these situations (as we give women).

Regardless of cause, the consequence of these differing views is that some services see women only, and some see both women and men. Historically, some services have not

seen children or young people, this variable often depending on other local service configurations.

Telephone Crisis Service availability by population group/location

Table 14 reflects the availability of crisis phone services within a geographic area for women, young women, children and their caregivers and for men. See Appendix 5 for detailed table demonstrating service availability to populations served.

Table 14: Telephone crisis service availability by population group/location

Population group	#	%	Full 24/7	Partial	Urban	Satellite Urban/ Rural
Women	28	93	15	13	18	10
Young Women (12-16 yrs)	25	83	15	10	17	8
Children / Caregivers	14	47	9	5	10	4
Men	15	50	7	8	11	4

Total number responses = 30

Twenty eight services of a total of thirty respondents are providing some form of telephone crisis support to women (the remaining two services provide ongoing counselling only). Of these services only just over fifty percent do so on a 24/7 basis with the remainder available during day time only. There is a drop in service availability for young women (aged 12-16yrs) and still a further drop in service available to children (or their caregivers) with less than half the services being available to children (or caregivers). Fifteen services have a crisis phone line available to men.

Emergency Call out available by population group/location

Table 15 reflects the services able to provide emergency call services within a geographic area for women, young women, children and their caregivers and for men. See Appendix 5 for detailed table demonstrating service availability to populations served.

Table 15: Emergency call out available by population group/location

Population group	#	%	Full 24/7	Partial	Urban	Satellite Urban/ Rural
Women	22	73	13	9	13	9
Young Women (12-16 yrs)	21	70	12	9	13	8

Children / Caregivers	12	40	7	5	8	4
Men	10	33	6	4	8	2

Total number responses = 30

A total of twenty-two emergency call out services are potentially available to women, with only thirteen of these available on a 24/7 basis. Due to services being available in the larger population centres, approximately 70% of the adult female population has such a service available to them.

Young women are nearly equally well served for call out services. Differing definitions of young people and service contract constraints can course some dilemma for services. Christchurch service Monarch Trust relates:

> *We provide counselling, support and advocacy for those (17 and over) who have been victims of sexual crime (whether rape, sexual assault or sexual abuse), support for parents of children who have been sexually abused, plus the SAFECARE 24hr rape crisis service for acute assistance.*

Due to contract constraints, it is not assured that a service would be available for a young woman in Christchurch when reporting to police.

Emergency support service availability for children is limited (7 services or 23% of services). Many services commented that although they are available for emergency call outs with children, most often CYFS (service line of MSD) are called as the intervention service.

Nine services across the country provide a call out service for men.

Face to Face Crisis Support Sessions available by population group/location

Table 16 reflects the services providing face to face emergency support sessions within a geographic area for women, young women, children and their caregivers and for men. See Appendix 5 for a detailed table demonstrating service availability to populations served.

Table 16: Face to face crisis support sessions available by population group/location

Population group	#	%	Full 24/7	Partial	Urban	Satellite Urban/ Rural
Women	28	93	1	27	18	10
Young Women (12-16 yrs)	25	83	1	24	17	8

Children / Caregivers	14	47	0	14	10	4
Men	13	43	0	13	10	3

Total number responses = 30

As already established, there is only one 24/7 full service available for face to face crisis support. Twenty seven services provide a crisis face to face service to women within limited hours. Some services run standard office hours but many of the smaller services run very limited office hours which reduced the partial availability of these services even further. Just under half of the services are available to children and to men on a partial basis only.

Ongoing Support and Recovery Services available by population group/location

Table 17 reflects the location and population served by support and recovery services. See Appendix 5 for detailed table demonstrating service availability to populations served.

Table 17: Ongoing support and recovery services available by population group/location

Population group	#	%	Urban	Satellite Urban/ Rural
Women	29	97	19	10
Young Women (12-16 yrs)	25	83	17	8
Children / Caregivers	13	43	10	3
Men	15	50	12	3

Total number responses = 30

All services, except one prevention education service, are able to provide a level of support and recovery service to women (17 years plus). This was described as working predominantly with Pakeha and Maori women who were abused as children, or where the assault is historical -

> *Main group is adult women abused as children – mainly Pakeha and Maori, even though the Asian population is growing their access is limited – same for Pacific peoples.*

However, one service identified that 50% of the referrals to their Therapy Team are for women who were sexually assaulted as adults.

Of note in the work with adults are the comments made about the complexity of the client group which is served.

We see people who are at the tough end of the market = less likely to access counselling privately. Clients with mental health, drug and alcohol, family violence – people who have multiple and significant problems – this is challenging.

Clients with significant other issues i.e. drug and alcohol we may refer first or work alongside for specific treatment.

We think that drink and drug use really impacts on the access to service – survivors often think it is their own fault and so they don't come for help.

There are fewer services specifically available to meeting the needs of young people (12-16years). Adolescents often engage with therapy in a different way than adults tending to have more short term interactions. Further, the issues in terms of age specific and developmental stages require specific knowledge and skill sets. Models of working with young women /adolescents are therefore different to those of working with adult women. Not all services have the capacity to meet the specialist needs of adolescents/young people.

The ability of these organisations to provide specialist sexual assault support and recovery for children is limited[11]. Only thirteen agencies across the country report that they are able to work with children. Like adolescents, the skill base required to work with children is highly specialized, and as a result, there are few counsellors available to provide this service. It is evident that this is particularly acute in the rural/satellite urban environment with only three services reporting having ability to a work with children in their rural areas. Some services report that although they do not work directly with children in a counselling support and recovery manner that they do offer this service to caregivers of children.

When services were asked to identify gaps in services, an ability to sufficiently support children and their families was frequently identified as a gap -

Support and recovery for children. Funding defines the boundaries of the service. I think that challenge is also with what gets to court and the limited number of convictions. With young people who have been sexually assaulted the attitudes is really shocking – believability and validation from police is lacking

[11] While this is so among these services engaged in this stocktake of services available to adults, in some areas, there are other services which only work with children and families and which were therefore not included in this stocktake.

Services for children and families – our capacity to provide in this area is limited – would like to be able to develop a specialist unit in the service which takes a much more systemic approach to working with children/families.

Fifteen services reported an ability to provide services working with male survivors in a support and recovery role. The nature of provision of services to men was not always made clear. Some services reported that they attempt to refer men to male counsellors – sometimes referring to external counsellors while others have contracted male counsellors to work within the organisation. Some services work with men but do not have gender specific services available for them. Services commented on an increase in the numbers of men wanting to access counselling services.

We never used to see male survivors but we are starting to pick up a few – I think it is because of having male counsellors available.

Three services particularly mentioned working with offenders who are themselves survivors.

Don't see perpetrators – only work with survivors (we would see a perpetrator if they were also a survivor to deal with this aspect only).

We will see offenders and do assessments in prison for inmates with sexual assault background.

With more men coming through – we are seeing more victims who are also perpetrators – where their abuse has seen them act out – this raises questions about our capacity to manage this – including degree of anger expressed in session.

One organisation identified a desire to work with offending at an early stage reporting that, "*services for offenders are limited. When offenders present early we should be working with these people*".

Men are less likely to be able to access support and recovery or offender based services in a rural/satellite urban environment than in a city environment.

Organisations' observations regarding client groups highlight some of the challenges facing specialist sexual violence services in terms of their capacity to meet the divergent needs of a mixed client group. In particular:

- the increasing number of male survivors coming forward to services that are often focused on addressing sexual violence from a gendered perspective and therefore are structured to more readily meet the needs of women

- the lack of capacity to work with children and families, and
- the high levels of clients presenting with co-morbid substance abuse and mental health issues

The ability of services to adequately meet the range of client needs is often compromised by capacity and funding issues.

Areas without specialist sexual violence services

Geographically ,there is an absence of service across much of the country. However, due to the distribution of the population, there is no *mainstream* specialist service covering about 30% of the female population, somewhat more for males.

Over the past five years, approximately seven specialist sexual assault services have closed. We attempted to make contact with people who had been associated with all of these services to ascertain reasons for closure. However, direct contact was only able to be made in 2 cases. Other information has been gathered through long-serving rape crisis members in other areas, and contact with another social service provider in one community. Of those services about which we were able to gather any information, closure was generally attributed to either financial difficulties, or change in police procedures to either contacting generic victim support services, or not contacting any support service. Such closures have left substantial population centres without specialist sexual assault services, for example, Tauranga and Levin. In other areas, individuals have carried on with the work that they used to do as a part of an organisation. They are known in their communities to have expertise in this area so are still called upon by those communities, often in an unpaid capacity. While in some areas informal networks might still exist for liaison and support, in others it can be an isolated role.

What happens in areas without specialist sexual assault services? Ideally we would be able to answer this question by having engaged with such communities about their responses to sexual violence, but this was beyond the scope of this project. However, in tracking down specialist services we have inadvertently talked to a number of people in areas where there is little or no service, and there has also been limited representation through the workshop aspects of the project. These contacts and other information gathered through the project, would suggest that in such areas there can be:

- Varying levels of professionalism in response to disclosures of sexual violence

- Other social services trying to fit the needs of survivors into the services that they have available
- Individuals known in their communities for their expertise doing some of the work
- police calling generic victim support services or using other ways of supporting survivors
- Some counselling done by counsellors in private practice approved for payment by ACC
- A belief that lack of a specialist service leads to relatively more sexual violence going undisclosed and unreported

Mainstream services working with Maori clients

Introduction

As noted in the introduction, although there has been a history of an extensive network of Maori specialist sexual assault support services, most of these are no longer operating. *Mainstream* services have established a number of responses in their attempts to best meet the needs of Maori clients who access *mainstream* services. These include established relationships with kaupapa Maori services to which they can refer clients; a bi-cultural operational framework and internal referral processes; and, cultural supervision and Te Tiriti training as a mechanism for deepening understanding to inform work with Maori clients.

The analysis and interpretation of supplied statistics has been noted in the methodology section as being unreliable. We are unable therefore to report with any real accuracy the number of Maori clients accessing *mainstream* services, though of those services who did supply statistics, figures for Maori ranged from 0- 27%. What we can report more fully in this section is the response from *mainstream* services to the question - What *does your service do to meet the needs of Maori?*

On reflection of the qualitative data, many of the responses gathered to this question are somewhat ambiguous – what people meant by Maori for Maori or kaupapa Maori services was not explicitly named or described, nor was the relative meaning of bicultural, nor detail sought on what was involved in Treaty of Waitangi training or the experiences of cultural supervision. This is a limitation of this stocktake, but it is hoped that further explorations can be undertaken in other research projects, such as that being undertaken to identify effective and promising practices of crisis support services. Research with Maori clients on their sense of cultural fit within a *mainstream* service and an exploration into the dynamics of 'choice' for referral from a client perspective would also be important questions to be explored in further research.

With consideration to the limitation on the ambiguity of definitions and meaning, the following section reports three aspects that organisations discussed as ways of meeting the needs of Maori - referring to kaupapa Maori services; running a bicultural service; and, training and supervision on issues Maori.

Referring to Kaupapa Maori Services

Organisations with established links to kaupapa Maori services within their region reported making referrals to Maori for Maori services.

Relationships between kaupapa Maori and "*mainstream*" services are currently limited to the main urban centres of Tamaki Makaurau (Greater Auckland area) Te Whaganui O Tara (Wellington), Otautahi (Christchurch).

One organisation, located within a high Maori and Pacific population base, both refers to external Maori for Maori services and offers internal work using a kaupapa Maori model. Crisis work is described as functioning within a partnership model based around clients' cultural associations. The practical functioning of this model was not explored.

> *Yes we refer to several Maori for Maori or main services with Maori arms. Crisis Team work from a bi cultural framework with everything in partnership and taking into account where clients are from and where their roots are. Clients have the option to work through the process in a Kaupapa Maori way – have 5 Maori staff in the agency to bring that aspect to the agency.*

Some organisations reported being able to refer to Maori for Maori services through iwi based services but acknowledged that these services were generic not specialist. Below is the description given by organisations that have the opportunity to refer externally to Maori for Maori services that run specialist sexual assault services.

> *We work with local Maori for Maori service. We offer all clients the possibility of referral to a culturally appropriate service.*
>
> *We have two Maori Counsellors. We offer Maori clients the option of those counsellors and also refer to a local Maori for Maori service. Maori counsellor uses models based on her own cultural frameworks as well as the mainstream frameworks.*
>
> *We are working closely with Maori for Maori services and continuing to work on those relationships.*
>
> *We work with Maori clients and have a relationship with the local kaupapa Maori service.*
>
> *27% of our clients are Maori. We do have Maori counsellors and a local kaupapa Maori service nearby. Would refer to Maori for Maori service but often people come to us as they do want a mainstream service.*

A couple of organisations made comment on the perceived notion that Maori clients prefer to work with *mainstream* services due to issues of confidentiality.

> *We have no Maori staff… We don't see it as an issue. For some Maori it is a seen as a bonus that we are not whanau – they feel that we are separate and more assured of confidentially.*
>
> *Do see many Maori clients who say they choose our service because they don't want exposure in their own community. Whanau connections within other*

services or by the offender are seen as a barrier to using iwi services - clients like having the choice.

Refer out but many want mainstream services. Give option on more than one occasion but ultimately their choice.

An interesting observation of the complexity of the issue of referral and choice was made as follows -

There are myriad complex issues here that need to keep being worked with so that we are continually improving the services offered to Maori. For example, while many Maori coming to our service refuse a culturally appropriate service due to their conflation of "Maori" with "abuse", we also see the opposite – when we had a Maori counsellor working with young people in schools, the uptake of the service by Maori young people increased dramatically.

An observed lack of resourcing for kaupapa Maori sexual assault services and therefore a sense of limited availability of that service for referral was reported. This quote illustrates an observed additional barrier for potential access to specialist kaupapa Maori services in the area.

Maori for Maori service very under resourced so not so easy to refer as the reality is they don't have staff and resources. The Maori service has recently moved out of the city so they are very hard to access for many people.

Those services engaged with kaupapa Maori services reflected a commitment to work within this model not just as support for Maori in general, but as an acknowledgment of best practice for meeting the needs of Maori clients.

Bicultural Services

Many services described themselves as working within a bicultural framework. Understanding what this actually means is difficult without deeper investigation. When services talk about *"Biculturalism as part of the training"* or *"We did have a bicultural worker..."* it is hard to know what that actually means in terms of meeting the needs of Maori clients. In this respect some responses offered up more questions than answers. For example, is biculturalism something that is learnt through training, or it is the act of being in partnership?

Providing access to Maori workers and counsellors is a commonly noted reference for meeting the needs of Maori. Services offering a Maori worker or counsellor often described their service as being bicultural.

Comments include:

We provide access to Maori Counsellors – all the Counsellors do Treaty of Waitangi training. We see ourselves as a bicultural agency, although the majority of workers are Tauiwi.

Bicultural service provision. When a survivor accesses our services we provide an opportunity to work with Maori worker. There are no special kaupapa Maori services

We have a bicultural team – we discuss with clients options for Maori for Maori services. We have one ACC accredited counsellor who is familiar with tikanga.

One of our counsellors is Maori. Did have a bicultural worker but recently left. Our service is very focused around ensuring we stay bicultural and have good working relationships with Maori in the area.

Training and Supervision

The most common feature discussed by organisations for meeting the needs of Maori is a commitment to their own training and supervision for enhancing cultural appropriateness or safety, and a willingness to gain a deeper understanding of tikanga and kaupapa Maori principles through cultural supervision. Organisastions referring to kaupapa Maori services also described engaging in their own training and staff development on issues Maori. Te Tiriti education was often seen as central to training.

In our collective we embrace Maori principles and concepts as they relate to community, healing and women. We work to make the space safe, using te reo, being open to meeting the needs of Maori. Having a commitment to kaupapa Maori but no specific Maori for Maori service. Treaty of Waitangi is part of our training.

We constitutionally recognize Te Tiriti– do not have a Maori worker currently – but do have Maori supervision every two weeks. Also do internal education. We do give options for services external (at the Marae). We see not having a Maori worker as a gap in our service.

Part of training is cultural appropriateness around Maori referral services…. Staff educated on how to be as culturally appropriate as possible… Treaty part of Kaupapa and training and supervision.

We do training with local Marae and women's refuge. Invited to come onto crisis roster but chosen not to come on board – can't attract Maori and PI crisis workers…. All counsellors have cultural supervision.

We are a päkehä organisation but we do have a cultural supervisor– a lady comes and helps us to keep on track – answers questions about Maori cultural issues which come up in sessions.

We have an understanding and training on the special needs of Mäori clients, whanau aspects. Have Maori specialist in for training.

Some *mainstream* agencies are clear about the limitations they currently face in providing for Maori clients-

We make it clear that if there are issues that are cultural we can't address those– and talk about issues to find best referral. I have a back up cultural supervisor who is Maori for safety and advice.

We did used to get cultural supervision but she left and we have not replaced. We refer some Maori clients on but there is no Maori Counsellor in the area. We actually do mainly work with Maori. Counsellors have their own supervision so they can explore if they have a problem or question specific to Maori culture or clients.

One organisation made reference to policies and procedures to assist Maori staff to get what they need in terms of cultural support while working in a *mainstream* organisation.

Limitations

What was not canvassed in the questionnaire was what might limit an organisation's ability to provide culturally appropriate or culturally safe services for Maori clients. However, in feedback to this report, organisations told us that a key issue is funding. At some point the requirement to provide culturally appropriate services was added to contracts, but no further funds came to achieve this. Costs are involved in: extra supervision, extra training, culturally appropriate support for Maori staff members, liaison and relationship building across services and service delivery itself with such fundamentals as engagement of whanau.

Summary

Most *mainstream* services attempt to meet the needs of Maori clients. Some organisations spoke of a struggle to fully engage the realities, challenges and costs of doing so within a *mainstream* framework, but acknowledged the absolute need to do so. Others answered the question as if meeting the needs of Maori clients has been straightforward for their services to do. This may well have been the case, however, it may also be that the context of the interview or lack of time may have invited them to answer in ways which did not reflect the full complexity of the issue. Alternatively, these differences may reflect different analyses of oppression and racism, privilege and

marginalization when it comes to meeting the needs of Maori clients and engaging with Maori for Maori services.

Mainstream Services Working with Pacific clients

People of Pacific origins have resided in New Zealand for at least a century, with an increasing number migrating after the Second World War (Anae, et al., 2000) as a result of population pressures in their countries of origin and the demand for labour in New Zealand's expanding secondary industries. Throughout the 1960s and 70s New Zealand saw an influx of Pacific peoples migrating to these shores, in search of the perceived opportunities for employment, education, health care and new experiences that influenced large scale migrations. During this time, Pacific peoples commonly entered the New Zealand labour force as semi-skilled workers in manufacturing, labouring, cleaning, the clothing industry, clerical work and care giving. This population also became faced with the challenges of adapting to and establishing themselves in a new country and a new social and economic environment (Statistics New Zealand, 2002).

Despite historical challenges and difficulties, such as the downturn of the New Zealand economy of the mid 1970s, being subject to harassment throughout the "dawn raids" and "overstayers" campaigns of the late 1970's, and the restructuring of the New Zealand labour market throughout the late 1980's and early 1990's, Pacific peoples in this country have now developed into a defining feature of New Zealand's society.

Today, the Pacific population in New Zealand is primarily young and diverse (the median age for Pacific peoples is 21 years compared with almost 36 years for the total population.) It is growing at a faster rate (14.7%) than Maori (7.4%) and European (-9.1%)[12] and 59% of the Pacific population is born in this country.

The demographic of people identifying as being from one of the many Pacific ethnic groups is significant. The large urban centres of Auckland, Wellington and Christchurch are the main geographical areas of Pacific populations; however provisional areas bring seasonal workers creating both permanent and transitory populations. Statistical breakdown of Pacific peoples show the people concentration as Auckland (66.9%), Wellington (13.1%), Waikato (4.4%) and Christchurch (4.1%).[13]

[12] http://www.mpia.govt.nz/information/understanding-about-pacific-peoples#who-are-the-pacific

[13] http://www.mpia.govt.nz/information/understanding-about-pacific-peoples#who-are-the-pacific

How do *mainstream* services meet the needs of Pacific People?

A similar spectrum of ideas were presented in response to the question, *What does you service do to provide for Pacific Peoples* – as they were for the question on meeting the needs of Maori clients. Some services have an established relationship with Pacifica/Fono based services/counsellors to which they can refer. Others have workers within the agency that they refer clients to or who play a role informing the agency on best practice for working with Pacific clients. Some agencies reported that they attempt, as with all clients who have culturally specific needs, to meet the needs of clients as best they can within limited resources. Lastly, some agencies suggested that their geographical circumstance was that they rarely encounter Pacific Peoples and had no particular plan or resource in place for working with Pacific Peoples.

Referring to Pacific Agencies

Auckland agencies were the only ones that reported having a Pacific specialist sexual assault agency to which they could refer. Other urban centres were aware of Pacific Health or generic counselling services but were unsure if they had the capacity to provide specialist sexual assault services.

For the Auckland service providing both crisis and support and recovery services, reported:

> *We work with Pacific Island Women's Health Project, along the same kind of lines as with Maori. We ask people when they callif specific cultural needs and can refer on. Training in Pacifica cultures has been difficult to access, though last year we had short notice of a comprehensive course. We managed to get one staff member on to this. We are looking at what kind of more comprehensive training we can put in place for all staff, but are still working through some of the difficulties here e.g. the basic assumptions of counselling are not necessarily in line with Pacific cultures, so preferable to see the development of culturally appropriate models of assistance being developed by Pacific peoples. This does not remove the need for us to be as culturally safe as possible, but means that alongside this it is really important for us to support the development of Pacific models and organisations.*

One other Auckland service working only in the area of education and prevention commented that:

> *We employed a Pacific male to help deliver Body Safe and general consultation. But, couldn't afford to keep him so he is now gone. But do liaise with (senior Pacific practitioner) and developed a whole school approach and that would involve Pacific development if we get the funding.*

Other agencies within the urban context with population based demand were less specific about referral, except for the Southland area which reported a service in Invercargill stating that "w*e have had referrals from Pacifica Trusts. We have a good mutual understanding of each other's work"*.

Some services talked about in-house provision and development with awareness that there is a real gap but potential for growth of culturally specific services for Pacific peoples.

> *Still working on that one – agency has employed 3 Pacific Island women who are just starting to get together to discuss those things. Working in the bi cultural framework we discuss the options for their care. Get training around Pacific Island and Maori culture from those on the teams and holding cultural supervision.*
>
> *One of our workers has an understanding of Pacifica issues– so we refer to her.*

Whilst the excerpt above indicates an attempt to address the needs of Pacific through relying on one worker within this service, it also reinforces the concept of a limited Pacific workforce capacity that is discussed further in chapter 3 of this report.

> *We have Pacific supervision even though we have very few Pacific Island clients - 3%. We are revamping our Pacific Island support, have consult but working on increasing the access. There are quite a few Pacific services around so maybe that is a reason not such a high uptake of the services?*
>
> *We do not currently have a Pacific person available but we network with the local community Pacific group and inform survivors of their availability to support.*

Limited Pacific workforce capacity is further highlighted within the following excerpts which exemplify how finding specialist services or counsellors to refer was an emergent issue within the data -

> *Look to refer out when we can but struggle in finding Pacific Island services and counsellors to refer to. Liaise as much we can with local groups but are not always specialist Sexual Assault counsellors or services that we are referring into.*
>
> *No ACC counsellors working with Asian and Pacifica community.*
>
> *Nothing specifically – just a general awareness that we may not be the appropriate service and dealing with any referral coming in looking for Pacific services. No specialist services in the area.*

Similar dynamics to Maori for Maori in terms of identifying that we might not be the best to work with Pacific Peoples – have a lot of work to de re: best referral places in region but we do talk to client about option. There is not a specific Sexual Violence agency for Pacific Peoples so more general places to refer. Don't pretend to provide, will provide a culturally appropriate service as Pakeha but we speak to this and explore the options and what treatment and support would look like. We find that often Pacific women want to stay in mainstream for anonymity.

It is important to reiterate at this point that the majority of Pacific peoples live in urban residence (primarily Auckland, Wellington, Waikato and Christchurch) and that this survey accessed services throughout New Zealand, many of which may be in areas with few Pacific people. Questions about being accessible and not seeing Pacifica clients through the service were both mentioned in relation to reasoning as to why no specific services or referrals systems were in place in services.

We don't have any pacific clients – they just don't come through the door. Pacific Trust in Christchurch– not sure if they are doing the work?

We really don't have many Pacific Island people in the area.

Work generally on cultural safety – don't have much of a Pacific Island community here.

No services that we are aware of. We have noted 3 people who selected Pacific Island as ethnicity in last 3 years.

Summary comments

Generally services, especially those operating in urban environments, reflected an awareness of the need to develop processes for referral and relationships with services that provide culturally appropriate sexual assault services for Pacific Peoples. There is a keenness to support the growth and development of specialist support and recovery and crisis intervention services that are specifically focused on meeting the needs of Pacific Peoples.

Response from Vaoga Mary Watts – senior practitioner from the Pacific community

We as Pacific people need to take on board this challenge and look at our Pacific communities to address this in the most appropriate way whether it will be Fono or specific cultural methodology to discuss any issues of how best we can work in terms of addressing 'sexual violence' in our own communities .**'Pacific for Pacific'** as we work with our communities and look how individual islands can address this issue. There are at least nine Pacific islands represented here in Aotearoa. Yes we all come from the Pacific but our language & culture are different. I believe our own learning is a huge barrier with cultural language protocols and I believe this is one of the contributing factor in the way we work in this field of 'sexual violence 'the huge challenge for us is to work out a model of practice that is in line with our language & cultural difference to our main stream providers.

Mainstream Services and Meeting other cultural needs

After reflecting on services for Maori and Pacific peoples, organisations were asked to comment on how they were able to provide more generally for people of other cultures using their service. Although cultural needs can be seen as wider than ethnicity, for example, queer cultures, and those living with differing physical or sensory abilities, all organisations approached this question thinking about meeting the needs of a new migrant/refugee, tourist or those from another ethnic grouping. A secondary question asked about how often English as a second language was an issue and how this was addressed.

New Zealand is increasingly multi cultural in its population base, and urban based services particularly are finding that they need to respond to diverse populations.

Organisations tended towards three kinds of response: - those that were networked or who sought networking and named specific issues in their community; those that either didn't have other services to refer and/or talked more broadly about cultural safety; and, those that did not identify with the issue.

Evidently services in the bigger urban areas have opportunities to meet with networks and discuss the issues relating to meeting the needs of other cultures. Some services refer where appropriate. Many services were able to draw on translation services if English as a second language was an issue.

> *We network with early settlers groups and hope to engage trainees sometime. We do endeavour to provide support to all ethnicities including keeping up to date with what's available in Auckland.*
>
> *Have a migrant refugee programme "Safe relationships in NZ". Mexican project manager and also a Pakeha and they liaise with different communities and pamphlets translated in 17 languages.*
>
> *In contact with a few groups in the Auckland area, e.g. work with Shakti, have recently found out about a language line for translation services, but mainly keep ear to the ground and liaise so can refer appropriately.*
>
> *We are part of the new settlement support group that is here - ARMS – network with a lot of Asian and Indian agencies. Starting to build solid relations with them. Talking with their management teams around what we do and exposing ourselves to other cultures to learn also. Liaising with cultural officers from the police who often have more access than we do.*
>
> *We would refer to refugee mental health services here. The Asian women's violence group – Shakti. About recognizing that people come in with specific*

needs and although we might not be able to meet all those we want to be able to refer to those that can.

Access and awareness of issues and services was not isolated to the urban context. These services from Wakatipu and the West Coast in the South Island, particularly tourist and high migrant worker areas, made the following comments –

Queenstown is so multicultural we get people from everywhere. We are accessing the people in those communities to get voluntary staff – we offer choice and support. It is all about community and links and relationships. We do work with Victim Support and we use other languages when we can find a match.

Ethnic demographics are changing a lot – the economic situation has drawn other communities in to work in the mines and local area. A lot of women have moved here that have no English – isolated by area and language. Some women have accessed our services for counselling from overseas sexual assault experiences (no ACC – but we support). This is a growing area of concern and commitment in our work. The migrant community is not specific to one people - very international.

Some services talked more broadly acknowledging the importance of being aware and able to meet people as they found them in either a crisis or support and recovery context.

We work generally on cultural safety. There are few people of other ethnic origins in the area – we have a few more Muslim women and South African women. They are a growing population that we are aware of.

We meet people where we can – counsellors are good at meeting people as they are – and being open to understanding each person's culture.

It comes down to meeting each person's needs – the individual who walks through the door and making sure we have things that suit them.

Some services referred to a lack of ACC registered counsellors able to work across specific cultures, and still other services did not feel able to provide a level of service to meet the needs of other cultures and looked to refer to other areas/districts for these services.

No ACC counsellors working with Asian and Pacifica community. We are the only agency for all.

No other specific services for other cultures here – have to go to Hamilton

Not aware of any specific services – we are trying to create these links. Not aware of any counsellors with particular background to refer.

When asked to comment specifically on how often English as a second language was an issue most services said that it had either never been an issue or that it was a rare occasion that they confronted the issue.

Three times in eleven years. However, we are noticing getting a few more minority and migrant people to the service - hard to get training in specific culture information. Again, trying to tap into resources through the translators and police to meet these needs.

Some services discussed why they thought they might not confront this issue - not that it didn't exist, but rather that language dynamics may relate to access –

Not a predominant issue, but might have stopped them accessing service. However, even with those referred by police, doesn't come up often as an issue. To what degree this reflects a reporting bias is not able to be established.

Think they screen themselves out. Did some research and have rung a lot of agencies and found that that is an obstacle and most agencies don't have the options of many other languages.

Believe that the service is not accessed as sexual violence is more accepted in some cultures. Would like research to look further at this.

Several services commented on the lack of ACC and social support services available to new immigrants and tourists, and particularly to the workers on transitory visas, and how this can have a real impact on the service provision.

This is a real challenge. We recently had a woman who had no English. The area is very transitory – no unemployment and 24hr work permits – they accept people to work who have no English – this is vulnerability. People of non NZ residency have no funding available to support. So we pick up a lot of unfunded work. No social services attached. All the other agencies are experiencing this as well.

While organisations did not address meeting the needs of non-ethnic cultural groups in the stocktake process, it was a focus of the vision workshop. In particular, recognition of the needs to provide culturally appropriate services to those who live with disability, "queer" communities and young people is included in the Vision for Crisis Support Services.

2.2: Funding sources and impacts on services

The section that follows describes funding sources for *mainstream* services, then looks separately at the specific funding sources for crisis services and support and recovery services, the impacts of *Pathways to Partnership*, and some of the impacts of this funding picture on organisations and their structures for service delivery.

The Funders

MSD

MSD funding generally comes as partial funding in the form of an annual grant or multi-year contract for delivery of specific services to a specified number of clients each year. Contracted outputs are regionally negotiated based on local need. This leads to variation in type of service contracted (e.g. client contacts or counselling) and significant variation in volume to funding ratios across agencies. The Pathways to Partnership funding package has resulted in moves towards establishing baseline measures for calculating volume to funding ratios. MSD's service line Child, Youth and Family inherited most of these funding contracts when it took over the functions of CFA, the Community Funding Agency.

ACC

ACC funding for support and recovery is tied into the provision of counselling to an individual client by an individual counsellor. Clients have to meet ACC eligibility requirements for funding and to fit the counselling schedule determined by the ACC provision. Furthermore services are obliged to use therapists/counsellors who are approved for payment by ACC in making assessment and applications on behalf of the client. A significant feature of ACC funding is that it is partial funding only therefore services need to either require a top up payment from clients or seek additional funding. Further, funding is dependent on attendance and with some client groups, particularly young people, clients with high and complex needs or highly marginalized clients, it can be challenging to establish regular attendance at counselling sessions.

In terms of crisis services funding, ACC has also funded a contract for a 24/7 telephone support service and face to face support sessions, though this contract is not being renewed after July 2009.

District Health Boards

Some DHBs have funded crisis support services since the first funder/provider split in health. This funding route arose in regions where abuse was defined as a health issue.

Clients

Some recovery and support services charge a top up fee, or ask clients for a contribution, to assist in covering the cost of service provision to clients. This can be by way of a scaled fee, a flat fee cost or a negotiated amount. Most services are reluctant to add the barrier of fee paying to access counselling services and work to keep the service free. Some however do require or accept client fees or contributions and record this as an aspect of fundraising for covering services. Most organisations do not ask for contributions or fees for provision of crisis support services.

Philanthropic Trusts

Grant writing to access money from Philanthropic Trusts is an essential aspect of many service providers' fundraising. Typically amounts are small and specific projects are better supported than ongoing salaries and administration costs.

> "*Organisations don't specifically fund for counselling but rather for support, rent, supervision. We don't have actual funds for seeing clients".*

Community

Community grant fundraising relates to accessing the local community gaming machine Trusts, or local council contestable funds that are only available to local community group services. As with Philanthropic Trusts, community and gaming Trusts typically prefer specific and tangible projects and at times the level of accountability required is disproportionate to the level of funding.

Community also refers to service initiated fundraising activities such as appeals, regular donor programmes, or events. Such activities provide agencies with funding which can be used as the organisation sees fit. While every dollar which members of the public give to support these services is heart warming as it contravenes the isolation of working in this area, the reality is that those dollars are hard to come by due to cultural perceptions of sexual violence.

Unpaid Staff

The use of unpaid staff to cover aspects of services was recorded by services when discussing funding, in particular the provision of after-hours crisis support services. Acknowledging the real costs associated with service provision and the role of unpaid staff in maintaining critical aspects of services at no financial costs was considered important.

Funding crisis support services

Services were asked to describe the source of their funding for crisis service provision. Only some of those services providing either 24/7 or partial crisis services (telephone service, emergency call-out service and support sessions) answered this section of the stocktake (no=18).

The table below shows the various sources from which services draw funds. A more detailed table reflecting the combination of sources of funding can be found as Appendix 6.

Table 18: Sources of funding for crisis services

Source of Funding	Total Services	Urban Services	Satellite & Rural Services
ACC – (expiring July 09)	1	1	0
MSD	14	9	5
DHB	3	3	0
Trusts – Lotteries etc	12	7	5
Community Funding	14	9	5
Clients	0	0	0
Unpaid Workers	10	5	5

Total number responses = 18

There are five services who report that they do not receive any direct funding for crisis services but are providing a partial service.

Mostly services rely on MSD funding for the running of crisis services. One service has a contract agreement with ACC for a part of these services (ending July 2009), and three with DHBs. No service is fully funded by any of these government agencies.

> *We have a contract with ACC for phone line, contract with DHB for call-out services. Probably covers 70% of the costs, then we need to fund-raise more by going out to philanthropic trusts. No voluntary staff and no client contribution for crisis services.*

No service charges clients for access to their crisis service. One service mentioned that they do receive donations from clients at times though the amount of money received is not a significant contribution to the total service costs.

Ten services include the use of unpaid workers for 'funding' crisis service provision. This is often an unaccounted cost for services, yet critical to their ability to provide a crisis service. Services could not function without the unpaid work of these staff providing phone and call out services. As noted in discussion on staff structure, and issues facing services, the use of unpaid staff for this work includes a cost in terms of training and consistency of service provision.

Funding support and recovery services

A breakdown of the sources of funding for support and recovery is reflected in the following table. It includes a detail of the combination of funding received by services.

Table 19: Combination of sources of funding for ongoing support and recovery services

Sources of Funding for Ongoing Support and Recovery Services	**Number of Services**
A single source of funding	
ACC	2
Two sources of funding	
MSD + Clients	1
ACC + MSD	1
Three sources of funding	
MSD + Trusts + Community	5
Trusts + Community + Unpaid staff	1
Four sources of funding or more	
MSD + Trusts + Community + Unpaid staff	3
ACC + MSD + Trusts + Community	4
ACC, MSD, Trusts, Community, Unpaid staff	3
ACC, MSD, Trusts, Community, Clients	2
ACC, MSD, Trusts, Community, Unpaid staff, Clients	1

Total number = 23

The majority of services (n = 13) are reliant on more than four sources of funding in order to provide their support and recovery service. There are five different combinations of funding routes within the thirteen services accessing four or more sources of funding. Ten of the thirteen combine ACC, MSD, Trust and Community grants, with the additional three accessing funding from clients and/or using unpaid staff to cover core service provision. MSD funds were available to all but three of the services (20 of 23). Two services rely entirely on ACC funding for their support and recovery service. A total of ten services do not access ACC as a way to funding their support and recovery; nine of these services are accessing three or more sources of funding and one utilizing two types of funds.

Impacts of *Pathways to Partnership*

Services were asked to comment on the impact of *Pathways to Partnership* funding and, if relevant to describe the approximate level of funding still required for running crisis and/or support and recovery services. In summary, those services who received *Pathways to Partnership* funding reported positive impacts, although many went on to report they were still facing shortfalls in their service funding. Many reported the immediate sense of relief gained from the improved funding as services were literally at a point of collapse.

The quotes below reflect common responses to the question - *what impact did* Pathways to Partnership *have on the adequacy of funding levels?*

> *Funding under this scheme is greatly appreciated and will assist the service through contributing about half of the deficit in running service to its current specifications. However, rather than leading to service expansion, it is likely that this will assist the service to stay afloat through the next few years as the current financial environment will significantly impact the service's success in fundraising from non-government sources.*
>
> *We now get 60 % of our previous year's figures, so still not adequate, as we are short 40%. Things are always changing, especially as we get out in the community more, no room for growth.*
>
> *Nearly double! It is fantastic. Has meant we have started to address some of the issues – can keep our pager service running and upgrade our staffing level with real pay. Won't cover education service as non essential, but this is still very much needed.*
>
> *A little bit- but actually it is a drop in the ocean.*
>
> *Funding levels for both Support and Recovery, and Crisis Service provision need to be more adequately supported as we have received minimal relief. We are to*

*receive [*Pathways for Partnership *funds] based on last year's budget for counselling and abuse prevention, as the crisis service was not included in our contract. In all honesty we will use some of this money to help support the crisis team.*

Yes, we had an increase, however, the impact this had only offset a decrease in funding from Child, Youth and Family for another contract we had with them which they have cancelled as they didn't believe it was their job to fund anymore?!!

Extra funding mainly went to increase counsellor's wages -more support and recovery than the crisis services.

2008/09 at 100% for contracted services for our face to face service– clients have to fit in 'children at risk' group. Which leaves some clients unfunded i.e. young women with no children.

Funding limitations require services to constantly prioritize functioning within an existing framework, versus responding to identifiable needs within their community. This can cause real stress and tension within services as differing aspect of the service competes for limited access to the budget. The following quote reflects this reality;

The Collective has voted not to support the employment of a Maori support worker as we can't afford it. While we did receive money from Pathways to Partnership, we need that money just to break even - doesn't actually allow for any service expansion.

Services were asked to describe how far from adequate they would describe their current levels of funding. Two services responded tentatively that they felt they had an adequate level of funds for their service, one reported saying, *"adequate at present – but might get harder. We rely very strongly on community grants".* All other services reported that funding was far from adequate.

Always struggling – which has a major impact on staff. Double would be a good start.

Very far from adequate. Not sure exactly how much more we need - at least triple would give a fighting chance of covering costs and increasing wages to parity.

Quadruple the budget needed.

One service described being on the brink of closure, and that staff were working in an unpaid capacity just to keep the service open,

> *We are desperately short. We are working on an unpaid basis a lot of the time. If there is no new contract/funding we will have to shut up shop.*

While *Pathways to Partnership* has had a very real positive impact on organisations in this sector, it is far from having solved the problems of inadequate funding for crisis services or support and recovery services. Funding limitations require a constant prioritizing within an existing framework, versus being able to plan responses to the identifiable needs within each community. This can cause stress and tension within services as differing aspects of the service compete for limited access to the budget, for example, improved wages for counsellors or increasing counselling services to reduce waiting lists competing with meeting office overheads or improved wages for administrative staff. Some services also mentioned issues of professional development, buying books, ongoing training as real costs which are not sufficiently met. All this impacts heavily on the quality of services which can be delivered and on the retention of staff.

Implications of this funding picture

This is a complex funding picture with significant implications for organisations to manage.

- No one government department is responsible for funding psycho-social responses to sexual violence. Nor is there an arrangement between government departments for who should fund what. This leaves agencies needing to manage multiple relationships and holding a level of responsibility for ensuring service provision which it could be expected would sit at a more formal level given New Zealand's commitments under the United Nations Charter for the Elimination of Discrimination Against Women which promotes provision of such services.

- Managing multiple funding sources means high application and compliance costs and a need for complex accounting systems.

- It also means that each year each organisation must put together a jig-saw of funds – funding from different sources comes with different requirements and outputs e.g. a service might be funded for a number of clients to be seen, then from a grant which pays the worker's wages for a few months which requires another grant to pay programme costs and general overheads, then when that

grant runs out it might be back to funding by client. Such jig-saws are labour intensive to manage, easy to develop unforeseen gaps in, or, due to time lags between funding applic ations and responses, easy to double up funding for one purpose leaving another unattended. It also makes it difficult to strategically plan service development, or sometimes even to plan services beyond the current quarter.

- Organisations rely heavily on local and national Trust applications, and community grants and fundraising for provision of core services. This leaves them vulnerable at all times to changes in the granting strategies of philanthropic and gaming organisations, and the focus on funding sports rather than social services. This vulnerability is heightened in the current economic environment whereby some significant philanthropic organisations have been unable to sustain capital growth and have reduced or deferred their distributions of funds.

- Funding levels are grossly inadequate.

Apart from the complexities of the funding picture and inadequacies of funding levels causing multiple difficulties for administrators and managers, funding also impacts on the ways services are configured and the types of service which can be delivered.

The ACC question – Funding and the therapeutic considerations

There is a common perception that ACC funds the recovery and rehabilitation needs of survivors of sexual violence, so services were asked about their use of this funding stream. Issues to do with ACC also arose from discussions about serving Maori and Pacific clients, barriers, gaps and issues from both client and service perspectives. Direct questions asked were: *are the people who do the support and recovery work in the agency approved for payment by ACC? if so what proportion? if not, is that the choice of the agency?*

For those services who responded to these questions (no=23), more services have counsellors who are approved for payment by ACC (either employed by or contracted to the organisation) than not – but only just.

Ten services said that they do not use ACC registered counsellors to provide their support and recovery services. While thirteen do, two have only a quarter of the counsellors registered, while another two services reported half their staff are registered and half not. One service reported that they are mostly ACC registered and commented:

We need to be able to employ the staff member best suited to the role, and we do try to get them ACC approved ASAP. This is not the case for those working with teenagers, as we have found the ACC system not appropriate for the kind of work that young people need – that is, they often engage for short periods of time but will re-engage repeatedly.

Three main issues about ACC funding surfaced throughout stocktake discussions. These were constraints to agencies in terms of funding clients and compliance costs, constraints of the system on therapeutic practice, and the constraints of the system on non-mainstream or ethnic-specific models of recovery, including Maori.

1. Both services using the ACC contributory funding model and those that have chosen to stay outside commented on the constraints of the ACC system to agencies both in term of funding clients and compliance costs.

   If no show no pay – for an agency this is difficult as we still pay the counsellor.

   Not our choice to have no ACC registered but as ACC tighten the guidelines we are losing ACC registered counsellors….. Fees don't go anywhere near covering the real cost of a session.

   ACC funding inadequate so we put some through CYFS [MSD). Not sure that ACC are best to be doling out funds for this sector and this kind of work

   There are not enough ACC counsellors doing the work– would be stuck if contracted counsellors move on – don't take counsellors who come directly out of training

   ACC system not user-friendly for seeing teens– they are suspicious about losing control over their personal information, they tend to engage when they have acute need and then disappear again which doesn't fit the rigid ACC system, they change their goals from one session to the next. So many things about what fits for them doesn't fit the system.

It should also be noted that a significant proportion of clients are not eligible for ACC funding for counselling. This includes New Zealanders who have lived out of the country for an extended period and who were assaulted while away, and new migrants who were assaulted outside of New Zealand. Additionally clients who present with pre-existing mental health or other conditions may be refused ACC cover, as are many clients who have few or confused memories of the abuse. These groups of clients access specialist services, not only because of the available expertise, but also because they are generally low-cost or free as the cost of what can frequently be long term therapy is a prohibitive expense for many clients.

2. The constraints of the ACC system on therapeutic practice:

Our choice not to have ACC registered therapists. We do provide information for all claims and support through the process including referral to an ACC accredited counsellor however this is the survivor's choice. All our services are free.

It is our choice not to go through ACC process – as we see it as abusive to the therapeutic relationship. We have no charges.

Logistically it is complex to get ACC approved counsellors and therapeutically clients have commented that working with ACC counsellors can be too intrusive

The ACC funding model can at times actively undermine the holistic and client centred approach to service delivery which organisations in the sector favour. Treatment of sexual violence can be a complex issue requiring multiple levels of intervention and counselling is at times only part of a support and recovery service being offered to clients. Other needs that may be required include:

- Liaison and advocacy– coordination and networking between services
- Extra support/contact outside of session
- Support and/or counselling and/or education of family members
- Availability of crisis intervention
- Social work support

While ACC may fund a small amount of liaison and one hour of telephone contact per client outside of the counselling session, services listed above are not otherwise covered by ACC funding yet they are in many instances an integral part of the client's recovery journey. Clients requiring these "extra" aspects of service provision, either before or alongside counselling, are often referred to sexual assault services rather than private practitioners due to the capacity and availability of organisations to provide these extra services.

The effects of sexual violence can be significant and have impact on many aspects of a client's life. The multiple layers of trauma and impact can mean that at times progress can be slow and the client may appear not to be making progress when assessed using indicators of behavioural change.

We work hard to address the needs of clients with varying mental health issues and provide sufficient training for our staff. However the mental health

issues/diagnosis can impact on ACC eligibility and also the client's ability to begin therapeutic work around issues of sexual violence.

Histories of sexual violence also correlate with a number of other life difficulties. Whether these were factors which contributed to a client's vulnerability, arose as a result of the client's experience of sexual violence, or having nothing to do with the sexual violence becomes irrelevant when providing counselling or psychotherapy as, regardless of cause, they can compromise a client's capacity to engage in counselling or psychotherapy for the direct effects of the experience of sexual violence. Common themes that emerge in working with clients with complex difficulties appear in the text box as follows.

- Abuse and neglect in family of origin – results in attachment difficulties and poor parenting knowledge and skills. This can lead to involvement with MSD's service line Child, youth and Family and children being taken into care.
- Abusive partners - ongoing Family Court involvement, access issues, physical ill-health, poor parenting, children with behavioural problems, involvement of Women's Refuge, accommodation needs, financial issues.
- Drug and Alcohol use– addressing addictions, using other services, financial issues, physical health, prostitution, criminal activity, undesirable networks from which it is difficult to separate, blackmail.
- Emotional ill health can result in – mental health involvement without full understanding of the aetiological role of sexual abuse in the client's presenting problems. Health professionals sometimes see a "narrow" picture, resulting in clients being labelled, inappropriately medicated and misunderstood.

3. The constraints of the ACC system on *non- mainstream* or ethnic specific models of recovery, including Maori

   The ACC funding model is far from perfect. It is so individualistic – an hour of counselling between one client and one counsellor

   Finding Maori ACC counsellors to refer to is proving to be difficult.

   While there have been a number of attempts by ACC over the years to work towards accommodating Maori world views, services reported that they believe that this has not been successful. Maori counsellors and clients are still forced into *mainstream* models of recovery.

These issues do raise the question of whether or not the ACC model of funding individual counsellors to provide limited services to certain clients is the most appropriate way to fund the support and recovery needs of survivors of sexual violence. While providing more funding for meeting the needs of survivors of sexual violence than can be accessed for survivors of other mind injuring experiences (e.g. childhood neglect), funding is still inadequate for client groups presenting with complex needs and it excludes many providers, survivors, and models and aspects of recovery other than counselling.

Structuring of crisis support services

Crisis support services described impacts on their service delivery of operating with insufficient funding. Strategies include:

a. Limit hours – to half days, office hours, weekdays, or some other configuration.

b. Limit pay. While this has traditionally been seen as a binary of paying staff or having volunteers, in this sector it seems to operate more as a continuum from appropriately paid work through to unpaid work. Some organisations pay all staff a low rate, others pay for some work (e.g. day-time hours) and not other (e.g. after hours) and others rely on paid staff to do further unpaid hours.

Some services use both strategies.

For those who limit hours and do not provide an after-hours service, answer phones tend to direct people to other services such as Lifeline. These communities are left without a 24/7 specialist sexual assault service. Support at police interviews tends to be done by generic victim support services in these areas.

Eleven of the sixteen services providing 24/7 telephone lines have unpaid staff on after-hours shifts. When asked what issues they face, services noted a real dilemma in attracting people to the work. A further issue, once services find staff who will work unpaid, is maintaining and adequately training them as people often move onto other paid work, burn out, or find that they are not suitable to the work.

Five of the thirteen services providing 24/7 call-outs ostensibly work entirely within a paid worker model. For some this is a philosophical stand from the viewpoint that the on-going vulnerability and victimization of women is supported by a world which doesn't pay for women's work. In this survey, it also correlates with urban centres where demand is high so a person "on-call" can expect to be called. However, even within this paid worker model, some work is done on a semi-voluntary basis as some staff are only paid for the shift if a call-out is done.

Whichever strategy is used, a significant amount of the work done in the sector is unpaid. While that may be true in a number of other types of work, in this sector it is not offset by good salaries for the work that is paid.

Summary

Most services are funded in part from tax payer funds through MSD or DHBs. This is supplemented with fund-raising through grant applications, community fund-raising and contributions from clients. About half of recovery and support services also use the ACC partial funding of counselling to fund this aspect of service delivery, though this brings difficulties for services and constrains therapeutic practice. While *Pathways to Partnership* has significantly improved funding for many services, for most it remains very inadequate.

This funding picture is difficult for services to manage in that it is piece-meal in a way which precludes planning and certainty, no area of government is responsible, and funding is almost invariably inadequate leading to high levels of unpaid work and unmet need in the sector.

2.3: Improving services

In order to develop the kinds of sexual assault services that the population should be able to expect, we also need to be able to identify gaps in service provision, and what services would change if they had the funding to provide the services that they believe are needed.

Areas without specialist services

For an exhaustive look at this issue across the country, it would have been ideal to be able to work also with communities which do not have specialist sexual violence services, to look at how such communities respond to sexual violence and what their needs are. While this was not possible within the resource constraints of the research, one person came to the Vision workshop for this reason, to bring the needs of her community into the visioning process.

Her role in her community is as the regional Family Violence Coordinator. To this work she brings a "sexual violence lens" having previously worked in specialist sexual violence services in another region. She described a community of social services which provides varying levels of professionalism in its responses to sexual violence due to lack of experience and skills in this specialist area. Recognition of this has led to sexual violence being prioritised in the local Family Violence Network strategic plan. As a part of this, local social services, ACC approved therapists and high schools have come together in the first of a series of hui to look at what sexual violence services the community has and what it needs.

> *While initially agencies spoke about the generalised support they could offer to survivors of sexual violence, it became clear that there was a need for both the building of capacity within existing services, as well as the need for a specialist service. The group felt that there was a need for such a service to provide support, education and professional development and guidance, to be the community's experts around sexual violence. Such a service would also be able to meet survivors wherever they are in the process, rather than the current processes whereby providers described needing to make a survivor's needs fit into a Family Violence paradigm or offering general support with the hope that a person would make the move to an ACC approved therapist at some point.*
>
> *It was also noted at the hui that there was a low rate of reporting to the police (0-4 cases each year), and that the local DSAC doctor was receiving fewer and fewer referrals. In recognition that a lack of reporting was probably connected to the community's capacity to respond to sexual violence, it was agreed that*

there was a need to establish some specialist sexual violence capacity in the community.

Community need for services

In order to develop a picture of service gaps, organisations were asked if they felt there was a greater need in their community than what they were meeting, if so, what was it and what restrained them from meeting this need. Most organisations felt that more could and should be done within their community to address the high impacts of rape and sexual violence.

A couple of organisations initially stated that they were adequately meeting the needs of the community and did not express a need to extend services beyond what they were already providing. However, further discussion reflected a fear that extending their view of need would not be matched by adequate funding, and that staying with core service provision was most important. Funding and resource constraints (including trained staff) were consistently cited as the reasons for organisations not being able to meet any identified needs beyond their current service provision.

Prevention and education work dominated responses to this question, while other needs identified were:

- Court support
- Services for male survivors
- Fully staffed and resourced Maori for Maori services
- Working with other agencies – collaboration and networking
- Waiting lists (support and recovery services), missed call-outs as not enough staff to follow-up and police not referring (crisis intervention services)
- More counselling – more demand than what we can meet - women on the waiting list
- Women from other ethnicities cultural/language needs not being met
- Services for children and their families – family therapy
- Meeting the needs of young people
- access and work with the disability sector
- marginalized high needs groups i.e. sex workers

Several organisations mentioned the need for community led research to enable identification of the most effective ways of defining and meeting needs e.g. finding new ways to engage with younger people would be really useful. Others talked about the constraints of funding and capacity and how it takes time to develop good strategies alongside the needs of existing service delivery.

Issues faced by services

Organisations were invited to respond to an open ended question that asked them to discuss *what issues face your service.* The most common and immediate response was funding - having adequate resources to meet the growing needs and demands, staff training and continuity of basic services. Other issues include visibility within the community, relationships with other services (police, DSAC, Victim Support), societal attitudes, and the impact of the court system.

Below is a summary table of quotes which give a sense of the issues in the words of organisations from around the country.

Issue	Example Quotes
Funding	*We can't afford to pay our staff well– so we lose them which affect the continuity of services.* *Financial constraints are huge – if we had more funding we could have more employment and meet more needs.* *Can't plan for the future due to funding, have to go with whatever contracts come along rather than having a strategic plan that we would like to pursue. The money comes and we have to follow it rather than planning best practice and seeking funding to follow that.* *Only partially funded for essential services which many believe to be funded by government so philanthropic funders will turn us down.* *Money huge issue – current contract for Crisis Team only covers wages nothing else – fundraising for most of the services. Can't employ anymore workers but the workload has increased.* *Main issue facing service is adequate resources for being able to provide services for clients.* *Funding – we are at a critical point with funding. Some staff work in an unpaid capacity (even when supposed to get paid) to ensure continuity of services – our very survival is at stake.*

	Spend too much time chasing money rather than being client focused. *The main struggle is funding the growth of our work. We would love to employ more staff as we need to – but no guaranteed funding.* *Very hard to access funding for prevention and education. All our work in school is self funded.*

Issue	Example Quotes
Staff **Training** **Standards**	*Attracting sufficient staff to do the work.* *We get short term contract which makes it difficult to retain specialist staff where we have invested in training them. Particularly males can't pay them enough.* *Other agencies have picked up the extra work with good intention but are not working effectively and we are getting lots of people who have been through several services before they get the right service. Maintaining skilled workers.* *Getting people to do the work. We have education funding but finding someone with ability to do the work is difficult.* *Staff are passionate about the work but most often they get more hours and better money for other work – so they move on. We need to have enough resource to support and hold experienced workers in the field.* *Maintaining a 24/7 line is a huge challenge – maintaining the staff who can handle this is difficult. Structure for this is not ideal – the jobs are anti social (hours on call) – not full time – so recruiting workers is limited – get a lot of students – so crisis work is really secondary work which means loss of continuity of trained staff.* *Funding – ramifications are massive particularly being able to retain staff or attract a high standard of applicant. Struggle to keep people and to create a plan to move forward in the organisation to create career pathways.* *Lack of crisis workers because we don't have the funding and also we don't have the people. Can't afford the specialist services at crisis level.*

Issue	Example Quotes

DSAC **Police**	*DSAC doctors – this is a big hike for people – need to get more locally trained* *At present it is gaining the trust of the police – they should be our main referrers – although we get referrals from other districts but not here. There is a history of mistrust which we have to undo. Does take time to rebuild the relationship.* *The police lack of communications and understanding of the needs of clients.* *Lack of referrals from most relevant services i.e. = Vitim Support and police*

Issue	Example Quotes
Court/Criminal Justice System	*Whole legal system – no confidence.* *Lack of criminal justice for victims. When convictions are made they are really limited.*

Issue	Example Quotes
Societal Attitudes	*Bigger picture of what rape is in our society. Trying to counter a whole society's perspective on what is rape, media, social and culture issues, feminist issues. Can't provide all of the services that are needed – e.g. more proactive follow-up, court support, social work support.* *NZ society not seeing Sexual Violence, especially within families, as being an offence. The Family Violence campaign has had some impact but sexual violence is still invisible within this.* *Community lack of knowledge. Still a tapu subject and denial in society.* *Stereotyping – Rape Crisis seen as radical lesbians.* *Feel we sometimes get a hard time – we keep Rape in our name and we are a political organisation – battle with community and others but social attitudes around rape and sexual abuse are challenging. Also maintaining an all woman space in the Agency is often challenged. Struggle with a move in sector to talk about Sexual Violence as gender neutral and it is the most gendered crime that there is – we need to understand who does it and why. There seems to be a push to see rape as a generic thing that happens to people, not that women suffer most Sexual Violence and men are the perpetrators. Feel that these are realities that we cannot name but then how effective can*

	we be if we don't.

Issue	Example Quotes
Visibility	*Invisibility of service and the work. Keeping the networks higher rather than low profile.* *Biggest issue is rebuilding our profile from loss of service. There are sectors of the community we are not reaching – like other cultures – is this because they don't know about us or is it a wider cultural issue?* *I come from a community development background so running a therapeutic environment is not enough without hooking into the wider community engagement process. Our ability is limited to direct service provision to clients. We have the vision to widen the work – but not the resource.* *Lack of money means we cannot advertise services in case we cannot provide them. Would also like to change our location and look at issues surrounding marketing of the service. Do we put it out there so people know where we are or keep back and in the shadows for comfort of access for some women?*

Issues faced by survivors

Organisations were asked to identify issues faced by survivors in both the contexts of crisis services and recovery and support services. While some of the issues identified were common across urban and rural areas, others were particular to the rural context.

- Rape myths
- Shame and prejudice leading to fear of social isolation
- Lack of empathy in the community
- Lack of public awareness and publicity - invisibility of the issue and services
- Rural isolation and associated financial costs for accessing services
- Structural and economic barriers in both rural and urban environments (childcare, transport etc)
- Waiting lists and affordable counselling
- General access to specialist services
- Under resourced medical services

- Lack of real compensation after assault
- The legal system – including the attitudes of police
- Low conviction rates and lack of justice
- Young women and alcohol abuse – limited options for safe entertainment increases vulnerability
- Pornography and the sexualisation of children

What if services were adequately funded?

Organisations were invited to consider what services might look like if funding levels were adequate.

They answered that they would improve services and survivor outcomes through:

- Expanding services, service hours and resources with more staff
- Improve speed of response to clients
- Improve worker conditions
- Provide more education and publicity
- Network properly to enable collaborative service provision.

Services see the link between valuing staff, increasing their availability, training and support and meeting the needs of clients as being intrinsically connected. Adequate funding to meet staffing needs is a clear priority for services.

Barriers to accessing services

Crisis services

A question asking about barriers to accessing services was answered from both external and internal points of view. Some organisations described their own capacity, or lack thereof to provide a full service as a barrier and the structural issues that sit behind that lack of capacity (i.e funding, geographic isolation, lack of infrastructure) while others named structural and external barriers experienced by clients accessing the service.

A couple of organisations felt that clients experience no real barriers as services were free and accessible. However, most organisations felt that barriers did pose an issue for clients.

Barriers named include –

- Lack of transport
- Phone coverage and expenses
- Knowledge of services – advertising / publicity
- Limited office hours – availability of staff
- Police and other agency referrals
- Funding

Example quotes from services:

> *Funding – not enough resources for travel etc. Onus falls to client because we haven't got the resource and this fails the clients as they also haven't got the resource*
>
> *"Transport for them to come to the centre; fear of the police and places like CYFS; funding – if we had more (funding currently on numbers not hours) we would be able to have advocates giving more. They have so far to travel to report. A lot of rural people don't have phones or transport. Infrastructure as well as economic barriers – might have cell phone but no reception.*

Support and Recovery Services

Barriers for survivors accessing support and recovery services have resonance with the barriers for survivors accessing crisis support. Similar issues include visibility of services, physical isolation from services, and internal barriers such as prejudice fear, shame, and the stigma experienced from society. As with crisis support, there are barriers that are unique to support and recovery services. These issues include:

- Length of waiting lists for accessing counsellors
- ACC structure for funding and its effect on the therapeutic relationship
- Physical barriers like transport and stairwell access only
- Financial costs including getting time off work, childcare, transport etc
- After hours service provision

- Lack of culturally appropriate services (particularly kaupapa Maori services)
- Visibility and acceptability
- Health and mental health status
- Tension between young people being ready to do the work and benefits of early intervention

Example quotes from services:

> *Clients with high and complex needs may have difficulty accessing and engaging within the timeframes that we can hold the service open (3 no shows), clients are low socio-economic groups so many have no transport and ACC transport assistance doesn't apply.*
>
> *We ask for contributory payment and many can't pay this. We carry some clients who can't pay and access disability allowance for some, but money is a significant issue.*
>
> *Waiting lists, money, transport, access – located in a relatively good area but can be tricky for those without transport.*
>
> *Lack of registered Maori counsellors – cost can be a barrier in the region very low income families.*
>
> *Opening hours are a barrier, particularly for school age young women. Used to go into colleges and work but so dependent on enough staff– and when we are free school is closed*.

Waiting List Times

As a secondary question to the barriers experienced for providing support and recovery, services were asked if they had a waiting list what was the average waiting time. The table below draws summary findings from the responses given to this question.

Some services noted variability in their waiting lists. For example, one service reported a possible wait of 1 week but up to 3 months, another noted 2-3 weeks up to 4 months, yet another service talked about only having a maximum of a 2 week waiting list because they then refer to external ACC registered counsellors. One service offered a variable in relation to meeting particular client groups, in this instance a 2 week wait for women and a 6 month wait for children.

The table below offers a total waiting time given across the country regardless of funding structure (ACC registered counsellors services or not). Where services did give variable wait times the reported time in the table is an average of the two times

offered. A more detailed table follows. This shows the breakdown of rural/urban services and those services that have ACC registered counsellors or not.

Table 20: Total waiting time given across the country regardless of funding

Waiting List Time	Number of Services
Nil	9
Days up to a week	3
2-4 weeks (1 month) 5-8 weeks (2 months)	5 3
9-12 weeks (3 months)	1
13 weeks + (3 months +)	2

Total number = 23

Just under two thirds of services /survivors experience some degree of waiting time before being able to access support and recovery counselling. Nine services reported a nil waiting list, 8 services reported a wait of up to a month. At the other end of the spectrum 6 services experience a waiting list of 2 months of more with 2 of those services some waiting up to 6 months.

The implications of waiting list on survivors are:

- Missing the opportunity to meet client when they are most ready to begin therapy
- Survivors connecting with generic counselling services which do not always meet the therapeutic needs of survivors – resulting in the journey being longer.
- Missing the alignment of factors that brought the survivor to the service at that time (the emotion, spiritual, physical capacity to do the therapeutic work at that time).
- For some clients there will be ongoing safety issues that may not be addressed in a timely manner

One service described not being available to survivors at the time of need as follows,

> *For many people there is a little window where they pick up the phone and ask for help and if you miss that opportunity they close the window.*

Although reference to that comment can be drawn to the need for crisis service provision and 24/7 availability of services, it is equally as relevant to the way by which survivors approach asking for help from a support and recovery service. Being able to move directly into placing the survivor with a support and recovery worker is as important as meeting the critical edge of trauma at the time of the event.

A more in-depth analysis of waiting times is shown in Table 20, Appendix 7. It shows how services across the country are experiencing differing waiting list times with services with non ACC registered counsellors appearing to have greater flexibility to see clients immediately. This may reflect the greater demand for ACC registered counsellors or possibly that counselling not linked to ACC is more accessible for clients. This difference was reflected across both urban and rural services. Overall however it did appear that rural services were more able to respond in a timely manner to requests for counselling.

Value of services

Crisis support

Organisations were asked what they valued about the crisis services that they provided. This was an open ended question with no prompts. The following themes capture the responses.

Quality of service as a specialist service, high quality, effective therapeutic interventions, bring understanding of dynamics of sexual violence so also effective advocates in the system, staff well-trained, professional, contribute to the well-being of the client, family and the community.

Independent and effective advocates, work way we want – informed by dynamics of sexual violence

Integrated to resemble a wrap-around service, smooth transitions, meet multiple needs of clients' at this point and in their journeys.

Accessible and free, outreach, 24/7, multiple access points, available when client has window to engage.

Political and able to bring this understanding to the work, advocate on all levels, keep the issues of rape in front of the community.

Approaches to the work are client focused, holistic, bring resources e.g. specialist libraries, wide ranging work – will respond to any need related to sexual assault, empowerment.

Community relationships – *are* respected, work collaboratively.

Local services for local people, local networks.

Dedication and committed to supporting women and children no matter what, long-standing staff .

Culture of work with good people, good teams, and look after staff well, long-standing staff.

Exist or there would be no specialist services .

Recovery and support

Key aspects of value named by services of having a support and recovery service and the way by w hich they operate include being client focused, available and accessible, free of financial cost, provide qualified and skilled workers within an appropriate setting, both being a specialist service and a wrap around service where named as being valuable and providing a feminist perspective with political will was also deemed of value.

Client Focused

Highly value our capacity to move with what client need is, for example, way we have developed the child and family service has been in line with what clients presenting to this service have needed, same with young people's service in schools.

Availability and Access

Our ability to be able to response quickly to the need. We are free and available to everyone. Our view is that we cater the support to the need of the clients. We make it as easy to access support they need as possible.

No Cost

That the service has had a long life– celebrating 25 years and we are able to provide the service free to clients.

Qualified and Skilled

We provide a professional service. Workers bring a significant level of experience for working with sexual violence.

Appropriate Setting

Our service is set up specifically for survivors so in a quiet cul de sac, no signage, can attend to those issues as don't have several groups using the service so can tailor to that.

Specialist

As a local specialist service we are able to meet the needs of our community from a position of expertise, but with considerable flexibility. Our service is driven by the needs of our clients rather than a set doctrine or business model.

Wrap around

We are client focused – we are able to provide a holistic wrap around – we can work as a team to provide the support one client may need – so we have youth worker, social worker, health, budgeting.

More than just a service

Very client focused and understands ERR trauma and need response- especially while waiting for court. We are more political– organize marches etc – creating a movement – empowering women.

This is indicative of a high level of commonality of value across organisations and services, despite differences in development and identity.

Conclusions

Crisis support services

We do still have a network of specialist sexual assault crisis support services covering much of the country, but there are significant gaps:

- Geographical – there are areas of the country without access to such services. This is particularly evident through the middle of the North Island.
- Hours of service – many services are not available on a 24/7 basis, in spite of nights and weekends being the time that much sexual assault occurs.
- Services – If we define core crisis support services as telephone crisis or support line, support at police interviews and forensic medical examinations, and face to face emergency sessions, then some services are doing all of this and much more, whereas others are not able to do some part of this, most frequently, support at police interviews and medical examinations. Many organisations also reported that they see court support as a further key component of service, with few services able to provide this.
- Populations – some services do not see males, and no other services were identified who did this work in those areas. In some areas crisis support services are also not supplied to children and/or their caregivers due to local arrangements with or practices of CYF, service line of MSD. While most services are active in finding ways to serve Maori clients through referral to kaupapa Maori services, provision of bi-cultural services or staff training and supervision, organisations were less organised in the ways that they spoke of what they did to meet the needs of Pacific peoples and those of other cultures. Clients with needs relating to non-ethnic cultures were not identified.
- Relationships – in some areas the specialist sexual assault crisis support service and police are not working together due to break down or lack of development of relationship.

However, in spite of the gaps, approximately 70% of the female population has access to 24/7 support at police interviews and medicals, when the police call.

Most organisations provide crisis services integrated with other services for survivors of sexual violence e.g. recovery and support services, and the community e.g. consultation, prevention education.

Some services have expanded their core services to better meet the needs of survivors, to meet the needs of their local communities, and/or to attract superior funding pools.

Government funding of crisis support services is primarily via MSD (14/18), with 3 services holding contracts instead with DHBs and 1 service having a contract with ACC for some of the work until July 2009. Most services also rely on community funding, philanthropic trust funding and the use of unpaid staff.

Few services describe themselves as having adequate funding to do the work. Organisations manage this lack of funds through limiting hours of service provision, not paying for some hours of service provision, and/or paying low wages.

Most of those organisations who received funding increases through Year 1 roll-out of Pathways to Partnership said that it had made a significant difference to them. Some were able to increase wages and services, while others used it to cover existing deficits. However, organisations spoke of still needing double, triple, or quadruple the funding to enable them to pay workers, increase staff numbers, increase services and increase hours in order to meet the needs for service.

There were many community needs which organisations identified as not currently being met including: Maori for Maori services, court support, more services to reduce waiting lists and call-outs missed due to insufficient staff, services for male survivors, education and prevention, collaboration and networking, , services for children and their families, and services for young people.

While lack of funding was indicated as the predominant issue that services faced, including its impacts on recruitment, retention and training of staff, a number of other barriers and issues were also identified. Barriers to people accessing services were identified as lack of transport, phone coverage and expenses, lack of knowledge of services, limited staff and office hours, and lack of referral by police and other agencies. Other issues related to the state of relationships with police, the lack of DSAC trained doctors, the nature of the court system and its impacts on survivors, the lack of justice, societal attitudes to sexual violence, invisibility of services and the issue of sexual violence. Issues for survivors mirrored these issues, and added the impact of societal attitudes on victims/survivors – shame and prejudice leading to social isolation, lack of real compensation, lack of empathy in the community, lack of practical supports, lack of justice, and the impacts of pornography and the sexualisation of children.

While services have found different ways of managing many of the difficulties of funding, relationships and visibility, the issues and barriers identified for services and survivors were remarkably similar across the groups who participated in the research. Similarly, when asked what people valued about their crisis services, a group of similar

values came forward, such things as: quality, independence, integration, accessibility, political, client focused, community relationships, local services, good work culture, and a dedication to supporting women and children no matter what, a determination to keep specialist sexual violence services available for those who need them.

Such commonality of problem identification, purpose and values suggests that in spite of different beginnings and varying paths, the group of organisations in this sector have much that is shared, enough to move forward with developing a vision for crisis services that can bring comprehensive specialist service provision back to the people of Aotearoa/New Zealand.

Support and Recovery

A number of key themes have emerged from this stocktake which build a picture of issues facing organisations providing support and recovery services for survivors of adult sexual violence. While some of the findings from this stocktake will have relevance for organisations providing service to other groups, such as children and their families, they can also be expected to have specific issues that fall outside of the boundaries of this research.

Key themes are as follows

- Support and Recovery Services offer a wide range of services for clients on their healing journey
- The relationship between crisis intervention and ongoing support and recovery provides a seamless transition for clients accessing services
- Support and recovery services aim to provide holistic, wrap around supports which are client focused
- Support and recovery services seek to be as accessible as possible in terms of free services, outreach or home visiting services, quick response and being aware of differing needs of client groups
- Support and recovery services highly value their expertise and specialized knowledge base and identify such expertise as a significant attribute they offer for clients accessing their services
- In terms of funding most services use a variety of funding avenues reflecting the diversity of needs and roads to healing that survivors may take, as well as the diversity of the client group.

- ACC funding is one part of a much broader service need in terms of funding. ACC's current eligibility and reporting frameworks actively exclude many survivors, including some who, in theory, could be eligible.
- Sustainable funding models for support and recovery is a critical issue and while some groups have benefited from *Pathway to Partnership* funding, others haven't except to remain in a status quo position. Funding to enable development of services and to ensure ongoing best practice is still elusive for most groups.
- Service infrastructure including staffing, remuneration, organisational profile and opening times are issues which have impact on the ability of services to meet client demand
- Several service gaps were consistently identified including children and families, men, kaupapa Maori and other cultural communities. In addition concern over waiting lists for counselling and the lack of prevention capacity was also highlighted.

Where to from here?

Vision

Communities are well-served by comprehensive specialist sexual assault services in order to provide for acute and on-going needs of survivors and those supporting them. Where possible, services are provided by culturally appropriate service providers. Where culturally appropriate services are not available, mainstream *services are well connected to cultural communities to enable culturally safe services and referrals.*

The organisations providing specialist sexual violence services consider themselves to be providing valuable service to their communities through provision of seamless services between a survivor's crisis, support and recovery needs; provision of wide-ranging and specialist services for those clients with high and complex needs and low funds; provision of consultation, training and education to their wider communities; and advocating for the needs of survivors and the end of sexual violence. However, the information gathered here clearly articulates need for changes in the funding of these services if they are to be able to fully serve the current needs of their communities, including appropriate relationships with cultural communities, and also the expanded need as sexual violence becomes more widely acknowledged through the work of the Taskforce for Action on Sexual Violence and the on-going education work of sexual assault service providers.

For support and recovery services, consideration needs to be given to the most appropriate model for service funding as well as the levels of that funding.

For crisis support services, a vision has been developed for the provision of optimum services. This vision needs to be costed for each community, and responsibility for funding of such services established.

Vision for *mainstream* early intervention and crisis support services

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

A. Critical Components of service

1. **24/7 telephone and internet communication service**
    a. Information
    b. Referral
    c. Support
    d. Acute counselling interventions e.g. safety assessments
    e. For survivors and their support networks
    f. Consultations for other service providers
    g. Liaise with police and doctors re call-outs

2. **24/7 Call-out service for advocacy and support**
   (ideally 2 staff available, 1 for survivor, 1 for whanau)
    a. Police interviews – from prelim to closure of case
    b. Forensic medical examinations
    c. Therapeutic medical examinations
    d. Follow-up medical examinations when requested

3. **Emergency face to face sessions – day-time.**
    a. To assist clients with stabilisation, assessing and arranging safety, and decision-making.
    b. Acute counselling interventions
    c. Support
    d. Referral
    e. Assistance with decision-making
    f. Arranging access to resources
    g. For survivors and their support networks

4. **Follow-up service**
    a. Co-ordinated follow-up including telephone, e-mail, text or face to face communications.

b. Depending on client need, arrangements with clients and course of case, this service might operate for anything from 1 month to multiple years.

5. **Case Tracking**
    a. Working alongside police, prosecution, courts, and corrections re progress of case. Regularly and appropriately communicated to survivor. Arrange other services client might need e.g. court preparation.

6. **Court Services**
    a. Court preparation
    b. Advocacy and liaison through court processes when possible and appropriate
    c. Court support – trial, verdict, sentencing, parole applications, release
    d. Emotional Harm and Victim Impact Reports

7. **Information bank**
    a. Specialist libraries – books, DVDs, tapes
    b. Pamphlets
    c. Web information – regularly updated
    d. For survivors and their support networks

8. **Resource bank – acute practical need**
    a. Clothing
    b. Transport
    c. Safety – alternative accommodation, respite care, alert systems, changing locks
    d. Funds

9. **Social work support e.g. assistance with WINZ, accommodation.**

10. **The above to be integrated with recovery and support services including:**
    a. Counselling
    b. Psychotherapy
    c. Support
    d. Support groups
    e. Services for those supporting survivors – family and friends

11. **Prevention and education services.**

12. **Advocacy – to end sexual violence, to improve conditions for survivors.**

13. Other services as locally determined.

B. Qualities of Service

- Sexual violence specialist – bring understanding of sexual violence and its dynamics and impacts to the work and the ways that we do the work.
- Quality services - well trained staff – code of ethics
- Independent from statutory or legal responses to sexual violence, but working within tri-partite relationship.
- Integrated service provision across spectrum of survivor needs in sexual violence – crisis and recovery.
- Community embedded and appropriate. Local.
- Work from client-centred model
- Free to users (including localised 0800 numbers)
- Accessible – 24/7, routes used by adults and young people – face to face, phone, e-mail, web-sites, texts. Video-conferencing for rural clients.
- Well staffed to enable service provision in a timely fashion.
- Good employer – staff working and training conditions appropriate to the nature of the work and able to support recruitment and retention.
- Physically discrete

C. Populations served

- Able to serve women and young women – provision of female staff
- Able to serve or provide access to specialist sexual violence services for men
- Able to serve Maori – can be a variety of different models for this e.g. both a Tauiwiservice and kaupapa Maori service in an area, bi-cultural services, close referral relationship with local Maori service/s.
- Able to serve Pacific peoples –
- Able to serve other cultural needs of local community – close referral relationships where available, access to consultancy, or internal capacity (staff or knowledge of culture and protocol.
- Able to serve people living with disabilities - internal capacity (staff or knowledge of culture and protocol), access to consultancy and/ or close referral relationships where available, access to interpreters.

- Able to serve lesbian, gay, transgender, transsexual and intersexual clients - internal capacity (staff or knowledge of culture and protocol), access to consultancy and/ or close referral relationships where available.

D. Relationships

- Working in or towards partnership with Maori
- Working in tri-partite relationship – regular local meetings, national forum.
- Collaborative relationships with survivor networks (where available)
- Collaborative relationships with offender services (where available)
- Collaborative relationships with other services to support client need.
- Community - Making issue of sexual violence visible in local community (e.g. regularly updated web-sites, school visits, ads after relevant TV shows) and to local services who might work with survivors (e.g. Mental Health Services).

E. Supported by national network infrastructure/s providing:

- training support
- resources
- consultations
- information on promising practices and guidelines for service delivery
- research
- statistics

See Appendix 8 for brief information about current network infrastructures.

F. Funding

Funding formulae would need to take into account the following factors:

- Current high levels of unpaid or underpaid work
- Costs of 24/7 availability
- Technological costs
- Need for local services with local knowledge
- Need for each organisation to have sufficient infrastructure to manage collaborative service delivery model required to serve all population groups
- Need for development of infrastructure capable of handling large increases in service demand – increases in request for service expected from work of

Taskforce, including: increases in number of people talking about sexual violence, number of people reporting, number of cases going to prosecution, and number of cases going to court. Each aspect of these increases will increase the work of early intervention and crisis support services. Further increases in both accessing of services and reporting to police can also be expected by the establishment and increased visibility of services in communities which currently have no such service.

- Need for careful and planned transitions.
- Sufficient resources to enable networking, training and supervision required to provide culturally appropriate or safe services.
- Services reliant on support and resourcing from national infrastructures – currently TOAH-NNEST and Nga Whiitiki Whanau Ahuru Mowai O Aotearoa National Collective of Rape Crisis and Related Groups of Aotearoa See Appendix ? for information about these networks.

G. Steps to achieve visions

1. ***Existing services*** – explore what each needs to provide services as per vision and local need in a sustainable way that can meet current and projected need. Collaboration with iwi services.

2. ***Existing non 24/7 or call-out services*** – where no other 24/7 specialist sexual assault service available in the area, explore if service wishes to move to full 24/7 and associated service provision, and what would be needed to do this sustainably. If not, move into community meetings as per 3 (below) with a view to development of a service complementary to existing service. Collaboration with iwi services.

3. ***Areas with no specialist sexual violence services*** – Facilitated community meetings to establish how to provide services as per vision in a way that would best serve that community e.g. Rape Crisis centre, specialist sexual assault service attached to local women's centre or other community service, iwi based service, specialist sexual assault person linked to TOAH-NNEST attached to another local service. To be conducted in conjunction with iwi services.

H. Associated service issues

Through the research processes, a number of issues and barriers to service were identified. While some of these have been addressed in the above vision - such as funding, geographical gaps, population gaps and access to resources – others are outside the realm of crisis support services to fix, but are necessary to assist services to run smoothly.

These include:

- Medical
    - Availability of female DSAC trained doctors
    - appropriate spaces and resources for medical examinations
- Police
    - Dedicated police – specialist and available
    - Environment of police interviews – victim rooms
- ACC
    - ease of access to resources for needs met e.g. compensation, if need to move house following rape, childcare, transport
- Courts
    - need recognition of victim advocacy, support and liaison roles.
    - Specialist Victim Impact reports
- Corrections
    - Liaison to ensure service advised on parole hearings and release of offender so can liaise appropriate with survivor/s.
- Restorative Justice
    - Access to specialist service
- Need for safe accommodation (refuge) even if not domestic relationship

Section 3: Pacific services for Pacific peoples

Background

This chapter focuses on Pacific responses to sexual violence for Pacific people. It consists of two sections. Section one provides information gathered from a stocktake of services questionnaire with Pacific providers. Section two presents, analyses and discusses the emergent themes and narratives from the National Pacific Sexual Violence Provider Fono (2009).

The *Sexual Violence and Pacific Communities Scoping Report* (Tiatia 2008), an earlier report for the Taskforce which was commissioned by MPIA, suggests that there is limited awareness amongst the small number of Pacific sexual violence providers of other approaches, paradigms, or models addressing sexual violence amongst Pacific communities. The Report also suggests that further investigation is required on, how best to develop a better co-ordinated approach to service delivery and, that there a need for the gathering of evidence that supports the development of effective service models and programmes for Pacific communities.

As Tiatia (2008) notes, literature related to sexual violence amongst Pacific communities is sparse thereby limiting solutions for local needs and issues. The discussions documented in this chapter are by no means exhaustive. They do however provide critical insights and glimpses into the shifting backdrops of the socio-cultural, economic and political arenas, and how these have seriously impacted on the ability of Pacific providers and Pacific people working from within mainstream organisations to develop a highly qualified and diverse workforce, and to deliver services which are responsive to the complex needs of ethnic specific and multi-ethnic Pacific communities.

Aims

The gathering of information included in this chapter was through a project commissioned by MSD with further input and assistance by MPIA. Its aim was to gather from national Pacific providers information that would inform the development of primary and preventative Best Practice Models and Frameworks. Other information relevant to the aim of this report include:

- Enablers and Barriers to effective service delivery
- Who are the current service providers, what services do they provide, and where are they located

- Effective models of practice for Pacific service providers; and workforce training required to support effective practice
- Monitoring and Evaluation

Introduction

The fono provided an opportunity for representatives of NGOs, Pacific providers and government agencies to meet as a pan-Pacific group to discuss and debate issues of sexual abuse and sexual violence across organisations, ethnic specific identities, and geographical boundaries.

The discussions began by asking questions from a stocktake questionnaire. Very early in the process however, it was found that the questions prompted rich anecdotal narratives. The responses to both the questionnaire and to the discussions are documented in this report. This allowed for questionnaire data to be contextualised within the experiences and specialised knowledge of participant narratives. Overall, the participants benefitted from the sharing and exchange of information and experiences and that, points of view which were relevant but not explicit in the questionnaire could be acknowledged.

These discussions are by no means new or unfamiliar to this particular sector. Comparisons to a similar forum held 25 years ago were noted by participants who had attended the 1983 Pacific workshop.[14] The critical point of tension in the 1983 discussions as it has arisen in this fono is one of cultural difference - the privileging of one way of seeing, living, and talking about the world against the recognition that there are multiple ways of experiencing and engaging with the world. The dialogue is not that different. The sense of urgency has not shifted. The passion and commitment for restoring wellbeing to individuals and their families has not waned. Some have become weary and cynical but find continued purpose in seeing that Pacific families will continue to benefit from their work.

The participants provided information, knowledge and a vision that is reflective and acutely informed. Voices are respectful and compassionate but no longer nuanced nor euphemistic. Decades of navigating and negotiating the shifting posts that govern funding and definition of terms has created workers who have developed a critical understanding of the issues at stake for Pacific families, communities, and society at

[14]Pacific Island workshop in YWCA Conference on Sexual Violence to Women and Children, Wellington

large. Central to the discussions in 1982 and at this fono, is the vision that Pacific families have wellbeing.

A question posed by a participant at the beginning of the fono was,

'What has changed over the last 25 years for (Pacific) victims and for perpetrators?'

There was common agreement that while individuals had moved on with their lives, it did not appear that much had moved in the area of sexual abuse or sexual violence. Against this mood, discussions were reflective, challenging, and passionate. There were moments of humour and song. Views which were shared found common ground amongst many. Information which was new to some participants, such as the homeless sector and the sex industry, highlighted the need for a greater appreciation of the complexities and overwhelming range of challenges facing the Pacific workforce and Pacific families.

Against the current global economic and political backdrop, future dialogue needs to continue. Of immediate importance is the question, who, what, and how will dialogue translate into action that is meaningful, and responsive to the challenges which Pacific individuals and families are now facing? Of critical relevance to this question is the issue of who defines the problem and who defines the solutions for Pacific workers and families?

Methods

Advisory Group

An Advisory group comprising five members was established to advise on and support the process to the project's completion. Members were selected on the basis of their longstanding work in the area of sexual violence, and their availability. Efforts were made to ensure that the Advisory group reflected the diversity of ethnic groups and geographical location.

Recruitment of Participants

An initial task of the Advisory group was to assist with the compilation of an invitation list. Twenty five individuals from various national Pacific provider organisations and working within mainstream organisations were identified and invited. Of those invited, fifteen individuals were available to attend the fono. Five individuals were not able to attend and sent apologies.

The Participants

All fifteen participants represented various Pacific ethnicity(ies). Seven participants work within Pacific specific organisations and eight in Tau Iwi services. In total, nine organisations were represented. Of the participants, one was male and the remainder,

female. Demographic and stocktake information relevant to the nine organisations represented within the fono is provided in detail within Section 1.

Gathering of Information

The main approach that was undertaken to gather information for this project was qualitative interviewing via a focus group (fono) setting. Themes from the gathered data were identified and are discussed in this report.

Participants also completed a revised version of the stocktake questions used for mainstream services.

Study Questions

The focusing question centred on identifying barriers and enablers to effective service delivery. Prompting questions throughout the discussion were semi-structured. This allowed for the discussions to be guided along the themes of the fono and also enabled flexibility for participants to introduce and discuss any other issues of concern to them.

In addition, participants completed the stocktake of services questionnaire (see Section 1). The information provided is by no means exhaustive as in, despite attempts to invite and cover all Pacific services in New Zealand, not all Pacific providers participated in the fono and many were from the Auckland region.

Issues covered in the questionnaire include:

- Record keeping
- Types of services provided
- Location of services
- Staffing
- Hours of service availability
- Funding sources
- Sessions per client
- Follow-up and adequacy
- Unmet needs

Limitations

It is important to note that not all provider voices have been heard on the issues discussed at this fono. It is also clear from the discussions that there is a potential wealth of information and expertise which needs to be tapped into.

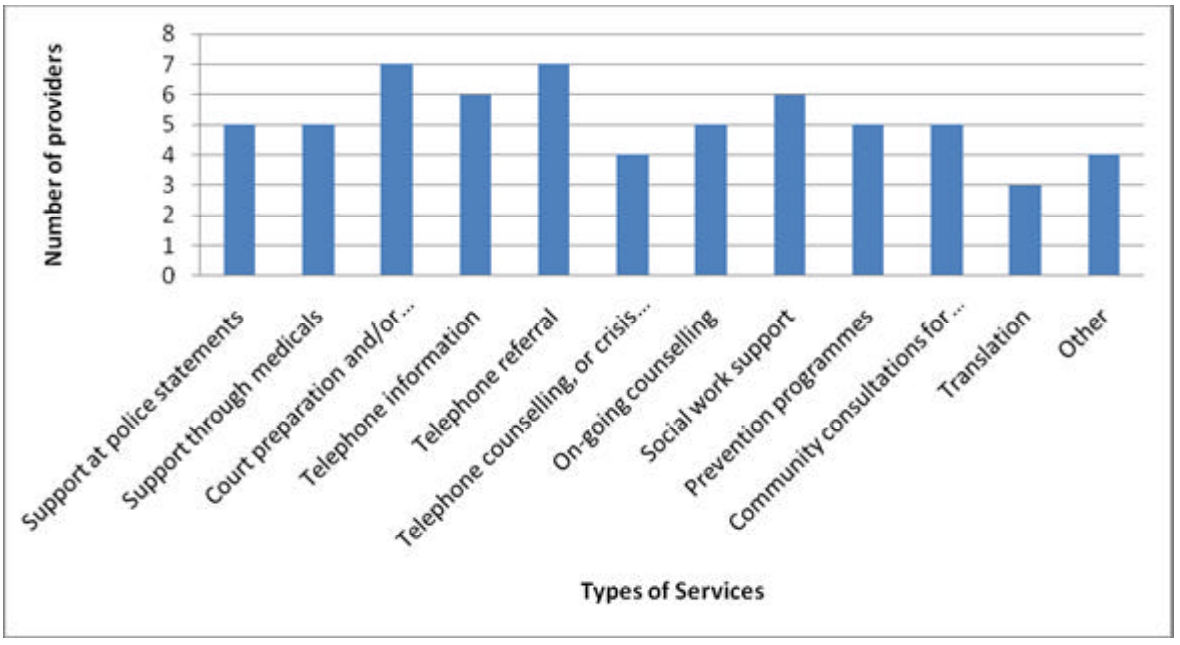
3.1: Who is doing what, where and for whom?

Service Provision

1. What service does your organisation provide in the area of sexual violence?

Services provided within the nine organisations that were represented at the fono are identified in Figure 1. The majority provide court preparation and/or support services, telephone referral, telephone information and social work support. This is closely followed by support with police statements and through medicals, on-going counselling, prevention programmes, community consultations for prevention and responses to sexual violence. Other types of services provided include referral and immigration support services, family support as well as the provision of advice to government and research institutes.

Figure 1 Services provided by the Pacific Sexual Violence Workforce



Two organisations provide all services noted above and one service provides all except translation. Another organisation provides most services except translation and community consultation for preventions and responses to sexual violence. Most services provide telephone referral and information, however only three of the nine organisations provide telephone counselling. One organisation only provides court preparation and/or support, translation and other services.

2. Do you also provide other services?

One service previously had a minding unit within their centre. This no longer operates. Another service provides extra curricula activities for youth, and another provides children's residential care.

3. Do you work with adults assaulted as adults?

Six organisations work with adults assaulted as adults. One service does not and for two of the participants at the *fono* this is not applicable.

Data Collection

- Four organisations hold statistical information on their clients and suggested alternative contact details, three did not and for two participants at the *fono* this is not applicable.
- Five organisations work with young people, one of these provides a referral service.
- Three organisations work with children, one in a referral capacity.

Crisis Services

Four organisations identified as providers of crisis services. The geographical range for these groups is:

- South Auckland to Bombay
- Waitakere, Central and South Auckland,
- Pukekohe to Wellsford and Northland
- Central, West and South Auckland

Two of these organisations are available 24/7.

Three of the four organisations are identified as being the primary contact for police, and the service that is not, considered that their organisation should be the primary contact. Of the three who are, only one of has a signed agreement. One of these service providers also named Victim Support, Hospitals, Rape Crisis and ASH as primary contact points for police in their area and noted that these teams would be more effective/appropriate if Pacific units/teams were connected with them.

Three of the four organisations identified as the primary contact point for DSAC doctors.

4. What do you value about your crisis support service and what you do for Pacific or how you do it?

It is important to note that whilst participants noted several features that they valued about their service, the discussion had within the fono and which is provided later in this report (see section 2) elaborates and broadens on the point noted in the survey form. Valued features within organisations that participants noted on their survey sheets include, cultural appropriateness, engaging with Pacific people and being able to support and advocate for this population.

5. Are there any barriers to Pacific clients accessing your service?

Consistent with the information provided on what participants valued about their services, responses to barriers were noted but were discussed in detail throughout the *fono* and are elaborated on within following *fono* proceedings. At this point, participants noted on their survey forms that barriers include limited resource to disseminate information out to the Pacific, language, assessment and treatment, limited workforce capacity, funding, immigration status and a lack of appropriate staff to identify and address cultural barriers.

6. In your opinion how effective are your services for Pacific?

Five organisations considered that their services were effective. Effectiveness in this sense encompasses the provision of a language appropriate Pacific programme, effective interventions in light of small workforce capacity, and working within an established and long-standing Pacific specific service. Three organisations considered that their services were not effective enough and that this should be improved not only for the benefit of clients but also for those in the Pacific sexual violence workforce.

7. How are these services monitored/evaluated?

Four organisations indicated that their services were monitored and evaluated. One stated that monitoring occurred on a six monthly basis and, others through reporting to funders and collecting internal statistical information.

8. Who funds your service? Is funding adequate? Have you had an increase in funding for this service due to Pathways to Partnership? What impact did this have on the adequacy of funding levels? How far from adequate would you describe your current levels of funding?

- Three services responded to these questions. Two received funding from government agencies such as CYF, MSD, DHB. One is not government funded and raises their own funds to support their service.
- Two services considered that government funding is inadequate to provide for the workforce capacity and capabilities that are required within the Pacific sexual violence field.

- Two services had received an increase in funding due to Pathways to Partnership; however both of these considered that this source of funds had very little impact and one stated that it was very tokenistic.
- Current levels of funding were identified by two providers as being very far from adequate. It was considered that adequate funding would enable 1) a work/service that is manageable, more resources, staffing and time to develop, more qualified human resources.

Support and Recovery Services

- ❖ Four organisations identified as support and recovery services and all indicated that statistical information on their clients is held and can be accessed via alternative means. One group stated that their client base consisted mainly of Samoan children and young adults rather than adults.
- ❖ Two services work with adult males, one service with adult females and one other works mainly with children and women (some men for domestic violence).
- ❖ Five services indicated that they work out of multiple sites. This includes home visits and being flexible to meet the client wherever they feel safe and comfortable.
- ❖ One organisation does not provide services to men.
- ❖ Participants noted that gaps in service provision include: Programmes for Pacific peoples in prison, placement of Pacific services in mainstream, Pacific men's groups.
- ❖ Geographical coverage of these four services was throughout the Auckland region.
- ❖ Average wait times for clients accessing these services was generally considered "long" (e.g. 4 weeks) and to be determined primarily by funding and workforce capacity.
- ❖ Two organisations identified that they had ACC approved counsellors. Two organisations did not for various reasons ("time permitting and ongoing philosophical views).
- ❖ Five organisations stated that there was no specific staff training for working with Pacific adults recently assaulted.

- Barriers to clients accessing services include: funding, language, not being approved to deliver the services, information gate-keeping.
- Five organisations considered that the effectiveness of their services could be improved (e.g. with additional funding and training on cultural approaches).
- One service identified that they have not yet been evaluated. Others considered that the collection of data within their services acts as a form of monitoring.

General Questions

9. What does your service do to meet the needs of Pacific? Staffing? Supervision? Referrals?

One organisation noted that the needs of Pacific clients and supervision for the staff are met through *"One to one working initially at beginning (Pacific to Pacific), cultural supervision, peer supervision and quarterly meetings with the whole centre."*

One organisation noted that needs are met by being a "*Pacific agency with Samoa, Tonga, Niue, Maori workers.*" Also "Supervision is encouraged, expected and resourced (i.e. funded)." Similarly, another organisation noted that "*all of the staff are Pacific people with a Pacific focus for Pacific communities.*"

Two services considered their organisations lacked in meeting the needs of staff and clients, primarily because of a limited workforce capacity ("only 2 Pacific people"). Another service noted that make referrals to appropriate agencies with Pacific staff member(s).

10. What does your service do to meet the needs of Maori?

Five organisations stated that they provide the choice for their clients to be referred to appropriate Maori service providers. One organisation has a Maori team and one other does not service Maori or Palagi clients.

11. How often is English as a second language an issue for Pacific people needing these services? What kinds of responses do you have to this?

Participants noted that responses to English as a second language include, access to bilingual sexual violence workers, translation of resources into Pacific languages, translation services and referral. Not all organisations have bilingual Pacific workers and it is noted that translation services can be accessed via Auckland District Health Board if required.

12. What kinds of issues face your service?

As noted earlier, Participants generally noted some issues in the survey format but elaborated on these further within discussions held in the fono. At this point, participants noted on their survey sheets that some of the issues faced in services include a lack of Pacific service providers, a lack of support to maintain current service provision, limited workforce capacity, and lack of funding.

13. What issues do survivors in your area face?

One organisation noted that survivors in their area are put at risk when programmes/monitoring is discontinued. At this point it is noted that others considered that survivors can experience flashbacks and that they should be empowered to determine and define their healing. These points are elaborated on further in the *fono* proceedings.

14. Is there more need in your community than you are meeting?

Participants noted that there is a need to build workforce capacity and that bilingualism is required as are more "ethnic" counsellors/social workers.

15. What stops you from meeting this need?

A range of factors were noted in the survey as barriers to meeting needs, and these are further discussed within the *fono* proceedings. At this point, participants noted that barriers include a lack of funding and resource, little acknowledgement within organisations and funding of the value that Pacific workers provide, as well as a growing need in the community and an increasing client base.

3.2: Improving Services for Pacific Peoples - Fono

Fa'aaloalo – face meeting face[15]

Whenever Pacific people come together to dialogue, whether as ethnic specific groups or, as a pan-Pacific collective, these gatherings are almost never meetings of individuals. The individual brings with them responsibilities, knowledge, and wisdom of past and present generations. *Fa'aaloalo* in contemporary times is termed as respect and its expressions are left open for individual interpretation. *Fa'aaloalo is* face meeting face in profound respect for the existential *other. Fa'aaloalo* is attendant to *va fealoaloa'i.*

The fono was opened with a welcome by Apulu Mary 'Autagavaia. Apulu spoke about two Samoan concepts which are relevant to fono participants and their work in sexual violence: Va fealoaloa'i and Fa'atalanoa – o faiva o tamaali'i le fetalai.

Va fealoaloa'i

In the Samoan context, the face to face meeting is mindful of the interconnectedness that exists between Samoan people and amongst Pacific people. All relationships are bound by covenants which govern the way in which behaviour between people is to be conducted. *Va fealoaloa'i* as one such covenant recognises that people are sacred beings and that there are obligations and duties to ensure that the primacy of the *other* is meaningfully valued. In working with perpetrators, victims, and families, v*a fealoaloa'i* engages dialogue and conversation in profound and meaningful ways through the agency of *talanoa*.

Fa'atalanoa – o faiva o tamaali'i le fetalai

Fa'atalanoa is to cause or to bring about discussion or conversation. Its root is *talanoa* which is to talk or to speak. *O faiva o tamaali'i le fetalai* refers to the belief that the skill and role of *matai* – and of leaders is to understand and articulate their lived world and the relationship to other ways of engaging within the world. The speech of the leader is knowledgeable, respectful and its purpose is to maintain wellbeing within relationships between people, between people and their divinities, between people and their environment. Right speech strengthens *va fealoaloa'i* between people. In the case of perpetrators, victims, and families, *talanoa* needs to be appropriate to bring to light their stories as part of effective service delivery.

A prayer was offered by elder Tufuga Lagatule completing the protocol surrounding encounters and connections of human relationships with each other and with God.

[15] Tui Atua Tupua Tamasese Efi (2002) More on Meaning, Nuance and Metaphor. Presentation to Central Region Pacific Health Fono "Moving Ahead Together", Porirua Wellington.

Key Themes

The focusing question asked of participants was to identify barriers and enablers to effective service delivery. Responses were documented under the respective categories of *barrier* and *enabler*.

Enablers to the specific barriers are discussed under each theme. It is important to note that the issues discussed under each theme while discussed within the context of that theme are also relevant to and overlap into other themes. Behaviour and attitudes that inform these do not exist in isolation, therefore many of the themes were revisited throughout the discussions.

Barriers saw seven themes identified. These are:

Models of Practice

Assessments

Responsibilities for victims

Strengthening Pacific Provider responsibilities

Workforce development

Qualifications and skills

Funders

Models of Practice

Western models - Ethnic specific contexts

Models of practice was discussed as a significant barrier to providing effective services to Pacific people. The overall feeling was that existing models do not work for Pacific people :

> *What has changed over the last 25 years for survivors and for perpetrators? The existing models don't work.*

The question - *Why work from Western models?* provided the basis of discussion around the way in which Pacific workers tied to funding agreements were often put in positions where culturally inappropriate practices were applied when working with Pacific individuals and families. As a result individuals and families would be victimised and re-

victimised by a process which was intended to help people through traumatic situations. Pacific workers by implication were also affected in that practices would often compromise cultural integrity. An issue which most of the participants shared as a common experience was the effectiveness of the psychological criteria within the assessment phase and the implications for Pacific peoples (further discussed in Assessments).

Models define rules of practice

Participants commented on two examples of models which while good were still not working. Some implied that programmes such as the 'It's not OK' campaign should be evaluated.

> *Violence is not Ok is not working for our people…We need to look at how it fits with Pacific Island ways - control and power, culture, language.*
>
> *The family violence messages are good but it is still happening. There is a need for a Pacific Taskforce.*

The participant comments suggest that promotional initiatives seeking to appeal to a Pacific audience should do so in a way which understands how Pacific people understand, relate, and respond to issues of violence. The Pacific population is now a growing multi-ethnic mix. Models therefore need to recognise that intergenerational experiences give rise to diverse ways of engaging, interpreting, and articulating the way in which these populations view their environments and the wider community.

Issues of who defines what the problem is and what the solutions should be ('control and power') and the use of culture and language were also raised. A suggestion with regard to family violence was the need for a Pacific Taskforce.

Evidence based models

Two views as to why Western models of practice were used was discussed. One view was that Pacific people do not have data to develop evidence. Another stated that data exists but do not fit the funders criteria,

> *We work on models which are driven by evidence. But Pacific don't have the data to develop evidence.*
>
> *Data collecting exists but they don't fit in the funder's models.*

While the discussion did not go into any great depth, issues that emerge from this exchange relate to the paucity of Pacific funded research to address the development of ethnic specific models of practice in the areas of sexual violence and family violence. Further to this is the need to recognise Pacific 'world view' research as a valid instrument for informing policy writing and subsequently influencing the development of funding models that adequately resource demonstrated innovative Pacific services.

A further challenge for ethnic specific groups is translating research that captures world views and concepts from their philosophical foundations into theoretical frameworks. These frameworks can then inform the development of models of practice for single and or multiple ethnicities.

Two growing populations of which there is a need for more information, are the elderly and Pacific people and youth who identify as having multiple ethnicities.

Funding as a companion tool of models that compartmentalise practice

Discussions raised concerns on the way in which workers were compelled by practice related policy to view and address issues of violence in a compartmentalised way. It was identified that this was because of the way in which funding models operated (refer to theme on Funding),

> *How do we view sexual abuse, sexual violence? Everything is put into boxes.*
>
> *Pacific social services working with families need to be working on both sexual violence and family violence.*

In actual life, perpetrators do not perform or view acts of violence as discrete sets of behaviour; or where in a series of events of being beaten and intermittently sexually assaulted, that victims perceive themselves as victims of sexual violence or of family violence in a disconnected way. In general, Pacific people will view violence in all its forms as serious violations and breaches of human relationships within ethnic -specific socio-cultural contexts. The Pacific perpetrator and the Pacific victim, belongs in the first instance within the holistic circumstances of extended family and community. The role of the Pacific worker is to understand and assess the situation from within these contexts.

Pacific - Ethnic specific models of Practice

> *There are models that exist in Pacific communities that need to be pushed and encouraged.*
>
> *Where are the models developed by Pacific?*

Concerns about Pacific models which have not been recognised as potentially effective and relevant tools for informing and validating Pacific workers' practices was raised. These models need to be identified, discussed, and supported by Pacific workers in the areas of violence.

As an example of the importance of Pacific and ethnic specific values, the involvement of families are believed to be an important part of the process in supporting and working towards positive treatment of clients. A participant who had worked for 25 years in the area of sexual abuse and family violence with at risk young men, women, and elderly found that the experiences of working only with individuals were ineffective, she noted that "a*t the end of the day, victims went home and there was no change because the families need to be involved".*

'*What is Pacific*?' Pacific [people] was a term coined by government agencies for reasons of political and economic expediency. It is a definition that has given rise to the perception that ethnic-specific populations are one homogenous group. Problems which have emerged from this perspective is a *'one size fits all'* approach to service development and delivery. This question highlights the need for funders and policy writers to actively recognise that the Pacific region constitutes independent and self defining ethnic specific groups who hold diverse cultural and contemporary views of sexual abuse and sexual violence. A respectful relationship between communities and government agencies occurs when the naming is meaningful, *"Everyone talks about the Pacific model. What is Pacific? It needs to be Samoan...ethnic specific".*

Uncluttering the clutter within culture

Scattered throughout the discussions, particular comments were made about culture. These comments require a reflective response. While it is not the intention to diminish the spirit of the contributions made, it is important to attend to these comments to not only bring to the attention of workers the value of vigilance in their developmental work but also to ensure that these types of statements are aired, challenged, and resolved to avoid the possibility of misinterpretation and their perpetuation as fact.

The three participant comments highlighted below demonstrate the need for Pacific workers within their ethnic specific groups to revisit and critically dialogue the way in which cultural values and beliefs are understood and articulated and to assess their explicit and underlying implications in working with issues of sexual violence,

> *Violence and sexual abuse is covered up, but there is a lot happening.*

As context to the following comments, this statement establishes that violence and abuse is prevalent within Pacific families and communities, and that these events are hidden by family members and their communities.

Sexual violence is tapu within families and this is what frontline people are dealing with.

The belief that '*sexual violence is tapu within families'* has been noted in past policy literature. In unpacking this comment, the literal message is that [talking about or disclosure of] sexual violence is forbidden. The way that the comment is phrased, represents the message as misleading however, unless there is understanding of the complexities of *va fealoaloa'i,* the embedded meaning within the message is true.

One function of *tapu is*, '*Tapu* within relationships between people ensures that the human condition remains in a state of wellbeing.'[16] In drawing on the Samoan example, the philosophical worldview holds that *va fealoaloa'i* is *tapu* which implies that all relationships between people are sacred. Violations of *va fealoaloa'i* are serious breaches of the boundaries which protect and enhance the value of human life. Relational breaches are spoken of as *the relational boundary which has been trampled and desecrated.*

In simple terms, sexual violations can be disclosed within (extended) families provided the victim is assured that the person to whom they are confiding will believe them. Also important is, that this person has influence within the family to have the violation exposed and resolved in a way that maintains the integrity and safety of the victim as well as that of the family. Whatever the situation, whether it is within or outside of family, the Pacific victim within the context of family (and often culture) is burdened with the purpose of negotiating sensitive and frequently resistant boundaries of relationships.

Often where there is no one in the family to whom the victim can confide, or where confidence has been betrayed, the options are to seek assistance outside of the family and community support (such as the church minister) or, to keep silent. The role of sexual violence workers is critical to the process of resolution and restoration primarily for the victim, and families [refer also themes on Responsibilities to Victims and section on Responsibilities to Pacific men who are offenders and perpetrators].

An observation is that, the term *tapu* has been co-opted and/or misinterpreted to explain and justify the silences within families surrounding sexual violence.

The third comment is,

The victims are always female, children, daughter, niece...the perpetrators continue to be men who are respected by communities. Culture blindfolds views on sexual abuse.

[16] O le Taeao Afua The New Morning. A Qualitative Invesitgation into Samoan Perspectives on Mental Health and Culturally Appropriate Services. K. Tamasese et al (1995)

The foundational values and beliefs of Polynesian cultures are very clear on behaviour within relationships which are either respectful or harmful of people. There is no evidence that sexual abuse or any form of violation especially towards family members is condoned by foundational values or beliefs. Current literature and studies have identified from informants that culture is a cause for violence within families and communities. If culture is experienced as 'blindfolding views on sexual abuse,' there has been a shift in the interpretation of core foundational values and it is important that these (mis)interpretations are revisited and corrected.

Models of Practice

The discussions were largely focused on those aspects within models of practice which do not work for Pacific workers when engaging with individuals and families. There was strong support for Pacific or ethnic-specific models to inform Pacific workers' practices and a comment that,

> *Pacific need to work separately from mainstream.*

Further discussions are needed to identify the points of positive engagement and collaboration between mainstream models and future pan-Pacific or ethnic-specific models of practice.

Enablers: Models of Practice

Criteria for assessing models of practice for Pacific workers.

A different set of criteria for assessing models of practice within services and organisations needs to be developed. There was strong agreement that ethnic specific models need to be developed. The values that need to be recognised within these models include:

- Involvement of families
- Spirituality
- Emphasis on concepts such as tapu; va fealoaloa'i
- Gendered approaches: males work with males; females work with females
- Concepts, perspectives, language, values, which are specific and unique to ethnic groups

Holistic approaches - The separation of sexual violence from family violence presents difficulties for workers because of the way in which funding agreements are formulated. The outcome is the delivery of fragmented services supported by stretched resources.

The ideal situation is to enable workers to be funded and resourced to provide services for both sexual violence and family violence.

Ring fenced funding and resourcing - Realistic funding and resourcing needs to be tagged to ensure that the development and implementation of models of practice for Pacific workers is effective, efficient and of high quality.

Assessments

Within the context of the discussions on Models of Practice, processes in psychological assessments were discussed. Six focus areas which were viewed as barriers were:

- Va fealoaloa'i – the gendering rule
- Language and modes of questioning
- Responsibilities to Pacific men who are offenders and perpetrators
- Issues of non-English speaking clients
- Clients of multiple ethnicities
- Report writing

Va fealoaloa'i – the gendering rule

It was identified that working with victims and working with perpetrators required specialised skills. Participants recognised that as female workers they needed to be clear about how they worked with the two groups.

Situations which were identified as being extremely difficult involved female workers being assigned to male clients. In terms of cultural sensitivities and in light of the issues of violation, control and power within sexual violence, mixed gendering is highly inappropriate and highly unsafe for both the worker and the client. The cultural message is that the male client is not respected and as a consequence there is no respect for the female worker. In this situation *va fealoaloa'i* has been excluded from an important process of initial and ongoing engagement. As a consequence, the context for establishing connections or boundaries of respect has been compromised and therefore disrespectful to both the client and the worker. The female worker and the client are placed in situations of potential risk and conflict.

> *It's about va. It is the most important concept for us as Pacific. How can perpetrators respect us as professionals if we are not respecting the va?*

Language and modes of questioning

Concerns around the difficulties in translating and interpreting information from English to an ethnic specific language were discussed. Translation and interpretation of Western concepts to ethnic specific contexts and vice versa are problems typified by inadequate languaging. Models of questioning were viewed as creating tensions between workers and clients.

Psychological assessments presuppose a particular approach in interaction and language. In working with Pacific males, the context for engaging is an ethnic specific one. This dynamic is weakened if the interviewing dialogue is not conducive or appropriate to the cultural relationship that exists between the worker and the client,

> *The problem is that the model of questioning is creating tensions. If it is psychological, it requires a particular response when talking to Pacific men.*

One participant stated that the office manual used for questioning is difficult to follow and that at times, the client will lead the discussions from which the worker will then ask the questions,

> *The work manual is used but it is difficult to follow and is not working.*

The use of psychological concepts was also said to be ineffective,

> *The clinical component is present in the Pacific process but we use different terms, language. Pacific people practice differently.*

The comment on the clinical component refers to the idea that ethnic specific groups have their own explanations of causes for behaviour and therefore words and terms to explain these behaviours. This approach underlines the belief that attitudes and beliefs that promote certain types of behaviour which are likely to be informed by culture and location.

Female participants also commented on the fact that they did not know the commonly used (or colloquial) terms such as arousal or words to describe sexual behaviour such as masturbation that ethnic specific Pacific males were familiar with, to ask the questions required by their organisations. The problem posed by inappropriate gendering is exacerbated through language,

> *How do we say words like arousal, masturbation?*
>
> *What language is used?*
>
> *The questions should be asked directly. It is best for men to work with men.*

There was a strong view that in order for the questions to be asked directly and in an environment of safety, that male workers are assigned to male clients.

Responsibilities to Pacific men who are offenders and perpetrators

An inherent belief amongst many Pacific people is the notion of obligations and responsibilities to the wellbeing of Pacific families and their members. Discussions dwelt on past approaches where male offenders were isolated from families and their centres of identity and places of belonging such as church and families. The prevailing view within the focus group was to strengthen approaches towards understanding pan-Pacific and ethnic specific views on sexual abuse and sexual violence and, to develop effective and appropriate ways of working with Pacific men and women. There was agreement that assessments should be about respecting men and restoring dignity.

> *It's about responsibility. In assessments, it's about how to restore dignity to men.*
>
> *Many want to go to church with their family because it is a way to come back into the family.*

The discussion on respect for Pacific men and processes for restoring dignity to men does not detract from the seriousness of perpetrator or offender behaviour and its impact on victims and the families of both victims and perpetrators. Respect and dignity is about face meeting face - *fa'aaloalo* and recognition of Pacific men's place in the context of *va fealoaloa'i.* Dialogue between worker and client is an important part of hearing the client's story.

The discussions identified a number of barriers in relation to working with Pacific men,

- God, the church, and the devil are used to avoid the responsibility of addressing problems,

The difficulty is about restoring. Research shows that if it's done once, he will do it again. Most Pacific men had arousal issues and blamed it on the devil but they go to church and deny it.

The client said that he had been forgiven by God and there was nothing further that the therapist could do.

- Perpetrators and offenders hide their stories

Men who perpetuate, don't know how to bring their stories out.

Most sex offenders hide their story. The more people who know your story, the more people will assist

- Shame and guilt

It was commented that *'shame is a huge factor'.* One example was where a client was so ashamed that it took him more than six months before he could say what he had done.

> *It's about safety. Many feel bad and guilty.*
>
> *Guilt shuts men down.*

Another example was policy around clients being accompanied by a support person. This was identified as a barrier because of the shame felt by the client. The shame and guilt prevents the client from fully engaging in the assessment phase.

- Lack of support from family members

A participant comment was that women did not want to know what had been done,

> *They don't want to know what was done, they just want the problem fixed.*
>
> The maintenance of family wellbeing means that Pacific workers from within their ethnic specific contexts work hard to achieve this,
>
> *The Pacific approach is all about maintaining family relationships. We need to grow the men's workforce in this area.'*

Non English speaking clients

Concern was raised around non English speaking clients in prison who were not being catered for. These clients were not benefiting from rehabilitation because they could not understand what was being said.

Clients with multiple ethnicities

Research surrounding the needs of multi-ethnic populations is sparse. Participants agreed that this group are not catered for in their work approach. One view was that some groups have no status but that a cultural context is known through the parents. It was suggested that multiple ethnic populations could be understood through the common values across Pacific groups. Responses argued that core values are expressed differently in each ethnic specific group and that approaches need to be considered before engaging with clients identifying multiple ethnicities,

> *We might have common core principles but these are played out differently within specific groups e.g. fa'amatai*
>
> *If we engage with someone of the same culture then its different from when we engage with for example, a Palagi and another Pacific group. We can't do this.*

This is an inter-cultural issue which needs to be thought about before even engaging.

One example of the types of difficulties experienced occurred where a client was meeting with two professionals - one worker was of the same ethnic group as the client and the other was non Pacific. The points of conflict did not come from the client but from the two professionals in their assessments of the client. Both Pacific, non-Pacific workers and clients are at risk where assessments fail to take into account the full context of a client's stories and experiences.

Report writing

Pacific counsellors found that writing clinical reports and assessments were barriers. Where some had mastered the process of report writing, others had given up and focused instead on working with their clients. The Massey Report has not been effective.

Enablers: Assessments

Ethnic specific contexts

The assessment phase needs to acknowledge the ethnic specific contexts of the male clients

Assessments should be based on Pacific and ethnic-specific values and models

To understand the family dynamic, offending needs to be unpacked from within the context of the clients' cultures

Research on appropriate assessment models

More research is required in the areas of assessment models appropriate to ethnic specific and multiple ethnic Pacific people

Referrals of Non English speaking clients

Referrals should go from the courts to the provider. The clients can be assisted through counselling sessions with ethnic specific language speakers

Responsibilities towards victims

Victims of sexual violence and sexual abuse are women, children, infants, youth at risk, and the elderly. Time did not permit the discussion of cultural beliefs regarding females, children, and the elderly as sacred within covenants and which is specific to some ethnic groups. This area of discussion for Samoan participants would focus on the concept of *va tapuia.*

Women

The weakening of indigenous and traditional support mechanisms, compounded by workforce and service delivery gaps has resulted in many women becoming more vulnerable to being blamed, stereotyped, and stigmatised not only by community perceptions but also from within their own families.

Barriers include womens' fears that they will not be believed and, how they will be perceived. Participants identified that the silences of women is not solely about safety. It is also about keeping family together,

> *In working with women who have been abused by someone they know, they want to tell someone. But they're afraid of how they will be viewed, or if they will be believed. It's not about safety, but about keeping family together and believed.*

Maintaining silence becomes a barrier to understanding the extent and nature of the problem. Consequently, women are caught in complex social and cultural dilemmas, and through their silence re-victimise themselves.

The question of why sexual violence continues to occur and the acknowledgement that a balance of service delivery and workforce needed to be achieved was made,

> *They keep silent and the survivor is re-victimised. We still haven't got the balance right. There is ongoing sexual violence, what does this mean?*

Ownership of the violence and abuse by families meant that families would take responsibility for addressing the problem. Once the offence goes to court, the problem becomes a responsibility of government,

> When it is exposed within the family, the family takes responsibility, not the court. When it becomes a court process, the state is taking over the problem.

Elderly

Literature and anecdotal information identify increasing incidences of elderly abuse and neglect, and of elderly as victims of family violence. That elderly people are subjected to these forms of violence is shameful for families. As a result, there are silences from families and from the elderly themselves; the primary concern of the elderly being the protection of their families. Incidences of physical sexual abuse and sexual violence towards the elderly are not forthcoming, if indeed this is occurring.

Fa'afafine

> *Service and workforce gaps are resulting in more Pacific people on the streets, and in homeless situations.*

It was identified that *fa'afafine* are being vulnerable to sexual violence and sexual abuse. Barriers for workers include information, resources, and support.

Pacific people who are homeless

The issue that Pacific homeless people can be victims of sexual violence and sexual abuse, or have been made homeless because of sexual violence in the home environment, was raised. In some situations, males who were homeless had been rejected by families because they were paedophiles.

It is worthwhile noting that in working with *fa'afafine,* and in the area of the homeless, the risks to workers are not dissimilar to those of their counterparts working with perpetrators and victims within home and community environments. Unique to the sex industry and the homeless (in cases relating to sexual offending) sectors, is that both sectors are located at the margins of societal and cultural boundaries of acceptance. Workers who are not adequately supported by organisations (for a range of reasons including stretched resources and a lack of understanding of cultural beliefs and practices) are therefore dependent upon informal support from other Pacific workers within related networks.

Enablers: Responsibilities towards victims

Key relational covenants within models of practice that are specific to ethnic groups. By reintroducing the values and beliefs within these covenants, it aims to provide a context that belongs to ethnic specific groups to strengthen family and community relationships.

Research

- Exploring and understanding the dynamics which lead to silences amongst victims and families, including stereotypes would assist with developing appropriate information and tools to changing attitudes and behaviour that lead to blaming victims for violations against them.
- Exploring the issues of sexual violence and sexual abuse in the areas of Pacific people who are homeless
- Exploring issues of sexual abuse and sexual violence related to *fa'afafine*

Victim support service - the establishment / strengthening of such service/s will have specific focus on the needs of survivors of sexual abuse and sexual violence. The inclusion of victims of family violence may be considered.

Strengthening Pacific Provider Responsibilities

A strong theme within the discussions was the need for Providers and workers within mainstream organisations to reassess their potential as a workforce of professional

workers and to be able to effectively advocate for relevant and appropriate services for Pacific families,

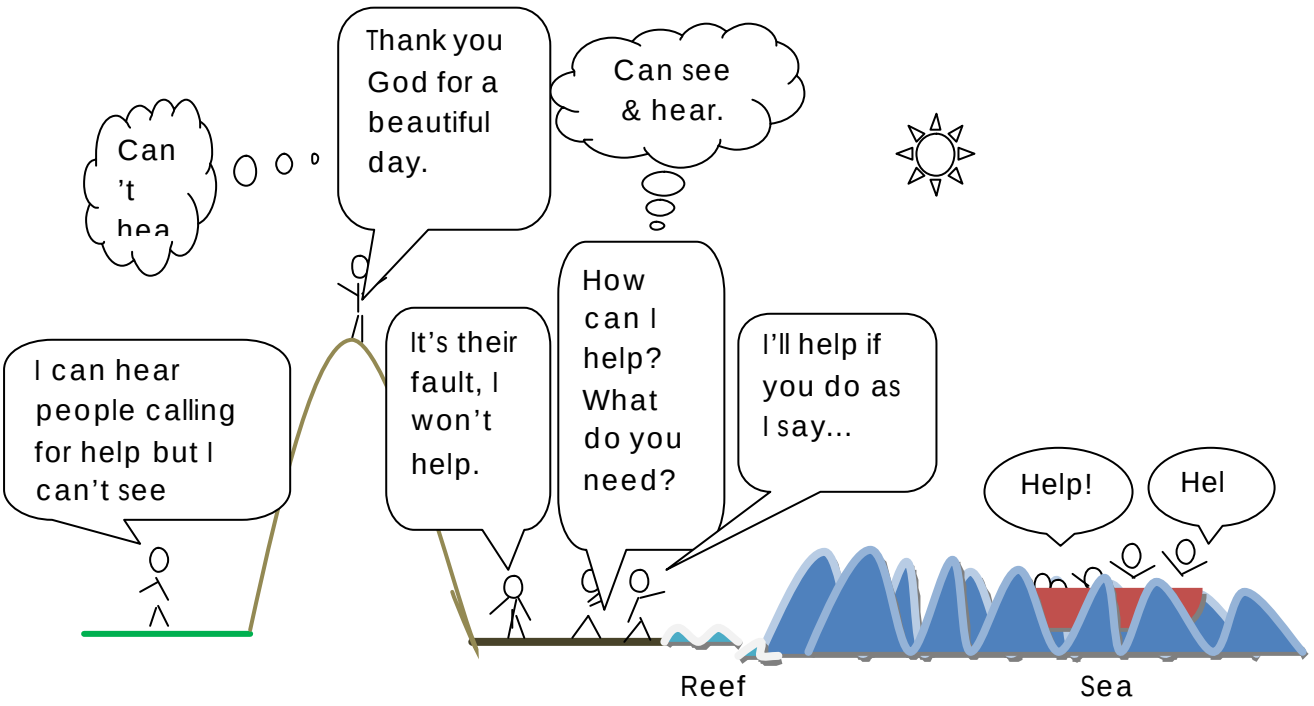
> *If we don't play a role in what is affecting our people, we are like shifting sand. We talk about abuse but we are not coming forward to provide Pacific Island alternatives. We have to say to New Zealand, there are eight nations here. Listen to us.*
>
> *We haven't been staunch about what we believe works. We need to have a conversation about how we view sexual violence and what stops us from doing something.*
>
> *Professional abuse. Our people are used in the community and there is no recognition of our work.*
>
> *We are conditioned to think like Palagi. But we are not Palagi. This needs to be challenged.*

Reef Model

During the 1970s and 80s, training workshops organised by NGOs and church organisations were held for Maori and Pacific Island services and community leaders throughout the country to promote discussions and critical debates on the social and economic challenges facing Maori and Pacific Island communities. Of value were the models used to illustrate specific points of discussion.

The Reef Model introduced by Fr Felipe Von Chet highlights the different types of power interactions between key positions and roles played by for example organisations, service providers, funders, policy writers, and leaders within communities and society. In this context, the people in the boat represent victims of sexual abuse and sexual violence. The people on land, mountain, and behind the mountain represent a range of institutional and community perceptions and assumptions as to what is happening to the people at sea, and their responses.

The Reef Model was presented to the participants. Of relevance is the question, where are the Pacific providers, and where the Pacific workers in mainstream organisations in the Reef Model?



Pacific workers in mainstream organisations

Participants noted that there were benefits such as management support and training. Identified also was the cost of identity as well as isolation, the need for network support and losing touch with their communities,

> *There is a cost to those Pacific people who have chosen to go to mainstream. We lose a sense of ourselves sometimes.*
>
> *In my world, I have to shut myself down and do the work. The focus is always on the offenders needs. Pacific Island people work in isolation and need to find network support. We lost touch with our communities.*

Pacific providers

Participants in provider organisations identified a range of barriers including difficulties with coordinating across services,

> *The barriers are resources, language, information to mainstream, flow of communication between mainstream providers (e.g. Rape Crisis) and our provider.*
>
> *We don't work well together, as Pacific organisations we struggle to get ourselves together.*
>
> *We fall over in the* areas of administration, management, and governance.

Communication and Coordination

Participants noted that small providers were being replaced by larger providers and the lack of support for Pacific organisations by funders and other Pacific provider groups. This was viewed to be symptomatic of the poor communication and coordination both within the provider networks as well as across mainstream providers and government agencies,

- Poor flow of communication between mainstream providers and Pacific providers
- Small groups are not being funded by government and are taken over by larger organisations
- Organisations that have been around for years are not supported by Pacific or funders

Leadership

Comment on leadership within families raised some views on encouraging and strengthening the roles of traditional leaders. Other views were that leadership is the responsibility of everybody in families,

> *There is a t-shirt that reads, violence free begins with me. Everybody must take responsibility for violence. Our workers are situated in different places. Communication needs to be better.*

Enablers: Strengthening Pacific Provider responsibilities

Strengthening relationships with MPIA. MPIA is viewed as being a vigilant advocate and conduit for change. Their role needs to be strengthened and Pacific issues on violence need to be resolved at this level.

Sexual Violence Taskforce should sit alongside the Family Violence Taskforce. There is a concern that the Sexual Violence Taskforce does not have the same access to the government wide and judiciary expertise and support as the Family Violence Taskforce. Given that the issues are of a similar nature and, that there are overlaps in service delivery, the participants are keen to support a collaboration between the two Taskforces.

Recognition and respect for work. Pacific workers recognise that they are in their roles because of their knowledge and expertise in working in the area of sexual abuse and sexual violence as well as their commitment to the wellbeing of Pacific families. Historically, relationships with funders and government organisations have been poor and often strained. The desire is for a relationship that mutually acknowledges and respects the collaborative work efforts between government and Pacific providers.

Working with families enables families to take responsibility. Working with families to take responsibility for establishing and maintaining violence free homes and environments, is a step towards the next generation of violence free leadership within every Pacific family.

Grow as providers from within ethnic-specific groups. Ethnic specific contexts provide insights into perpetrator and survivor behaviour and attitudes. It also provides some explanation for the way in which stereotypes and stigmatising of women, fa'afafine, homeless people who are violated, are developed and harboured within families (who collectively make up communities). The proactive Pacific response to violations is punitive to a point; its end is not in punishing nor isolating individuals but in restoring and reconciling individuals and families to states of wellbeing. Ethnic specific contexts do not hold all the solutions to the problems that issue from sexual violence, sexual abuse, and family violence. Mainstream skills and knowledge are as important, but not singly

pivotal to understanding ethnic specific world views. The call to move away from the blanket approach of Pacific policy to enable ethnic specific approaches and responses is a reflection of the need for change.

Networking. Consolidating formal and informal networks for the purposes of for example, professional information sharing, aligning work programmes, strategic development, resource sharing is viewed to be a positive way forward to improving efficient communication and coordination for Pacific providers and Pacific workers in mainstream organisations. A 'clearing house' model is envisaged as a possible design.

Workforce Development

Participants recognised that overall numbers of Pacific workers in the sexual violence and sexual abuse workforce was significantly small relative to the size of demand. The comment that,

Not many Pacific people want to do this work or are qualified to do this work

identified two initial barriers – that there were few qualified workers, and that Pacific people were not drawn to this type of work.

Profession gaps and recruitment

The identified profession gaps are psychologists, therapists, and counsellors who are regarded as essential to the assessment and rehabilitation phases. The few numbers of frontline workers w as also identified as a barrier to effective service delivery. Comments noted that this latter group and in particular police need more training in working with Pacific families.

Critical to recruitment approaches is the targeting of Pacific ethnic specific males both young and older to provide culturally appropriate gender matches with their female counterparts.

Some of the participants had attempted to recruit Pacific community workers however,

Community workers were not recognised because they don't have qualifications.

It was also noted that mainstream providers were recruiting and drawing on (unqualified) Pacific people to work for them, yet this was a group who could be tapped into and trained to work in the area of sexual violence.

Mentoring

Mentoring is an effective means for addressing issues of work and study support, familiarising with work environments and practices, and isolation,

One solution is that for anyone wanting to work in this area, they need to be mentored by a group to go through this process.

Working strategically

The comment that Pacific people, "*..are naturally inclined as practitioners"* provides a natural springboard from which aspects of workforce capability could be developed in a focused approach. While this may over time lessen the burden on frontline capacity, it does not address barriers to capacity and capability gaps in the areas of assessment and rehabilitation.

There was agreement that Pacific workers *need to work smarter and collectively* in all strategic points of development, coordination and communication, and implementation.

Enablers: Workforce development

Recruitment with a focus on ethnic specific populations, and males to reduce workforce gaps in identified profession areas.

Increase numbers of ethnic specific males. Innovative recruitment approaches in all settings where Pacific people gather.

Grow specialist and generic capacity and capability. These include psychology, counselling, and therapy. Explore avenues where training and upskilling can be upgraded as in staircasing to high qualifications; transferred within work areas of violence (e.g. sexual violence and family violence) as well as across related sectors such as health and social and community services .

Mentoring. Development and implementation of mentoring models which are conducive to mainstream and pacific provider settings.

Funding and resourcing. Funding and resourcing for recruitment, training, mentoring model development and implementation need to ring-fenced.

Qualifications and Skills

A disincentive and therefore a barrier to seeking qualifications and formal training is financial support and time,

> *You have to belong to a professional body. Once you qualify you apply to a professional body and then that body requires forms to be filled out. By then a lot of money has been spent to get there. Many Pacific Island people don't want that. It took me 5 years to get there. Once you are there, then you can apply for money.*

Studying for a degree in an academic environment involves the study of Western ways of thinking and assigning meaning to behaviour and thought. Pacific people already have an understanding of the way in which other Pacific people perceive and respond to a range of situations,

> *You need a degree and cognitive thinking. Clinical component is present in Pacific process but Pacific use different terms and language.*

A further barrier is when criteria for qualifying and accessing funding are continuously changing,

> *People continue to shift the posts on Pacific Island people.*

Years of investing time, money, and effort towards a qualification is not always an assurance of expected increases in salary, or funding from funders,

> *Getting qualifications and meeting criteria does not guarantee funding.*

Enablers: Qualifications and skills

Research. Explore and identify

- the range of qualification requirements for specialised roles and generic roles within sexual violence and sexual abuse work
- pathway options to achieving minimum qualifications for all relevant tertiary institutions in the main centres in New Zealand
- availability of funding, grants and scholarships through government, tertiary institutions, and other funding bodies
- course programmes offering electives related to the broad area of violence

Stocktake. Identify the types of qualifications held by Pacific sexual violence workers, and the relevance of qualifications to their current roles.

Funders

Participants were very concerned about the extent to which funding models defined how workers should work, and its impact on their ability to deliver responsive services.

The experiences of participants was that funding for sexual violence work was ring-fenced for what funders wanted and not what providers believed was needed. An example was a suggestion as to whether MoUs between funders and providers would be useful. A response was,

We tried something similar but the funders had no money because their contracts were held with other services. Funders know that providers will accept their contracts because we have no-where else to go. It's more than being about qualifications.

The expectation from funders is that providers should work in a certain way; ways they deem to be appropriate. They are working from particular models. We find that this is doing the clients over and over again. It is around beliefs in how we do our work.

One participant did not explain why they felt that they were ineligible for funding but was confident that it was not because their workers were not / not adequately qualified. A second participant believed that their ineligibility was to do with the (Pacific) beliefs underlying their work. As a result, clients were revictimised because no funding was available.

Doubt around the way in which funding processes were conducted was also expressed,

There are a lot of gaps. It doesn't add up. Funding defines how we operate.

Another participant stated that their organisation raised their own funds (and through sponsorships). This participant is the only Pacific person in the organisation and their work practice is a one shoe fits all approach. As a result, their service does not adequately cater for the needs of their Pacific clients,

We raise our own funds. One shoe fits all. Pacific Island people fall through the cracks...

The following two comments are examples of how government policy based funding has implications for the way in which workers practice, and the subsequent impact on clients,

Funding is determined by government whose focus is now on prevention. For clients who don't fit in the funding model, they are sent back to court for re-sentencing.

Our funding determines a 12 month programme. Some clients need more than 12 months. Clients attend group sessions as well as one to one sessions.

Another barrier identified was the poor communication between funders and providers,

We have four Pacific workers. Our funder provides separate funding for sexual abuse but we are not updated with what is going on with funding.

Enablers: Funders

MPIA lead discussion. The funding and policy cycles are inter-related and this is likely to be an area where MPIA can facilitate further discussions with the providers and the funders.

Summary of Enablers

Overall, this chapter has discussed the overarching emergent themes identified within participants discourse at the fono[17]. Each section on these themes includes a subsection of enablers and potential ways forward for the Pacific sexual violence workforce which can has positive implications for Pacific survivors of sexual violence as well as families and perpetrators.

Models of Practice

Develop culturally appropriate criteria for assessing ethnic-specific models of practice for Pacific workers which:

- Recognise values such as involvement of families and spirituality
- Emphasise concepts such as tapu; va fealoaloa'i
- Encourage gendered approaches: males work with males; females work with females
- Acknowledge concepts, perspectives, language, values, which are specific and unique to ethnic groups
- Fund and resource the Pacific workforce to provide both services for both sexual violence and family violence.
- Reserve appropriate and realistic funding/resource for the Pacific sexual violence workforce in mainstream and Pacific specific services.

Assessments

- Utilise current assessment models within ethnic specific contexts and values for Pacific clients.
- Encourage the assessment of offending within the centrality of family and the context of client's culture(s).
- Commission/Conduct research on appropriate assessment models for ethnic-specific and multiple ethnicity Pacific populations.

[17] Models of Practice, Assessments, Responsibilities for Victims, Strengthening Pacific Provider Responsibilities, Workforce Development, Qualification and Skills, Funders.

- Encourage the referral of Non English speaking clients from the courts to the provider.

Responsibilities towards Victims

- Enable interventions to strengthen family and community relationships through re-visiting the values and beliefs of key relational covenants within models of practice that are specific to ethnic groups.
- Commission/Conduct research exploring the dynamics which lead to silences amongst victims and families, including stereotypes. Utilise this evidence to develop appropriate tools and information that can influence attitudes and behaviour that lead to blaming victims for violations against them.
- Commission/Conduct research on the issues of sexual violence and sexual abuse amongst homeless Pacific peoples and amongst the *fa'afafine* population.
- Conduct a needs based analysis of Pacific sexual violenc/abuse victims to inform the establishment of and/or strengthen current victim support services.

Strengthening Pacific Provider Responsibilities

- Strengthen relationships with the Ministry of Pacific Island Affairs.
- Encourage and advocate for improved collaboration between the Sexual Violence Taskforce and the Family Violence Taskforce.
- Acknowledge and value the role/contribution and extra-curricular work that is undertaken by Pacific sexual violence workers through 1) appropriate funding and recompense 2) formalising relationships between funders and organisations.
- Encourage, empower and enable families to take responsibility and maintain violence free homes and environments.
- Develop ethnic-specific Pacific policy to enable specific approaches and responses that reflect a changing and developing heterogenous Pacific population.
- Consolidate formal and informal networks through the establishment of a National Pacific Sexual Violence Provider Association. Such a group would encourage professional information sharing, aligning work programmes, strategic development, resource sharing and co-ordination amongst a currently fragmented workforce.

Workforce Development

- Encourage the recruitment of ethnic-specific Pacific workers to address workforce gaps. Emphasise the need to increase numbers of ethnic specific males.
- Develop a Pacific sexual violence workforce development strategy that not only links with other health and social community sectors but also caters to the professional development needs of both regulated and non-regulated workers.
- Reserve appropriate and realistic funding/resource for recruitment, training, mentoring model development and implementation.

Qualifications and Skills

- Commission/Conduct research to explore and identify:
- the range of qualification requirements for specialised roles and generic roles within sexual violence and sexual abuse work
- pathway options to achieving minimum qualifications for all relevant tertiary institutions in the main centres in New Zealand
- availability of funding, grants and scholarships through government, tertiary institutions, and other funding bodies
- course programmes offering electives related to the broad area of violence
- current types of qualifications held by Pacific sexual violence workers, and the relevance of qualifications to their current roles.

Funders

- The Ministries of Social Development and Pacific Island Affairs to facilitate further discussions with providers and funders.

Conclusion

In turning to past conversations between Pacific communities and government agencies that span over two decades, central questions from those discussion return through the participant voices in this document. These are, 'Who is defining the problems for Pacific people?' 'Who is defining the solutions for Pacific people?' 'Whose values and beliefs have primary place in the lives of Pacific people?'

There are important statements that can be made about the way in which Pacific have chosen to collect their data for this project. The most important is that, space for dialogue has been cleared for the workers who engage in the face meeting face arena to respond to the questionnaire and to also reflect back those concerns which

are of value to their work and to the wellbeing of Pacific families. Where human lives are at stake, there is no place in Pacific research ethics for tick box exercises.

This chapter covers the range of work areas which participants have identified as presenting barriers to effective service delivery. Enablers have been proposed as strengthening and taking on new ways of thinking and working forward. The discussions are not the final voice and ongoing dialogue needs to be continued with all providers and key stakeholders.

The participant voices are not seeking exclusive domains for working. They continue to advocate for collaboration, partnership, and an inclusive place for the values, practices, and beliefs of ethnic specific groups within policy writing and funding allocation. For this group of participants who attended the fono, there is the awareness that respect for other ways of seeing and understanding the environments which Pacific and non-Pacific people share will keep the dialogue and discussions open and debates constructive.

Pacific families now live in extremely demanding times. There is no doubt that violence in all its forms will continue to impact on the lives of the most vulnerable in communities. The barriers and enablers within this report will form part of ongoing discussions and debate within the Pacific sexual violence sector. It will hopefully be a springboard to galvanising practical and innovative ways to creating violence free environments within Pacific families, communities and our society.

Ia manuia.

References

Anae, M., Fuamatu, N., Lima, I., Mariner, K., Park, J., & Suaalii-Sauni, T. (2000). *The Roles and Responsibilities of Some Samoan Men in Reproduction*. Auckland: Pacific Health Research Centre; The University of Auckland

Campbell, R., Sefl, T., Barnes, H.E., Ahrens, C.E., Wasco, S. & Zargoza-Diefeld, Y. (1999) Community services for rape survivors: enhancing psychological well-being or increasing trauma? *Journal of Consulting and Clinical Psychology, 67, 6*, 847-858.

Campbell, R. (2006) Rape survivors' experiences with the legal and medical systems. Do rape victim advocates make a difference? *Violence Against Women 12, 1,* 30-45.

Fry, D. (2007) A room of our own: sexual assault survivors evaluate services. A research report for the New York City Alliance Against Sexual Assault: New York.

Gavey, N & Gow, V (2001). '"Cry Wolf", cried the wolf: Constructing the issue of false rape allegations in New Zealand media texts'. *Feminism and Psychology, 11*, 3, 341-60.

Jordan, J. (2004). *The word of a woman? Police, rape and belief*. Palgrave Macmillan: New York.

Lievore, D. (2005) No longer silent: a study of women's help-seeking decisions and service responses to sexual assault. A report prepared by the Australian Institute of Criminology for the Australian Government's Office for Women. Canberra, Australia.

Lovett, J., Regan, L. & Kelly, L. (2004) Sexual assault referral centres: developing food practice and maximising potentials. Home Office Research Study 285. Home Office Research, Development and Statistics Directorate: UK.

Read, J., Hammersley, P & Rudegair, T. (2007) Why, when and how to ask about childhood abuse. *Advances in Psychiatric Treatment, 13*, 101-110.

Tiatia, J. (2008). *Sexual Violence and Pacific Communities Scoping Report.* Wellington: Ministry of Pacific Island Affairs.

Wasco, S.M., Campbell, R., Howard, A., Mason, G.E., Staggs, S.L., Schewe, P.A., Riger, S. (2004) A statewide evaluation of services provided to rape survivors. *Journal of Interpersonal Violence 19*, 2, 252-263.

Appendix 1: Stocktake Questionnaire Guide

Ministerial Task Force for Action on Sexual Violence
TOR 2: Stock-take of Tauiwi crisis and recovery and support services.

Please fill in the following questionnaire and/or make a time for Sue Berman to call to collect the information via a telephone interview. Email s.berman@hyper.net.nz

Name of Organisation:
Date:
Contact person/details:

1. What services does your organisation **currently** provide in the area of sexual violence?

Y/N support at police statement
Y/N support through medicals,
Y/N court preparation and/or support
Y/N telephone information,
Y/N telephone referral
Y/N telephone counselling, or crisis face to face emergency sessions
Y/N on-going counselling
Y/N social work support,
Y/N prevention programmes,
Y/N community consultations for prevention, responses to sexual violence other – please describe
Comment:

2. Is the service only a specialist sexual assault service, or do you also provide other services?
Was this always the case? Please include a herstory to this?

Do you work with adults assaulted as adults, that is, assaulted at 16 years of age or older?

Crisis services

3. If you provide crisis services:
    1. Please describe the geography – urban, provincial, and rural? Where to where?
    2. Available 24/7? Structure of staff cover for this?

Are you primary contact point for police?
If yes, do you have a signed agreement? If not, who is the primary contact point for police in your area? Is this who you think it should be? Why/not?

Are you primary contact point for DSAC doctors?

4. Do you have statistics for how many clients you provide crisis services to that you could send through to us? We are interested in breakdown by ethnicity or culture, gender and age.
Do you work with ...
Adult females, that is, 16 years and over

Adult males, 16 years and over
Young people
Children
If **NO** to any of these groups, is there another service in your area which does this work with these age or gender groups?

5. What do you value about your crisis support service in what you do or how you do it?
6. Are there any barriers to clients accessing your service?

Support and Recovery services
If you provide recovery and support services ...

7. Are you able to give numbers for how many clients you provide recovery and support services to?
   We are particularly interested in break-downs by ethnicity or culture, gender and age.
8. Do you know what proportion of these clients have been assaulted as adults?
9. Do you work with...
   Adult females, that is, 16 years and over
   Adult males, 16 years and over
   Young people
   Children
   If **NO** to any of these groups, is there another service in your area which does this work with these age or gender groups?

10. Do you work on one site or multiple? If multiple, reason for this?
    Do you do home visits?

11. Client groups – is there any particular group you see, or don't see?
12. Are there any gaps that you are aware of?
13. Geographical coverage?
14. What is the average wait time to see a counsellor?
15. Are the people who do the work approved for payment by ACC? What proportion?
    If **NO**, is this the choice of your agency? Comment

16. Does your staff have specific training for working with adults recently assaulted?
17. What do you value about your support and recovery service in what you do or how you do it?
18. Are there any barriers to clients accessing your service?

General questions relating to both crisis services and support and recovery services
19. What does your service do to meet the needs of Maori?
For example bi-cultural service, staffing, cultural supervision, referrals.
Do you refer to any Maori for Maori services – who provides this in your area?
20. What does your service do to meet the needs of Pacific peoples?
21. What does your service do to meet the needs of any other group with cultural or other needs? Do you refer to any culturally or context specific services?
22. How often does 'English as a Second Language' come up as an issue for people needing services? What kinds of responses do you have to this? E.g. translation services, referral on etc.
23. What kinds of issues face your service?
24. What issues do survivors in your area face?
25. Is there more need in your community than you are meeting?
a. If yes, what is it?
b. What stops you from meeting this need?

Funding for Crisis Service Provision (if you do crisis work)

26. Who do you receive funding from for crisis services
ACC,
CYF or MSD,
DHB,
Philanthropic Trusts,
community fundraising, (lotteries, gambling trusts etc),
client contribution,
using voluntary staff
Other – describe funding
Is this funding adequate? If not adequate, what **would be** different if you had adequate funding?

Have you had an increase in funding for this service due to Pathways to Partnership?

What impact did this have on the adequacy of funding levels?

How far from adequate would you describe your current levels of funding?

Funding for Support and Recovery Services
27. Who do you receive funding from for support, recovery and/or counselling services
ACC,
CYF or MSD,
DHB,
Philanthropic Trusts,
community fundraising (lotteries, gambling trusts etc),
client contribution,
using voluntary staff
Other – describe funding
Is this funding adequate? If not adequate, what **would be** different if you had adequate funding?

Have you had an increase in funding for this service due to Pathways to Partnership?

What impact did this have on the adequacy of funding levels?

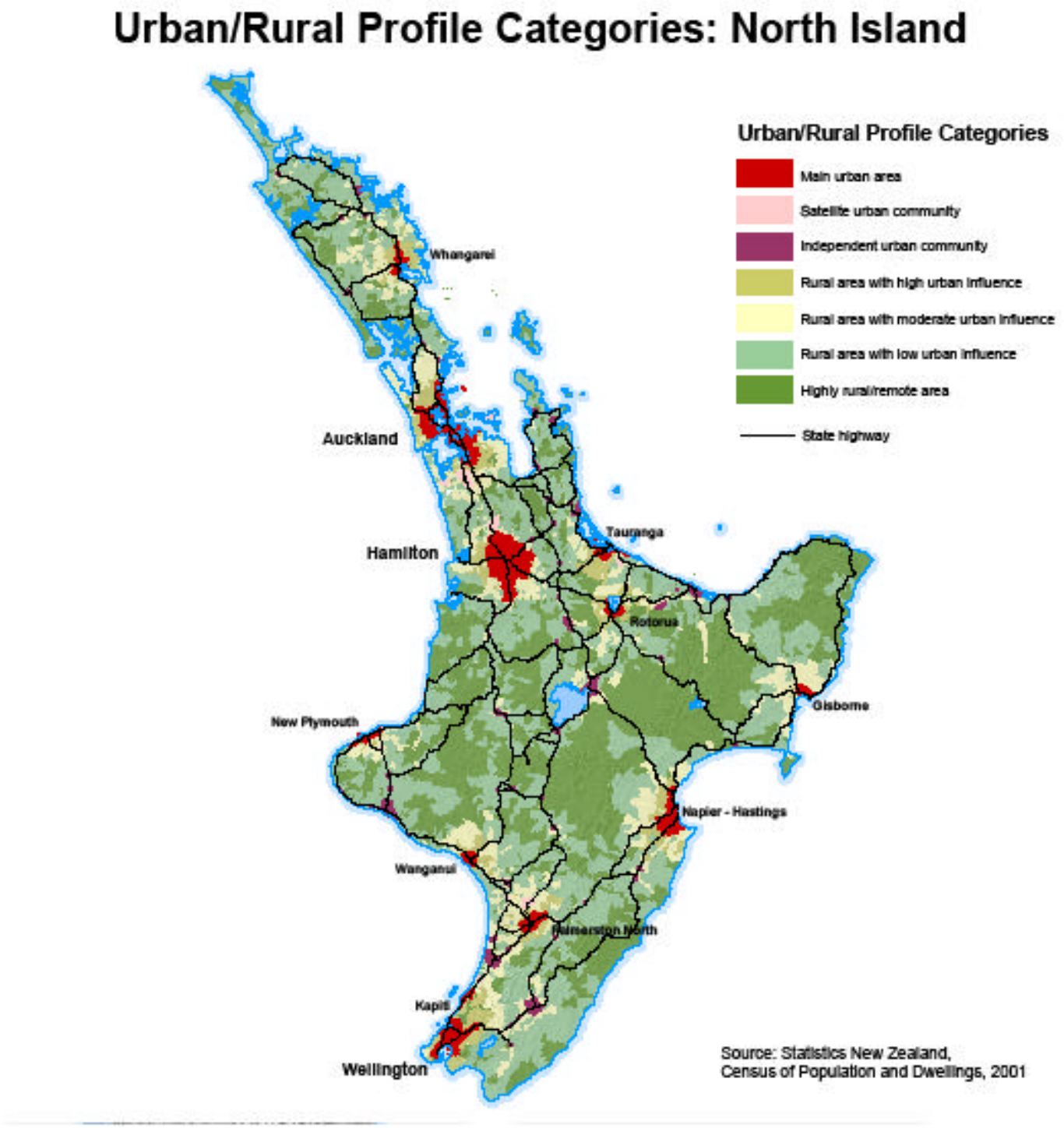
How far from adequate would you describe your current levels of funding?

28. Is there anything else that you would like to say – either more about something we addressed earlier or something that I haven't covered?

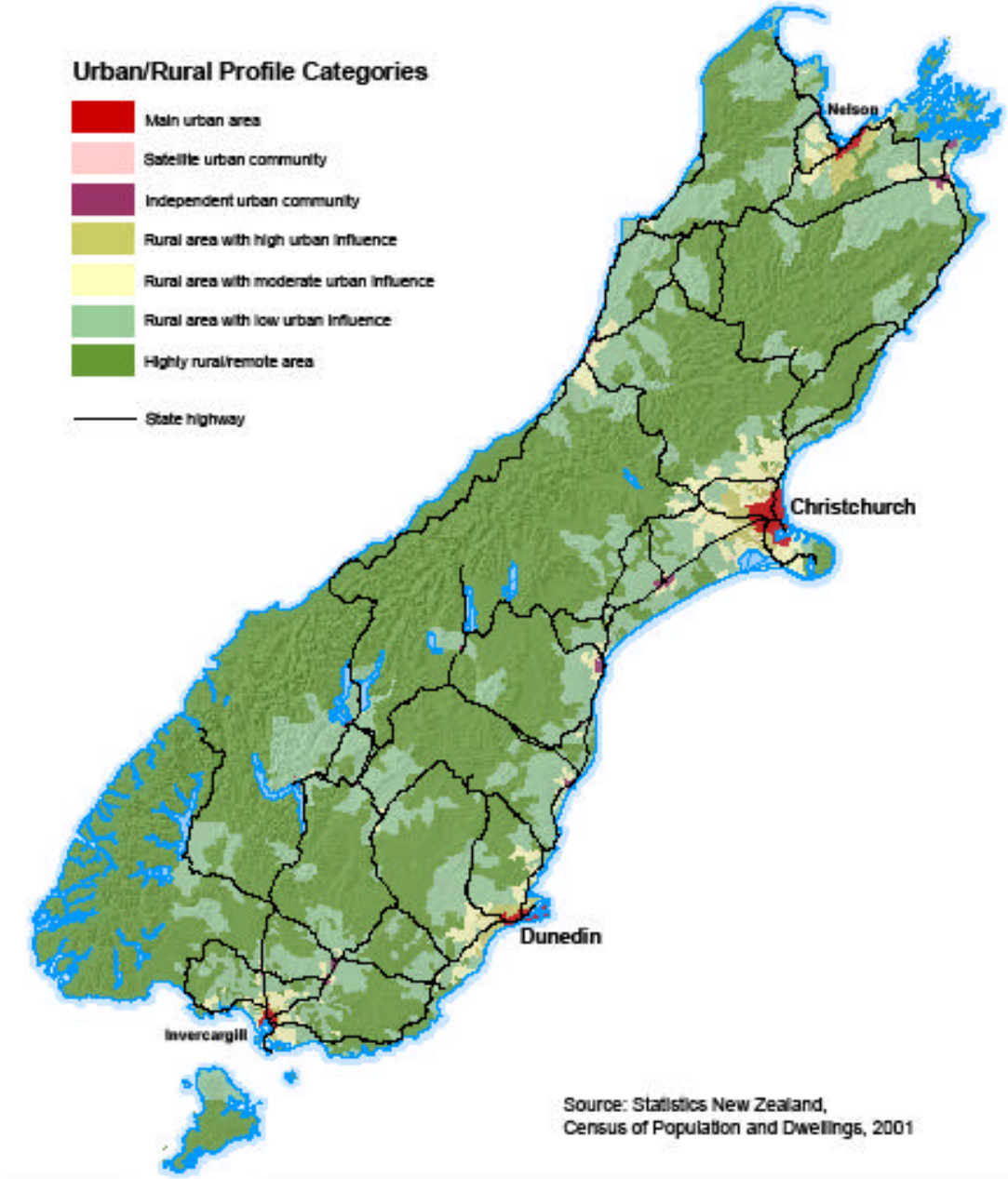
This research is a work in progress, so as we make sense of it, if there is any further information that we need, would it be OK for me to give you a quick call back, or an e-mail?

Thanks for participating.

Appendix 2: Statistics NZ geographically defined areas



Urban/Rural Profile Categories: South Island



Appendix 3: Role of the crisis support worker

NZ Police Adult Sexual Assault Investigation Policy requires that a specialist crisis support person be contacted so as to be available during police interviewing of a complainant of sexual assault.

Role of the crisis support worker or counsellor is primarily to:

- Minimize the psychological consequences of trauma by attending to the emotional and psychological needs of the complainant

Traumatisation occurs when a person's resources for coping are overwhelmed.

We aim to minimize the degree to which a person is traumatised through:

- Helping a person to best access her or his own resources
- Providing external resources where people are so overwhelmed they can no long access their own.
- Working to avoid replication of the dynamics of sexual assault – violation, objectification and disempowerment.

Ways we do this are:

- Trained support workers and counsellors can be emotionally attuned to a distressed complainant, regardless of the nature of the assault. This, along with carefully timed and chosen communications can lessen the amount of distress a person experiences along with helping to shore up the person's own coping defences.
- Working with the myths about sexual assault that the person holds – challenging those which are not helpful (those of self-blame) and assisting the person to maintain those which help her/him to feel safe (those which give perceptions of control).
- Facilitating decision-making – although important decisions may need to be made, this can be difficult to do when traumatised.
- Offering appropriate information about procedures and resources and what the person's journey through the process may look like.
- Sorting through practical issues the person may not be able to attend to themselves – safety, how to tell family etc.
- Supporting the person to recount the experience in ways which encourage understanding but avoid traumatisation.
- Assessing the person's needs for further resources, e.g. safe housing, assessment for medication, and making referrals as appropriate.

A key factor in preventing the development of Post Traumatic Stress Disorder is perceived social support. ***We work to maximise the social support the person will have available though:***

- Supporting and coaching friends and family. This may include providing information, working with any myths that they hold about sexual violence, supporting them through their own emotional responses and assisting them to access counselling for themselves where this is needed.
- Being a link to the 24-hour follow-up services provided by the crisis support service
- Providing referrals to other relevant services

When a person has already been traumatised, their ability to cope with further stressors is much reduced. Rape and sexual assault inherently involve violation of personal boundaries and gross disempowerment. The medical, interviewing and other processes involved in the police report of a sexual assault can easily become stressful to a degree that can overwhelm the resources of an already traumatized person. To the survivor they can also at times feel like a replication of the dynamics of violation and disempowerment.

Therefore, we also negotiate with police and doctors:

- To moderate the stress of these processes for the survivor of sexual abuse/assault
- To avoid experiences of the replication of the dynamics of violation and disempowerment
- Where it seems that rights under the Victims of Offences Act may be being violated, e.g. where the person is not being treated with courtesy, compassion and respect for personal dignity and privacy.
- When it seems that more full evidence would be available through a change in circumstances e.g. having a break for food or sleep.

Appendix 4: Map of Police Districts

map-of-nz-police-districts-496x684.gif (GIF Image, 496x684 pixels) http://www.police.govt.nz/district/map-of-nz-police-districts-496x684.gif

Appendix 5: Services by population group.

Table 21: Services by population group.

Service/s No = 30	Telephone Crisis Service	Emergency call out	Face to Face Crisis Support Service	Ongoing Support and Recovery
Kaitaia Women and Children Fresh Start Support Group	24/7 Women Young Women Children	Partial Women Young Women Children	Partial Women Young Women Children	Women Young Women Children
Mid North Family Support	Partial Women Young Women Children	Partial Women Young Women Children	Partial Women Young Women Children	Women Young Women Children
Support of Sexually Abused (Rape Crisis) Dargaville	24/7 Women Young Women & Children	24/7 Women Young Women & Children	Partial Women, Young Women Children	Women Young Women
Whangarei Rape Crisis	24/7 Women Young Women Children	24/7 Women Young Women Children	Partial Women Young Women Children	Women Young Women Children
Miriam Centre	None	None	None	Women Young Women Children Men
Rape Prevention Education	Partial Women Young Women Children Men	None	None	None
Auckland Sexual Abuse HELP Foundation	24/7 Women Young Women Children Men	24/7 Women Young Women Children Men[18]	Partial Women Young Women Children Men[19]	Women Young Women Children Parents and caregivers

[18] While the service is funded to see women only, it does provide service to male survivors also when possible. Staff have the option of whether or not they will work with male survivors, with the

Waitakere Abuse and Trauma Counselling Service	None	None	Partial Women Young Women Children	Women Young Women Children
Counselling Services Centre	24/7 Women Young Women Children Men	24/7 Women Young Women Children Men	Partial Women Young Women Children Men	Women Young Women Children Men
Ngaruawahia Community Care and Crisis Centre	Partial Women Men	None	Partial Women Men	Women Men
Hamilton Rape and Sexual Abuse Healing Centre	Partial Women Young Women	None	Partial Women Young Women	Women Young Women
Healing and Rape Crisis Centre Te Awamutu	24/7 Women Young Women	Partial Women Young Women	Partial Women Young Women	Women Young Women
Sexual Abuse Centre (Rotorua) Inc	Partial Women Young Women Children Men	Partial Women Young Women Children Men	Partial Women Young Women Children Men	Women Young Women Children Men
Rape Crisis Gisbourne	24/7 Women Young Women Children	Partial Women Young Women Children	Partial Women Young Women Children	Women Young Women Children
Taranaki SAFER Centre	Partial Women Young Women Children Men	None	Partial Women Young Women Children Men	Women Young Women Children Men
Hawera Rape Crisis	24/7 Women	24/7 Women	Partial Women	Women

call-out passed to another staff member if the person rostered chooses not to provide the service.

[19] Services are provided to male survivors in the absence of a comparable service being available to them. However, due to the specialist nature of the work, male survivors are referred on as soon as possible.

	Young Women Children Men	Young Women Children Men	Young Women Children Men	Young Women Children Men
Manawatu Rape and Sexual Abuse Centre	Partial Women Young Women Men	Partial Women Young Women Men	Partial Women Young Women Men	Women Young Women Men
Wanganui Sexual Abuse Healing Centre	Partial Women Young Women Children Men	Partial Women Young Women Children Men	Partial Women Young Women Children Men	Women Young Women Children Men
Rape Crisis Wairarapa	24/7 Women Young Women Men	24/7 Women Young Women	Partial Women Young Women	Women Young Women
Hutt Rape Counselling Network Incorporated	24/7 Women Young Women Children Men	24/7 Women Young Women Children Men	Partial Women Young Women Children Men	Women Men
Wellington Rape Crisis	Partial Women Young Women Men	None	Partial Women Young Women Men	Women Young Women Men
Wellington Sexual Abuse HELP Foundation	24/7 Women Young Women Children Men	24/7 Women Young Women Children Men	Partial Women Young Women Children Men	Women Young Women Children Men
Nelson Rape and Sexual Abuse Network Inc	24/7 Women Young Women	24/7 Women Young Women	Partial Women Young Women	Women Young Women
Marlborough Women's Refuge & Sexual Assault Resource Centre Marlborough Inc	24/7 Women Young Women	24/7 Women Young Women	Partial Women Young Women	Women Young Women
Rape and Sexual Abuse Support (West Coast)	Partial Women	Partial Women	Partial Women	Women

Monarch Centre	24/7 Women Men	24/7 Women Men	Partial Women Men	Women Men
The Sexual Abuse Centre	Partial Women Young Women Men	None	Partial Women Young Women Men	Women Young Women Men
Rape Crisis Dunedin Inc	24/7 Women Young Women	24/7 Women Young Women	24/7 Women Young Women	Women Young Women
Wakatipu Abuse Prevention Network	24/7 Women Young Women Men	24/7 Women Young Women Men	Partial Women Young Women Men	Women Young Women Men
Rape and Abuse Centre Southland.	Partial Women Young Women Men	Partial Women Young Women Men	Partial Women Young Women Men	Women Young Women Men

Appendix 6: Combination of sources of funding to crisis services

Table 22: Combination of funding to crisis services

Funding Sources	Partial Services	24/7 Phone & Call out
Has a single source of funding		
MSD	1	
DHB		1
Community		1
Two sources of funding		
MSD + DHB		1
MSD + Unpaid workers		1
Unpaid workers + Community	1	
Three funding sources of funding		
MSD + Trusts + Community	3	1
Trusts + Community + Unpaid workers	1	
More than three funding sources		
MSD + Trusts + Community + Unpaid workers	1	6
ACC + DHB + Trusts + Community		1

Appendix 7: Waiting list time by urban/rural service and ACC and non ACC registered counsellors

Table 23: Waiting list time by urban/rural service and ACC and non ACC registered counsellors

Waiting List Time No = 23	Urban with ACC registered counsellors	Rural/ Satellite ACC registered counsellors	Urban - no ACC registered counsellors	Rural/Satellite no ACC registered counsellors
Nil	3		2	4
Days up to a week			2	1
2-4 weeks (1 month)	2	2	1	
5-8 weeks (2 months)	2		1	
9-12 weeks (3 months)		1		
13 weeks (3 months +)	2			
Total each category	9	3	6	5

Appendix 8: National networks and infrastructures

These are relationships of key importance for some providers of services to survivors.

Nga Whiitiki Whanau Ahuru Mowai O Aotearoa National Collective of Rape Crisis and Related Groups of Aotearoa

Eleven of the specialist sexual assault providers for adult victims/survivors belong to this collective. It could be considered to have been the mainstay of this part of the sector since the early 1980s. Its collective structure lived out the values of co-operation and consensus which are key for many of those who work with the impacts of sexual violence. The group is bi-cultural and provides many support functions for its members, including:

- Efficient provision of comprehensive training and standards packages for its members. This allows local groups to focus their resources on service delivery and other aspects of local need. These packages include kaupapa Maori training.
- Sharing of institutional knowledge which allows groups and individuals to begin this work with little prior experience of responding to sexual violence, as they can draw on the collective knowledge and experience of other members.
- Connection – the work is by its nature counter-cultural and can be traumatising. Connection with those with similar experiences can support people in handling the negative feedback sometimes received from those who want sexual violence to remain hidden, along with strengthening people's resilience to trauma.
- Advocacy – the dominant paradigm which seeks to minimise sexual violence and blame victims/survivors means that there is a constant need for an alternative view to be made public. The Collective does this in a number of ways, for example, by responding to media requests and maintaining the vehicle of Rape Awareness week for local groups to use in their local communities as they see fit.

Te Ohaaki a Hine - National Network Ending Sexual Violence Together

This national infrastructure was established more recently in response to the needs of groups in the sector to come together to work for changes – both improvements in services for those affected by sexual violence, and to end sexual violence. The network consists of two "houses" designed to reflect the relationship envisioned in Te

Tiriti o Waitangi. Members include both survivor and offender focused services, individuals, academics, and survivor networks.

TOAH-NNEST reflects its membership groups in working at multiple levels to promote the changes necessary to enable all people to live free of sexual violence and its effects. It supports services through networking, and provision of resources and information; provides access to consultation about sexual violence for other sectors, and works with government to promote wider social and legal change.

Both national groups operate separately and in their relationships with each other from foundational values of co-operation. Both are considered necessary to take the sector forward from its current position. Maintenance of Nga Whiitiki Whanau Ahuru Mowai O Aotearoa National Collective of Rape Crisis and Related Groups of Aotearoa is an essential support structure for its members which can be widely spread through provincial centres, while TOAH-NNEST provides a wider forum bringing together groups and individuals from most parts of the sector.