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TE MANATŪ WHAKAHIATO ORA

Rapid evidence review to inform post-crisis support services for victims of sexual violence

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Glossary

Term	Definition
Advocacy	Services which aim to meet victims'/survivors' needs and entitlements for employment, education, housing, financial, childcare and legal services and information, often by helping them navigate complex systems (eg medical and legal) and connecting or referring them to appropriate services.
Cognitive behavioral therapy	A broad label for types of psychological therapy (including cognitive processing, stress inoculation, exposure, and eye movement desensitization and reprocessing therapies) in which cognitions/thoughts are challenged and changed, and coping strategies are developed. Cognitive behavioral therapies are generally accepted as well-supported by robust scientific evidence for reducing symptoms of a number of psychological conditions such as depression, anxiety and post-traumatic stress disorder.
Cognitive processing therapy	A type of cognitive behavioural therapy for treating post-traumatic stress disorder in which victims/survivors develop a new understanding of their trauma and associated thoughts in order to reduce associated psychological distress.
Counselling/supportive counselling	A type of relationship in which a counsellor supports victims/survivors, normalises their experiences and helps them develop generic coping strategies, but is not necessarily trained in any specific psychological/clinical techniques or therapies.
(Prolonged) Exposure therapy	A form of cognitive behavioural therapy for treating post-traumatic stress disorder in which victims/survivors confront triggers of trauma in order to reduce the psychological distress they otherwise elicit.
Eye movement desensitisation and reprocessing	A type of psychological therapy for treating post-traumatic stress disorder in which victims/survivors recall trauma while performing specific sensory tasks such as eye movements. The evidence base is less established here than for other cognitive behavioural therapies, including questions about the theoretical foundation of the intervention.
Formal supports	People such as police, healthcare workers and sexual violence support workers who can potentially support a victim of sexual violence in processing and recovering from their experience and have some professional or other training or experience in providing either the associated services or support for sexual violence victims in particular.

Term	Definition
Grey literature	Research and other documents produced by non-academic organisations, such as government research reports and papers, and evaluations from and/or for government and non-government organisations.
Informal supports	People such as family, whānau and friends who can potentially support a victim of sexual violence in processing or recovering from their experience, but who do not necessarily have any specialist training in providing such support or services.
Non-clinical services	An umbrella term for other types of services provided which do not involve specific therapies or services (eg medical, legal) from a trained professional, but may complement these services and/or support clients in other ways.
(Complex) Post-traumatic stress disorder	A psychological condition which is triggered by experiencing a traumatic event and often includes symptoms such as flashbacks, avoidance of traumatic reminders, and anxiety or being 'on edge'. Complex PTSD involves multiple, repeated or chronic traumatic events.
Psychological/clinical therapies	An umbrella term for different types of therapies that involve talking to a trained professional in order to reduce symptoms of psychological distress.
Stress inoculation therapy	A form of cognitive behavioural therapy for treating post-traumatic stress disorder in which clients develop improved methods of coping with psychological symptoms.

1. Executive summary

This rapid evidence review was completed to provide the Ministry of Social Development (MSD) with a summary of the available evidence about the nature and effectiveness of post crisis support services for victims/survivors of sexual violence. The key question to be answered in this review was: *What does the evidence say about the nature and effectiveness of post-crisis services for helping victims/survivors of sexual violence recover from its negative impacts?* The agreed method was a rapid narrative review of accessible academic and grey literature. The review synthesises and summarises findings from the available identified evidence, and does not include consideration of other factors in decision-making such as cost and alternative options.

Key findings of the review included:

- International guidelines and evidence recommend the provision of support beyond an initial crisis response, and the ability of these services to cater for a range of victims'/survivors' needs. Both an immediate and ongoing responses are necessary for optimal outcomes.
- For victims/survivors with severe and complex needs such as post-traumatic stress symptoms, clinical therapies including cognitive behavioural therapies have the strongest evidence of effectiveness, particularly when delivered individually rather than group-based, and over a sufficient period of time (at least 4-5 months).
- Non-clinical services such as supportive counselling and advocacy services are well-received by clients with less severe needs, and help to support clients through service interactions and connect with other supports. However these services do not have clear evidence of effectiveness at reducing psychological distress symptoms, and still need to be individualised for different needs.
- Both clinical and non-clinical services need to be delivered by staff with specialist training in sexual violence. Clear referral pathways also increase the effectiveness of post-crisis support services.
- Evidence is mixed regarding the optimal service model for post-crisis support services. A coordinated response across a variety of service providers is one promising option, as is supporting informal supports (eg victim's/survivor's family, whānau and friends).
- Evidence was limited and often related only to subgroups of potential victims/survivors. Further evaluation and investigation of promising approaches is recommended in order to strengthen the evidence base in this field.

2. Purpose and background

The purpose of this evidence review was to assist MSD to understand post-crisis support services for victims/survivors of sexual violence in New Zealand¹. Such post-crisis support services would aim to mitigate the negative effects of trauma resulting from sexual violence. The key aim of this review was to summarise and synthesise available evidence on the types of post-crisis services that are effective in helping victims/survivors of sexual violence recover from its negative impacts. The key question to be answered in this review was: *What does the evidence say about the nature and effectiveness of post-crisis services for helping victims/survivors of sexual violence recover from its negative impacts?* The client for this evidence review was MSD's Family and Community Services Team, who design and manage the provision of psycho-social support services for people affected by sexual violence. The review was carried out in August and September 2018.

Note that this review summarises the relevant evidence but does not intend to prescribe particular types of services. Other factors such as local context, cost, alternatives and trade-off options also affect decisions about service design, and these are not addressed in this evidence brief.

2.1 Review scope

Sexual violence includes a number of different types of experiences that may reflect different needs. For example:

- stranger attacks
- intimate partner, dating or domestic violence
- historical and/or childhood sexual abuse
- paedophilia victims
- cyber-experiences of sexual violence
- experiences of Māori, Pacifica, refugees and migrant New Zealanders (including those who experienced sexual violence outside of NZ), rainbow communities, people living with disability, the elderly, and children.

The definition of *crisis* (and therefore *post-crisis*) applied here is that used by MSD's Family and Community Services team: "Crisis is not defined by the actual event, but by the person's response (and the response of their family/whānau/community) to that event, so a victim/survivor may still be considered in crisis if the event is historical".

¹ Post-crisis support services are not currently funded consistently in NZ, other than through ACC Integrated Services for Sensitive Claims as described above. MSD currently funds sexual harm crisis support services and have consulted a very small sample of providers, victims/survivors and others from the Sexual Violence Sector to gain some insight into the current nature, availability and effectiveness of post-crisis support services. See <https://www.msd.govt.nz/about-msd-and-our-work/work-programmes/initiatives/family-and-sexual-violence/specialist-services/crisis-support.html> for more information.

Potential clients of post-crisis support services are those who:

- are no longer in crisis but require support beyond existing crisis support services
- are not eligible for ACC Integrated Services for Sensitive Claims, for example because they:
 - do not have a diagnosed 'mental injury'
 - have a mental injury but it is not solely attributed to the sexual violence event/experience
 - the sexual violence event occurred outside New Zealand
- are on the waitlist for ACC Integrated Services for Sensitive Claims support.

For example, clients of these services might have:

- a mental health issue presenting at the time but which is related to other trauma-related experiences, not the sexual violence experience
- "milder" needs which require support but do not meet the criteria for a mental injury
- "delayed" needs that are part of a normal response to trauma (eg denial, depersonalisation, some symptoms of post-traumatic stress disorder [PTSD])
- the same symptoms as ACC clients but where ACC services are unavailable.

2.2 Methodology

Evidence needed to inform decision-making in this project needed to be produced quickly because the area of post-crisis support services for victims/survivors of sexual violence in NZ is still being explored and no dedicated funding is available. Consequently, the agreed method was a rapid narrative review of accessible academic and grey literature. Haby et al. (2016) define a rapid review as "a type of systematic review in which components of the systematic review process are simplified, omitted or made more efficient in order to produce information in a shorter period of time, preferably with minimal impact on quality. Further, they involve a close relationship with the end-user and are conducted with the needs of the decision-maker in mind." Current evidence suggests that in situations requiring a trade-off between timeliness and thoroughness, rapid reviews can offer similar conclusions to a more comprehensive or systematic review (Abou-Setta et al., 2016), with a comparable impact on decision-making (Haby et al., 2016). The rapid review completed here was non-systematic in that search terms were iterative and only immediately relevant search results were screened for inclusion (ie not all search results). A full description of the methods used is provided in the Appendix.

2.3 Comment on the state of the evidence in this field

The literature/evidence identified for this review most often addressed only one of the potential client subgroups outlined in section 2.1. Therefore the literature summarised here often only relates to a single subgroup of the potential clients of post-crisis recovery services, most commonly women victims/survivors of male-perpetrated sexual violence in adulthood.

It was also common for evidence regarding sexual violence to be conflated with domestic or intimate partner violence. Evidence in this area was presented where sexual violence was included in its scope and there were no obvious reasons to expect differences in findings for sexual and other forms of violence.

In some cases the research cited was not recent (eg 1990's or early 2000's). Age does not generally affect the validity of research, but it is possible that older evidence reflects social factors (eg behavioural norms) that have since changed.

In general the research on support services for victims/survivors of sexual violence was limited and in the early stages. Most of the evidence reviewed here focused on what types of interventions are effective, whereas more specific questions such as how long they should be available for, or what 'dosage' is optimal, do not yet appear to have been explored. Evidence relating to a New Zealand context was used where available.

Recommendations presented in this review are based only on the identified evidence and should be interpreted with these limitations in mind.

3. Review findings

3.1 Evidence supports the need for provision of specific *post-crisis support services* in addition to early crisis support

Provision of post-crisis services in addition to immediate crisis supports is consistent with international guidelines: The World Health Organisation (2013) guidelines for sexual violence services (based on synthesis of the available evidence, recommendations from an expert group incorporating consideration of cost implications and human rights, and stakeholder review) recommend the provision of support services both in the immediate crisis period (ie the first five days) following a sexual violence event, as well as a further post-crisis period (ie the following three months) afterwards.

In addition, MSD's operational definition of post-crisis services (see section 2.1) aligns with evidence that services should be based on victims'/survivors' response to sexual violence rather than a strict time-based criterion. For example, most victims'/survivors' disclosures of sexual violence occur later rather than immediately after the event (Ullman & Filipas, 2001), and therefore services need to consider the needs of victims/survivors at any stage after a sexual violence event.

Early intervention is especially important in the field of sexual violence services because initial levels of distress about the experience are strongly related to the severity of trauma-related symptoms even months later (Macy et al., 2009). In addition, sustained provision of mental health services can reduce the otherwise detrimental impact of experiences with the medical and/or legal systems for sexual violence (Campbell et al., 1999).

Sexual violence victims/survivors are also known to reach out to informal supports such as friends, family and whānau more frequently than they do to formal supports such as healthcare professionals, police, or community workers (Sabina & Ho, 2014; Ullman & Filipas, 2001). This is particularly so for victims/survivors whose sexual violence experience falls outside of a typified 'stranger rape' scenario. Implications of these patterns are that those in need of post-crisis support services can have a range of possible experiences, and services will need to be able to cater for their consequent range of needs. In addition, it highlights the need for supporting informal supports. This point is explored further in section 3.8.

3.2 Psychological therapies are recommended for victims with more severe needs such as complex post-traumatic stress disorder

Evidence supports the provision of psychological therapies for reducing psychological symptoms such as depression, anxiety and PTSD resulting from sexual violence (Regehr, Alaggia, Dennis, Pitts, & Saini, 2013), especially when the victim's needs are complex, severe or delayed (eg exhibiting symptoms of complex PTSD, have experienced multiple or ongoing traumas, and/or in victims who have experienced childhood sexual abuse; Macy, Giattina, Sangster, Crosby & Montijo, 2009; World Health Organisation, 2013). Effective psychological therapies in these circumstances include cognitive processing

therapy, prolonged exposure therapy, stress inoculation therapy, and eye movement desensitisation and reprocessing (Regehr et al., 2013). The stages of therapies for victims with these kinds of complex needs can involve (Cloitre et al., 2012):

1. Ensuring safety, reducing symptoms and increasing key emotional, social and psychological competencies. Macy et al. (2009) and the World Health Organisation (2013) include these types of objectives in their description of immediate/crisis support services². If used, medication treatments would also usually be administered alongside this phase of psychological therapy (World Health Organisation, 2013). Treatments in this stage are generally effective (and evidence for this includes high-quality randomised controlled trials; Cloitre et al., 2012), but they are even more effective if combined with at least some elements of the second stage described below (Cloitre et al., 2012).
2. Processing unresolved aspects of trauma to reintegrate traumatic memories into an adaptive narrative for the client about their identity and relationship to the world. This phase usually involves some method of reprocessing trauma, such as cognitive behavioural therapy or eye movement desensitisation and reprocessing.
3. Outward focus on applying treatment progress to facilitate better engagement in relationships, work/education, and the community. Involves a plan for education/employment and social activities, potential for booster sessions, and relapse prevention planning.

Other types of treatment for clients with complex or severe needs have less or weaker evidence to support them (Cloitre et al., 2012). For example, supportive counselling is not as effective as the psychological therapies described above, and may be no more effective than simply putting clients on a waiting list (eg for ACC services; Foa, Rothbaum, Riggs & Murdock, 1991).³

Evidence also shows that clinical services for victims/survivors with more severe needs tend to be more effective when delivered individually rather than in group settings, and when they are tailored and responsive to the needs of the client. For example, sexual violence victims/survivors often have several inter-related treatment targets that require different types of interventions (Briere & Jordan, 2004).

There is little consensus regarding treatment duration for victims/survivors with complex needs (eg complex PTSD), but existing trials which show benefits are offered for at least 4-5 months (Cloitre et al., 2012). Importantly, some therapies with these populations require longer time periods in order to adequately address clients' needs. For example, exposure therapy is very effective for clients with simple, contained, or single-trauma-related symptoms (Cloitre, 2009), but has potential risks for clients with more severe or complex needs. Clients with complex PTSD may be more likely to drop out of treatment early in response to the distress caused by initial exposure to traumatic cues, and therefore a well-established relationship with the therapist is required first in order to keep victims/survivors engaged throughout the healing stages of therapy (Regehr et al.,

² Note that in NZ, sexual harm crisis support services also include similar objectives, such as "physical, emotional and psychological safety for victim/survivors". See <https://www.msd.govt.nz/documents/about-msd-and-our-work/publications-resources/service-guidelines/sexual-harm-crisis-support-service.pdf>

³ Note that feedback to MSD from sexual violence service providers in NZ also suggests that some victims/survivors who are not ready to engage in clinical treatments may prefer to access non-clinical treatments instead.

2013). Consequently, services for victims/survivors with severe needs should be delivered over a sufficient period of time to allow effective relationship establishment, addressing of multiple treatment targets, and progression through multiple treatment stages.

3.3 For victims/survivors with less severe needs, services such as advocacy, counselling and support groups are well-received but have little conclusive evidence of effectiveness for reducing mental health symptoms

Service evaluations and client satisfaction surveys generally shows that non-clinical support services are received well by victims/survivors. For example, victims/survivors rate counselling services well, and hotline, advocacy and shelter services moderately (Bennett, Riger, Schewe, Howard & Wasco, 2004). However, the quality of this evidence is relatively low (it contained no comparison groups or pre-post measures) and applies to domestic violence services broadly rather than sexual violence specifically. Similarly, in NZ Women's Refuge (a shelter, advocacy and support service) has been rated universally helpful by clients (Fanslow & Robinson, 2010).

There is insufficient evidence of the effectiveness of advocacy services, and both major systematic reviews of this topic have been limited to women victims of intimate partner abuse rather than sexual violence specifically. For example, Rivas et al. (2016) found that advocacy interventions show no clear evidence of beneficial effects on women's mental health, or on their risk of subsequent sexual abuse. Further, Ramsay et al (2009) concluded that the effect of advocacy interventions for reducing psychological distress and mental health symptoms was unknown – despite being associated with greater use of safety behaviours and of social support. The authors concluded that the evidence base does not yet demonstrate effectiveness of advocacy interventions – however this isn't the same as ineffectiveness, simply inconclusive evidence (Ramsay et al., 2009). In addition, advocacy services generally don't aim to reduce psychological symptoms, but instead focus on supporting victims/survivors through service interactions and connecting them to other supports.

Advocacy interventions have been shown to help rape victims/survivors have better experiences of the medical and legal systems (Campbell, 2006), and to access other community resources (for domestic violence more broadly; Allen, Bybee & Sullivan, 2004). However this effectiveness requires the availability of comprehensive and individualisable services to meet their potentially broad range of needs (Briere & Jordan, 2004).

In the absence of evidence for effective non-clinical interventions, evaluation of services is of crucial importance to build the knowledge base for future decision-making. In addition, new and emerging approaches (such as education for victims'/survivors' social networks on appropriate responses) might be warranted and indeed have been recommended in NZ (Fanslow & Robinson, 2010).

3.4 Regardless of the type of service provided, evidence supports a number of general underpinning principles

Common themes encountered across reviews of academic literature findings and grey literature recommendations (Macy et al., 2009; World Health Organisation, 2013) were that services for victims/survivors of sexual violence should:

- include practical care and support that responds to the client's needs but does not intrude on their autonomy
- provide a sense of normalcy and normalise the client's emotional response
- have an environment of acceptance, empathy and encouragement
- promote relationships, connections to supports, and referral to appropriate services
- provide educational information as well as therapeutic components
- provide a comforting place for the client to discuss their experience while not pressuring disclosure.

In addition, services must be able to be tailored to the client's needs (whether these are milder or more severe). This is important given the large range of potential sexual violence experiences and the complexity of interactions with other types of needs (Briere & Jordan, 2004; Ramsay et al., 2009).

3.5 Both clinical and non-clinical services should be delivered by staff with specialist training in sexual violence

Clinical (psychological) therapies as described in section 3.2 must be administered by a highly trained clinician, psychiatrist or psychologist (World Health Organisation, 2013), and key to their effectiveness is that this relationship is safe and trusted (Macy et al., 2009).

In some settings, non-clinical services have been delivered by other staff such as healthcare personnel. However evidence suggests that it is important for these non-clinical staff to instead have specialist training in sexual violence response, because staff without specialist training are more likely to react in unhelpful ways (eg victim-blaming) than specialist workers (Campbell & Martin, 2001; Ullman & Filipas, 2001). Receiving unhelpful responses from legal or medical systems (eg victim-blaming) increases the severity and prevalence of post-traumatic stress symptoms; this risk is higher than those of victims who do not seek any assistance at all (Campbell et al., 1999).

Consequently, post-crisis support services might be advised to include training for first-line formal support workers (eg healthcare, police) in how to respond helpfully to victims of sexual violence (Campbell, 1998; Sabina & Ho, 2014; Ullman & Filipas, 2001).

Even a small amount of training can improve the effectiveness of workers in delivering sexual violence services. For example, Gatuguta et al. (2017) found that community health workers (sometimes volunteers) with limited training improved outcomes for victims and reduced the strain on specialist resources. Their performance also tended to

be better when they were more educated, experienced with health conditions, trusted in the community, and supervised by professionals (Gatuguta et al., 2017).

Training needs to be specialised in sexual assault and trauma – even general mental health knowledge is not enough to meet the needs of sexual violence victims (Macy et al., 2009). Some guidelines recommend that only clinically-trained professionals should deliver psychosocial interventions (eg support groups, counselling and peer support networks), whereas others suggest trained staff could deliver these services (Macy et al., 2009).

3.6 Referral pathways from crisis services need to be clear and efficient

A clear referral pathway from crisis support services (for healthcare providers in particular) is likely to increase the effectiveness of post-crisis support services (World Health Organisation, 2013). In addition, multicomponent and repeated training for health services staff and crisis support workers about the factors that would indicate referral to these services is crucial.

“Whatever model is used, it should aim to reduce the number of services and providers that a [victim/survivor] has to contact (and tell [their] story to), and facilitate access to services [they] may need, in a manner that respects [their] dignity and confidentiality and prioritizes [their] safety.” (World Health Organisation, 2013).

3.7 Multiple service delivery models could be used, but should include integration into existing health services where possible

There is generally no specific service model (eg ‘one stop shops’ vs co-location with health or other services) that is known to be more effective than any other, and in fact different models may be effective in different settings (World Health Organisation, 2013). The use of multiple models for service provision and innovative approaches may be fruitful until there is further evidence about what makes different models effective in some settings but not others (Fanslow & Robinson, 2010; World Health Organisation, 2013). In these cases, evaluation is vital (World Health Organisation, 2013).

Nevertheless, multiple sources (Gatuguta et al., 2017; World Health Organisation, 2013) recommend that at least some sexual violence services are integrated into existing health services as much as possible, both for efficient use of resources as well as to prevent barriers to access. Both NZ and international evidence shows that specialist violence services can be infrequently accessed due to low awareness and misperceptions about how ‘severe’ an experience needs to be in order to qualify for crisis services (Campbell, Wasco, Ahrens, Sefl & Barnes, 2001; Fanslow & Robinson, 2010).

Regardless of the location, one promising model (which may cut across both crisis and post-crisis services) is a coordinated response where a variety of service providers work as a team to deliver services which meet a range of needs. Such a model is more practical and efficient than separate services for different types of needs, or a single service trying to meet multiple needs (Campbell et al., 2001). It reflects an

understanding of both the local context of service delivery from providers' perspectives, and of the victim's perspective at all levels of care due to extensive communication between different providers' roles and streamlined support (Campbell & Ahrens, 1998).

Characteristics of this type of effective coordinated service response (Campbell & Ahrens, 1998) include:

- integrated service delivery, for example:
 - bringing teams together in one location
 - partnerships where rape crisis services can be delivered in other settings such as churches, drug and alcohol treatment programmes, refuges
- voluntary interagency training programmes delivered in diverse formats and for a variety of audiences
- community-level groups aiming to change societal factors rather than deliver services (eg legislative reform, public education).

One example of this model is Sexual Assault Response Teams, which bring police, lawyers, doctors, nurses, social workers and victim advocates together in one location to help rape victims/survivors (Campbell & Ahrens, 1998). Such teams have been shown to increase victims'/survivors' referrals to services. Members of the team also believe they can improve system personnel interactions with victims/survivors and reduce secondary trauma to victims/survivors (Greeson & Campbell, 2013). However, this evidence is of relatively low quality (being subjective and vulnerable to a potentially high level of personal bias). There are also no reported findings yet of the effect of Sexual Assault Response Teams on client satisfaction or client outcomes (Greeson & Campbell, 2013).

3.8 Greater reach and effectiveness could be achieved by working with both formal and informal supports

Evidence shows that actual and perceived negative reactions from formal support sources contribute to lower rates of disclosure through formal supports (Filipas & Ullman, 2001; Sabina & Ho, 2014). A range of evidence including reviews and large-scale studies shows that informal support can be very effective for victims/survivors (Sabina & Ho, 2014), sometimes even more so than formal supports (Filipas & Ullman, 2001). For example, the presence of good social support for victims/survivors of partner violence almost halves their risk of poorer mental health outcomes (Coker et al., 2004). NZ-specific evidence (Fanslow & Robinson, 2010) is consistent with these perceptions of formal and informal support. It suggests that our response to sexual (and other forms of) violence should consider both innovative responses to help family and friends provide better support for victims/survivors (such as wider distribution of information about helpful responses to disclosures of sexual violence), as well as high quality and sustainable formal support systems.

Collectively, the implications of these findings for service design are that interventions to promote good social support from family, whānau and friends could help a larger number of victims/survivors as well as reduce the likelihood of negative reactions when they disclose. However this support needs to be more than 'just talking' – and should include

emotional support and often practical help with issues such as housing (Fanslow & Robinson, 2010).

3.9 Further evaluation and research in this field will improve our understanding of promising approaches

While limited, the evidence in this field provides a number of clear recommendations about the principles and importance of providing support services for victims/survivors of sexual violence beyond an initial crisis response. A number of promising approaches have also been developed, which warrant further evaluation and investigation in order to strengthen the evidence base. In particular, detailed evaluations of coordinated responses, approaches to working with informal supports, and investigation of non-clinical services for victims/survivors with less severe needs are strongly recommended.

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5. Appendix

5.1 Review methods

The review scope was agreed between the author and the key client. The author searched MSD's Koha database and Google Scholar using the terms shown in Table 1 below. Initial search strings were based on the scope of the review and targeted at high quality systematic review evidence. Subsequent strings were informed by results of previous searches (including a broader range of evidence) and feedback from the MSD's Family and Community Services team. Search strings were deliberately specific in order to generate focused results.

Due to the time constraints for this rapid review and the number of search results (eg the initial search string *best practice crisis support sexual violence systematic review* returned 65 million results in Koha), the review was non-systematic in that not all search results were screened. Instead, search results were sorted by relevance and their titles and abstracts screened for inclusion until saturation was reached for each database and search string (where saturation was defined as 50 consecutive results that did not offer relevant content).

Given the anticipated limited state of the evidence in this area, there were no exclusion criteria placed on the evidence. Inclusion criteria were that the evidence was accessible and related to the scope of the review outlined above. Relevant literature was then summarised and synthesised into the narrative review below. Where possible, review evidence was emphasised over other evidence such as single studies.

Table 1: Search strings used in the review

Initial search strings	best practice crisis support sexual violence systematic review
	crisis support sexual violence systematic review
	recovery services sexual violence systematic review
	recovery sexual violence systematic review
	sexual assault review what works
	sexual violence trauma review what works
	sexual assault trauma review what works
Subsequent search strings	sexual violence trauma treatment
	sexual violence treatment
	sexual violence treatment victims
	community care services for sexual violence victims
	community support services for sexual violence victims
	effectiveness social workers sexual violence
	effectiveness advocacy sexual violence