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Adult specialist services for victim-survivors of sexual violence and abuse: a systematic map of evidence

Sarah Lester, Claire Khouja, Meena Khatwa, Gary Raine, Rebecca Rees
Irene Kwan, Kath Wright, Amanda Sowden, James Thomas

2022

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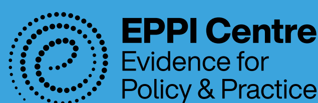

Adult specialist services for victim-survivors of sexual violence and abuse:

a systematic map of evidence

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2022

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Abbreviations

APPG	All Party Parliamentary Group
ART	Accelerated Resolution Therapy
BME	Black and Minority Ethnic
CAED	Clinician-Assisted Emotional Disclosure
CAT	Cognitive Analytic Therapy
CBT	Cognitive Behavioural Therapy
CCG	Clinical Commissioning Group
CSA	Childhood Sexual Abuse
CPT	Cognitive Processing Therapy
CRIM	Cognitive Restructuring and Imagery Modification
CSEW	Crime Survey for England and Wales
DBT	Dialectical Behaviour Therapy
EMDR	Eye Movement Desensitisation and Reprocessing
FGM	Female Genital Mutilation
HIV	Human Immunodeficiency Virus
HCP	Healthcare Practitioner
HT	Human Trafficking
ISVA	Independent Sexual Violence Advisor
LGBTQI*	Lesbian, Gay, Bisexual, Transgender, Queer or Intersex (inclusive)

MST	Military Sexual Trauma
OECD	Organisation for Economic Co-operation and Development
PCC	Police and Crime Commissioner
PE	Prolonged Exposure
PTSD	Post-Traumatic Stress Disorder
RCT	Randomised Controlled Trial
SANE	Sexual Assault Nurse Examiner
SARC	Sexual Assault Referral Centre
STAIR	Skills Training in Affective and Interpersonal Regulation
STO	Specially Trained Officer
VA	Veteran Affairs
VAWG	Violence Against Women and Girls

Terms used in this report

See also section 2.2 for further explanation of concepts used in this map.

Specialist services	We use 'specialist services' to describe any provision of support specifically for victim-survivors of sexual violence or abuse. This covers statutory and voluntary services, as well as adaptations of general services tailored towards supporting victim-survivors of sexual violence and abuse (see section 2.2.3).
Trans	An umbrella term to describe people whose gender is not the same as, or does not sit comfortably with, the sex they were assigned at birth. Trans people may describe themselves using one or more of a wide variety of terms, including (but not limited to) transgender, transsexual, gender-queer (GQ), gender-fluid, non-binary, gender-variant, crossdresser, genderless, agender, nongender, third gender, bi-gender, trans man, trans woman, trans masculine, trans feminine and neutrois (Stonewall, 2017).
Victim-survivor	While 'victim' may seem disempowering, 'survivor' may not always be appropriate either. In order to acknowledge the personal choice of how people subjected to sexual violence may self-identify, and how this may change over time, we have combined these terms (see section 2.2.2).

EXECUTIVE SUMMARY

Background

Around one in five women and one in twenty-five men are estimated to have experienced sexual violence or abuse since the age of 16. When combined with rates of child sexual abuse this figure is even higher. Sexual violence is detrimental to an individual's physical health, emotional wellbeing and relationships, and incurs huge social and economic costs. Appropriate support and care for victim-survivors can help to protect against these negative consequences.

Around 90% of sexual offences are committed by someone known to the victim and for a variety of reasons, cases often remain unreported to the police. Many victim-survivors mistrust statutory services to respond to their needs. While underreporting is still common, the number of police records of sexual violence crimes has increased considerably over the last few years. There has also been an increase in demand for specialist support services. In part, these patterns are thought to be linked to improved police recording procedures and a growing awareness of sexual violence and abuse through high-profile cases and related social media campaigns.

This surge in demand, and especially the need for support for non-recent sexual abuse, coincides with severe budget cuts, and where commissioning of support services has been devolved to local commissioning bodies. Commissioners require evidence-based guidance on which services they should be commissioning in order to best serve victim-survivors.

Overall aims

To provide a systematic map of available evidence on any specialist adult services for victim-survivors of sexual violence and abuse. We included:

- studies of people's views about services in the UK
- evaluations of interventions (using controlled and before-and-after designs, and cost-effectiveness studies) from OECD countries,
- systematic reviews containing these kinds of studies

The map will signal where there are gaps in the evidence base and where there is potential for an in-depth review of evidence to guide decisions about services for victim-survivors.

Review question

What is known about the effectiveness and appropriateness (availability, acceptability and accessibility) of specialist adult services for people who have experienced sexual violence and abuse?

Method

We conducted searches of electronic databases; website searches; reference list harvesting and contacted topic experts to identify potentially relevant items. We applied exclusion criteria to screen all items on title and abstract alone, and then retrieved reports and screened the full-text of all records included at title and abstract stage. All studies included at full-text screening were coded to describe their main

characteristics – for example, the study's purpose (people's views of services, evaluation to improve services, or reviewing other studies), its geographic setting, who had provided data, and which type of sexual violence and/or service was being explored.

We held a stakeholder event to consult on the initial findings from the map with victim-survivor advocates, service providers and practitioners and policy representatives. Suggestions from this event informed further analysis and the structure for presenting the narrative about the studies identified.

In addition to the narrative contained in this report, EPPI-Mapper software was used to produce online interactive maps to visually display the findings and allow users to see the detail of included studies.

Stakeholder influence on the map

The stakeholders' feedback informed the later iterations of the coding tool – for example, the age categories and additional population and service characteristics that we captured. Discussions at the stakeholder event also helped us to distinguish between population sugroups when categorising the studies, and influenced the descriptive terms that we used to describe these sets. Stakeholders also highlighted forthcoming and recently published studies. Four were added to the review to be screened on full text, one of which was included in our map.

Summary of findings

Studies included in the map

In total we included 163 studies in our systematic map: 36 views studies, 106 evaluation studies, and 21 systematic reviews.

Studies of people's views about services in the UK (n=36)

Of the 36 UK views studies, 26 focused on targeted services for victim-survivors of sexual violence and 10 focused on adaptations that general services, such as maternity or health services, could make to meet victim-survivors' needs.

The studies which focused on targeted services (n=26) were further categorised into four groups: targeted services for a specific population subgroup (n=9); services for victim-survivors who have additional forms of disadvantage (n=8); services for any type of victim-survivor of sexual violence (n=5); and how victim-survivors needs are met by services across a broad range of provision (n=4).

Specific victim-survivor population subgroup

Studies in this group (n=9) focussed on services for: people who had experienced so-called 'honour' based violence (n=1); child sexual exploitation (n=1); childhood sexual abuse (n=1); ritual abuse (n=1); forced marriage (n=1); male rape (n=1); and female black and minority ethnic (BME) victim-survivors (n=3).

Victim-survivors with additional disadvantage

Eight studies (n=8) focused on populations with co-existing vulnerabilities or disadvantage, including: mental health and substance misuse problems; learning or physical disabilities; and women seeking asylum.

Any victim-survivor

Five studies (n=5) concentrated on specific types of services or roles that support all victim-survivors of sexual violence. These were mostly located in the statutory sector. Two addressed specialist provision in the criminal justice sector, and three addressed Sexual Assault Referral Centres (SARC), of which one was a comparison between SARCs and voluntary sector services.

Victim-survivor needs in relation to broad provision of services

Four studies (n=4) explored views on how any needs were met (or otherwise) by broader provision of services. Two of these were needs assessments across regional areas, one looked at ways to best deliver group work, and one explored the potential of co-production in Violence Against Women services in Wales.

Adaptations (n=10)

The remaining studies (n=10) addressed how general services, such as maternity, general healthcare, mental healthcare and the police could meet the needs of victim-survivors of sexual violence by way of adaptations.

Evaluations of interventions to support victim-survivors of sexual violence (n=106)

Evaluation studies were mainly US-based (n=62). Across all OECD countries, most evaluations aimed to assess a therapy for improving mental health outcomes (n=84). Other interventions included education for professionals (n=8) or victim-survivors (n=4), services such advocacy or police services (n=9) and secondary prevention of HIV among victim-survivors (n=1). Most evaluations reported quantitative findings about outcomes or impact (n=86), eight studies were qualitative evaluations of processes only, and 12 studies were evaluations of both outcomes and processes.

All UK outcomes evaluations assessed types of therapies (n=4). We found eight UK-based process evaluations of: a national advocacy service in Scotland (two evaluations); a Rape Crisis Centre in Tyneside; training for mental health practitioners to improve practice around abuse histories; a pilot project to support victim-survivors of historic child sex exploitation in Leeds; a specialist sexual assault police investigation unit; and specialist services for female victim-survivors of childhood sexual abuse (two evaluations).

Systematic reviews (n=21)

The systematic reviews focused on four distinct population types of victim-survivors of sexual violence including those who had experienced: female genital mutilation (FGM) (n=8), sexual violence including rape and sexual assault (n=6), sexual abuse as a child (n=5) and human trafficking (n=2).

Most reviews (n=16) examined the effectiveness of interventions. The types of interventions reviewed were predominantly mental health and psychological interventions to reduce post-traumatic stress disorder (PTSD) and improve psychosocial wellbeing (n=11). The other five intervention reviews addressed early intervention; non-surgical responses to FGM; the role of the forensic examiner; educational interventions to increase awareness of sex trafficking among healthcare professionals; and interventions to reduce HIV and sexually transmitted infections. Three reviews explored views and experiences of service-users and two explored the views of professionals about skills and attitudes. Included studies were conducted in different countries with the majority in the US, while only 15 out of 309 studies were conducted in the UK.

Gaps in the evidence

We identified no effectiveness or cost-effectiveness studies of UK specialist services for victim-survivors of sexual violence.

UK views studies focussing on a range of perspectives and populations were included in the map. However, only one study looked at male victim-survivors. This study sought professionals' views only, so we did not locate any studies which addressed male victim-survivors' views.

Stakeholder group

Stakeholders described research conducted in the US as being of limited relevance to their own practice. Information on cost-effectiveness and cost-saving was highly sought after by stakeholders, although it was understood to be scarce. Service providers wanted to know the best way to spend their money, and indicated they would value a review examining which therapies, counselling or service referrals are most effective, in which contexts, and also the benefits of specialist service provision in the voluntary sector over those provided by a generic health provider.

Stakeholders expressed their interest in evidence relating to pathways and referral, relationships between commissioners and providers, the effects of cuts to services, access to services, access to mental health services, suicide risk, and service waiting lists and "turn-away" rates. Outcome measurements relating to empowerment and feeling in control, relationships, and ability to work and study were all seen as important ways of assessing victim-survivors' recovery.

Implications and conclusion

We identified a lack of evidence on the effectiveness (and cost-effectiveness) of UK statutory and voluntary specialist services for victim-survivors of sexual violence. However, a lack of evidence should not be interpreted to mean that these services are not effective.

We identified eight process evaluations and a range of UK views studies which give insight into the views and experiences of victim-survivors and the professionals that support them. Some studies focus on services that serve all types of victim-survivor of sexual violence, whereas others focus on different subgroups of victim-survivor populations (BME women, people subjected to sex trafficking 'honour'-based violence and forced marriage) and victim-survivors who have additional vulnerabilities or

disadvantage (women with mental health or substance misuse problems, women who are disabled, women seeking asylum).

These sets of UK studies warrant quality appraisal and in-depth synthesis or syntheses which could provide a nuanced understanding of UK victim-survivors’ service needs across a range and population subgroups and types of sexual violence.

1 BACKGROUND

1.1 Prevalence of sexual violence and abuse in the UK

The Crime Survey for England and Wales (CSEW) found 24.4% of women, and 4.5% men aged between 16 and 59 years have experienced some form of sexual violence since the age of 16 years. This is equivalent to an estimated 3.4 million female and 631,000 male victims (Office for National Statistics, year ending March 2018).

The yearly figures from the CSEW reveal that while the prevalence of sexual violence and abuse halved between March 2006 and March 2014 (from 3% of 16- to 59-year-olds being victims once or more in the last year in 2006, to 1.5% in 2014), it started to to rise again in the following years (2.7% in March 2018, see figure 1).

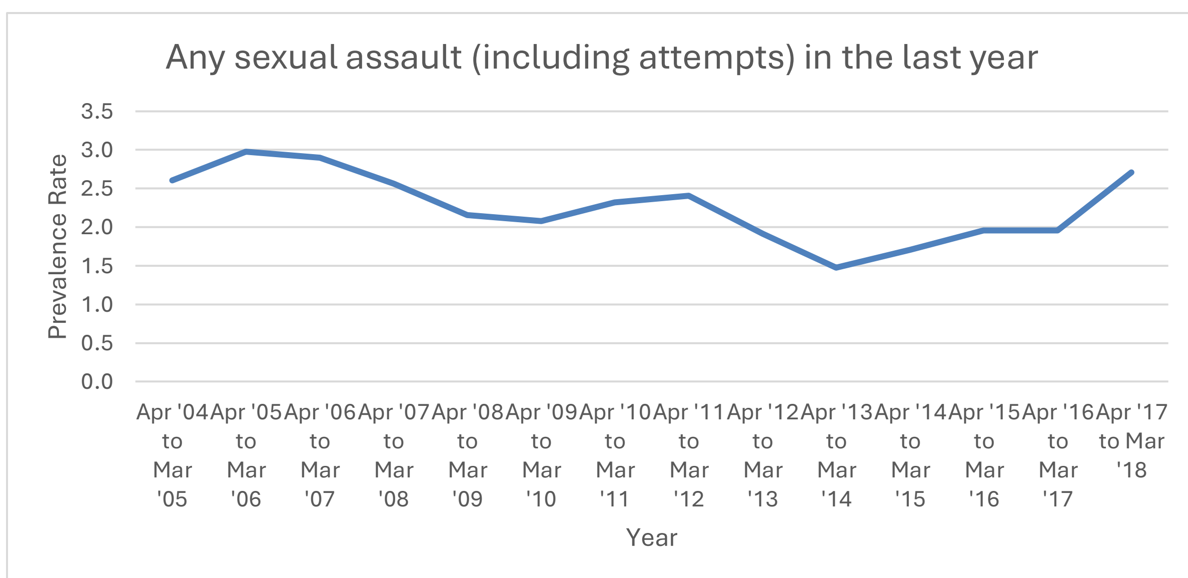


Figure 1: CSEW figures for percentage of 16-59 year olds who have been victims of any sexual assault once or more in the last year

The CSEW (year ending September 2021) reveals that fluctuations in sexual offences reported to police were especially pronounced in the first part of the 2020s. As shown in figure 2, reductions in offences coincided with Covid-19 lockdowns during the first years of the pandemic. However, the period following the release of restrictions saw an increased level of reported offences. The year ending September 2021 had the highest number of sexual offences recorded within a 12-month period (170,973 total reported offences, with rape accounting for 37% of those offences).

Although the CSEW provides some of the most rigorous evidence on the prevalence of sexual violence in England and Wales, it has some limitations. The sample comprises adults aged up to 59 (since 2017 this has risen to 74), living in private households. As such, groups identified as being particularly at risk of sexual violence such as people in prison or detention centres; people with a limiting illness or disability; and people who are homeless or rough sleepers – are not included (Gray & Garner, 2015).

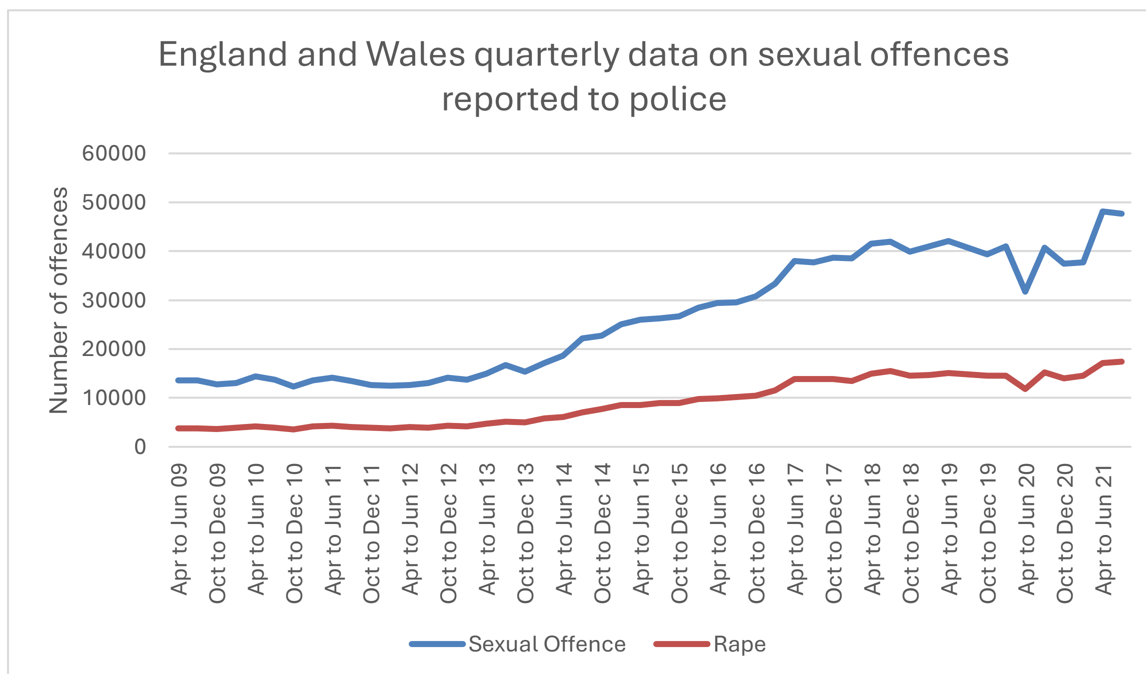


Figure 2: CSEW figures for quarterly data on number of sexual offences reported to police

Meta-analyses suggest that the minimum estimates of childhood sexual abuse are currently 15-20% for girls and 7-8% for boys, although figures vary considerably, depending on the definitions used and the methods used to record responses (Kelly & Karsna, 2018).

Public awareness around female genital mutilation (FGM) in the UK has grown over the last decade, due to various campaigns and policies to support victim-survivors and to eradicate the practice. In 2015 over 100,000 women aged 15-49 years were estimated to be living with FGM in England and Wales, with no local authority in the UK thought to be free of victim-survivors affected by FGM, and London having by far the highest prevalence (Macfarlane & Dorkenoo, 2015).

While these figures allude to the pervasive nature of sexual violence in its various forms, the true extent of victimisation across the life-course remains largely unknown due to underreporting. Many victim-survivors do not report their experiences, or delay their disclosures for many years owing to personal, social, and cultural factors, such as fear of not being believed (Morrison et al., 2018); the persistence of rape myths and victim-blaming (Waterhouse et al., 2016); re-victimisation through the criminal justice process and extremely low conviction rates (Kelly, 2005).

While the time lag between experiencing child sexual abuse and reporting (which may not occur until adulthood) is widely acknowledged, we do not have reliable statistics of how the rate of disclosure has changed over time (Parke & Karsna, 2019).

Sexual violence and abuse can affect anyone, at any age, and in any situation (see section 2.2.2 for the definition used in this report). Although men and boys are subjected to sexual violence, women and girls are victimised more than men and boys (CSEW, 2018). Sexual violence is inextricably linked with abuses of power, control and trust by the perpetrators of these acts (Jewkes et al. 2002). These gendered, cultural and social dimensions should not be overlooked.

1.2 Policy context

The Violence Against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015 (VAW Act) is the first piece of legislation in the UK to address violence against women as opposed to 'domestic violence' generally.

The Ending Violence Against Women and Girls (VAWG): strategy 2016-2020 (HM Government, 2016) details the government's pledge to reform services to help women and girls rebuild their lives after experiencing violence or abuse. Working with local commissioners the government aims to make early intervention and prevention the foundation of their approach, whilst maintaining levels of crisis response services.

Ensuring a secure future for rape and sexual abuse support centres (for example, Rape Crisis Centres, and member agencies of The Survivors Trust and Male Survivors Partnership), refuges and FGM and Forced Marriage Units is one way the government intends to fulfil their promise that 'victims [and survivors] get the help they need when they need it' (p.10).

While acknowledging that sexual violence and abuse disproportionately affects women and girls, a complementary piece of work to the VAWG strategy, the Male Victims Position Statement, issued in March 2019, sets out the government's commitments for supporting male victim-survivors (HM Government, 2019).

In the spring of 2019, the Government commissioned the 'End-to-end rape review'– a two-year project aiming to improve the Criminal Justice System's response to rape in England and Wales (HM Government, 2021). The action plan intends to build confidence of rape victims to report sexual violence crimes and to increase related conviction rates.

The NHS Long Term Plan states that it will expand provision of Sexual Assault Referral Centre (SARCs) to ensure that victim-survivors are offered integrated therapeutic mental health support, both immediately after an assault and, where appropriate, with later continuity of care (NHS, 2019). In February 2022, NHS England and NHS Improvement launched a three-month campaign to raise awareness of SARCs which encouraged victims and survivors to come forward for support regardless of when the assault or abuse happened (NHS, 2022).

The Victims Strategy vows to improve SARC services and pathways by increasing spending from £31m in 2018, to £39m in 2020/21. The government has also commited to funding national rape and sexual abuse support services, such as Rape Crisis Centres, for a minimum of two years, and will 'explore further local commissioning of services by PCCs' (ibid. 23) nto improve support for victim-survivors of sexual violence. The strategy also presents the government's plan to work with the police to increase awareness of SARCs for lesbian, gay, bisexual and transgender (LGBT) victims, and consider how to improve support for people identifying as non-binary or intersex.

Similarly, NHS England's Strategic Direction for Sexual Assault and Abuse Services (2018 to 2023) commits to working with the police to raise awareness of the services provided by SARCs, particularly in 'LGBT communities, BME communities and vulnerable women's centres' (p.13, NHS England, 2018). As well as developing easy-reading materials on the role of a SARC for people with learning disabilities. The

strategy highlights the role of the third sector, and emphasises collaboration and reduction in fragmentation, in service provision.

In the UK, it has been illegal to carry out FGM for almost 35 years (Prohibition of Female Circumcision Act, 1985). In England, Wales and Northern Ireland, the Female Genital Mutilation Act 2003 made it illegal for a UK national or habitual UK resident to perform FGM abroad on a UK national or resident, or assist a girl to perform FGM on herself in England or Wales. In Scotland, the law around FGM is laid out in the Prohibition of Female Genital Mutilation (Scotland) Act 2005, and a bill was put forward in 2019 to propose new protections for those at risk of FGM and to reduce further risk for victim-survivors of FGM (Scottish Parliament, 2019).

Various campaigns and changes to policy and practice have been introduced with a view to eradicating the practice, both in the UK and overseas. The Serious Crime Act 2015, strengthened the 2003 FGM Act to make it an offence to fail to protect a girl from risk of FGM. It also introduced a mandatory duty for teachers and health and social care staff in England and Wales to report 'known' cases of FGM, in girls under 18 years old, to the police. Ultimately, frontline professionals are being asked not just to respond to known cases, but also to work together to implement measures that will prevent and help to end the practice of FGM (HM Government, 2014).

In practice, these laws are difficult to enforce. FGM occurs under a 'cloak of secrecy' (Dyer, 2019) and is hugely underreported. There were no successful prosecutions until a landmark case took place in London, in March 2019. A mother whose daughter underwent FGM at the age of three years was found guilty of committing FGM as well as a range of other offences (CPS website, 2019).

1.3 Specialist sexual violence services

The first NHS-funded SARC was established in Manchester in 1986 (Lovett et al., 2004), and there are currently 47 SARCs in England. Located in the statutory sector, SARCs should be co-commissioned by NHS England (for the sexual assault public health element); local police and Police and Crime Commissioners (PCCs) (for the forensic medical, criminal justice and local rape support elements); Clinical Commissioning Groups (CCGs) (for other health services and mental health elements) and local authorities (for children and family services and preventive public health) (NHS England, 2015). They provide special facilities where recent victims of rape or sexual assault can receive forensic examinations, support and advice, and signposting to other services (NHS England, 2018a). A crisis worker or Independent Sexual Violence Advisor (ISVA) should be available to provide emotional and practical guidance, regardless of whether the victim-survivor chooses to report to the police or not (NHS England 2018a, 2018b).

The majority of SARCs are not designed to provide long-term support. Instead, they are required to refer victim-survivors to other types of specialist services, many of which are located in the voluntary or third sector (NHS England, 2018a).

The responsibility for commissioning non-SARC rape and sexual violence services, such as voluntary services, lies with the Ministry of Justice, at a national level (services for those aged 13 years or older); and, at a local level, CCGs, PCCs) (including for victim referral hubs), and local authorities (Green & Skeates, 2018; NHS England, 2018b). Sector mapping research on the member organisations of The Survivors Trust revealed

that many specialist sexual violence and abuse support services are dependent on funding from charitable trusts to meet at least 50% of their overall funding (Consult Research and The Survivors Trust, 2010).

The first voluntary sector services working with victim-survivors of sexual violence were established in the 1970s, offering advocacy and support for women, with services extended to male victims from the 1980s. The sector is represented by three umbrella agencies – Rape Crisis England and Wales, The Survivors Trust and the Male Survivors Partnership.

The types of help offered in the voluntary/third sector vary depending on the specific service and the demographics of the population they are serving, but the following types of support are commonly offered:

- helplines
- walk-in or appointment-based support
- one-to-one or group counselling
- group activities
- signposting to additional services
- trauma-informed advocacy
- long-term support which is offered regardless of when the sexual violence or abuse was experienced (NHS England, 2108b; Berry et al. 2014; Coy et al. 2009).

When running at their optimum, these services create confidential spaces where victim-survivors are safe to tell, be believed and respected, and able to explore options (Coy et al. 2011).

Some organisations provide support specifically for female (Rape Crisis), male (Survivors UK), LGBTQI* (GALOP), or female BME (Imkaan) victim-survivors.

1.4 Research on specialist services for victim-survivors of sexual violence and abuse

The evidence on the availability of specialist services in the UK, is over a decade old. In 2007 and 2009, End Violence Against Women (EVAW) published Map of Gaps 1 and 2 (Coy et al., 2007, 2009), which graphically represented the 'postcode lottery' of access to specialist support services for women who have experienced domestic or sexual violence, FGM or sexual exploitation. At this time, most women across Great Britain did not have access to a Rape Crisis Centre or a specialist support service (27.5% of local authorities had a service or centre; there was one small service, for children, in Northern Ireland). Provision of specialist services was lower (11% of local authorities) for violence against Black and minority ethnic women, and lower still (9%) for prostitution, trafficking and sexual exploitation (Coy et al. 2007, 2009).

In 2014, Berry et al. mapped specialist domestic abuse and sexual violence service provision in Wales as part of a broader review to inform the Ending Violence Against Women and Domestic Abuse (Wales) Bill, which was introduced in 2015. One of their recommendations (14) was that specialist services need long-term contracts to gain stability and capacity in provision. Another two (16 and 17) recommended that skills in specialist provision should be protected and shared with other organisations.

The fragile and precarious nature of sexual violence and abuse services has been highlighted by the All Party Parliamentary Group (APPG) on Sexual Violence's 2018

report (Green & Skeates, 2018). They received evidence that many Rape Crisis Centres and specialist voluntary service providers were operating waiting lists and even having to close these lists due to rising demand for services. They reported that many services were operating on short-term grants and contracts, making it difficult to maintain the service and diverting their resources into applying for grants every year.

In April 2019, the APPG for Adult Survivors of Childhood Sexual Abuse published part one of its report *Can adult survivors of childhood sexual abuse access justice and support in England and Wales?* This report highlighted the enormous increases in demand for support services (up to 30% year on year in some cases) and the insufficiency of government funding to keep up with that demand (APPG for Adult Survivors of Sexual Abuse, 2019).

The financial cost of sexual violence and abuse to society is high. Including physical, emotional, health, legal, police, lost output and other costs, in 2015/16, each adult rape was estimated to cost around £40,000, with a cost to society of £4.8bn, while other sexual offences cost £7.4bn (https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/732110/the-economic-and-social-costs-of-crime-horr99.pdf). Some of these costs, such as long-term mental health care costs, might be avoided with a greater provision of specialist services. Similarly, without the current services, these costs to society could rise.

This map was commissioned to establish what evidence is available on the effectiveness of specialist services for victim-survivors, in the UK. The systematic reviews are described in section 3.

1.5 Why is the research needed?

Despite the hidden nature of a lot of sexual violence crimes, there has been an unprecedented increase in demand for services. In the last year alone (2017-18), there was a 17% increase in the number of people who accessed Rape Crisis specialist services in England and Wales, compared with the previous year (Rape Crisis England & Wales website).

This is likely to be driven by a rise in the reporting of non-recent sexual abuse cases as well as improved police recording. Since 2013, police statistics reveal large year-on-year rises in the reporting of cases of allegations of sexual abuse dating back over a year (NSPCC, 2017). A cultural shift, engendered in part by a litany of high-profile sex abuse cases in the media, and the collective voice of #MeToo and #TimesUp social media campaigns, has emboldened people to speak out and share their experiences of assault or abuse, sometimes dating back decades.

This surge in demand has come at a time when commissioning for services has been largely devolved to a local level. Changes in commissioning responsibilities have produced many challenges for services in terms of maintaining the stability and consistency necessary to support victims and survivors of sexual violence and abuse (Green & Skeates, 2018). Public health practitioners have noted that the political leaning of local authorities influences the types of services that are commissioned (Kneale, 2019). Stakeholders and agencies have described how feminist-inspired, single (female) gender services were seen to be at risk on account of the drive towards gender neutralisation of services by PCCs who may not fully understand the

ramifications of such a move (Simmonds, 2019). Similarly, Imkaan's *From survival to sustainability* report (Imkaan, 2018) concludes that current commissioning processes are generally failing organisations specialising in ending violence against women and girls in BME communities.

One of the greatest challenges for commissioners and practitioners is working within restricted and reduced budgets. Public sector funding cuts resulting from the Comprehensive Spending Review in 2010, and other government policies introduced under austerity in the intervening years, has meant that specialist services are under threat. In a recent report on funding and commissioning of specialist sexual violence support services, many services described themselves as being at crisis point. They are under-commissioned to meet demand and have to divert efforts to repeatedly apply for short-term grants in order to survive (Green & Skeates, 2018). A complex and competitive commissioning landscape has led to the loss of experienced staff; soaring, or closed, waiting lists; and pressure to merge or broaden population focus.

For example, in 2008 Southall Black Sisters – a specialist provider of Violence Against Women services to BME women – was threatened with having its funding withdrawn as they faced accusations from Ealing Council of being discriminatory under the Race Relations Act (for exclusion of the majority population) (https://southallblacksisters.org.uk/campaigns/save-sbs-campaign-2008/). Although they won the legal challenge in the High Court after a hard-fought campaign (http://www.irr.org.uk/news/victory-for-southall-black-sisters/), this case is indicative of the types of pressures and challenges that specialist services targeted at particular groups face.

Thousands of victim-survivors have been left without adequate services, or completely unsupported, at a time when they are particularly vulnerable and in need of ongoing dedicated support (Green & Skeates, 2018).

A systematic map of evidence showing the extent of the evidence on the effectiveness and appropriateness of specialist adult sexual violence services will help commissioners, providers, practitioners and researchers to understand the research landscape, where there is evidence which can be used to inform decisions, and where there are gaps. Together with suggestions from the stakeholder advisory group this systematic map can be used to guide decisions about where an in-depth synthesis could be carried out to inform commissioning and provision of services.

2 BRIEF METHODS

The objective of this report is to present the evidence on what is known about the effectiveness and appropriateness of specialist adult services for victim-survivors of sexual violence. Two strands of work were undertaken:

- **Systematic map of evidence**: a systematic map of UK-only views studies, outcomes and process evaluations, including cost-effectiveness studies, from OECD countries, and systematic reviews including studies with these characteristics.
- **Advisory group consultation**: we held a stakeholder event in July 2019 in order to gather the views of victim-survivor advocates, practitioners, services providers and policy representatives.

2.1 Policy stakeholder engagement

Reviews Facility team members (SL, RR) met with the DHSC commissioning team at regular intervals to ensure the review remained closely aligned with their needs and emerging policy requirements.

2.2 Concepts and definitions used in this map

2.2.1 Victim-survivor

While legally the term 'victim' is used to describe those who have experienced sexual violence and abuse, it has been criticised for denying agency to the violated person (Kelly, 1998). In light of this, individuals who have been affected by sexual violence or abuse may prefer to identify themselves as 'survivors' (McNaughton et al. 2012), although the appropriateness of this term has also been questioned (Walby et al. 2013). In keeping with the practice of using both terms together which has developed within the field (IICSA, 2017, McGlynn & Westmarland, 2019) we will use the term 'victim-survivor' wherever possible in this report. Despite the limitations of the individual terms described above, 'victim-survivor' has the advantage of encompassing a range of experience and covers the different ways in which people may self-identify over time and depending on context.

2.2.2 Sexual violence

Throughout our work we use the term sexual violence to refer to sexual violence and abuse. In line with NHS England's strategic direction for Sexual Assault and Abuse Services, our definition of sexual violence covers any non-consensual act or attempt to obtain an act of a sexual nature, regardless of the context and the relationship between the perpetrator and the victim. It covers marital rape and rape.

Examples of offences include (but are not exclusive to):

- sexual acts involving a child, sexual harassment, forced marriage, honour-based violence, female genital mutilation, human trafficking, sexual exploitation and ritual abuse; or
- any unwanted sexual activity with someone without their consent or agreement.

Sexual assault and abuse can happen to men, women and children, at any age; it can be a one-off event or repeated. It may involve technology such as the internet or social

media, which can be associated with grooming, online sexual harassment and trolling (p.7, NHS England, 2018).

2.2.3 Specialist services

We are using 'specialist' to denote services which are provided by staff and volunteers with the appropriate skills and expertise specifically tailored to support adult victim-survivors of sexual violence and abuse. This may relate to services provided in a variety of sectors, but most likely to be located in the criminal justice, health or voluntary sectors. We acknowledge that this support may be delivered within services for domestic abuse, and other Violence Against Women and Girls services. Where this is the case, we include only services that are mainly aimed at providing support to victim-survivors of sexual violence and abuse, or where these services are reported separately from the other services.

2.2.4 Age limit

Adult specialist services include people as young as 13 years. For inclusion in the map we applied a lowest mean cut-off point of 16 years. Legally, anyone under the age of 18 years is defined as a child according to both the UN Convention on the Rights of the Child and the Children Act 1989. However, owing to the age of consent in the UK being 16 years, older teenagers are offered much less in the way of protection than younger children and this group is especially vulnerable to sexual exploitation (Pona & Baillie, 2015).

2.3 Aims and Research Question

Systematic evidence maps are often used to identify and report on the range of research which has been produced within a broad topic area, and can provide a foundation for more in-depth syntheses (Saran & White, 2018). As we were responding to a broad policy question in an area in which we anticipated a lack of robust evidence, we adopted a systematic map approach which would allow us to identify research gaps to inform future research priority setting and identify possible avenues for in-depth review.

We sought to answer the following research question:

What is known about the effectiveness and appropriateness (availability, acceptability and accessibility) of specialist adult services for people who have experienced sexual violence and abuse?

2.4 Study identification

2.4.1 Searching for studies

To identify relevant studies we searched six electronic databases: ASSIA, CINAHL, Criminal Justice Abstracts, Epistemonikos, MEDLINE and PsycINFO.

The literature search was undertaken in April 2019. The search strategy was developed and implemented by an information specialist (KW) in collaboration with two other members of the team (CK, SL). An example of the search strategy is presented in Appendix A. After deduplication, this process identified a total of 15,477 studies.

We also searched online sources including the websites of sexual violence charities and organisations, undertook reference harvesting and contacted experts in the field. An additional 26 studies were located which resulted in a total of 15,503 potentially relevant items being uploaded to EPPI Reviewer to be screened on title and abstract.

2.4.2 Screening for studies

To be included in the systematic map, studies had to:

- be about adult (16 and over) specialist services for victim-survivors of sexual violence and abuse (including statutory, third-sector and voluntary organisations);
- report findings about the effectiveness and/or appropriateness of these services*;
- focus on services aimed at adults, of any gender, over the age of 16 years who have experienced sexual violence and abuse at any point in their life;
- be published in or after 2009; and
- be published in the English language.

* In terms of study designs, we included:

- Qualitative studies conducted in the UK of the views and experiences of people seeking or providing specialist adult services;
- Evaluations conducted in the UK of intervention processes (process evaluations);
- Evaluations of the outcomes of interventions that:

a) use a comparative design (cost-effectiveness, RCTs, controlled trials and before-and-after studies), and

b) are conducted in OECD countries; and

- Systematic reviews (published between 2014 – 2019) which include any of the above types of study

Qualitative studies coded as 'views' studies were distinct from those that set out to measure the impacts of such services for services users (outcome evaluations). They were also distinct from studies that explore people's views of specific service initiatives with the aim of improving them (process evaluations).

We used 2009 as a cut off date in order to capture research conducted in the years following the public-sector finding cuts following the 2010 comprehensive spending review. For systematic reviews we applied the more recent cut-off date of 2014, as they contain access to older primary studies.

Six reviewers (SL, IK, MK, RR, CK, GR) co-screened an initial sample of abstracts which amounted to 10% of the total. Abstracts were independently screened and results were compared in groups of at least two reviewers, differences were resolved by group discussion. Once inclusion agreement was over 95%, the remaining abstracts were screened by single reviewers.

The full texts of all references that met the inclusion criteria, or where it was unclear if they met the criteria, were retrieved. These items were screened on full text using the same criteria used for 'Title and Abstract' screening, but with two additional criteria. Firstly, we excluded case studies which had fewer than five participants, and outcome evaluations which did not have a comparison group or a before-and-after design because of their inability to prove causality and limited generalisability.

Secondly, we excluded conference abstracts because they are not often sufficiently informative due to their suboptimal reporting of methodological details.

2.4.3 Information extraction

We developed an extraction tool to capture information on: study aim, study design, population type (victim-survivors/professional/both); characteristics of populations (age, gender, sexual violence experience); intervention type, and service and country setting. After piloting the extraction tool all reviewers worked independently.

The development of the extraction tool was iterative. We continued developing the tool in order to allow a fuller understanding of the information following discussion with stakeholders and once we were more familiar with the types of studies identified. All reviewers extracted information from the studies. During the writing-up process reviewers checked and consolidated the data entered by other reviewers to ensure that we worked with consistency across the different sets of studies.

2.4.4 Creation of interactive maps

Interactive online maps were generated using EPPI-Mapper software (Thomas 2018) which provides an interactive user interface powered by EPPI-Reviewer (Thomas et al. 2020).

2.5 Stakeholder involvement

We recruited stakeholders to act as an advisory group. We met with the advisory group and outlined the evidence identified focusing on the types of studies and their characteristics. We discussed how we might best present the evidence map and possible directions for a more in-depth review and synthesis.

We recruited 12 stakeholders and ultimately eight attended the meeting. See section 7 for details of the meeting's findings and section 9.4 for detailed methods. The group were sent a draft version of this report and were invited to comment. Stakeholders' comments were incorporated into the final report.

3 OVERVIEW OF THE EVIDENCE

The searches located 22,899 references, and after removal of duplicates, this left a total of n=15,477 unique records (an additional n=26 records were added from our grey literature and scoping searches). After applying the exclusion criteria 167 reports were included documenting 163 individual studies: 36 UK views studies (from 41 reports), 106 evaluations (outcome and process evaluations) and 21 systematic reviews. An image of the interactive map of all studies (n=163) by country of study and date of publication is shown below (figure 3). The size of each bubble indicates the relative number of studies within each cell. See the link to the interactive map for details and figures for each group of studies, and each of the included studies. See figure 4 for the flow of evidence through the mapping process. Studies excluded on full text are listed in Appendix B.

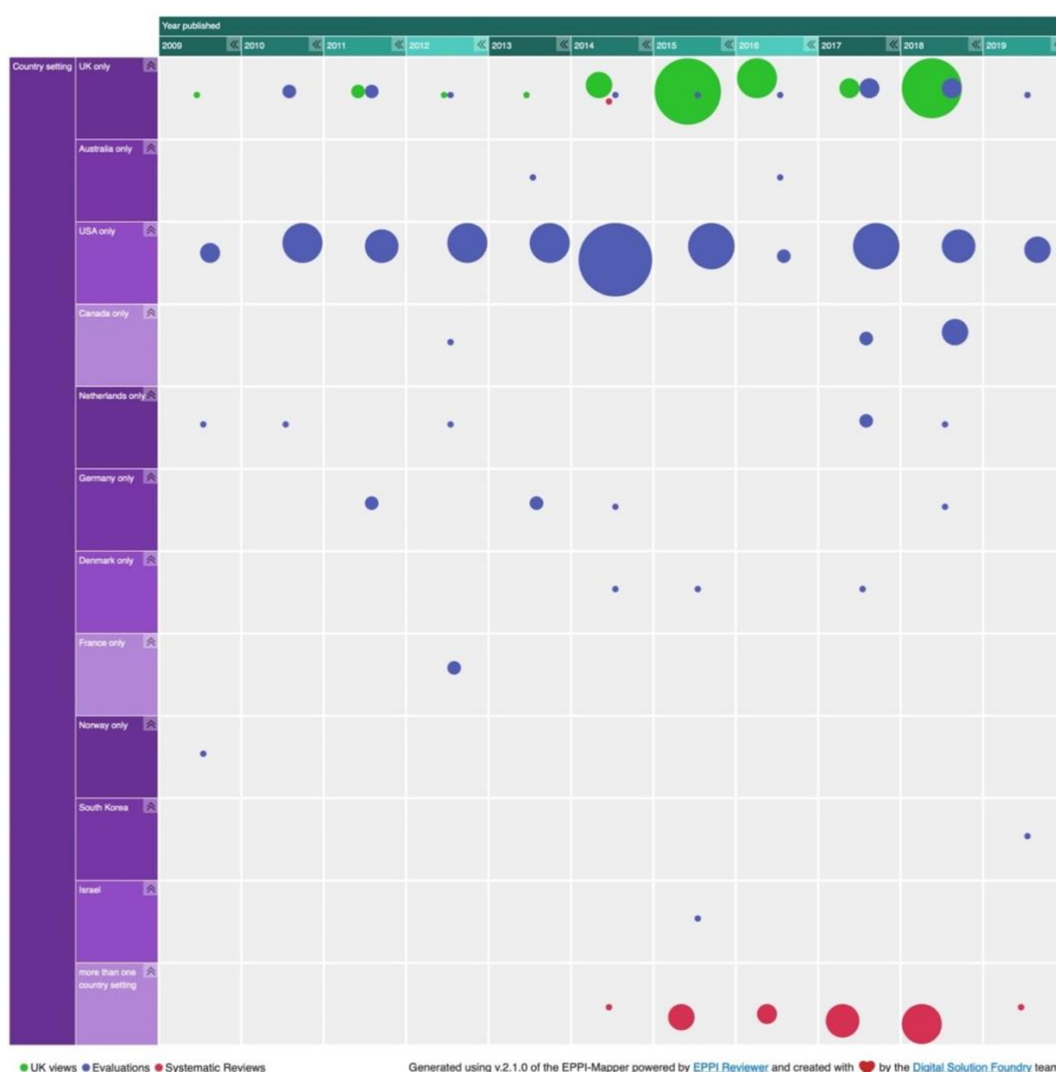


Figure 3: All studies (n=163) included in the systematic map of evidence by year of publication and country

Link to interactive map:
https://eppi.ioe.ac.uk/cms/Portals/0/ALLSTUDIES.html?ver=2022-07-11-111244-537

3.1 Flow of evidence

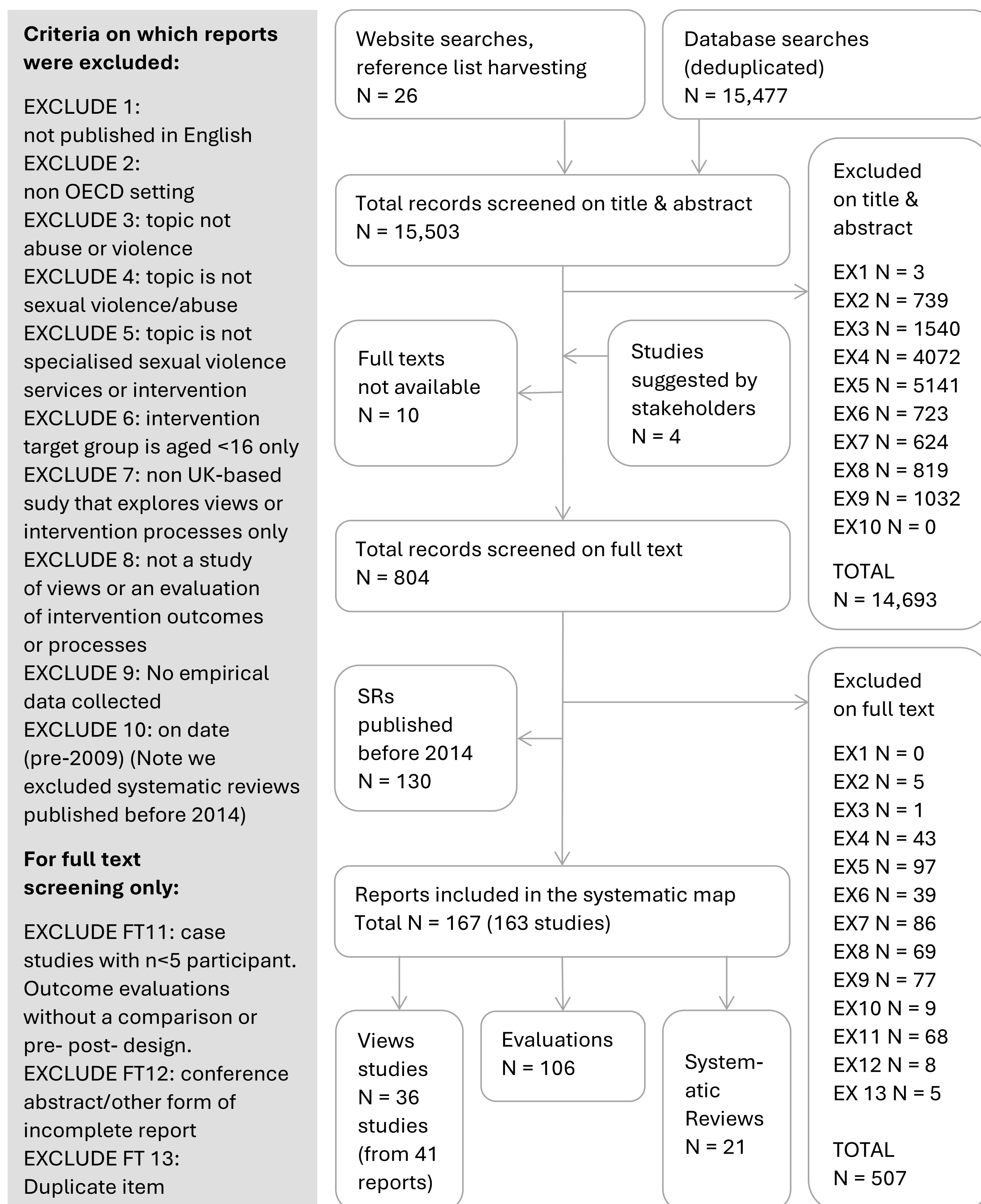
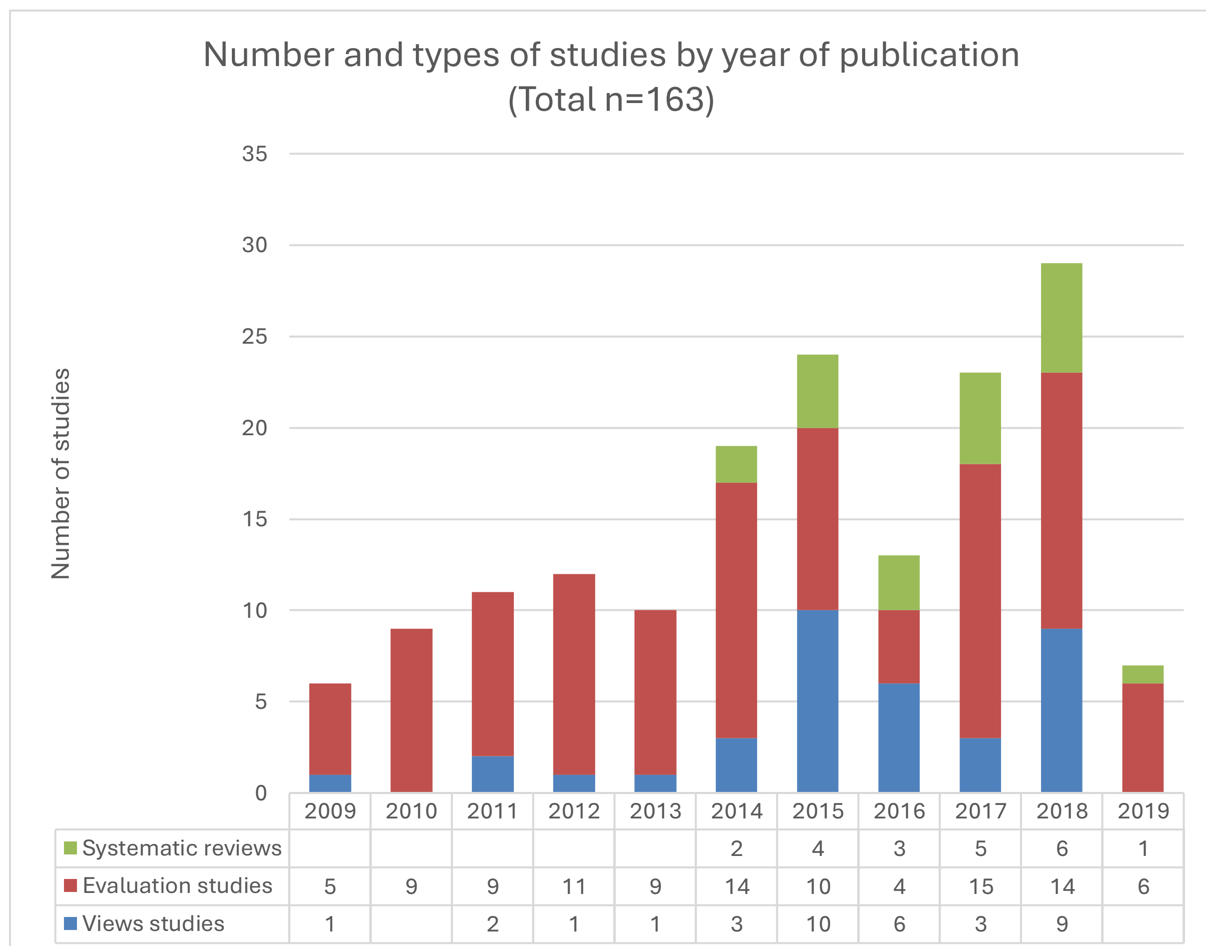


Figure 4: Flow of evidence through the systematic map

The following sections provide an overview of the 163 studies included in our map.

3.2 Publication date

We included UK views studies and evaluations with a publication date of 2009 or later. The rate of publications relevant to this map peaked in 2018 (total n=29). It should be noted that for the year 2019, searches only captured studies published between January and April (see figure 5).



	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Systematic reviews						2	4	3	5	6	1
Evaluation studies	5	9	9	11	9	14	10	4	15	14	6
Views studies	1		2	1	1	3	10	6	3	9	

Figure 5: All studies by year of publication

3.3 Country of publication

The evidence is dominated by US-based evaluations. Fifteen evaluations took place in the UK, compared with 62 in the USA. Overall, 51 primary studies were conducted in the UK, of which 36 are views studies (see figure 6).

Systematic reviews included 309 primary studies from 11 different countries, including 15 from the UK.

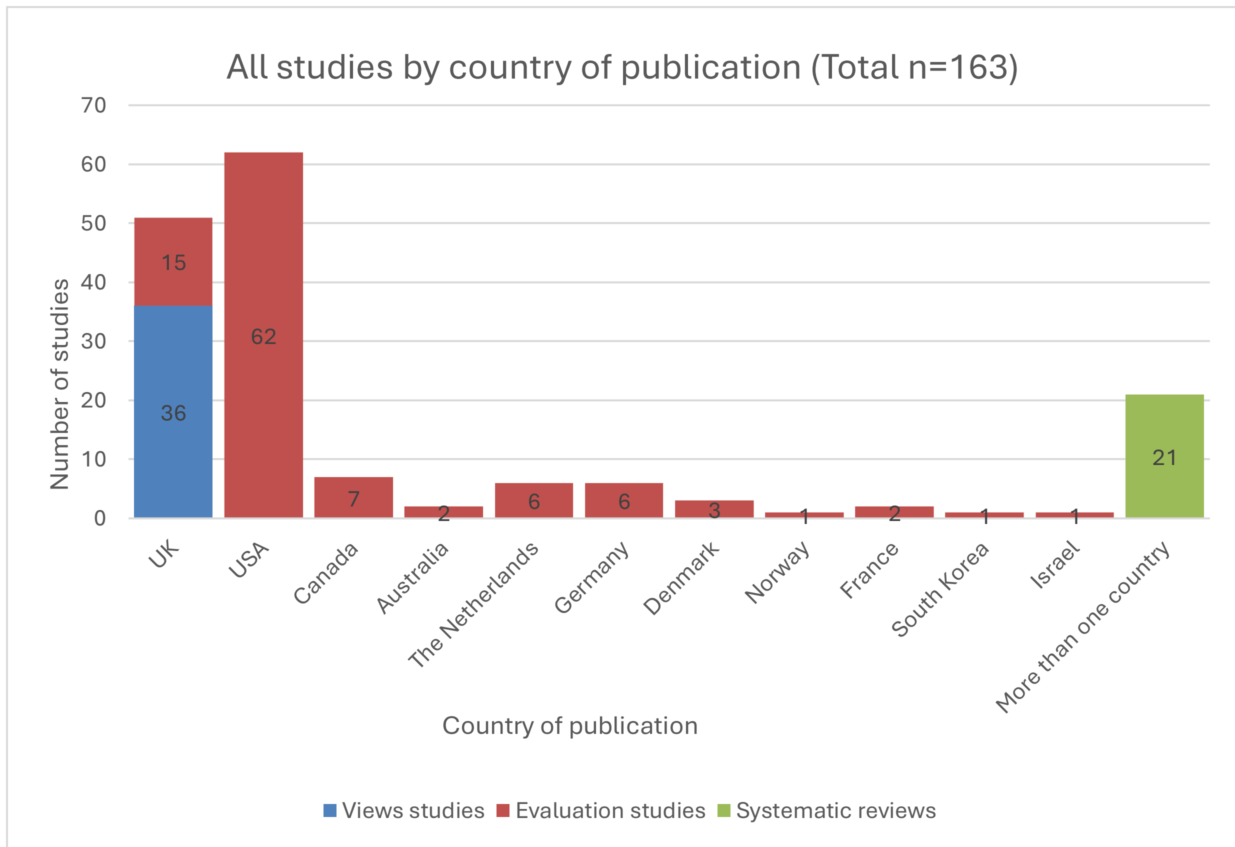


Figure 6: All studies by country of publication

3.4 Population focus

Most studies focused on non-recent abuse experienced as a child or rape and abuse occurring at any point in a person's life. US-based evaluations also focussed on veterans with experience of military sexual trauma (n=16). Eight systematic reviews focused on FGM, however five of these were 'empty reviews' (i.e included no primary studies) (see figure 7).

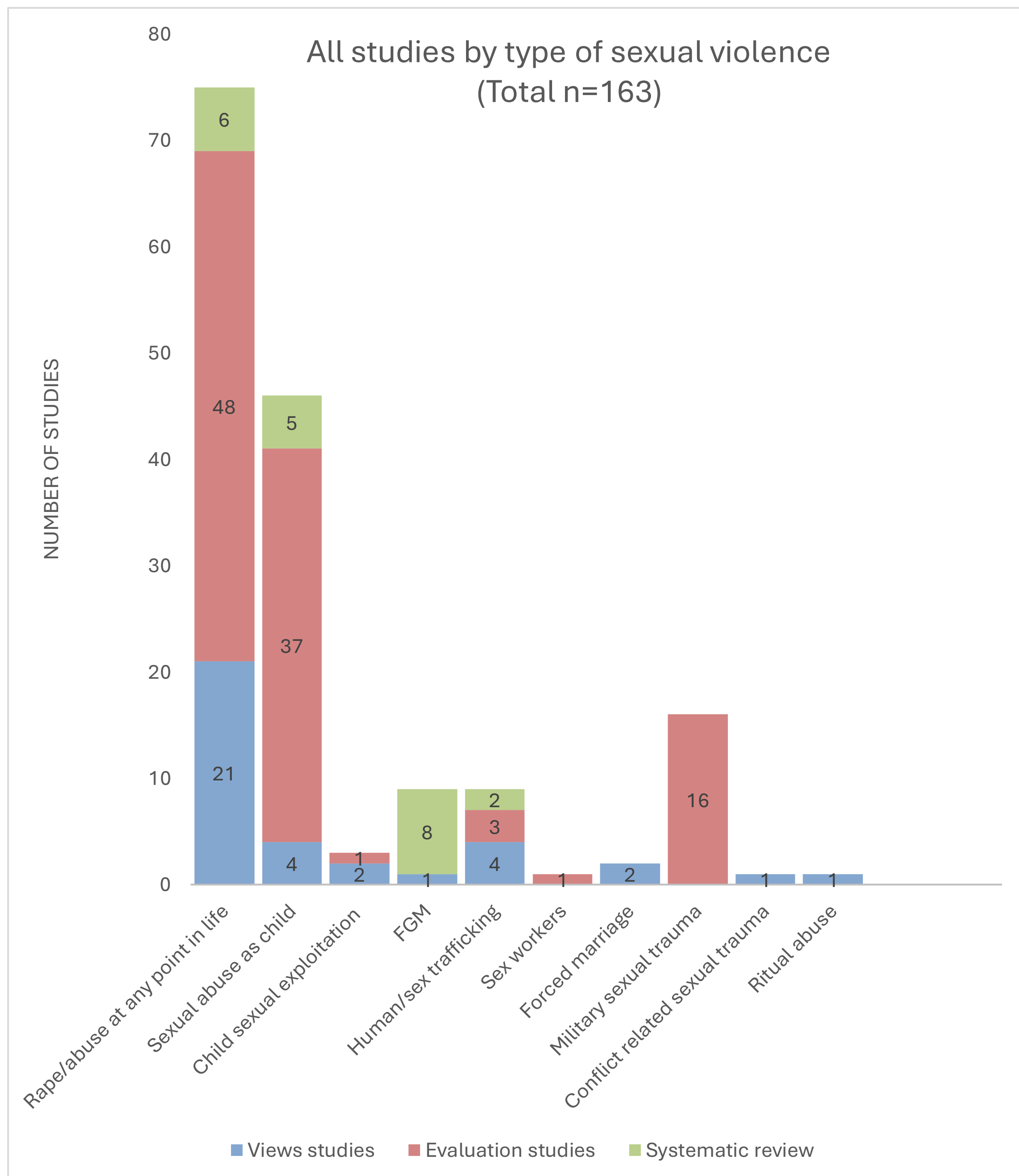
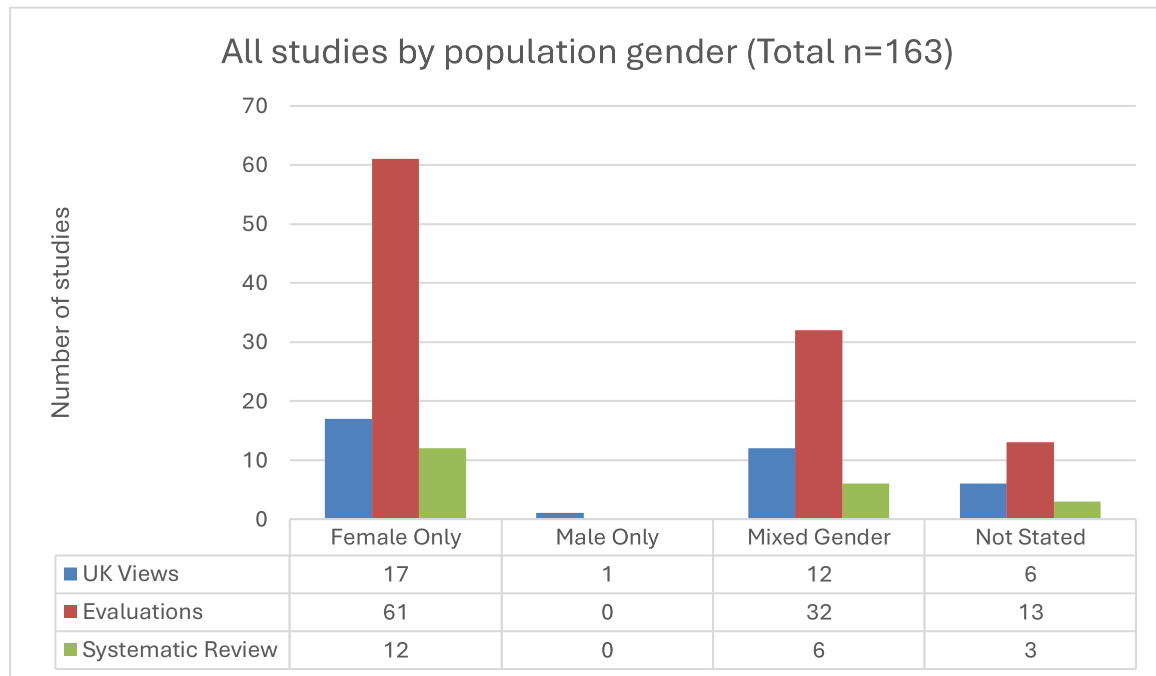


Figure 7: All studies by type of sexual violence

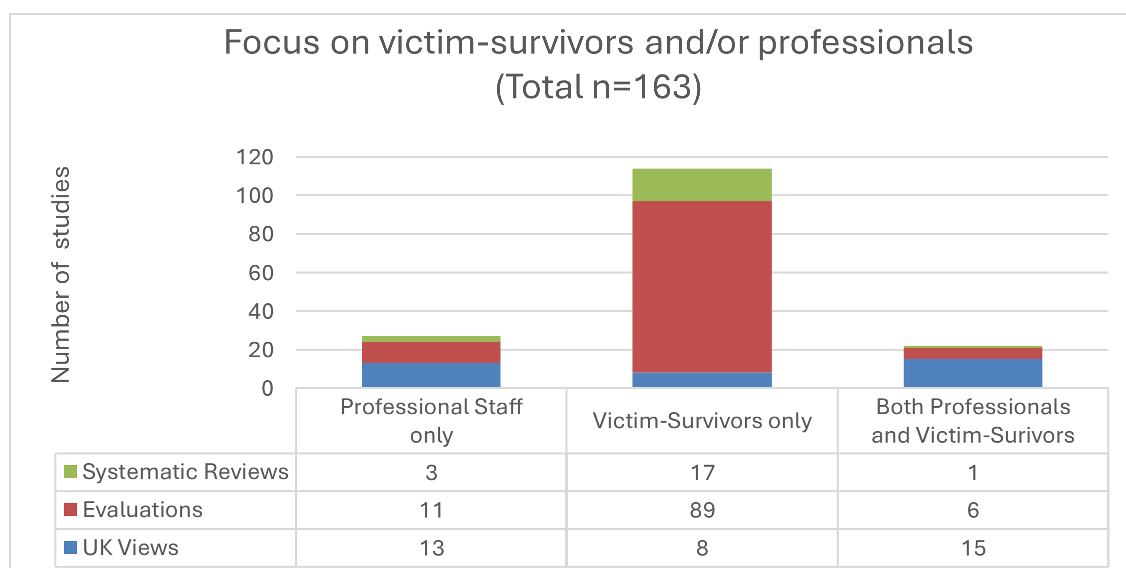
Most studies included female participants only (total n=90). A further 50 studies included males and females (total n=50). Only one study focussed exclusively on male victim-survivors (see figure 8). Where the gender of victim-survivors was not stated this was often because the study focussed on professionals who provided support to victim-survivors.



	Female Only	Male Only	Mixed Gender	Not Stated
UK Views	17	1	12	6
Evaluations	61	0	32	13
Systematic Review	12	0	6	3

Figure 8: All studies by population gender

Approximately 70% of the included studies (114 out of 163) assessed interventions for victim-survivors or sought their views. Twenty-seven studies (n=27) focussed on professionals only, and 22 (n=22) included professionals and victim-survivors (see figure 9).



	Professional Staff only	Victim-Survivors only	Both Professionals and Victim-Surivors
Systematic Reviews	3	17	1
Evaluations	11	89	6
UK Views	13	8	15

Figure 9: All studies by focus on victim-survivor / professional / both

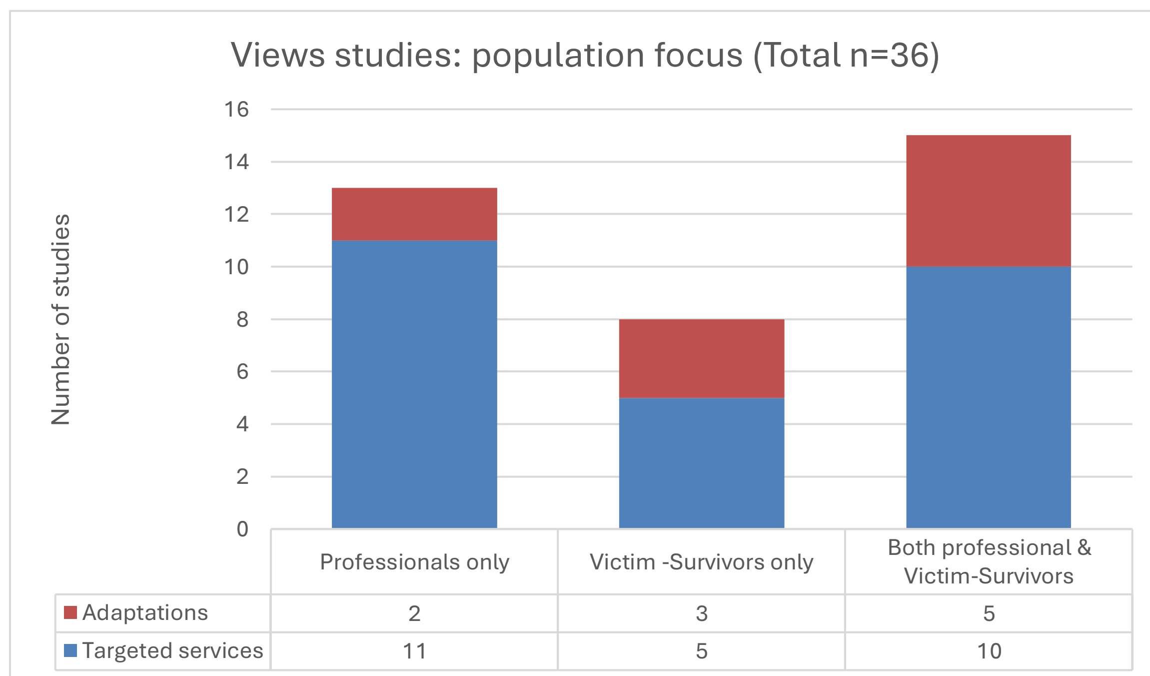
The following sections describe the included studies, grouped by study type.

4 UK VIEWS STUDIES

4.1 UK studies of the views of victim-survivors and service providers (n=36)

We identified 36 studies (reported in 41 publications) that used an open-ended approach to explore the views of participants about services for people who have experienced sexual violence or abuse. We have called these 'views studies' (see table 1 and Appendices C and D for the list of included studies and study details.

The 36 views studies collected data that related to people's experience of receiving or providing sexual violence services or their views about what should be provided. The largest group of studies included both professionals and victim-survivor perspectives (n=15). Thirteen studies sought views of professionals only (n=13), and eight sought the views of victim-survivors alone (n=8) (see figure 10).



	Professionals only	Victim -Survivors only	Both professional & Victim-Survivors
Adaptations	2	3	5
Targeted services	11	5	10

Figure 10: UK views studies by focus on victim-survivor / professional / both

We grouped the studies into two broad sets: those that explored services to address sexual violence specifically (targeted, n=26); and those that explored how general services, such as maternity or healthcare, could be adapted to support people who have experienced sexual violence (adaptations, n=10).

The most common type of sexual violence addressed was rape or sexual abuse at an unspecified point in someone's life (total n=18). Three studies classified as 'adaptations' focussed on general service response to people who have been sex trafficked (n=3) and three 'adaptation' studies addressed victim-survivors who were sexually abused as a child (n=3) (see map below, figure 11). By following the link to the interactive map detailed figures for targeted services and adaptations by population and study participant can be obtained, along with the details of studies in each group.

Figure 11: UK views studies (n=36) by subgroup population and type of sexual violence and abuse experience

Link to interactive map:
https://eppi.ioe.ac.uk/cms/Portals/0/VIEWS.html?ver=2022-07-11-111908-680

A third of the studies contained victim-survivor participants in the age range category ‘aged 18 and over only’ (n=12). Three studies included victim-survivors under the age of 16 years (n=3). Two of these studies aimed to capture young people’s views on responses to child sexual exploitation, with participants’ ages ranging from 12 or 13 up to 23 years (Gilligan, 2016, Franklin & Smeaton, 2017). The other study, on the service experiences of victim-survivors of childhood sexual abuse had a wide age range, from 15 to 72 years (Smith et al, 2015). Four studies (n=4) included victim-survivor populations which were aged 16 to 18 and over (Domoney et al., 2015, Thiara et al. 2015, Stanley et al, 2016, and Voscur, 2018). The remaining studies (n=17), many of which sought professional views only, did not state age ranges of victim-survivors. We did not find any UK views studies which looked at the experiences of older teenagers aged 16-17 years only (see figure 12).

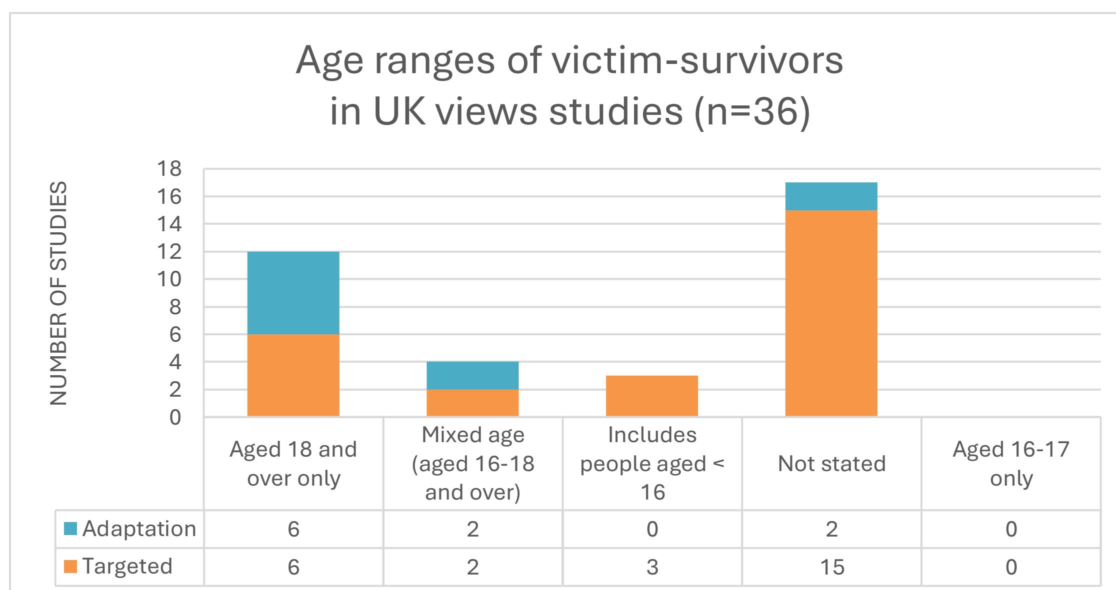


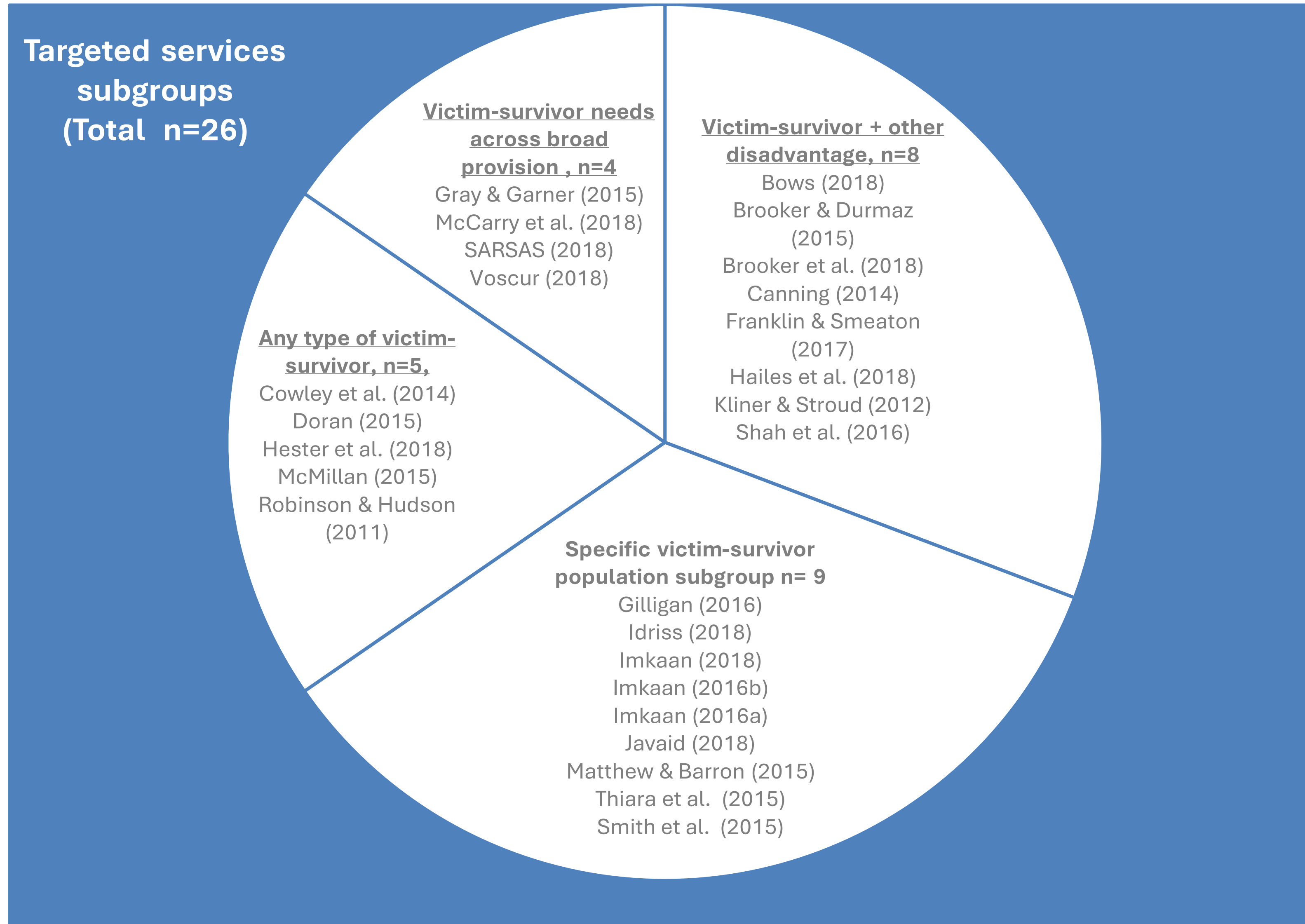
Figure 12: Population age range for UK views studies

4.2 Studies of views about targeted sexual violence services (n=26)

A total of 26 studies focused on targeted sexual violence services. We categorised these further using the sexual violence experiences and any service-user characteristics that the services had been set-up to serve.

Nine studies were about targeted services for a specific population subgroup (n=9); eight addressed victim-survivors who had additional forms of disadvantage (n=8); five studies focussed on services or professional roles established to serve any type of victim-survivor of sexual violence (n=5); and four studies looked at how victim-survivors needs were met by services in terms of broad provision (n=4) (see figure 13).

Figure 13: Sub-categories of 'targeted services' UK views studies



Studies within the targeted services group sought a mixture of victim-survivor only, professional only, and both professional and victim-surivivor perspectives. All subgroups had at least two studies which elicited professionals' and victim-survivors' views together, and in the case of the broad provision category all four studies sought both professional and victim-survivor views (see figure 14).

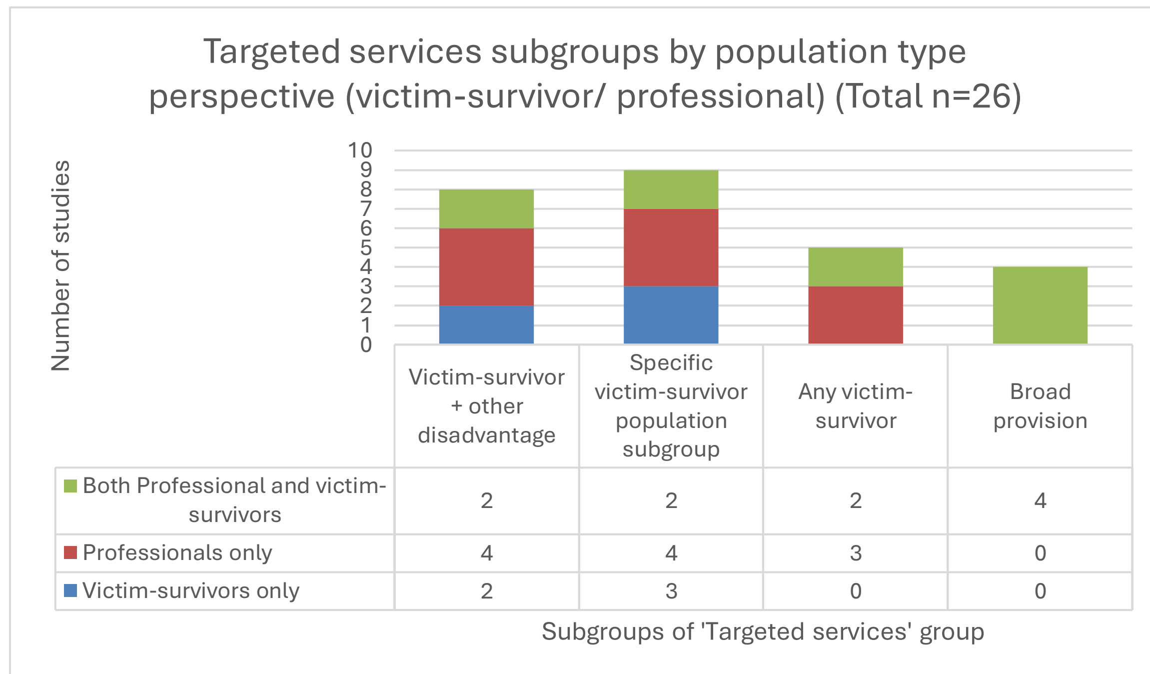


Figure 14: Targeted services by population (victim-survivor or professional) focus

Services for specific victim-survivor populations subgroups (n=9)

Three studies in this group focused on people who have experienced abuse or exploitation as a child (Gilligan, 2016, Matthew & Baron, 2015, Smith et al. 2015). All three studies sought victim-survivors' views only. One study specifically focused on young women's recovery after child sexual exploitation (Gilligan, 2016), one was a co-produced research study on ritual abuse (Matthew & Baron, 2015), and one study elicited views on the service experiences and needs of adult survivors of childhood sexual abuse (Smith et al. 2015).

Three studies focused on the provision of services for BME women and girls (Imkaan 2016b, Imkaan 2018, Thiara et al. 2015). A further two studies addressed services for women who have experienced forced marriage (Idriss 2018, Imkaan 2016a). Of these five studies, two sought the views of both survivors and professionals (Idriss 2018, Imkaan 2016b) while the remainder involved professionals only.

One study (reported in four reports) explored voluntary agencies' response to male rape by interviewing professionals who provided support for male victim-survivors (Javaid, 2018).

Services for victim-survivors with additional disadvantage (n=8)

Eight studies included people with experience of various types of disadvantage in addition to their sexual violence victimisation. Three studies included people with either mental ill-health or substance use issues (Brooker & Durmaz, 2015, Brooker et al., 2018, Hailes et al. 2018). The remaining studies focussed on older survivors (defined as 60 years and over) (Bowes, 2018); women seeking asylum who had experienced conflict-related sexual violence (Canning, 2014); people who have experienced trafficking (Kliner & Stroud, 2012); young people with learning disabilities (Franklin & Smeaton, 2017) and disabled women (Shah et al., 2016).

Of these eight studies, two sought views from survivors (Hailes et al, 2018, Shah et al. 2016), four sought views from service providers (Bowes, 2018, Brooker, 2015, 2018, Kliner & Stroud, 2012) and two sought views from both groups (Canning, 2014, Franklin & Smeaton, 2017).

Sexual violence services for any victim survivor (n=5)

Five studies explored views about specialist sexual violence services delivered by the statutory sector to any adult victim-survivor. Three of these focused on SARCs or Sexual Assault Nurse Examiners (SANEs) or both (Cowley et al. 2014, Doran, 2015), with one comparing SARCs with voluntary sector services (Robinson & Hudson, 2011). A further two studies focused on specialist provision within the criminal justice sector. One of these (presented in two reports) focused upon the role of ISVAs in meeting the needs of victim-survivors (Hester, 2018), and the other explored the role of Specially Trained Officers (STOs) who conduct police investigations in cases of rape and sexual assault (McMillan, 2015).

Three of these studies sought views from professionals only (Cowley et al. 2014, Doran, 2015 and McMillan, 2015). The study on ISVAs and the comparison between SARCs and voluntary sector services sought both professional and victim-survivor views (Robinson & Hudson, 2011; Hester, 2018).

Victim-survivors' needs across broad provision of services (n=4)

Four studies explored views on how victim-survivors needs were met (or not) by the broad provision of sexual violence services either regionally (Gray & Garner, 2015, Voscur, 2018), nationally (McCarry et al, 2018), or both (Somerset and Avon Rape and Sexual Abuse Support, 2018).

Two of these studies were needs assessments conducted in the London Borough of Newham, and Somerset and Avon respectively (Gray & Garner, 2015; Voscur, 2018). One study looked at how best to deliver group work to victim-survivors of rape and childhood sexual abuse (Somerset and Avon Rape and Sexual Abuse Support, 2018). McCarry and colleagues explored the potential of co-producing Violence Against Women services in Wales (2018).

All four studies sought both professional and victim-survivor perspectives.

4.3 Studies of adaptations of general services (n=10)

Ten studies addressed general services and the experiences or potential needs of sexual violence victim-survivors within those services. We included studies of non-specialist services because they relate to how their services specifically cater for victim-survivors of sexual violence, and we refer to these as adaptations.

Three studies focussed on maternity care (n=3), two focussed on general healthcare (n=2), one looked at police response (n=1) and the remaining studies addressed general mental health care, counselling or talking therapies (n=4).

Of the three studies which addressed maternity care, two focussed on the needs of women who had been sexually abused (Jackson & Fraser, 2009; Montgomary et al., 2015) and one focussed on trafficked women (Bick, 2017).

The studies on healthcare sought views of young people who had been trafficked and the healthcare professionals supporting them, about the accessibility of health services as a whole (Stanley et al. 2016); the other looked at the specific needs of women recovering from rape or sexual assault when accessing healthcare services (Ranjbar & Speer, 2013).

The study on police service adaptation explored victim-survivors' and professionals' views of police responses to sexual assault by intimate partners in the South Asian community (Gill & Harrison, 2016).

Of the four studies relating to counselling and mental health services, one addressed victim-survivors' perspectives of their journey to recovery with a focus upon statutory mental health services (Chouliara, 2015); another sought perceptions about and experiences of 'talking therapies' (Chouliara, 2011). One study explored the views and experiences of counselling professionals about their training needs around FGM (Jackson, 2017). The remaining study explored mental healthcare services' responses to identifying and providing care to trafficked people (Domoney et al. 2015).

4.4 Table of UK views outlining categories and population and service details (Total n=36 from n=41 reports)

Table of UK views studies (n=36) Author(s), year. [Linked reports]	Targeted or Adaptation	Victim-Survivor Population (type of sexual violence and other characteristics)	Type of service or role (Statutory/voluntary/ range) Regional/national	Victim-survivor/ professional perspective
Bick et al. (2017)	Adaptation	Trafficked women	Statutory. Maternity.	Both
Bows (2018)	Targeted: + other disadvantage	Older people (defined as 60 years +)	Range	Professional only
Brooker & Durmaz (2015)	Targeted: + other disadvantage	Already known to mental health services	Statutory. SARCs	Professional only
Brooker et al. (2018)	Targeted + other disadvantage	Mental health problems	Statutory. SARCs + mental health services (pathways)	Professional only
Canning (2014)	Targeted: + other disadvantage	Women fleeing conflict/ seeking asylum	Range. Organisations providing conflict related sexual violence support in Merseyside	Both
Chouliara (2011)	Adaptation	Sexual abuse as a child, who have not used mental health services	Statutory. n/a Theoretical framework development	Victim-survivor only

Table of UK views studies (n=36) Author(s), year. [Linked reports]	Targeted or Adaptation	Victim-Survivor Population (type of sexual violence and other characteristics)	Type of service or role (Statutory/voluntary/ range) Regional/national	Victim-survivor/ professional perspective
Chouliara (2014)	Adaptation	Sexual abuse as a child	Statutory. Talking therapy services	Both
Cowley et al. (2014)	Targeted: any victim-survivor	Any type of sexual violence	Statutory. SANEs Sexual Assault Nurse Examiners in England	Professional only
Domoney et al. (2015)	Adaptation	Trafficked people	Statutory. Mental healthcare	Both (through analysis of clinician's notes)
Doran (2015)	Targeted: any victim-survivor	Any type of sexual violence	Range. Counsellors working in NHS SARCs and a specialist voluntary agency in the North West of England	Professional only
Franklin & Smeaton (2017)	Targeted: + other disadvantage	Young people with learning disabilities/ child sexual exploitation	Range. Stakeholders working in a range of services across statutory sector (social care, police, health and education) and voluntary sector.	Both
Gill & Harrison (2016)	Adaptation	Women and children from South Asian communities/ sexual abuse.	Statutory. Police from four police areas in England and Wales	Both

Table of UK views studies (n=36) Author(s), year. [Linked reports]	Targeted or Adaptation	Victim-Survivor Population (type of sexual violence and other characteristics)	Type of service or role (Statutory/voluntary/ range) Regional/national	Victim-survivor/ professional perspective
Gilligan (2016)	Targeted: specific population	Young women/ Child sexual exploitation	Voluntary. Two voluntary-sector projects	Victim-survivor only
Gray & Garner (2015)	Targeted: broad provision	Any type of sexual violence	Range. Sexual and domestic violence and social care services across Newham	Both
Hailes et al. (2018)	Targeted: + other disadvantage	Women facing multiple disadvantage (including mental health and substance misuse issues)/ Sexual and domestic violence	Range. Including police, health, mental health, housing, substance use and children's services.	Victim-survivor only
Hester & Lilley (2018) [Linked report: Hester & Lilley (2017)]	Targeted: any victim-survivor	Victor-survivors of rape or sexual abuse engaging with criminal justice system	Statutory. ISVAs Independent Sexual Violence Advisors	Both
Idriss (2018)	Targeted: specific population	'Honour' based violence & forced marriage	Range. Police, education, social care, health.	Both
Imkaan (2016a)	Targeted: specific population	Forced marriage	Range. In England and Wales	Professional only
Imkaan (2016b)	Targeted: specific population	BME women	Range. Mental health services	Both

Table of UK views studies (n=36) Author(s), year. [Linked reports]	Targeted or Adaptation	Victim-Survivor Population (type of sexual violence and other characteristics)	Type of service or role (Statutory/voluntary/ range) Regional/national	Victim-survivor/ professional perspective
Imkaan (2018)	Targeted: specific population	BME women	Voluntary. Violence Against Women and Girls for BME populations (funding)	Professional only
Jackson & Fraser (2009)	Adaptation	Sexual abuse as a child	Statutory. Midwives	Professional only
Jackson (2017)	Adaptation	FGM	Statutory. Counselling professionals	Professional only
Javaid (2018) **[Linked reports:** **Javaid (2017, 2017, 2019)]**	Targeted: specific population subgroup	Male victim-survivors of rape	Voluntary. Police officers and practitioners working in voluntary agencies	Professional only
Kliner & Stroud (2012)	Targeted: + other disadvantage	Sex trafficked	Range. Health and social care staff, Northern city in England	Professional only
Matthew & Barron (2015)	Targeted: specific population subgroup	Ritual Abuse Survivors	Range. Rape services, police, domestic violence, health, and social services.	Victim-survivor only
McCarry et al. (2018) **[Linked report:** **Berry et al. (2014)]**	Targeted: broad provision	Rape/ abuse by intimate partner	Range. Violence Against Women Services in Wales	Both
McMillan (2015)	Targeted: any victim-survivor	Rape/ sexual assault	Statutory. Police. Specially Trained Officer	Professional only

Table of UK views studies (n=36) Author(s), year. [Linked reports]	Targeted or Adaptation	Victim-Survivor Population (type of sexual violence and other characteristics)	Type of service or role (Statutory/voluntary/ range) Regional/national	Victim-survivor/ professional perspective
			(STO) in one county in England	
Montgomery et al. (2015)	Adaptation	Women, sexually abused as children	Statutory. Maternity	Victim-survivor only
Ranjbar & Speer (2013)	Adaptation	Women, victim-survivors of sexual assault	Statutory. Health	Victim-survivor only
Robinson & Hudson (2011)	Targeted: any victim-survivor	Any type of sexual violence	Range. SARCs and voluntary-sector-based projects (with and without ISVAs) in UK	Both
Shah et al. (2016)	Targeted: + other disadvantage	Women with disabilities (including cognitive, sensory, and physical)	Range. Specialist support services in UK	Victim-survivor only
Smith et al. (2015)	Targeted: specific population subgroup	Sexual abuse as a child	Range. Across UK	Victim-survivor only
Somerset & Avon Rape Sexual Abuse Support (SARSAS) (2018)	Targeted: broad provision	Victim-survivors of rape and childhood sexual abuse.	Range. Group work	Both
Stanley et al. (2016)	Adaptation	Young people who have been trafficked.	Statutory. Health services in UK	Both

Table of UK views studies (n=36) Author(s), year. [Linked reports]	Targeted or Adaptation	Victim-Survivor Population (type of sexual violence and other characteristics)	Type of service or role (Statutory/voluntary/ range) Regional/national	Victim-survivor/ professional perspective
Thiara et al. (2015)	Targeted: specific population subgroup	BME women and girls	Range. Sexual violence services and a sample of specialist BME domestic violence services	Professional only
Voscur (2018)	Targeted: broad provision	Adult victim-survivors of sexual violence	Range. Adult sexual violence services in Somerset & Avon	Both

Table 1: Details of UK view studies (Category/ population and type of services or roles covered) Total n=36 studies from 41 reports

5 EVALUATIONS

5.1 Type of evaluation (n=106)

In total, 106 evaluations of specific interventions for victim-survivors of sexual violence or for those providing a service for victim-survivors were identified. A list of included evaluation studies is available in Appendix E. Study characteristics are shown in Appendix G. Of these 106 studies, most (n=86) reported quantitative findings about outcomes or impact. Eight studies were qualitative evaluations of processes only, and 12 studies were evaluations of both outcomes and processes.

5.2 Geographical setting of evaluations (n=106)

Figure 15 shows the number of evaluations by country. More than half of the evaluations were conducted in the USA (62/106 studies). Fifteen studies were conducted in the UK – 12 in England, and three in Scotland. Seven studies were conducted in Canada, six in Germany and six in the Netherlands, three in Denmark, two in France and in Australia, and one each in Israel, South Korea, and Norway.

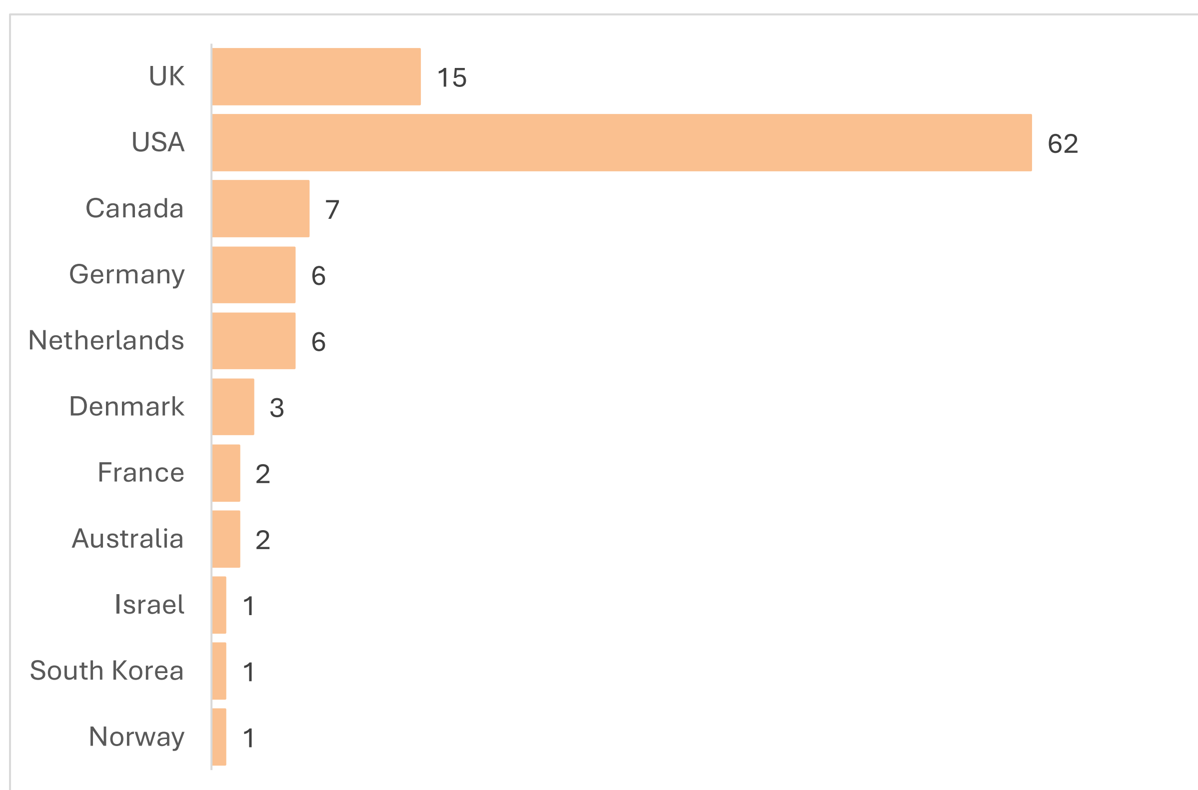


Figure 15: Number of evaluation studies by country of publication (Total n=106)

5.3 Details of UK-based evaluations (n=15)

Of the 15 UK-based evaluations, four reported outcomes only, eight processes only and three outcomes and processes. All four outcome-only evaluations were conducted in England (Calvert, 2015; Clifford, 2018; Ellis, 2012; Robjant, 2017). The eight UK process-only evaluations were conducted in England (Donohoe, 2010; Donovan, 2011; O'Neill, 2016; Saha, 2011; Van Staden, 2010; Williams, 2017) and Scotland (Brooks, 2017; Brooks-Hay, 2018). The three UK outcome and process evaluations were

conducted in England (Harding-Jones, 2018; Rumney, 2019) and Scotland (Karatzias, 2014).

Table 2 below, provides a breakdown of the type of sexual violence addressed in the 15 UK evaluation studies, by whom the intervention was targeting (provider, victim-survivor or both).

Table 2: Type of sexual violence by sampled population in UK evaluation studies

	Sexual abuse – as a child	Rape or abuse – any point in life	Rape or abuse – as an adult	Trafficked – for sex slavery	Sexual exploitation – as a child	Total
Victim-Survivors only	4	1	2	1	0	8
Both professionals and victim-survivors	0	3	0	1	1	5
Professional Staff only	0	2	0	0	0	2
Total	4	6	2	2	1	15

Further study details of the UK evaluations are presented in Appendix D.

5.3.1 UK outcome evaluations

The four UK outcome evaluations were conducted in specialist services (Clifford, 2018; Robjant, 2017), a range of settings, such as GP surgery, church, or prison, but mainly specialist services (Ellis, 2012), and a public healthcare (NHS) setting (Calvert, 2015). Three were before-and-after studies, and one was a non-randomised study with a no-treatment control group (Calvert, 2015). The studies assessed Cognitive Analytic Therapy (Calvert, 2015), Skills Training in Affective and Interpersonal Regulation (STAIR; Clifford, 2018), writing therapy (Robjant, 2017), and equine therapy; Ellis, 2012), and the outcomes measured were PTSD (Clifford, 2018; Robjant, 2017), depression (Calvert, 2015; Clifford, 2018), wellbeing or functioning (Calvert, 2015; Ellis, 2012), and suicidal thoughts (Ellis, 2012).

5.3.2 UK process evaluations

The eight UK process evaluations were in specialist services (Brooks, 2017; Brooks-Hay, 2018; Donovan, 2011; O'Neill, 2016; Saha, 2011; Williams, 2017), police (Van Staden, 2010), and NHS public healthcare (Donohoe, 2010) settings. They were all qualitative studies, one of which also assessed skills, knowledge and behaviour; this was not classified as an outcome evaluation because it only assessed these measures after the intervention and with no comparator (Donohoe, 2010). They assessed advocacy services including, Rape Crisis (Brooks, 2017; Brooks-Hay, 2018); support and advocacy services, also including Rape Crisis (Donovan, 2011; O'Neill, 2016); police services (Van Staden, 2010); other therapy, such as group therapy (Saha, 2011; Williams, 2017); and education for professionals (Donohoe, 2010). They reported

skills, knowledge, and behaviour after the intervention only (Donohoe, 2010), and views (all eight studies).

5.3.3 UK outcome and process evaluations

The three UK outcome and process evaluations were conducted in sexual-violence services (Harding-Jones, 2018), adaptations to police services (Rumney, 2019), and NHS public healthcare (Karatzias, 2014). Two used a before-and-after design and one was a non-randomised study, with a usual-care control group (Rumney, 2019). They assessed police services (Rumney, 2019), Cognitive Behavioural Therapy (Harding-Jones, 2018), and education for victims (Karatzias, 2014), and they reported PTSD (Harding-Jones, 2018; Karatzias, 2014), wellbeing (Harding-Jones, 2018; Karatzias, 2014), depression or anxiety (Karatzias, 2014), dissociation (Karatzias, 2014), legal (Rumney, 2019), views (all three studies), behaviour (Karatzias, 2014) and referral (Rumney, 2019) outcomes.

5.3.4 UK study populations

Out of the 15 UK-based evaluations, eight focused on victim-survivors only (Calvert, 205; Clifford, 2018; Ellis, 2012; Robjant, 2017; Karatzias, 2014; Brooks, 2017; Saha, 2011; Williams, 2017), two on professional staff only (Donohoe, 2010; Van Staden, 2010) and five on both professionals and victim-survivors (Harding-Jones, 2018; Rumney, 2019; Brooks-Hay, 2018; Donovan, 2011; O'Neill, 2016). Ten out of the 13 evaluations that included victim-survivors were female-only; the other three were both male and female (Karatzias, 2014; Rumney, 2019; Brooks-Hay, 2018), with 11% or less of each sample being male. Eleven were focused on individuals aged 18 years and over only, while two included data from both adults and people under 18 years (Rumney, 2019; Brooks-Hay, 2018). The oldest reported UK victim-survivor was 61 years old (Saha, 2011), and across three studies (Calvert, 2015; Clifford, 2018; Karatzias, 2014), the mean age of victim-survivors ranged from 28 to 38 years. Five UK victim-survivor studies reported ethnicity; the populations were mainly (80% or more) White British (Calvert, 2015; Rumney, 2019), mixed ethnicity (Clifford, 2018), mainly (80% or more) minority ethnicity (Robjant, 2017), and all White British (Saha, 2011).

5.4 Type of sexual violence addressed in evaluations (n=106)

The type of sexual violence addressed in the 106 evaluation studies is shown in figure 16.

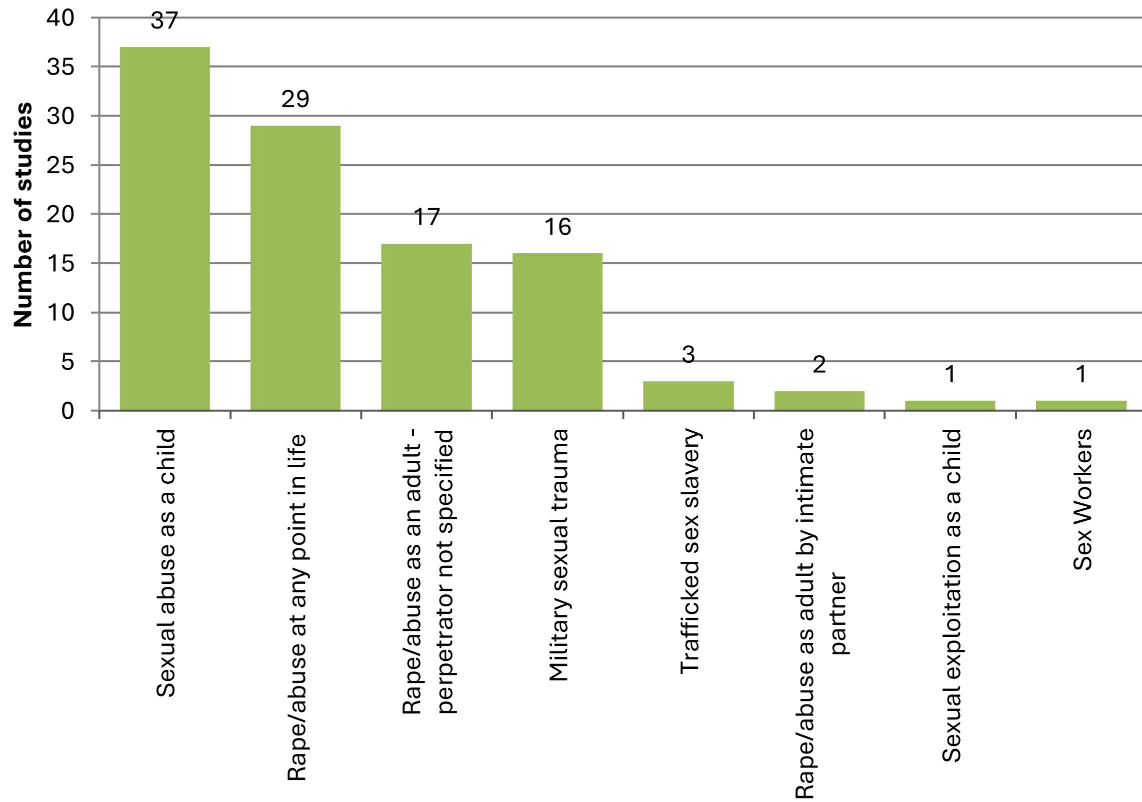


Figure 16: Type of sexual violence for all evaluations (n=106)

Figure 17 shows a screenshot of the interactive map of evaluation studies by type of sexual violence. The size of each bubble indicates the relative number of studies within each cell. By following the link to the interactive map detailed figures for type of intervention by population and study participants can be obtained along with details of each study.

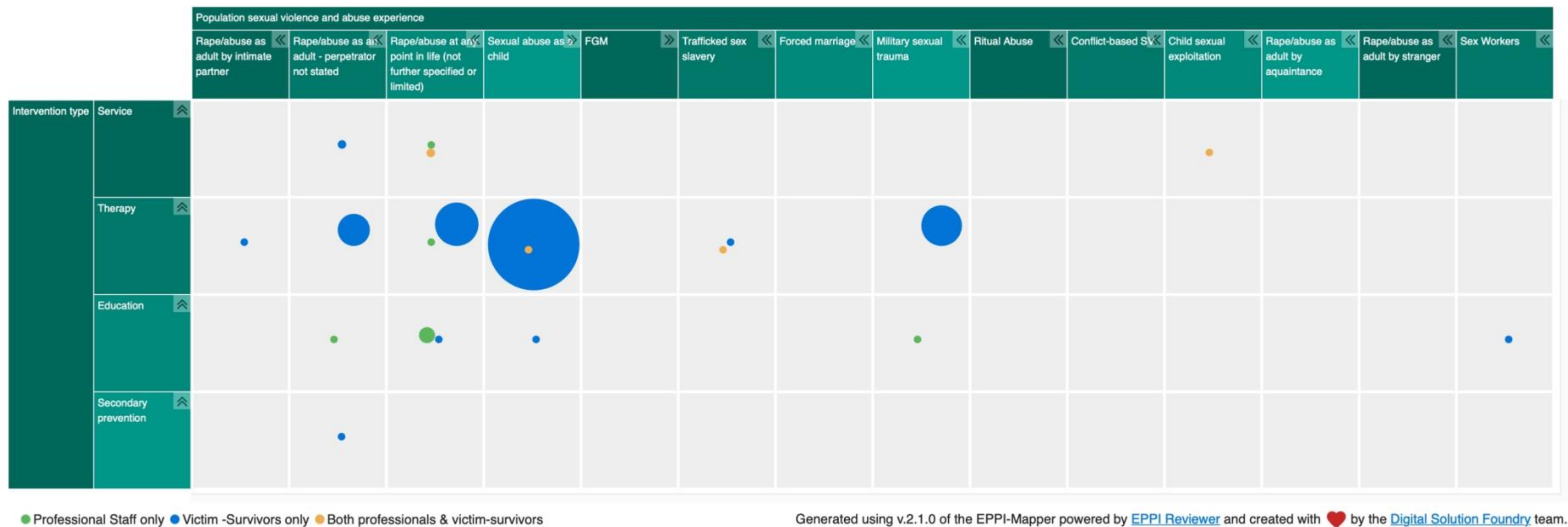


Figure 17: Evaluation studies (n=106) by type of sexual violence and intervention

Link to interactive map:
https://eppi.ioe.ac.uk/cms/Portals/0/Evaluations_revised.html?ver=2022-07-11-134818-210

A majority of evaluations (66/106) were focused on two types of sexual violence: 'sexual abuse as a child' (n=37) or 'rape/abuse at any point in life' (n=29). A similar proportion of evaluations focused on 'rape/abuse as an adult' (n=17) and military sexual trauma (n=16). A small number of studies addressed sex trafficking (n=3), 'rape/abuse as an adult by an intimate partner' (n=2), child sexual exploitation (n=1), and sex workers (n=1).

5.5 Service setting of evaluations (n=106)

The setting where the evaluation was carried out was classified as public healthcare (n=25), military medical care (n=18), specialist sexual violence service (n=17), university or educational institution (n=13), residential care (n=8), delivered online (n=3), voluntary services (n=3), or police or legal services (n=2). Ten studies were conducted in a mix of settings, and seven studies did not describe the delivery setting (see figure 18).

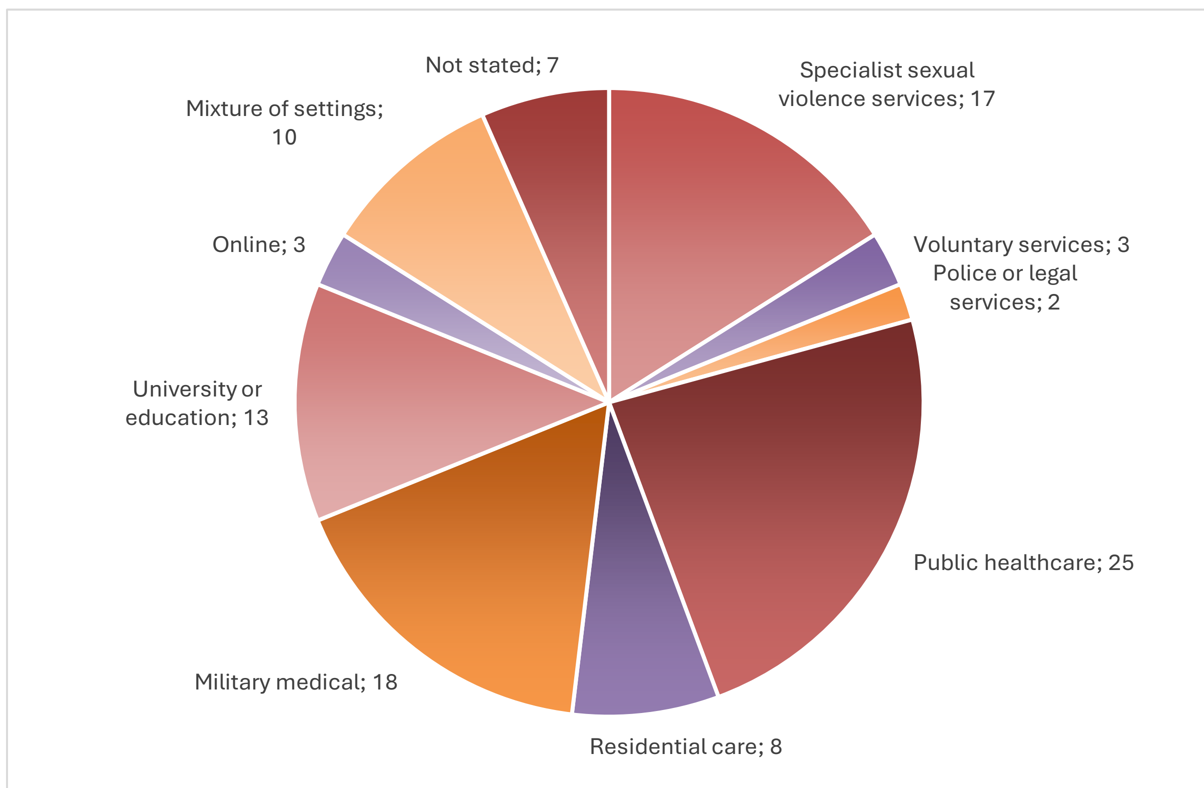


Figure 38: Number of evaluation studies by setting in which the service was delivered (n=106)

5.6 Study design of evaluations (n=106)

As figure 19 shows, most of the included evaluations had before-and-after (n=48) or randomised controlled trial (RCT) (n=36) designs. Nine studies compared interventions for alternative populations, such as those with or without military sexual trauma and five studies had a non-randomised controlled design. The eight qualitative studies were all process-only evaluations. The 12 outcome and process evaluations had before-and-after (n=7), RCT, non-randomised controlled (n=2), and alternative population (n=2) designs, as well as collecting views.

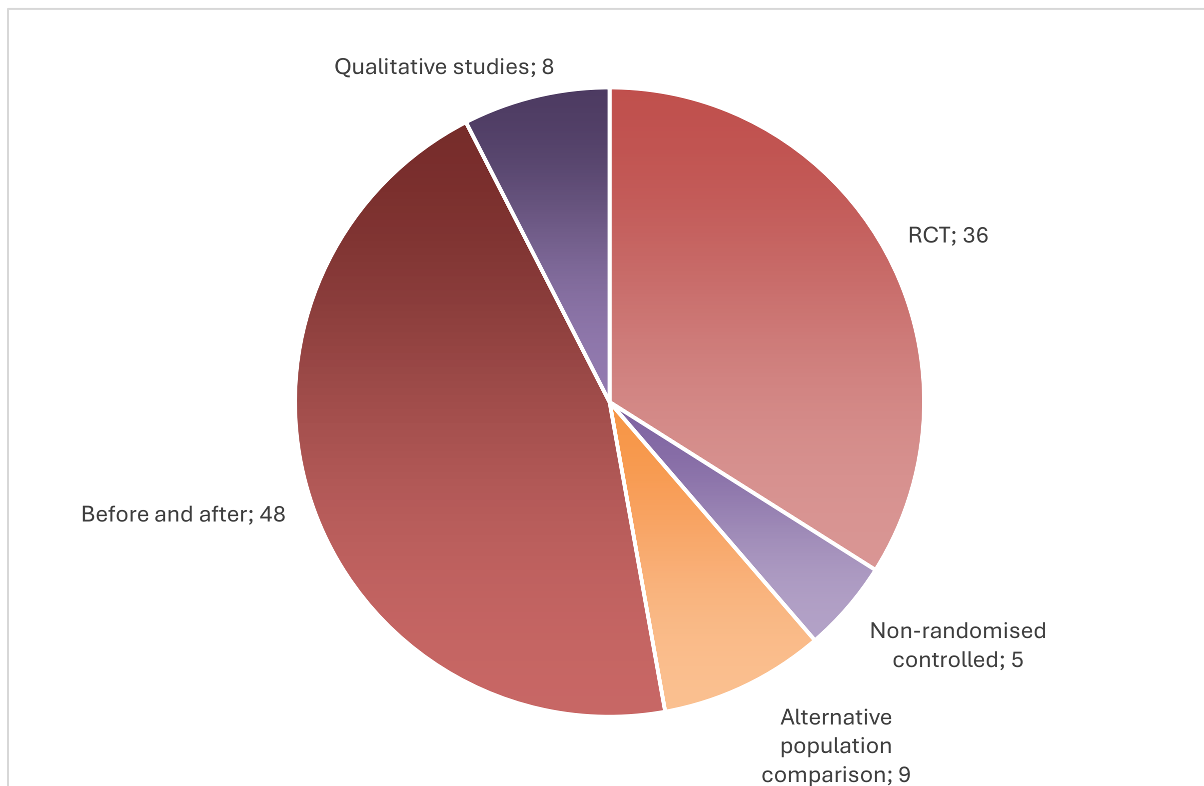


Figure 19: Number of evaluation studies by study design (n=106)

5.7 Intervention types evaluated (n=106)

Interventions were classified as services, therapies, education or secondary prevention (see figure 20). Services covered the whole provision, such as therapy, advocacy, support, advice, therapy, and referral to therapy. Therapies could be delivered in any setting and were therapy only. Education was for providers to help them provide the service, or for victim-survivors to help prevent re-victimisation. Secondary prevention describes interventions to prevent further harm after sexual violence, such as HIV prevention medication. Most studies (84/106) assessed a therapy, such as Cognitive Processing Therapy (n=13), Mindfulness (n=5), or writing therapy (n=5). Nine studies assessed services; three on SANEs and two each on advocacy, support and advocacy (including Rape Crisis), and police services. Twelve studies assessed education for professionals (n=8) or victims (n=4). One study assessed the prevention of HIV following sexual assault.

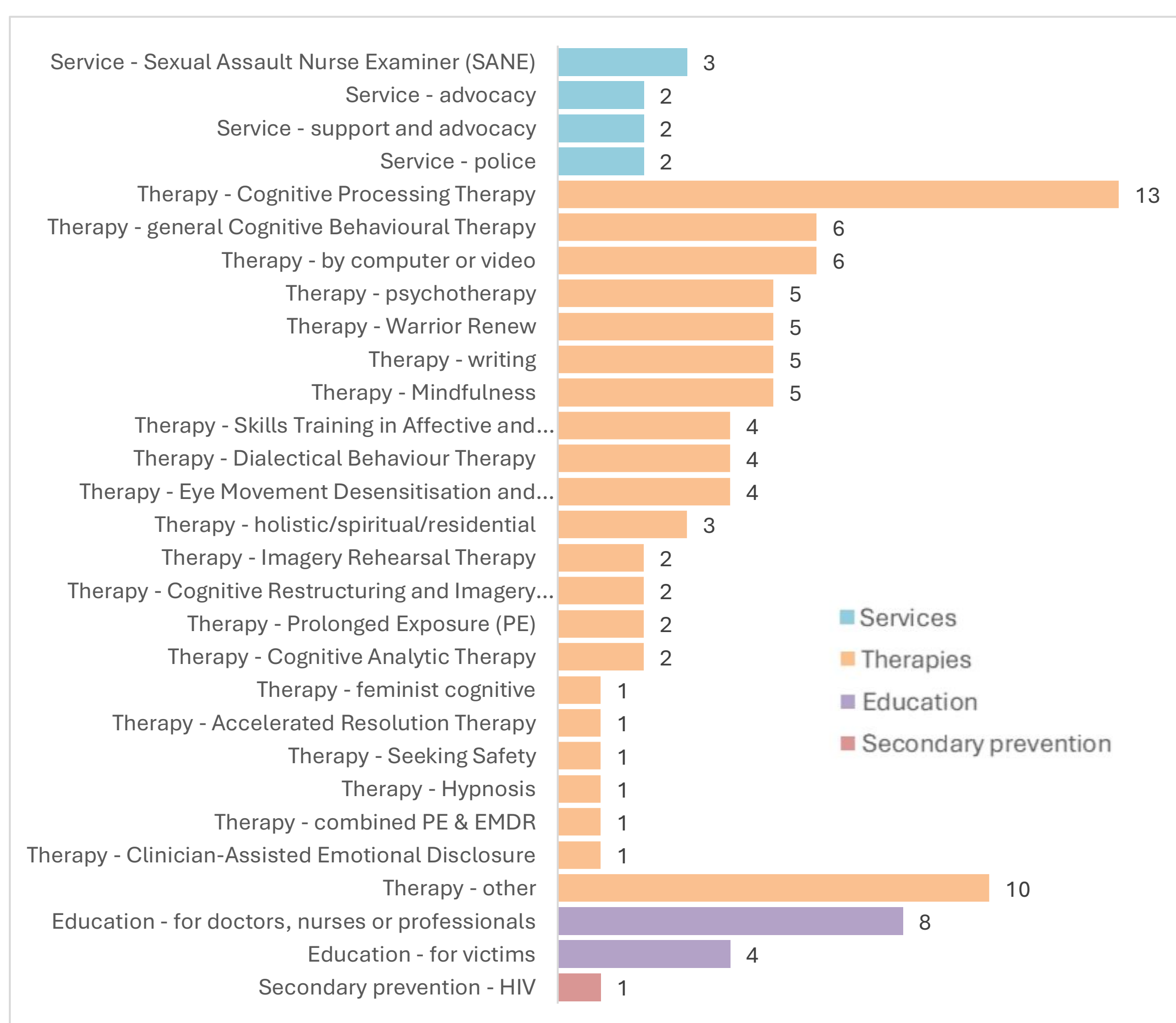


Figure 20: Number of evaluation studies by intervention type (n=106)

5.8 Comparators used in controlled evaluations (n=36)

Within the 36 RCTs 16 compared one treatment with an alternative treatment, 11 compared treatment against usual care, eight compared it with no treatment (or being on a waiting list), and one trial did not describe their control (figure 21).

Within the five non-randomised controlled studies, two compared one treatment with an alternative treatment, one compared the intervention with usual care, one compared it with no treatment (or waiting list), and one did not describe the control.

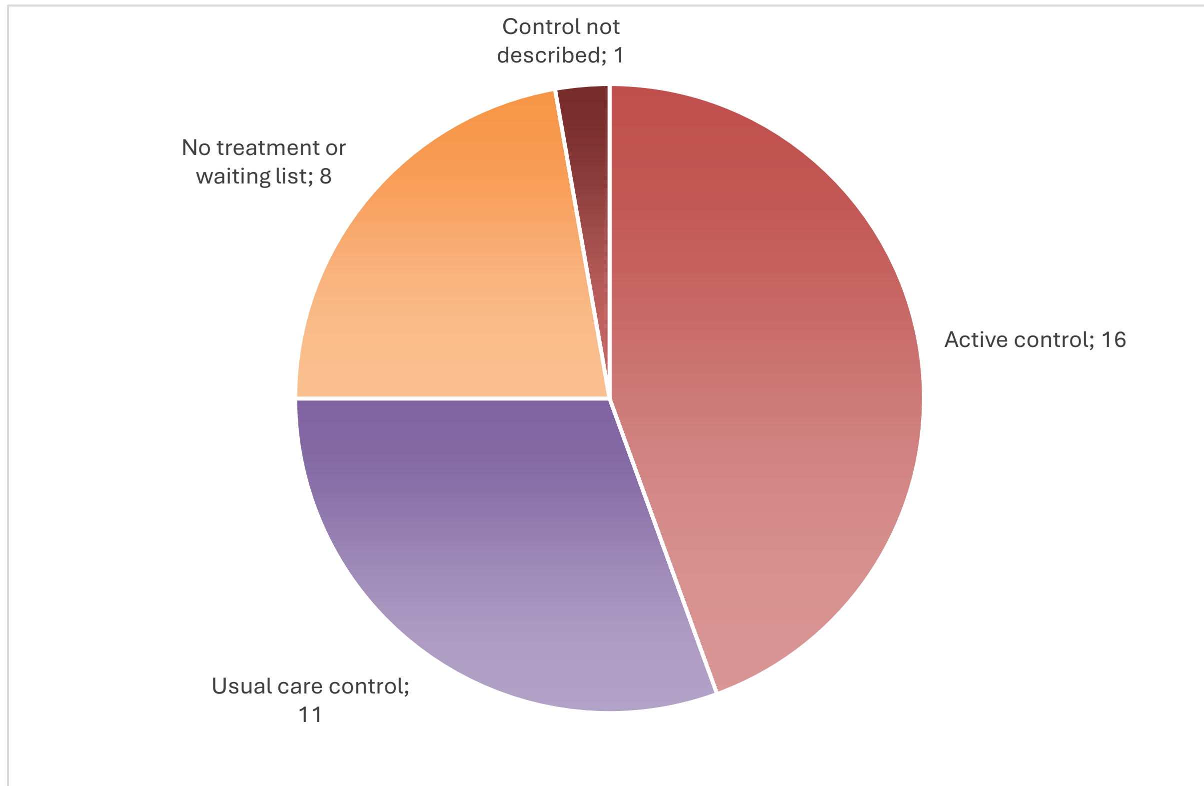


Figure 21: Number of RCTs by type of control (n=36)

5.9 Outcomes measured in evaluations (n=106)

Most evaluations reported three to five outcome types; some reported ten or more outcomes. The most common outcome was any scale that measured PTSD symptoms reported in 69 out of the 106 studies. Scales measuring depression and/or anxiety were used in 45 studies, and wellbeing or functioning scales were used in 44 studies. Other scales were used to measure other moods (n=12), dissociation (n=5), social support (n=3), suicide attitudes (n=3), contamination (n=2), coping strategies (n=2), physical health (n=2), borderline personality symptoms (n=1), and interpersonal problems (n=1).

Views were reported in 22 studies, and knowledge, attitudes or skills were assessed in 15 studies. Other outcomes were behaviour or service use (n=10), sleep issues (n=6), legal outcomes (n=3), re-victimisation (n=3), side-effects (n=3), drug or hormone tests (n=2), sexual interest or arousal (n=2), adherence to guidelines (n=1), psychophysiological outcomes (heart rate, acoustic startle, and skin conductance; n=1), referrals to specialist support (n=1), and themes from writing therapy (n=1) (see figure 22).

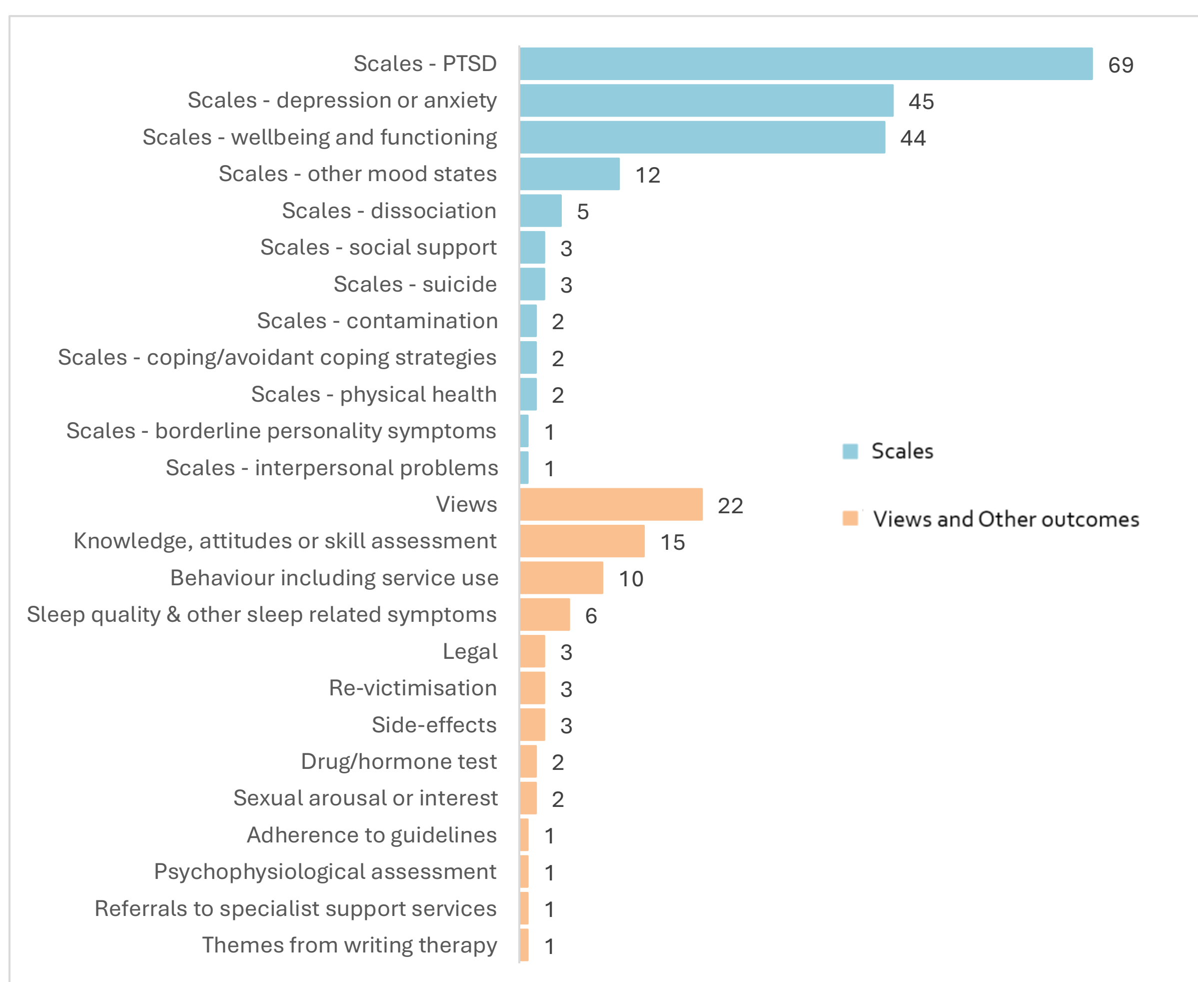


Figure 22: Number of evaluation studies reporting each type of outcome (n=106)

5.10 Specific population focus of evaluations (n=106)

In total, 71 evaluations had a focus on a specific victim-survivor population or professional group, and these are shown in Table 3. The largest number focused on individuals with PTSD (n=26) followed by military populations (n=10) and military personnel with PTSD (n=8). Six studies were conducted with university/college students and four with health professionals (emergency department staff, including residents in a military hospital, n=3; and mental health practitioners, n=1). Four other studies focused on individuals with substance abuse issues including injection drug users, and individuals taking methadone. Other population groups included individuals with HIV, law enforcement officers, and people with learning disabilities. The 35 studies without a specific population focus included all victim-survivors or providers, without limitations on their background (for example, military), experiences (for example, PTSD) or characteristics (for example, learning disability).

PTSD	26
Military	10
Military with PTSD	8
University/college students	6
Health professionals	4
Substance abuse	4
Depression	3
HIV+	2
Law enforcement/legal	2
SANEs	2
Acute Stress Disorder	1
Deliberate self-harm	1
Learning disabilities	1
Older or elderly	1
No specific population focus	35

Table 3: Characteristics of specific evaluation populations (n=106)

5.11 Intervention target population of evaluations (n=106)

Most evaluations were of interventions targeted to victim-survivors (89/106). Eleven studies were based on a sample of professional staff only, and a further six evaluations were based on both professionals and victim-survivors. The following sections provide details on the 95 studies (89 plus six) that included victim-survivor populations.

5.12 Gender of victim-survivors in evaluation studies (n=95)

The gender of victim-survivors is shown in figure 23. It can be seen that almost two thirds of evaluations involving victim-survivors reported a female-only population (60/95, 63%). Thirty-one studies reported a mixed-gender sample, but most were predominantly female; males comprised 25% or less of the sample in 20 out of the 29 mixed-gender studies that reported disaggregated proportions. No evaluations focused on male-only or trans-only populations.

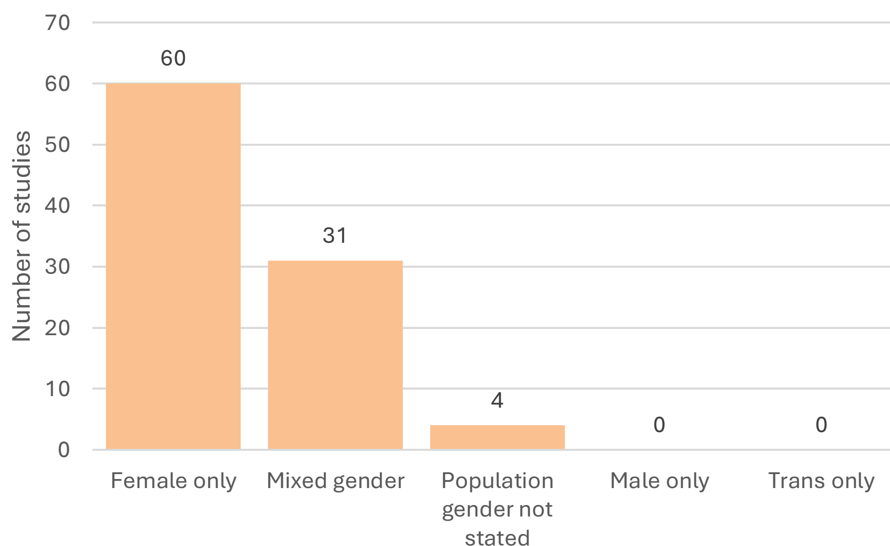


Figure 23: Gender of victim-survivors in evaluation studies (n=95)

5.13 Age of victim-survivors in evaluations (n=95)

A large proportion of evaluations (84/95, 88%) focused on adult victim-survivors only (aged 18 years and over). In two studies, the sample comprised victim-survivors aged 16 years and older. Nine evaluations included adults and some young victim-survivors under the age of 16 years old; the mean age of the population in all evaluations was over 16 years old. One US study (Bowland, 2012) assessed a spiritual intervention for older women victim-survivors, with a mean age of 61 years (range 55 to 83 years).

5.14 Ethnicity of victim-survivors in evaluation studies (n=95)

As figure 24 reveals, the largest proportion of evaluations comprised a population of both White and minority ethnic victim-survivors (38/95). In 16 evaluations, the population was mainly White (80% or more), and a further four comprised mainly minority ethnic individuals (80% or more). Five studies had an all White sample.

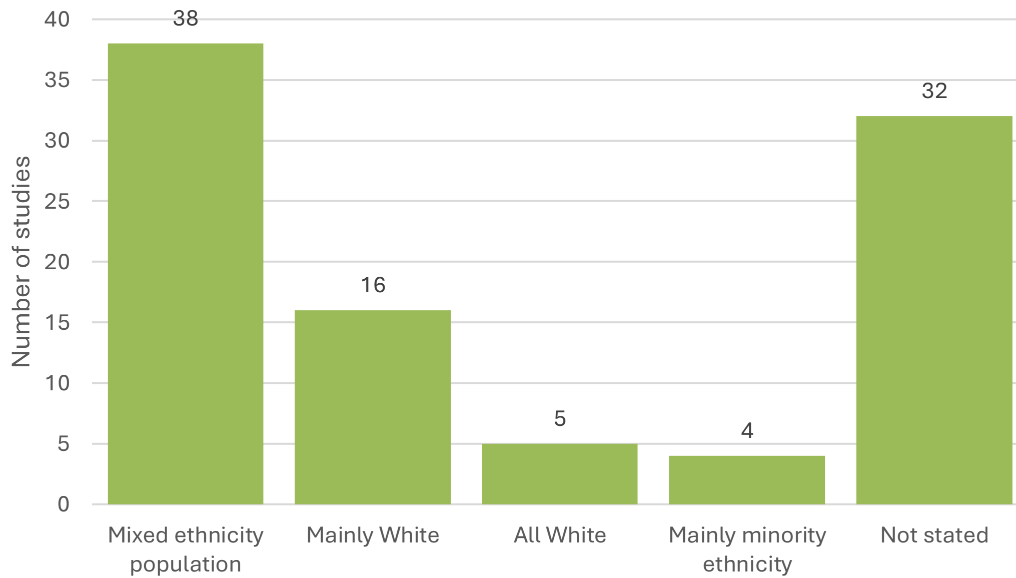


Figure 24: Ethnicity of victim-survivors (n=95)

6 SYSTEMATIC REVIEWS

6.1 Overview of systematic reviews (n=21)

We identified 21 systematic reviews. A list of included systematic reviews is shown in Appendix H and study details of these reviews are presented in Appendix I. The populations of interest were victim-survivors of sexual violence (n=17) and professionals (n=4). The reviews contained a total of 309 primary studies. The number of included primary studies ranged from 0-99 as several 'empty' systematic reviews (n=5) relating to FGM identified no eligible studies.

The types of interventions reviewed were predominantly mental health and psychological interventions to reduce PTSD and improve psychosocial wellbeing (n=11). There were three reviews which explored views and experiences of service-users and two reviews on views about skills and attitudes from professionals. Methodological designs of included studies varied from RCTs to mixed methods and qualitative studies. Included primary studies were conducted in different countries with the majority in the USA, while only 15 out of 309 studies were conducted in the UK.

The inclusion criteria of some of the 21 systematic reviews varied in terms of the types of population, types of sexual violence and interventions. In this systematic map, we present only data from the included primary studies that are relevant to our research question. For example, we excluded from the review studies which addressed domestic abuse/intimate partner violence, we also excluded studies involving interventions for sexually abused children aged under 16 years and sexual offenders.

We categorised the 21 systematic reviews into four population types of sexual violence: female genital mutilation (n=8), sexual violence including rape and sexual assault (n=6), sexual abuse as a child (n=5) and human trafficking (n=2) (see figure 25).

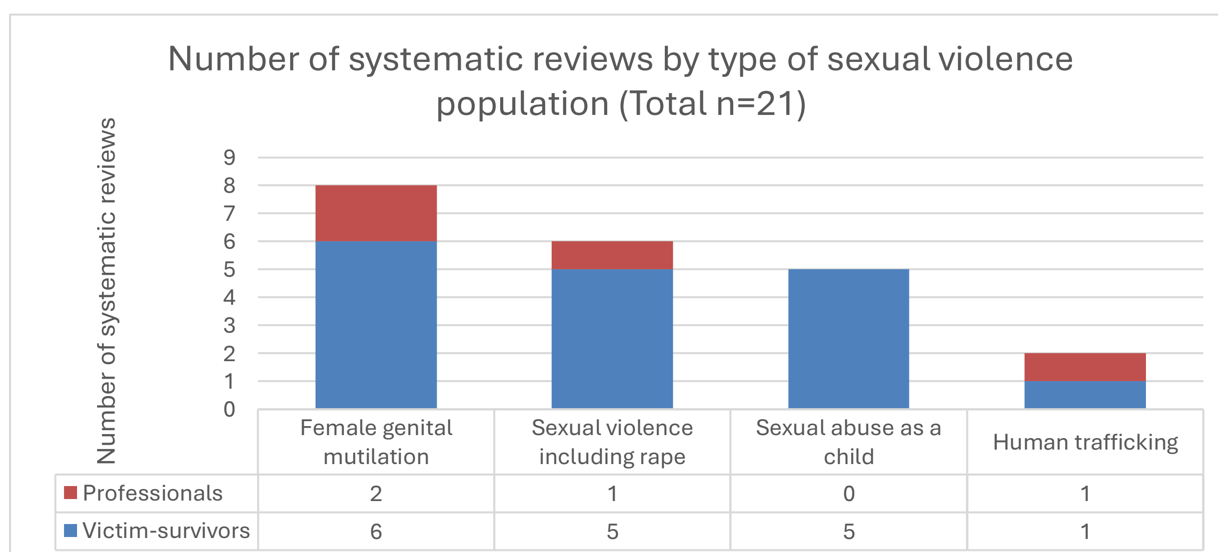


Figure 25: Systematic reviews by type of sexual violence

Across all categories, mental health and psychological interventions were the most common (n=15 out of 21).

Number of systematic reviews by types of study designs of included studies

Comparative studies with a control group to evaluate the effectiveness of interventions were selected, as an inclusion criterion, in 12 systematic reviews, studies of various method designs was selected in five, and a before-and-after design in one review. Three systematic reviews selected qualitative studies of elicited views (see Figure 26).

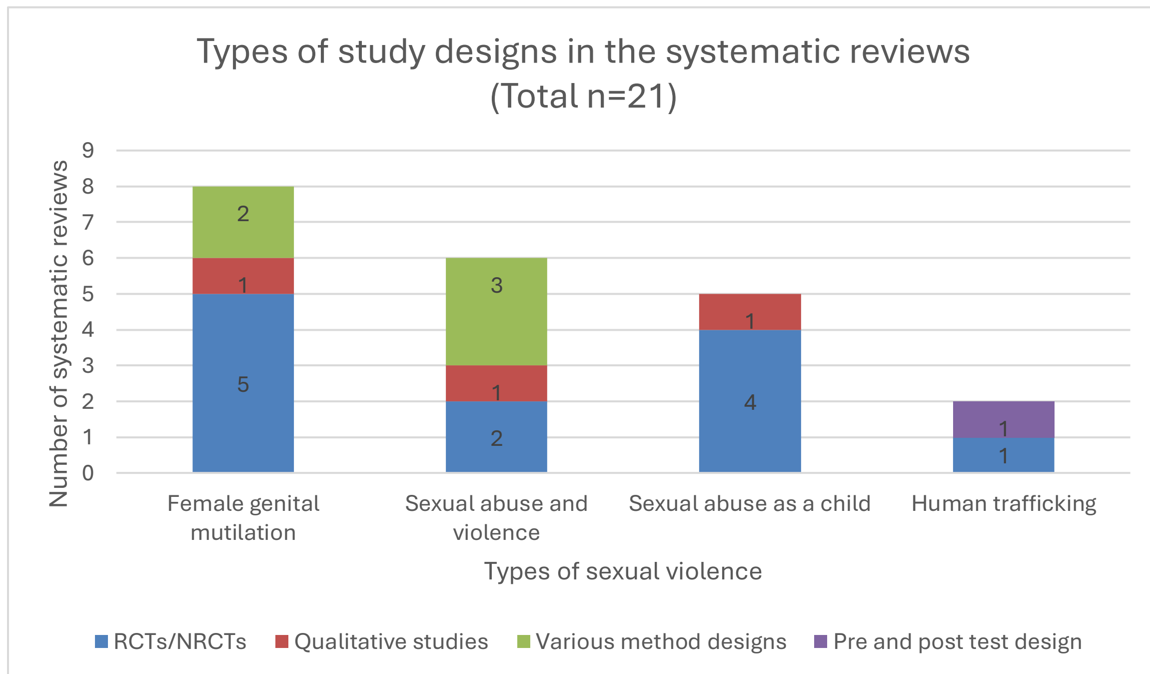


Figure 26: Types of study designs of included systematic reviews by sexual violence population

Number of systematic reviews by types of outcomes

The most common outcomes assessed in these reviews were psychosocial outcomes such as PTSD, anxiety, and depression (n=11). Other outcomes assessed were sexual functioning (n=2), safe-sex practices (n=1), and efficacy of SANEs (n=1). Views on access to services, attitudes, knowledge and perceived needs of service-users and professionals were explored in six reviews (see figure 27).

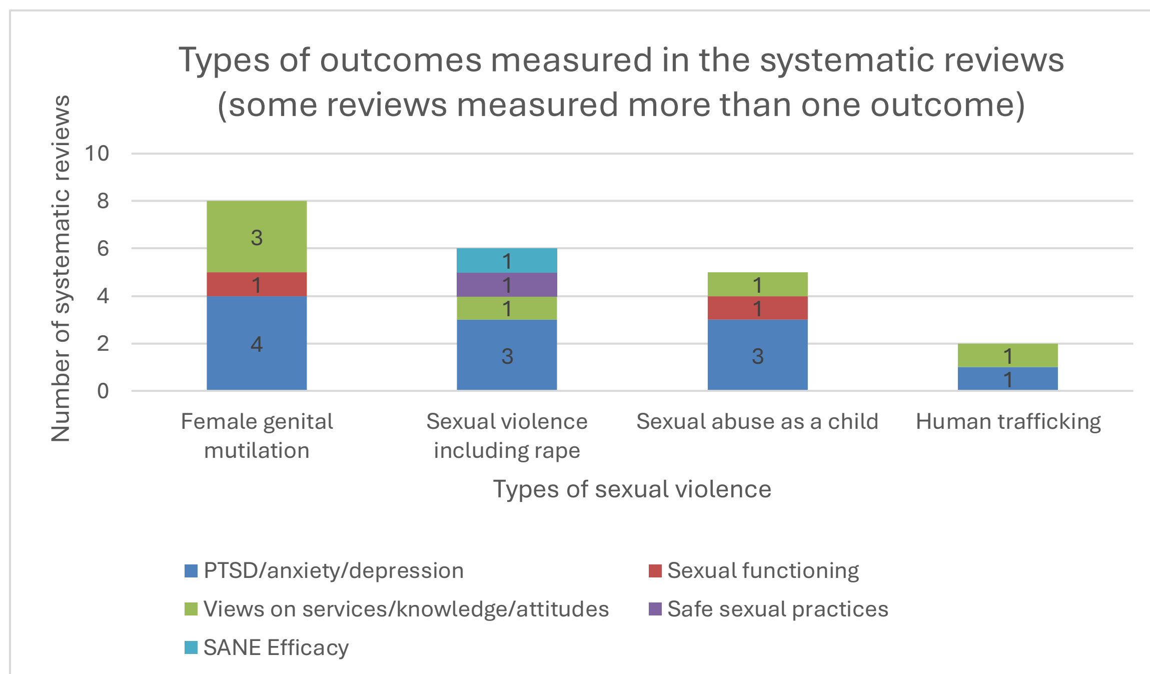


Figure 27: Types of outcomes measured in the systematic reviews by sexual violence population

Number of systematic reviews by number of included studies

The highest number of included studies was found in the five systematic reviews on the sexual abuse as children category (n=147), followed by the six reviews on sexual abuse and violence (n=103), eight reviews on female genital mutilation (n=42), and two reviews on human trafficking (n=17). Five of the eight reviews on FGM did not identify any eligible studies for inclusion. The majority of the included studies were from the USA. Only 15 out of 309 studies were conducted in the UK.

Number of systematic reviews by methods of data synthesis

The most common method of synthesis in these reviews was narratives (n=10), followed by thematic (n=3) and meta-analysis (n=3). The remaining five reviews (n=5) did not include any studies so no synthesis methods were applied.

6.2 Characteristics of systematic reviews by types of sexual violence (n=21)

6.2.1 Female Genital Mutilation (n=8)

We identified eight systematic reviews relating to FGM. Four assessed mental health interventions (Abayomi 2017; Adelufosi 2017; Bello 2017; Okomo 2017), one looked at surgical and non-surgical interventions (Ezebialu 2017) for women and girls, who were victims of FGM. One review explored birth and labour experiences of FGM victim-survivors (Hamid 2018) and two reviews assessed the knowledge, attitudes and training experiences of healthcare professionals working to support FGM victim-survivors (Dawson 2015; Zurynski 2015). As noted above five 'empty' FGM systematic reviews identified no eligible studies. Very few UK studies (n=8) were included in these eight reviews (see Table 4 below).

Table 4: Female genital mutilation: summary of review characteristics

Characteristics of reviews (n=8)					
	Victim-survivors (n=6)			Professionals (n=2)	
Number of reviews	4	1	1	1	1
Author/Year of publication	Abayomi 2017; Adelufosi 2017; Bello 2017; Okomo 2017	Ezebialu 2017	Hamid 2018	Dawson 2015	Zurynski 2015
Populations/age	Women and girls with FGM of any age	Women and girls with FGM of any age	Women with FGM	Healthcare professionals	Healthcare professionals
Types of interventions/views	*Mental health interventions	**surgical and non-surgical interventions	Views	Views	Views
Study design of included studies	RCTs and NRCTs	RCTs and NRCTs	Qualitative studies	Mixed designs	Cross-sectional and qualitative studies
Types of outcomes	PTSD, anxiety, depression, patient satisfaction, sexual dysfunction, medico-legal complaints	Vulvar and clitoral pain, post-op adverse events	Labour and birth experiences	Experience and needs in supporting women with FGM	Knowledge and attitudes of FGM in clinical practice
Other participant characteristics	na	na	African immigrant women in countries of resettlement	Nurses, midwives, doctors, gynaecologists	Nurses, midwives, obstetricians, social workers, psychologists

Search dates	Inception -2015	Inception -2015	Inception -2016	2004-2014	2000-2014
No. of included studies	0	0	14 (3 UK studies)	10 (2 UK studies)	18 (3 UK studies)
Types of synthesis	na	na	Thematic (meta-synthesis)	Narrative	Narrative

* supportive psychotherapy, education, cognitive behaviour therapy, counselling, sexual counselling

**deinfibulation and reconstruction, analgesic medication

Not applicable (na)

6.2.2 Sexual violence including rape and sexual assault (n=6)

Of the six systematic reviews on sexual violence including rape and assault two examined the effectiveness of mental health interventions on PTSD (Berry 2014; Parcesepe 2015), and one examined the impact of safe sexual practices on HIV/STI prevention (Deming 2018) among victim-survivors. The timing of interventions was examined in another review (Dworkin 2018) and one review examined the efficacy of SANEs in terms of STI/HIV prophylaxis and conviction rates (Toon 2014). The views of sex workers were explored in one review (Platt 2018) on how the criminalisation of sex work impacts on their safety, health and access to services. Only five studies conducted in the UK were included in these six reviews (see Table 5).

Table 5: Sexual violence including rape and sexual assault: summary of review characteristics

Characteristics of reviews (n=6)						
	Victim-survivors (n=5)					Professionals (n=1)
Number of reviews	1	1	1	1	1	1
Author/Year of publication	Berry 2014	Parcesepe 2015	Dworkin 2018	Deming 2018	Platt 2018	Toon 2014
Populations/age	Adult women	Adult women	Adult men and women	Adult women	Men and women sex workers (age 14- 68 years)	SANE
Types of interventions/ views	ᵻ Mental health interventions	ᵻ Mental health interventions	Timing of response/ Interventions	HIV/STI intervention	Views	SANE care vs non-SANE care

Study design of included studies	Mixed designs	RCTs and NRCTs	Mixed designs	Mixed designs	Qualitative studies	RCTs and NRCTs
Types of outcomes	PTSD, anxiety, depression, satisfaction	PTSD, anxiety, depression, distress-fear	PTSD Help-seeking experiences	Safe sexual practices	Safety, health and access to services related to criminalisation of sex work	Efficacy (STI, pregnancy and HIV prophylaxis; prosecution /conviction rates)
Other participant characteristics	na	na	na	na	Includes trans gender people	na
Search dates	2000-2014	1985-2012	Not stated	2007-2017	1990-2018	Inception -2014
No. of included studies	10 (1 UK study)	9	15 (2 UK studies)	17	46 (1 UK study)	6 (1 UK study)
Types of synthesis	Narrative	Narrative	Narrative	Narrative	Thematic synthesis	Meta-analysis

ɨ Cognitive behavioural therapy (CBT), supportive psychotherapy and counselling, Imagery rehearsal therapy, Eye Movement Desensitization and Reprocessing (EMDR), coping skill/assertiveness training, stress inoculation therapy, and others

Sexual Assault Nurse Examiner (SANE)

6.2.3 Sexual abuse as a child (n=5)

Of the five systematic reviews identified on sexual abuse as a child, four evaluated the effects of mental health and psychological interventions on PTSD (Wilen 2015; O'Driscoll 2016; Korotana 2016; Chen 2018) in adult men and women with a history of child sexual abuse. One review explored the views of this population on how trauma-focused talking therapies helped them in the process of healing in developing trust and discovering a sense of self (Parry 2016). Only two studies conducted in the UK were included in these five reviews (see Table 6).

Table 6: Sexual abuse as a child: summary of review characteristics

Characteristics of reviews (n=5)					
Victim-survivors (n=5)					
Number of reviews	1	1	1	1	1
Author/Year of publication	Wilen 2015	Parry 2016	O'Driscoll 2016	Korotana 2016	Chen 2018
Populations/age	Adult survivors	Adult men and women	Adult women	Adult men and women	Adult men and women
Types of interventions/views	ⱡ Mental health interventions	Views on interventions	ⱡⱡ Psychological interventions	ⱡ Mental health interventions	ⱡ Mental health interventions (EMDR)
Study design of included studies	RCTs	Qualitative studies	RCTs	RCTs and NRCTs	RCTs

Types of outcomes	PTSD, anxiety, depression, suicide	Experience of healing, connecting with others, discovering hope for the future	Sexual dysfunctions and concerns	PTSD, anxiety, depression, emotional functioning	PTSD, anxiety, depression
Search dates	Not stated	Not stated	Inception-2015	Not stated	Inception-2017
No. of included studies	18	23 (2 UK studies)	4	99	3
Types of synthesis	Meta-analysis	Thematic synthesis	Meta-analysis	Narrative	Narrative

ǂCBT, supportive psychotherapy and counselling, Imagery rehearsal therapy, EMDR, coping skill/assertiveness training, stress inoculation therapy, and others

ǂǂ Trauma Affect Regulation: Guide for Education and Therapy, Supportive group therapy, Trauma focus expressive Writing, Sexual schema-focused expressive writing, Cognitive-processing therapy, Prolonged exposure, Minimal attention condition, Present-centred therapy.

6.2.4 Human sex trafficking (n=2)

We identified two systematic reviews on victim-survivors of human sex trafficking. One review assessed the impact of mental health interventions on PTSD and quality of life on victims of human trafficking (Menon, 2018) and one review evaluated the effectiveness of educational interventions for healthcare professionals to improve awareness of trafficking and skills in identifying trafficking victims (Fraley, 2019) (see Table 7). No studies included in these reviews were conducted in the UK.

Table 7: Human sex trafficking: summary of review characteristics

Characteristics of reviews (n=2)		
	Victim-survivors (n=1)	Healthcare professionals (n=1)
Number of reviews	1	1
Author/Year of publication	Menon 2018	Fraley 2019
Populations/age	Adult women (age not stated)	Healthcare professionals
Types of interventions/views	ɫ Mental health interventions	Educational intervention (one-to-one, web-based)
Study design of included studies	RCTs	Pre- and post-test design
Types of outcomes	PTSD, anxiety, depression, self-reported health-related quality of life	Awareness of and attitudes towards victims of human trafficking, confidence in identifying trafficking victims
Other participant characteristics	na	Medical doctors, nurses, social workers, mental health providers, health educators
Search dates	Inception – 2017	2000 -2018
No. of included studies	10	7
Types of synthesis	Narrative	Narrative

ɫSpiritually focused group therapy, educational video, computer-based, interference control training, image rehearsal therapy, sexual revictimization prevention training, culturally sensitive trauma-focused cognitive behavioral therapy, CBT.

7 STAKEHOLDER / ADVISORY GROUP MEETING

A total of eight stakeholders attended the advisory group meeting. Attendees had a range of experience and covered a spectrum of victim-survivor and professional perspectives. Attendees included representatives from the Survivors Trust, Survivors' Network, Imkaan and Galop, alongside the Lead for National Implementation of SAAS from NHS England, a policy analyst from DHSC and a practitioner working as a sexual health advisor at Guy's and St Thomas' Hospital.

We held a three-hour meeting during which we:

- gave an introductory overview of the research followed by time for discussion and comments
- discussed the relevance of three abstracts which various members of the review team had sought a second opinion on which had been sent out in advance of the meeting
- discussed options for presentation and grouping of the evidence
- ended with general discussion about the usefulness and generalisability of the types of studies that we had found to UK policy and practice.

7.1 Main themes

The session was structured to be interactive and we invited stakeholders to share their views and join in the discussion wherever possible. The following main themes emerged:

7.1.1 Issues around definitions

As the map covers a wide range of services and interventions, populations, and types of sexual abuse and violence, we discussed different elements of the scope:

Sexual violence
As sexual violence is used as an umbrella term, stakeholders urged us to be clear about the definition we had adopted and ensure that we are consistent with the terminology used. For example, sexual exploitation is not to be used interchangeably with abuse.

Age
Stakeholders suggested it would be helpful to separate young people (16/17 years or even those aged 13+) from adults (18+) when presenting findings. It was acknowledged that studies focusing on 16- and 17-year-olds may be applicable to adults, but that older teenagers have specific considerations owing to complexities around their legal status and, in some cases, heightened vulnerabilities.

Stakeholders also suggested that where possible, we should address older adults as a discrete category. As, along with younger victim-survivors, they are a vulnerable group who are at risk of being dismissed as unreliable reporters. It was noted that the Crime Survey for England and Wales has recently started to ask about sexual violence up to age 74 years (since April 2017 – used to be up to age 59 years), but that this is still missing a large proportion of the population who are aged over 75 years.

7.1.2 Outcomes

Accessibility, cost savings, health and wellbeing outcomes were seen to be the most useful. However, the usefulness or relevance of outcome measures was context

specific. Outcomes had to be considered in terms of the aim of the intervention or service and whose perspective, or range of perspectives, they were looking at.

Stakeholders commented that the outcomes captured, which were health, wellbeing and criminal justice related, from both professional and victim-survivor perspectives – were broad and not comparable.

Commissioners have their own targets and outcomes, and collect data on time travelled, surveys before and after the service, or end-of-service satisfaction. This information is rarely made available to the wider public, and it contrasts with the kinds of outcomes that are more commonly used in published research.

From a victim-survivor perspective, stakeholders discussed the importance of measuring outcomes relating to empowerment and safety. However, this could be interpreted in various ways – it could include service related measures such as feeling safe in a service setting, through to a range of distal measures such as: keeping a job or a home, or living a life free from fear.

Recovery was discussed in terms of offering opportunities to disclose and respond; acute crisis support; and, in relation to long term wellbeing. Victim-survivors' outcomes might change over time and may not always take a linear path. As such outcomes need to be assessed over extended periods of time in order to show effects over the short, medium and longer-term.

Criminal justice related outcomes are not always relevant to victim-survivors, but evidence gathering processes, and support from ISVAs, is. For example, a qualitative study on victim-survivors' experience of receiving support from an ISVA would reveal much more than prosecution or conviction rates considered in isolation.

7.1.3 What stakeholders want to know

Understandably, information on cost-effectiveness and cost-saving was highly sought after, although it was understood to be scarce. Service providers and commissioners wanted to know the best way to spend their money, which interventions are most effective, and the benefits of specialist service provision in the voluntary sector over those provided by a generic health provider.

As discussed above, wellbeing and empowerment outcomes were highly valued by many providers and victim-survivor advocates said they would welcome guidance on how to measure these, and which outcomes to measure.

Stakeholders expressed an interest in evidence relating to pathways and referral, relationships between commissioners and providers, the effects of cuts to services, access to services (as an outcome), access to mental health services, suicide risk, and service waiting lists and "turn-away" rates. The level of unmet need would be a useful way to justify the spending, and likelihood of cost saving, through commissioning adequate, fit-for-purpose, services.

Stakeholders discussed the need to better understand the barriers to and reasons why people did not access services at the earliest opportunity. Online testing asks the person if they have recently been a victim of a sexual assault. If they respond affirmatively a Health Advisor will try and contact that person to signpost them to appropriate services. However, there are many instances where people do not disclose

because they are afraid or do not recognise what happened to them as a crime, or because they fear judgement or having to relive their traumatic experience through criminal justice processes. Reluctance to report may be particularly heightened when drugs or alcohol have been involved, for example, in cases of sexual assault relating to chemsex (sex, often with multiple partners, under the influence of psychoactive drugs). A face-to-face consultation can support victim-survivors who do not self-identify, or for whom the assault or abuse was not recent, to seek help. With online testing methods, there are fewer opportunities to gain another person's perspective or refer people to services, which means there is increased likelihood of victim-survivors reaching crisis points.

Lastly, the group expressed that it would be useful to be able to draw on clear examples of good practice relating to co-ordinating and optimising services.

7.1.4 Relevance of studies included in the map

Stakeholders expressed some doubt as to the relevance or usefulness of many of the evaluations included in the map for informing UK practice. For example, CBT, and in some cases, EMDR, may be provided but when applied to a different population, within a different context the outcomes may be different. Particular mistrust was voiced over the relevance of the US evidence. Stakeholders stressed the limitations of US evidence which focuses on a criminal justice system which is not comparable, evaluations involving SANEs, which is a role which has been established in the US for much longer than in the UK, and evaluations of interventions addressing military sexual trauma.

The stakeholders felt that the UK views studies, which would provide insight into victims-survivors' and professionals' experiences, would be more useful and provide a better sense of what works and what is lacking in regard to service provision.

As suggested by the term 'specialist', the stakeholders described their services as providing tailored interventions, with agreement between the attendees that different people require different types of support which may also be delivered in a variety of different ways. Naturally, context is particularly important.

Stakeholders were particularly keen to know more about evidence on the voluntary sector, as well as SARCs and ISVAs, and, where possible, for studies that are conducted in the UK.

7.2 Following the meeting

The above views were discussed by the research team. After the event we were more aware of how to distinguish between population subgroups, such as making sure we distinguished between sexual exploitation and childhood sexual abuse, when coding the studies and writing up the report. Their feedback also helped us to clarify our definitions of adults (adult and child services versus who the specialist services cater for), and instructed how we captured and reported age categories and additional population characteristics in the map. Discussion with stakeholders alerted us to the different ways in which 'specialist services' could be interpreted. As such, we opted to use descriptive terms such as 'targeted services' and 'adaptations of general services' when describing UK views studies identified for our map, and highlighted that our definition of 'specialist services' for the purposes of this map was inclusive and applied across all sectors.

8 DISCUSSION AND CONCLUSIONS

8.1 Summary and discussion

This systematic map sets out the nature and extent of the evidence on adult specialist services for victim-survivors of sexual violence. The evidence spans a broad range of interventions and services across statutory and voluntary agencies from both victim-survivor and professional perspectives.

As this is a systematic map, its main purpose is to present an overview of the available research, to highlight gaps in the evidence-base and to indicate where in-depth synthesis is possible.

While there are significant gaps in relation to the UK evidence (see section 8.3), there are pockets of research which can give insights into the current UK landscape of sexual violence services. We located process evaluations of a national advocacy service in Scotland (Brooks, 2017; Brooks-Hay, 2018); a Rape Crisis Centre in Tyneside (Donovan 2011), and an evaluation of a pilot project to support victim-survivors of historic child sex exploitation in Leeds (O'Neill, 2016).

We identified 26 UK views studies on targeted services for victim-survivors of sexual violence. These studies provide insight into the views of BME victim-survivors and those who have experienced so-called 'honour'-based violence or forced marriage and the professionals who support them. We also identified studies which focussed on victim-survivors with additional vulnerabilities or disadvantage such as women who are disabled, women seeking asylum, younger people with learning disabilities, and women who have mental health or substance misuse problems.

This evidence base would benefit from quality appraisal and subsequent in-depth synthesis which could provide a nuanced understanding of UK victim-survivors' needs and experiences across a range of population subgroups and types of sexual violence. The evidence spans voluntary and statutory services, at local, regional, and sometimes national level. Synthesising these studies would allow a greater understanding of kinds of services that victim-survivors should be offered and how they should be delivered. A more sophisticated grey literature search is also warranted, in order to ensure relevant research which is not published in mainstream publications is captured.

Often, those who are at a higher risk of being subjected to sexual violence, such as women from gypsy or traveller communities, or individuals BME or LGBTQI* communities, also face the most barriers in accessing support services, or are mistrustful of 'formal' sources of support (Cemlyn et al., 2009; Love et al,. 2017). The risk of re-victimisation, or secondary traumatisation, through poor treatment in statutory services is high for victim-survivors of sexual violence. Victim-survivors' experiences of medical and legal systems, in particular, have been described as not just unsatisfactory, but distressing and stigmatising (Cambell, 2006, Smith et al. 2015).

Regardless of whether the victim-survivor reports to the police, control, empowerment and the ability to live a life free from fear or blame are all crucial components of recovery. Westmarland & Alderson (2013) incorporated these concepts when they piloted a tool to evaluate the effectiveness of Rape Crisis Centres in England. Discussions at our stakeholder event also highlighted the importance of being able to capture broader life outcomes – such as ability to work, autonomy, and feeling in

control – which, arguably, enables a more holistic understanding of how well a victim-survivor is coping in the long term, when compared with mental health outcomes alone.

Involving victims and survivors in the development and improvement of services is a core priority of NHS England's strategic direction for sexual assault and abuse services (NHS England, p.5, 2018). Co-producing research is one way that this could be achieved. One study we identified in our map involved victim-survivors of ritual abuse in a collaborative piece of research on the help-seeking behaviour of this particular population (Matthews & Barron, 2015). Another looked at the potential for co-production in developing Violence Against Women services in Wales (McCarry et al., 2018).

Two forthcoming/ongoing NIHR-funded studies in England show particular promise at addressing some of the gaps identified in the research and issues which were highlighted in the stakeholder event. Firstly, a co-research study on the role, funding and commissioning of specialist services provided by the voluntary sector (https://www.fundingawards.nihr.ac.uk/award/18/02/27). Secondly, a much needed longitudinal study to evaluate SARCs and other sexual violence services, which is due to complete in 2022. The study will follow victim-survivors' recovery trajectory over two years and will assess outcomes such as relationships, work and education and safety (http://www.isrctn.com/ISRCTN30846825).

8.2 Strengths and limitations

Our scope is intentionally broad as we wanted to capture all the available evidence on the range of services for people of all genders and population groups, aged 16 years or older, who are victim-survivors of sexual violence and abuse. As such, our definition of 'specialist services' is not restricted by service setting, sector, or role of professional or volunteer but is defined by the provision of care or support to victim-survivors of sexual violence, regardless of their pathway. This inclusive approach is useful for a systematic map, whose primary purpose is to assess the size and scope of research in a particular topic area (Katz et al. 2013).

One potential limitation is that we excluded studies relating to services or interventions for violence against women, domestic violence or intimate partner violence, unless they contained a specific reference to sexual violence or abuse. We acknowledge that sexual violence is linked in complex ways to other forms of gender-based violence and disadvantage and that victim-survivors may present to services through a variety of routes (Welsh Assembly, 2010; Hailes et al. 2018).

All the same, it was beyond the scope of this map to address these relationships and overlaps in any depth. There is also a strong rationale for looking at sexual violence services in isolation. Historically, sexual violence services have been largely overshadowed by domestic violence services and, in the current competitive commissioning landscape providers of sexual violence services feel at risk of being subsumed by them (Green & Skeates, 2018).

A potential weakness is that our searches may not have identified all relevant research. Alongside searching six electronic databases we also carried out searches to identify grey literature. We did not have the resources to conduct these searches exhaustively and one oversight is that we did not search more online sources, such as

Social Care Online. Our Google search string was basic, which may have resulted in missing relevant studies which were not published in mainstream journals.

Lastly, to highlight the issue of 'double counting', it is highly likely that the same included studies were shared among some of the included systematic reviews. Many of the primary evaluation studies reviewed in section 5 are also likely to be included in some of these 21 systematic reviews. However, as we have not delved into the results of the studies, or attempted to combine them, the only risk is a slight over-representation of the research conducted in certain areas.

8.3 Gaps in evidence base

We identified a lack of evidence on the effectiveness of UK specialist services for victim-survivors of sexual violence. However, a lack of evidence on effectiveness of these services should not be interpreted to mean these services are not effective.

Research produced for the Government Equalities Office a decade ago highlighted the lack of evaluations of community-based support for rape victim-survivors in England and Wales (Brown et al., 2010) and the approach to evaluating services ten years on still appears to be piecemeal.

To our knowledge, there is also little robust research on the cost-effectiveness of specialist support services for victim-survivors of sexual violence and abuse. Professor Sylvia Walby has researched the economic aspects of Violence Against Women services, focussing for the most part on primary prevention. Towers and Walby (2012) warned that the full impact of the cuts to UK services would not be realised for years to come, and they highlighted the need for better collection of data to allow evidence-informed decision-making.

The five empty systematic reviews on FGM (Abayomi, 2017; Adelufosi, 2017; Bello, 2017; Ezebialu, 2017; Okomo, 2017) suggest that little research has been carried out on this type of sexual violence. As discussed in section 1.2, prevention, identification and support for victim-survivors of FGM is a topic which is gaining a lot traction in UK policy and practice. The lack of research on FGM was also highlighted by the Centre of Expertise on Child Sexual Abuse, especially in the context of young people (Sharps-Jeffs et al. 2017).

Aside from one systematic review on male and female sex-workers' experience of safety and access to services in the face of criminalisation (Platt, 2018), no other research has addressed trans or non-binary populations, and no studies exclusively addressed these populations. However, since completing the map, we have identified two studies which address trans populations' and marginalised groups and report their experiences of accessing services (Rymer & Cartei, 2015 and Love et al. 2017). Both studies were published in *Critical and Radical Social Work* which was not indexed by any of the databases we searched and, as they are not classified as service evaluations, were not captured by our grey literature search.

Only one UK views study related to male victim-survivors. The study sought the views of professionals providing support and, as such, no studies were included in the map which directly sought male victim-survivors' views.

9 DETAILED METHODS

This section provides a detailed account of the methods used to identify and characterise the studies included in the map. EPPI-Reviewer 4 software was used to manage the processes. The project, including stakeholder involvement, received full ethical approval from the UCL IOE Research Ethics Committee. A protocol was agreed with DHSC and was shared with all review team members and stakeholders. As PROSPERO does not currently accept protocols of systematic maps we did not register it at this stage. The protocol is presented in Appendix I.

9.1 General methods

Systematic evidence maps are often used to identify and report on the range of research which has been produced within a broad topic area, and can provide a foundation for more in-depth syntheses (Saran & White, 2018). Evidence mapping is also a useful way to identify gaps in knowledge and future research needs (Katz et al. 2003).

As we were responding to a broad policy question, in an area in where there is a dearth of research, we adopted a systematic map approach which would allow us to identify research gaps and inform future priority setting and in-depth reviews in future.

9.2 Review question

What is known about the effectiveness and appropriateness (availability, acceptability and accessibility) of specialist adult services for people who have experienced sexual violence and abuse?

9.3 Study identification

9.3.1 Searching for studies

To identify relevant studies we searched six electronic databases spanning social science, psychology, healthcare and criminal justice:

- ASSIA
- CINAHL
- Criminal Justice Abstracts
- Epistemonikos
- MEDLINE
- PsycINFO

The literature search was undertaken in April 2019. The search strategy was developed and implemented by an information specialist (KW) in collaboration with two other members of the team (CK, SL). The search was limited to studies published in English, as we did not have the resources available to translate reviews published in other languages. We used 2009 as a cut-off date for publication.

An example of the search strategy, as used in MEDLINE, is presented in Appendix A.

The MEDLINE search consisted of four sections: a section including search terms for specific sexual offences (for example, rape, sexual assault) which was combined (using AND) with a range of terms for services (for example, primary health care, sexual

assault unit); the section including search terms for specific sexual offences was also combined (using AND) with a set of search terms describing specific therapies (for example, CBT, counselling). The resulting two sets were then combined together (using OR). A further set of search terms attempted to exclude all non-OECD papers.

A total of 22,899 records were identified by all database searches. These items were loaded into EndNote bibliographic software to leave a total of 15,477 unique records after deduplication.

In order to ensure that we identified relevant grey literature, we also searched online sources, including the websites of sexual violence charities and organisations, undertook reference harvesting, and contacted experts in the field. In April 2019, we searched the following sources:

- Imkaan – https://www.imkaan.org.uk/research, https://www.imkaan.org.uk/resources
- Rape Crisis – https://rapecrisis.org.uk/get-informed/reports-briefings/
- Centre for Women's Justice – https://www.centreforwomensjustice.org.uk/policy-research
- Solace Women's Aid – https://www.solacewomensaid.org/get-informed/resources-library
- NIA Ending Violence – http://www.niaendingviolence.org.uk/about_us/research.php
- Survivors UK – https://www.survivorsuk.org/resources/publications/

We also undertook the following Google searches, using the advanced search interface to limit results to the UK and PDF documents. As a minimum, the first 15 pages of results were then screened to identify any potentially relevant reports:

- "sexual violence" service evaluation
- "sexual assault" service evaluation
- "sexual abuse" service evaluation
- rape service evaluation

An additional 26 studies were located through these extra searches, which resulted in a total of 15,503 potentially relevant items being uploaded into EPPI-Reviewer to be screened.

9.3.2 Screening for studies

We applied the following exclusion criteria when screening on title and abstract:

EXCLUDE 1	Not published in English
EXCLUDE 2	Non-OECD setting
EXCLUDE 3	Topic not abuse or violence
EXCLUDE 4	Topic is not sexual violence/abuse. Has to be mention of sexual violence/rape in the abstract. Mention of domestic violence or of intimate partner violence alone is insufficient.
EXCLUDE 5	Topic is not specialised sexual violence services or intervention Study is NOT about specialised services for victim-survivors of sexual violence and abuse. Needs to address the effects on an individual of the experience of sexual violence (so primary prevention efforts should be excluded). Testing (for sperm) alone is not enough. Forensic interventions are out unless there is specific reference to psycho-social efforts, for example, counselling. Perpetrator interventions are beyond remit. Pathways, procedures and referrals should be included. Includes attitudes and training for professionals.
EXCLUDE 6	Intervention target group is aged <16 years only The subjects of the intervention are NOT adults, of any gender, over the age of 16 years who have experienced sexual violence and abuse at some point in their life. For consistency: Unless age otherwise stated to enable a decision: If it mentions only girl/boy/child(ren) – EXCLUDE If it mentions adolescents – INCLUDE
EXCLUDE 7	Non UK-based study that explores views or intervention processes only
EXCLUDE 8	Not a study of views or an evaluation of intervention outcomes or processes Anything where there are no terms that indicate views or evaluative goals should be excluded. Studies that explicitly identify themselves as studying prevalence of service provision only would go here.
EXCLUDE 9	No empirical data collected For example, report is an editorial, discussion piece, set of guidelines, consensus/position statement, literature review or just ‘review’.
EXCLUDE 10	Published before 2009

Therefore, to be included in the systematic map, studies had to:

- be about adult specialist services for victim-survivors of sexual violence and abuse (including statutory, third-sector and voluntary organisations);
- provide findings about the effectiveness and/or appropriateness of these services*;
- be about services aimed at adults, of any gender, over the age of 16 years who have experienced sexual violence and abuse at any point in their life;
- be published in or after 2009; and
- be published in the English language.

* In terms of study designs, we included:

- Qualitative studies conducted in the UK of the views and experiences of people seeking or providing specialist adult services;
- Evaluations conducted in the UK of intervention processes (process evaluations);
- Evaluations of the outcomes of interventions that

  a) use a comparative design (cost-effectiveness, RCTs, controlled trials and before-and-after studies), and

  b) are conducted in OECD countries; and

- Systematic reviews which include any of the above types of study

Six reviewers (SL, IK, MK, RR, CK, GR) co-screened an initial sample of abstracts which amounted to 10% of the total number. Abstracts were independently screened and then compared in groups of at least two reviewers, differences were resolved by group discussion. Once coding was completed on this sample and reviewers had reached over 95% agreement, priority screening – which uses text-mining and machine learning technology to pull out the most relevant studies – was activated. The remaining abstracts were screened by single reviewers. One member of the team (PM) joined the review at a later stage and completed screening for the final 10% of items on title and abstract. The inclusion rate was very low by this stage, on account of priority screening, and no includes were found.

The full texts of all references meeting the inclusion criteria, or where it was unclear if they met the criteria, were retrieved. These items were screened on full text where we applied the same criteria as we did on 'Title and Abstract' screening, but with two additional criteria.

EXCLUDE 11	Case studies which had fewer than five participants and outcome evaluations which did not have a comparison group or a before-and-after design.
EXCLUDE 12	Conference abstracts or other forms of incomplete reports.

9.3.3 Information extraction

We developed a coding tool in order to extract characteristics from the studies included on full text. We captured information relating to: study aim, study design, population type (victim-survivors/professionals/both); characteristics of populations (age, gender, sexual violence experience); intervention type, and service and country setting.

The development of the coding tool was iterative. We added extra codes, such as extra dimensions of population characteristics, following discussion with stakeholders and once we were more familiar with the types of studies included in the map. All reviewers extracted information from the studies. During the writing up process reviewers double checked and consolidated the coding entered by other reviewers to ensure that we worked with consistency across the different sets of included studies.

9.3.4 Creation of interactive maps

Interactive online maps were generated using EPPI-Mapper software (Thomas 2018) which provides an interactive user interface powered by EPPI-Reviewer (Thomas et al. 2020).

9.4 Stakeholder methods

We aimed to hold a stakeholder event in order to discuss the initial findings of our map. This would allow us to give a picture of the characteristics of the types of studies we had found and discuss priority setting and possible directions for an in-depth review.

This began with submitting an ethics form in April to conduct a consultation with stakeholders. Once this was approved, two members of the review team worked on stakeholder recruitment and engagement (MK, RR). The pair researched and searched various reports such as, *All Party Parliamentary Group on Sexual Violence Report in to funding and commissioning of sexual violence and abuse services 2018* to identify key people as potential advisory group members.

The researchers also outreached with external experts in the field of sexual health at Guy's and St Thomas' NHS Foundation Trust and Lewisham LGBT Forum to help find participants. An extensive list was created keeping in consideration the aims and research questions as stated in section 2.3.

One researcher (MK) then led the stakeholder work, reducing the extensive list to a workable sample of 17 which included a broad range of people who work in the field of sexual violence: victim-survivor advocates, service providers and co-ordinators, policy analysts and developers, academics and practitioners. As this is a highly sensitive issue it was apparent from searching on the websites that names of staff are not always listed for confidentiality purposes, the researcher had to make phone calls to discern a main contact. The researcher successfully managed to recruit 14 out of the 17 contacts directly, gathering key names and email addresses of CEOs, directors, researchers and frontline staff. For the remaining three contacts (two academics) names and email addresses were easily found on the university website and one was the secretary for a FGM clinician who would pass on the invite.

In May, emails were sent out to 17 contacts about the project, inviting them to join the advisory group, the following information and attachment was provided:

- more information on our project and the scope of our map
- information on possible dates for the stakeholder event
- terms of reference outlining what their involvement would entail.

The majority of the stakeholders, expressed a positive response for the opportunity to be involved and described the work as 'much needed'. Once stakeholders had

confirmed availability and date was set for meeting, two further emails were sent out to participants. The second email was only sent to 14 out of the 17 participants. Three participants were not able to take part: two had busy schedules and one invitee had concerns about whether a systematic review was the right approach. The ones who were keen to participate in the advisory group were sent the following information:

- details of meeting (time and date)
- a request for accessibility and dietary requirements
- Information about subsidy request for public involvement (INVOLVE)

In total 12 participants agreed to attend the advisory group meeting and two of the participants from Survivors Trust and Galop requested a telephone conversation for clarity on the project and expectations of advisory group members. The discussions were very informative and helpful for both the participants and researcher (MK) whereby the individuals shared their views and experiences of working in their particular area of sexual violence support provision. In the run up to the event we sent confirmed attendees:

- details of venue, time, and agenda
- a copy of the protocol to comment on in the group discussion
- excerpts from three example studies to examine in meeting

Those who were unable to make that particular date passed on details to colleagues working in similar roles some of whom attended in their place. On the day of the event which we held on July 17th 2019, four people were unable to attend owing to travel disruption and other urgent business, so, ultimately, we held the event with eight stakeholders. The invitees who couldn't attend were very apologetic as they were looking forward to the meeting and offered their assistance if it was required.

See section 7 for details of the findings from the stakeholder event.

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Appendix A: Search strategy

MEDLINE via OVID

Search date 8th April 2019

4093 records identified

Ovid MEDLINE(R) ALL <1946 to April 05, 2019>

1 exp Sex Offenses/ (22337)

2 Rape/ (6139)

3 (sexual adj2 (assault$ or aggress$ or coercion or harass$ or violen$)).ti,ab. (10529)

4 rape.ti,ab,kw. (7267)

5 exp Domestic Violence/ (42114)

6 exp Intimate Partner Violence/ (8641)

7 ((abus$ or battered or violen$) adj2 (boyfriend$ or girlfriend$ or husband$ or partner$ or spousal or spouse$ or wife$ or wive$)).ti,ab. (8434)

8 "Adult Survivors of Child Abuse"/ (1909)

9 (historic$ adj6 abuse).ti,ab. (158)

10 (survivor$ adj10 sexual abuse).ti,ab,kw. (556)

11 Sex Work/ (5836)

12 (prostitution or sex work$).ti,ab. (7235)

13 (sex$ adj2 (exploit$ or traffick$)).ti,ab. (680)

14 Human trafficking/ (306)

15 Coercion/ (4389)

16 Marriage/ (22698)

17 15 and 16 (50)

18 forced marriage$.ti,ab. (87)

19 ((honor or honour) adj killing$).ti,ab. (31)

20 Circumcision, Female/ (1241)

21 (FGM or female genital mutilation).ti,ab. (1443)

22 breast ironing.ti,ab. (1)

23 Erotica/ (1690)

24 pornograph$.ti,ab. (1053)

25 revenge porn$.ti,ab. (4)

26 sexting.ti,ab. (133)

27 Stalking/ (175)

28 ((harmful or inappropriate) adj6 sexual behavio$).ti,ab. (193)

29 1 or 2 or 3 or 4 or 5 or 6 or 7 or 8 or 9 or 10 or 11 or 12 or 13 or 14 or 17 or 18 or 19 or 20 or 21 or 22 or 23 or 24 or 25 or 26 or 27 or 28 (79376)

30 Community Health Services/ (30461)

31 Community Mental Health Services/ (18058)

32 "Delivery of Health Care"/ (83560)

33 Health Services Accessibility/ (68345)

34 Mental Health Services/ (31501)

35 Primary Health Care/ (71351)

36 Social services.ti,ab. (6104)

37 (voluntary organi?ation$ or voluntary sector$ or third sector$).ti,ab. (1258)

38 Women's Health Services/ (3745)

39 30 or 31 or 32 or 33 or 34 or 35 or 36 or 37 or 38 (284275)

40 29 and 39 (3567)

41 (sexual abuse adj6 (center$ or centre$ or effective$ or evidence or intervention$ or prevent$ or program$ or project$ or service$ or support$ or treatment$ or unit$)).ti,ab. (1355)

42 (sexual assault adj6 (center$ or centre$ or effective$ or evidence or intervention$ or prevent$ or program$ or project$ or service$ or support$ or treatment$ or unit$)).ti,ab. (1020)

43 (sexual trauma adj6 (center$ or centre$ or effective$ or evidence or intervention$ or prevent$ or program$ or project$ or service$ or support$ or treatment$ or unit$)).ti,ab. (120)

44 (sexual violence adj6 (center$ or centre$ or effective$ or evidence or intervention$ or prevent$ or program$ or project$ or service$ or support$ or treatment$ or unit$)).ti,ab. (483)

45 (rape adj6 (center$ or centre$ or effective$ or evidence or intervention$ or prevent$ or program$ or project$ or service$ or support$ or treatment$ or unit$)).ti,ab. (832)

46 41 or 42 or 43 or 44 or 45 (3599)

47 (sexual abuse adj6 (access$ or collaborat$ or commission$ or integrat$ or joint$ or partner$ or pathway$ or refer or refers or referring or referral$ or statutory or third or voluntary)).ti,ab. (401)

48 (sexual assault adj6 (access$ or collaborat$ or commission$ or integrat$ or joint$ or partner$ or pathway$ or refer or refers or referring or referral$ or statutory or third or voluntary)).ti,ab. (257)

49 (sexual trauma adj6 (access$ or collaborat$ or commission$ or integrat$ or joint$ or partner$ or pathway$ or refer or refers or referring or referral$ or statutory or third or voluntary)).ti,ab. (26)

50 (sexual violence adj6 (access$ or collaborat$ or commission$ or integrat$ or joint$ or partner$ or pathway$ or refer or refers or referring or referral$ or statutory or third or voluntary)).ti,ab. (339)

51 (rape adj6 (access$ or collaborat$ or commission$ or integrat$ or joint$ or partner$ or pathway$ or refer or refers or referring or referral$ or statutory or third or voluntary)).ti,ab. (268)

52 47 or 48 or 49 or 50 or 51 (1234)

53 Assertiveness/ (1675)

54 assertiveness.ti,ab. (1606)

55 Brief behavioural intervention$.ti,ab. (23)

56 Brief behavioral intervention$.ti,ab. (73)

57 Clinician assisted emotional disclosure.ti,ab. (3)

58 Cognitive analytical therapy.ti,ab. (3)

59 Cognitive Behavioral Therapy/ (23093)

60 Cognitive behaviour$ therap$.ti,ab. (4672)

61 Cognitive behavior$ therap$.ti,ab. (9728)

62 CBT.ti,ab. (9285)

63 Cognitive processing therap$.ti,ab. (251)

64 Cognitive restructuring.ti,ab. (794)

65 Counseling/ (33953)

66 (counseling or counselling).ti,ab. (84861)

67 (crisis adj2 support$).ti,ab. (217)

68 Dialectical behaviour therap$.ti,ab. (141)

69 Dialectical behavior therap$.ti,ab. (456)

70 Emotion focused therap$.ti,ab. (102)

71 Eye Movement Desensitization Reprocessing/ (172)

72 Eye Movement Desensitization.ti,ab. (444)

73 Eye Movement Desensitisation.ti,ab. (68)

74 EMDR.ti,ab. (471)

75 Forensic nurse examiner$.ti,ab. (21)

76 "Imagery (Psychotherapy)"/ (1657)

77 Image rehearsal therap$.ti,ab. (4)

78 Prolonged exposure.ti,ab. (9444)

79 Progressive muscle relaxation.ti,ab. (491)

80 Social Work/ (14809)

81 (Supportive adj (counselling or counseling)).ti,ab. (346)

82 specific coping skills train$.ti,ab. (7)

83 Systematic desensitisation.ti,ab. (13)

84 Systematic desensitization.ti,ab. (376)

85 Stress inoculation therap$.ti,ab. (4)

86 Supportive psychotherap$.ti,ab. (538)

87 "Skills training in affect and interpersonal regulation".ti,ab. (3)

88 53 or 54 or 55 or 56 or 57 or 58 or 59 or 60 or 61 or 62 or 63 or 64 or 65 or 66 or 67 or 68 or 69 or 70 or 71 or 72 or 73 or 74 or 75 or 76 or 77 or 78 or 79 or 80 or 81 or 82 or 83 or 84 or 85 or 86 or 87 (160746)

89 29 and 88 (3980)

90 40 or 46 or 52 or 89 (10978)

91 (Afghanistan or Albania or Algeria or Angola or Antigua or Barbuda or Argentina or Armenia or Armenian or Aruba or Azerbaijan or Bahrain or Bangladesh or Barbados or Benin or Byelarus or Byelorussian or Belarus or Belorussian or Belorussia or Belize or Bhutan or Bolivia or Bosnia or Herzegovina or Hercegovina or Botswana or Brasil or Brazil or Bulgaria or Burkina Faso or Burkina Fasso or Upper Volta or Burundi or Urundi or Cambodia or Khmer Republic or Kampuchea or Cameroon or Cameroons or Cameron or Camerons or Cape Verde or Central African Republic or Chad or China or Colombia or Comoros or Comoro Islands or Comores or Mayotte or Congo or Zaire or Costa Rica or Cote d'Ivoire or Ivory Coast or Croatia or Cuba or Cyprus or Djibouti or French Somaliland or Dominica or Dominican Republic or East Timor or East Timur or Timor Leste or Ecuador or Egypt or United Arab Republic or El Salvador or Eritrea or Ethiopia or Fiji or Gabon or Gabonese Republic or Gambia or Gaza or Georgia Republic or Georgian Republic or Ghana or Gold Coast or Grenada or Guatemala or Guinea or Guam or Guiana or Guyana or Haiti or Honduras or India or Maldives or Indonesia or Iran or Iraq or Isle of Man or Jamaica or Jordan or Kazakhstan or Kazakh or Kenya or Kiribati or Korea or Kosovo or Kyrgyzstan or Kirghizia or Kyrgyz Republic or Kirghiz or Kirgizstan or Lao PDR or Laos or Lebanon or Lesotho or Basutoland or Liberia or Libya or Macedonia or Madagascar or Malagasy Republic or Malaysia or Malaya or Malay or Sabah or Sarawak or Malawi or Nyasaland or Mali or Malta or Marshall Islands or Mauritania or Mauritius or Agalega Islands or Micronesia or Middle East or Moldova or Moldovia or Moldovian or Mongolia or Montenegro or Morocco or Ifni or Mozambique

or Myanmar or Myanma or Burma or Namibia or Nepal or Netherlands Antilles or New Caledonia or Nicaragua or Niger or Nigeria or Northern Mariana Islands or Oman or Muscat or Pakistan or Palau or Palestine or Panama or Paraguay or Peru or Philippines or Philipines or Phillipines or Phillippines or Puerto Rico or Romania or Rumania or Roumania or Russia or Russian or Rwanda or Ruanda or Saint Kitts or St Kitts or Nevis or Saint Lucia or St Lucia or Saint Vincent or St Vincent or Grenadines or Samoa or Samoan Islands or Navigator Island or Navigator Islands or Sao Tome or Saudi Arabia or Senegal or Serbia or Montenegro or Seychelles or Sierra Leone or Sri Lanka or Ceylon or Solomon Islands or Somalia or South Africa or Sudan or Suriname or Surinam or Swaziland or Syria or Tajikistan or Tadzhikistan or Tadjikistan or Tadzhik or Tanzania or Thailand or Togo or Togolese Republic or Tonga or Trinidad or Tobago or Tunisia or Turkmenistan or Turkmen or Uganda or Ukraine or Uruguay or USSR or Soviet Union or Union of Soviet Socialist Republics or Uzbekistan or Uzbek or Vanuatu or New Hebrides or Venezuela or Vietnam or Viet Nam or West Bank or Yemen or Yugoslavia or Zambia or Zimbabwe or Rhodesia).hw,kf,ti,ab,cp. (2612841)

92 90 not 91 (9070)

93 limit 92 to (english language and yr="2009 -Current") (4093)

Appendix B: List of studies excluded on Full Text

Not an OECD country (n=5):

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Appendix C: List of included views studies n=36 from 41 reports

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Appendix D: Study details for UK views studies

Table of UK views studies (n=36) Author(s), year. [Linked reports]	Aim of study	Populationlation characteristics	Type of sexual violence	Service/ setting	Any other information
Bick et al. (2017)	To explore health care needs, service use and challenges among women who became pregnant while in the trafficking situation in the United Kingdom (UK) and clinicians' perspectives of maternity care for trafficked persons.	Population type: Professionals staff Age: 18+ Gender: not stated Ethnicity: not stated	Trafficked women	Maternity care for trafficked persons.	
Bows (2018)	To examine practitioner perceptions of the effects of sexual violence on people aged 60 and over, the impact that age has on experience and challenges this creates in accessing and providing support services, and the current gaps in service provision.	Population type: Professionals and victims Age: 18+ Gender: female only Ethnicity: mainly Minority ethnicity	Rape/abuse as an adult	Range of services	Older people (defined as 60 years +)

Brooker & Durmaz (2015)	To investigate the mental health status of SARCs' victims and the extent to which this is being addressed 2) to elicit basic information about the work of SARCs (Sexual Assault Referral centres) in the field of mental health	Population type: Professionals Age: not stated Gender: not stated Ethnicity: not stated	Rape/abuse at any point in life	SARCS	Already known to mental health services
Brooker et al. (2018)	The aim of the survey was to elicit forensic physicians' (FPs) views about the assessment of mental health in Sexual Assault Referral Centres (SARCs) both for children/young people and adults). A further aim was to obtain FPs' views about the adequacy of mental health pathways out of a SARCs for follow-up care	Population type: Professionals Age: not stated Gender: not stated Ethnicity: not stated	Rape/abuse at any point in life	SARCs + mental health services (pathways)	The majority were female (80%); The whole sample had worked in a SARC for an average of 9 years and assessed on average 4.45 adults (SD=4.379) and 3.71 children/young people (SD=4.452) per month
Canning (2014)	To explore conflict related sexual violence support for women seeking asylum in Merseyside.	Population type: Professionals and victims Age: not stated	Women fleeing conflict/ seeking asylum	organisations supporting women who are seeking asylum in Merseyside.	

		Gender: female only Ethnicity: mainly Minority ethnicity			
Chouliara (2011)	To elicit the perspectives of adult survivors of Childhood Sexual Abuse (CSA) and of professionals working therapeutically in this field about talking therapy services, especially regarding helpful and hindering experiences and perceived satisfaction of needs.	Population type: Professionals and victims Age: 18+ Gender: female only Ethnicity: not stated	Sexual abuse as a child who have not used mental health services		Out of the 31 professionals, 16 worked in the statutory and 15 in the voluntary sector, six were male and 21 were female. Victims: data on participants' age, ethnic background, and the abuse itself were not collected. This was a pragmatic choice in order to minimize intrusion and ensure acceptability of the study by heads of services and participants as much as possible.

Chouliara (2014)	To elicit experiences of recovery from CSA in male and female survivors who have/have not utilized mental health services to propose a theoretical model of personally meaningful recovery.	Population type: Professionals Age: not stated Gender: not stated Ethnicity: not stated	Sexual abuse as a child	Talking therapy services	
Cowley et al. (2014)	To explore the role of SANEs currently working in England.	Population type: Professionals and victims Age: 18+ Gender: female only Ethnicity: not stated	Rape/abuse at any point	Not stated	5 SANEs were White British women aged 40–55 years and worked in SARCs in different areas of England.
Domoney et al. (2015)	To understand how people are identified as potential victims of trafficking within mental health services and the challenges that mental health professionals experience in responding to trafficked people's needs.	Population type: Professionals and victims Age: mixed age (age16-18) and over.	Trafficked women	South London and Maudsley NHS Foundation Trust	Medical notes written up in medical encounters at South London and Maudsley NHS Foundation Trust (SLaM) and stored on the Biomedical Research Centre (BRC) Case Register Interactive

		Gender: Mixed gender Ethnicity: not stated			Search (CRIS) database. The SLaM Patient Journey System (PJS), an integrated electronic clinical record used across all SLaM services that provides a comprehensive record of all clinical information recorded during patients' contacts with SLaM, has over 200,000 cases which are returnable through the CRIS system.
Doran (2015)	To illuminate the experiences of sexual violence counsellors (n=4), working both in an NHS SARC and a specialist voluntary agency in the North West of England	Population type: Professionals Age: not stated Gender: not stated Ethnicity: not stated	Trafficked people	NHS SARC	

Franklin & Smeaton (2017)	1) detail current provision of services for disabled children 2) explore the views of practitioners, managers and local and national policymakers looking into both enablers of and barriers to good practice 3) understand the needs of children and young people with learning disabilities who are at risk of, or who have experienced, CSE, and gather their views on current practice 4) identify gaps in policy, provision, evidence and research 5) generate evidence-based recommendations for future developments in this area of work. These aims were defined by the funder.	Population type: Professionals and victims Age: includes under 16yrs (12-23) Gender: mixed Ethnicity: not stated	Child Sexual Exploitation	Learning disabilities services	Learning disability
Gill & Harrison (2016)	To explore the barriers preventing women and children from South Asian communities,	Population type: Professionals and victims	Women and children from South Asian communities/ sexual abuse.	Police from four police areas in England and Wales	

	living in England and Wales, from reporting sexual abuse.	Age: not stated Gender: female only Ethnicity: mainly minority ethnic			
Gilligan (2016)	What Do Young Women (current or former service users of two voluntary-sector projects specialising in services for young people and who have been or are at risk of child sexual exploitation (CSE), say Helps them to Move On from Child Sexual Exploitation?	Population type: Victims/survivors Age: includes under 16yrs Gender: mixed Ethnicity: not stated	Child sexual exploitation	Two voluntary-sector projects	
Gray & Garner (2015)	The Rape and Sexual Abuse Support Centre (Rape Crisis South London) was commissioned by the London Borough of Newham in October 2014 to conduct a needs assessment for victim-survivors of sexual violence in the Borough, focused on identifying and understanding the needs of victim-survivors of sexual	Population type: Professionals and victims Age: 18+ Gender: mixed Ethnicity: mixed	Rape/abuse at any point	Range of sexual and domestic violence and social care services across Newham	

	violence in Newham aged over 16 years.				
Hailes et al. (2018)	Peer researchers conducted interviews with other women in their communities to ensure that the voices of those with lived experience shape the recommendations of a national commission focusing on domestic & sexual abuse against women facing multiple disadvantage	Population type: Victims/survivor Age: 18+ Gender: female only Ethnicity: mixed	Rape/abuse at any point	Range – including police, health, mental health, housing, substance use and children's services.	Women with lived experience of domestic and sexual abuse, but also multiple disadvantage: 38% of women specifically mentioned being diagnosed with some form of mental health issue, and all women clearly described the traumatic impacts of abuse. 30% disclosed using substances, with cocaine and heroin being the most common. Less women mentioned using alcohol – 13% discussed this. However, some women mentioned parents' or partners' problematic drinking negatively affecting them. 25% of women had experienced some form of social services

					involvement in relation to their children.
Hester & Lilley (2018) [Linked paper: Hester & Lilley (2017)]	To explore the ISVA role(s), including emotional support, the link with other sexual violence services, and the ways in which the needs of victims/survivors are experienced by the victims/survivors themselves and how well they see these as being met.	Population type: Professionals and victims Age: not stated Gender: mixed (12 women and 3 men) Ethnicity: not stated	Rape/abuse at any point	ISVAs Independent Sexual Violence Advisors	During the research period there were eight ISVAs employed in the research location, four full-time and four part-time, including a male ISVA and a specialist children's and young person's ISVA. A Life Enhancement Skills Adviser (LESA) worked as part of the ISVA team to specifically support victims with regard to practical issues
Idriss (2018)	To consider whether the recommendations made by the House of Commons Home Affairs Committee (HCHAC) about Honour Based Violence emergency responses and intervention have been acted upon eight years since the report was first published. It will consider the responses of 38,	Population type: Professionals and victims Age: not stated Gender: female only Ethnicity: mainly minority ethnicity	Forced Marriage	Range – police, education, social care, health	Survivors: All but one of the eight survivors were South-Asian and Muslim (one survivor was a South-Asian Hindu). All were residing in Northern and Central England at the time of interview. Five of the survivors were born in Pakistan,

	mainly female, participants who have directly witnessed or experienced emergency responses and intervention from public agencies, whether as victims or as frontline professionals.				two were born in the UK, and the remaining survivor was born in India. Many had little or no post-16 education as they were prevented from going to college or had arranged marriages at a young age. Only one UK-born survivor had university qualifications and was in full-time employment during her abuse. Professionals: Most of the key agent sample were drawn from refuge or support work (18); others were employed by the criminal justice system as serving police officers of various ranks (8); solicitors/legal workers in the CPS (2); and local authority employees (2).

Imkaan (2016a)	This report documents the findings of a series of events held in Cardiff, London, Manchester and Sheffield by Imkaan and Rights of Women to reflect on local and regional responses to forced marriage in 2015.	Population type: Professionals Age: not stated Gender: female only Ethnicity: not stated	Forced marriage	Statutory and voluntary organisations	Participants were from different sectors, including: academic; CJS (criminal justice system); legal practitioners; statutory health services; specialist VAWG services
Imkaan (2016b)	The discussions focused on women's experiences of mental health and wellbeing, access to services provision as well as the quality of services they may have received.	Population type: Professionals and victims Age: not stated Gender: female only Ethnicity: not stated	Rape/abuse at any point	Mental health services UK	BME specialist organisation – Ethnicity not reported
Imkaan (2018)	To inform Imkaan's public policy work and Oak Foundation's Issues Affecting Women Programme strategy for the UK; as well as providing further evidence about the state of the BME ending VAWG sector.	Population type: Professionals Age: not stated Gender: female only Ethnicity: not stated	Rape/abuse at any point	Rape crisis, sexual violence service providers	Providers mainly in BME sector

Jackson & Fraser (2009)	To investigate midwives' knowledge and attitudes in relation to caring for women who have been sexually abused.	Population type: Professionals Age: not stated Gender: female only Ethnicity: not stated	Rape/abuse at any point	Community and hospital midwifery – four NHS trusts in Midlands	Caring for pregnant women in childbirth after SV
Jackson (2017)	There is a dearth of literature that has looked at the psychological impact of female genital mutilation/cutting (FGM/C), and little is known about the understanding and awareness of FGM/C amongst counselling professionals	Population type: Professionals Age: 18+ Gender: mixed Ethnicity: not stated	FGM	Counselling professionals	Over half of respondents (n = 1133, 54.7%) indicated that they work in private practice (defined here as practitioners who work independently) and/or the third/charitable/voluntary (TCV) sector (n = 939, 45.3%). Almost three-quarters (n = 1509, 72.8%) had trained in a humanistic/person-centred therapy.

					Despite the relatively low response rate, the demographic and workplace characteristics of survey respondents are broadly reflective of the wider BACP membership (BACP, 2016), suggesting that the sample was fairly representative of BACP members more generally
Javaid (2018) [Linked reports: Javaid (2017, 2017, 2019)]	To explore: * how notions of sexualities affect British state and voluntary agencies' understanding of male rape and their views of men as victims of rape; * how do notions of gender, sexualities and masculinities affect and shape state and voluntary agencies' understanding of male rape and their views of men as victims of rape? * what roles do gender, sexualities and masculinities play in the discourse of male sexual victimization?	Population type: Professionals Age: not stated Gender: male only Ethnicity: not stated	Rape and abuse at any point	police and voluntary agencies	Specialist police officers (4); police detectives (4); police constables (34); police sergeants (9); police response officers (2); male rape counsellors (7); male rape therapists (3); and voluntary agency caseworkers (7). In terms of gender, the participants comprised 33 males and 37 females. The sample is predominantly white

					and most of the participants are under 40 years of age and are mostly from highly educated and middle-class backgrounds. The respondents provide services for many male rape victims. On average, the respondents have had around seven years of experience of working with male rape victims and male victims of sexual assault; most of their clients are middle-class men. Some of my participants had no training in relation to male rape and sexual assault against men, but most had training in female rape and sexual assault against women, considering that violence against women is still a salient issue

Kliner & Stroud (2012)	This study aims to assess the psychological and physical impact on health and social care staff working with an identified sex-trafficked population in a Northern City within England and identify methods to assist staff to manage this complex population.	Population type: Professionals Age: not stated Gender: female only Ethnicity: not stated	Sex trafficked	Health and social care staff, Northern city in England	Twelve participants were chosen by purposive sampling and included staff within the voluntary and community sector managing the women's overall care, a wide range of healthcare professionals in general practice managing the women's health needs and support workers who manage the women's daily needs in order to ensure that a wide range of views and experiences were included in the study.
Matthew & Barron (2015)	Participatory action research was utilized to design a survey and semi-structured interview to investigate ritual abuse survivor experience of seeking help.	Population type: Victims and survivors Age: 18+ Gender: mixed Ethnicity: not stated	Ritual abuse	Range. Rape services, police, domestic violence, health, and social services	

McCarry et al. (2018) [Linked report: Berry et al. (2014)]	Draws on focus groups and interviews with fifty-three service users and thirty-one purposively selected service providers to explore their perspectives on Violence Against Women (VAW) service provision in Wales.	Population type: Professionals and victims Age: not stated Gender: female only Ethnicity: not stated	Rape/and abuse by intimate partner	Violence Against Women Services in Wales	Stakeholders: Eight were key strategic leads holding commissioning and/or policy roles and twenty-three were direct service providers in the VAW sector.
McMillan (2015)	To explore factors influencing attrition (from police service) in rape cases 'to explore the role of the STO in rape and sexual offence cases from the perspective of the officers who perform this role and those who work directly on rape and sexual offence reports.'	Population type: Professionals Age: not stated Gender: not stated Ethnicity: not stated	Rape/abuse at any point	Police. STO in one county in England	14 Female and 26 Male officers Ethnicity not reported
Montgomery et al. (2015)	To inform practice by exploring the impact that childhood sexual abuse has on the maternity care experiences of adult women	Population type: Victims/survivor Age: 18+ Gender: female only	Sexual abuse as a child	Maternity	Participants were all users of one maternity service in the South of England. women for whom speaking or understanding English was difficult were excluded

		Ethnicity: white			
Ranjbar & Speer (2013)	This study explores participants' own accounts of recovery from an experience of sexual assault, and to identify factors that they perceived as facilitating or impeding their recovery process.	Population type: Victims/survivors Age: 18+ Gender: female only Ethnicity: not stated	Rape/abuse at any point	Participants recruited through British organizations that address sexual assault	Participants experienced sexual assault and considered themselves as having "recovered". self-defined experience of sexual assault after the age of 13 years
Robinson & Hudson (2011	To compare the advantages and limitations of different models of support for victims of sexual violence (SARCs and voluntary-sector-based projects, each with and without Independent Sexual Violence Advisors)	Population type: Professionals and victims Age: not stated Gender: mixed Ethnicity: not stated	Rape/abuse at any point	SARCs (Sexual Assault Referral Centres) with specialist support workers (ISVAs - Independent Sexual Violence Advisor);	
Shah et al. (2016)	To generate data about the social world of a sample of disabled women across the United Kingdom who are survivors of violence and	Population type: Victims/survivors Age: 18+ Gender: female only	Rape/abuse as an adult by intimate partner	support services	women with disabilities (including cognitive, sensory, and physical) from different ethnic backgrounds

	have experience of specialist support services	Ethnicity: mixed			
Smith et al. (2015)	The research aims to identify: • what services are used by adult CSA survivors in the UK; • to what extent services met survivors needs; and • the adequacy and availability of information about services.	Population type: Victims/survivors Age: 18+ Gender: mixed Ethnicity: not stated	Sexual abuse as child	All settings – national survey	87% female, 13% male
Somerset & Avon Rape Sexual Abuse Support (SARSAS) (2018)	To investigate and provide a valid experience of current group work service provision from a broad and thorough cross section of consultation with other specialist organisations local and nationally who currently deliver group work with survivors of sexual violence and to investigate and provide a valid experience of current service users' experience of group work.	Population type: Professionals and victims Age: not stated Gender: female only Ethnicity: not stated	Rape/abuse at any point	Group work	

Stanley et al. (2016)	Young people who have been trafficked may have experienced significant trauma and violence but little is known about their health and healthcare needs. This UK study aimed to address that gap.	Population type: Professionals and victims Age: mixed aged Gender: mixed Ethnicity: All BME	Young people who have been trafficked.	Health services in UK	16 to 21 years 24 female, five male Participants originated from 12 countries, including Nigeria, Albania, and Slovakia. The majority originated from African countries, with two-fifths (10) of the young women from Nigeria. Nearly a third (7) of the young women were Eastern European.
Thiara et al. (2015)	To generate an initial body of evidence about the extent to which BME women and girls are disclosing sexual violence and accessing support services; To gather evidence on emerging barriers and gaps to accessing support.	Population type: Professionals Age: Mixed age Gender: female only Ethnicity: All BME	Rape/Abuse at any point	Sexual violence services and a sample of specialist BME domestic violence services	Marginalised women from BME communities also in the table included Young women (14-18 years)
Voscur (2018)	The aim of this research is to ascertain the needs of survivors, and consider how adult sexual violence services in Avon and	Population type: Professionals and victims	Rape/Abuse at any point	Adult sexual violence services in Somerset & Avon	Aged 16-25 years

	Somerset can better meet those needs.	Age: mixed Gender: mixed Ethnicity: not stated			

Appendix E: List of included evaluation studies n=106

UK studies are marked with *

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Appendix F: Study details for UK evaluations

No.	First Author (Year)	Location Population Type of Sexual Violence Setting	Design Intervention Comparator Outcomes	Gender of victim-survivors Age of victim-survivors Ethnicity of victim-survivors Specific population
Outcome evaluations				
10	Calvert (2015)	UK – England Victim-Survivors Sexual abuse as a child Public healthcare – NHS	Non-randomised controlled Therapy – CAT No treatment or waiting list control Scales – wellbeing and functioning; depression or anxiety	Women only Aged 18 and over only Mainly White No specific population
14	Clifford (2018)	UK – England Victim-Survivors Rape/abuse as an adult – perpetrator not specified Specialist sexual violence services	Before and after Therapy – STAIR NA Scales – PTSD; depression or anxiety	Women only Aged 18 and over only Mixed ethnicity PTSD
23	Ellis (2012)	UK – England Victim-Survivors Sexual abuse as a child	Before and after Therapy – Other NA	Women only Aged 18 and over only Not stated

No.	First Author (Year)	Location Population Type of Sexual Violence Setting	Design Intervention Comparator Outcomes	Gender of victim-survivors Age of victim-survivors Ethnicity of victim-survivors Specific population
		A mixture of settings	Scales – wellbeing and functioning; suicide	No specific population
65	Robjant (2017)	UK – England Victim-Survivors Trafficked sex slavery Specialist sexual violence services	Before and after Therapy – Writing NA Scales – PTSD	Women only Aged 18 and over only Mainly minority ethnicity PTSD
Outcome and process evaluations				
91	Harding-Jones (2018)	UK – England Both Profess and VS Trafficked sex slavery Specialist sexual violence services	Before and after Therapy – general CBT NA Scales – PTSD; wellbeing and functioning. Views	Women only Aged 18 and over only Not stated No specific population
93	Karatzias (2014)	UK – Scotland Victim-Survivors Sexual abuse as a child Public healthcare – NHS	Before and after Education – for victims NA	Mixed gender Aged 18 and over only Not stated No specific population

No.	First Author (Year)	Location Population Type of Sexual Violence Setting	Design Intervention Comparator Outcomes	Gender of victim-survivors Age of victim-survivors Ethnicity of victim-survivors Specific population
			Scales – PTSD; wellbeing and functioning; depression or anxiety; Dissociation. Views; Behaviour including service use	
98	Rumney (2019)	UK – England Both Profess and VS Rape/abuse at any point in life Police or legal	Service – police Usual care control Legal; Views; Referrals to specialist support services	Mixed gender Includes people aged <16 Mainly White Law enforcement/legal
Process evaluations				
99	Brooks (2017)	UK – Scotland Victim-Survivors Rape/abuse as an adult – perpetrator not specified Specialist sexual violence services	Process evaluation Service – advocacy NA Views	Women only Aged 18 and over only Not stated No specific population
100	Brooks-Hay (2018)	UK – Scotland Both Profess and VS Rape/abuse at any point in life	Process evaluation Service – advocacy NA	Mixed gender Includes people aged <16 Not stated

No.	First Author (Year)	Location Population Type of Sexual Violence Setting	Design Intervention Comparator Outcomes	Gender of victim-survivors Age of victim-survivors Ethnicity of victim-survivors Specific population
		Specialist sexual violence services	Views	No specific population
101	Donohoe (2010)	UK – England Professional Staff Rape/abuse at any point in life Public healthcare – NHS	Process evaluation Education – for professionals NA Knowledge, attitudes or skill assessment; Views; Behaviour including service use	NA NA NA Health professionals
102	Donovan (2011)	UK – England Both Profess and VS Rape/abuse at any point in life Specialist sexual violence services	Process evaluation Service – support and advocacy NA Views	Women only Aged 18 and over only Not stated No specific population
103	O'Neill (2016)	UK – England Both Profess and VS Sexual abuse as a child Specialist sexual violence services	Process evaluation Service – support and advocacy NA Views	Women only Aged 18 and over only Not stated No specific population

No.	First Author (Year)	Location Population Type of Sexual Violence Setting	Design Intervention Comparator Outcomes	Gender of victim-survivors Age of victim-survivors Ethnicity of victim-survivors Specific population
104	Saha (2011)	UK – England Victim-Survivors Sexual abuse as a child Specialist sexual violence services	Process evaluation Therapy – Other NA Views	Women only Aged 18 and over only All White No specific population
105	Van Staden (2010)	UK – England Professional Staff Rape/abuse at any point in life Police or legal	Process evaluation Service – police NA Views	NA NA NA Law enforcement/legal
106	Williams (2017)	UK – England Victim-Survivors Sexual abuse as a child Specialist sexual violence services	Process evaluation Therapy – Other NA Views	Women only Aged 18 and over only Not stated No specific population

NA = not applicable – no comparator, or no victim-survivors

Appendix G: Study details for 106 included evaluations

Population, sexual violence and setting

Highlighted rows are evaluations conducted in the UK.

	Author	Aim	Country Population Type of sexual violence Service setting	Study Design Intervention type Comparator Outcome types	Gender Age Ethnicity Specific population
Outcomes only					
1	Anderson (2010)	To assess the effects of clinician-assisted emotional disclosure (CAED), in ameliorating distress experienced by survivors of sexual assault	USA Victim-Survivors Rape/abuse as an adult – perpetrator not specified University/education	RCT Therapy – CAED No treatment or waiting list control Scales – PTSD; wellbeing and functioning; Depression or Anxiety	Women only Aged 18 and over only Mainly Caucasian University/college students
2	Auten (2015)	To determine the effectiveness of a low-fidelity hybrid simulation-based educational intervention in improving the comfort and competence of physicians in training at a	USA Professional Staff Rape/abuse at any age Military medical	Before and after Education – for professionals NA Knowledge, attitudes or skill assessment	NA NA NA Health professionals

	Author	Aim	Country Population Type of sexual violence Service setting	Study Design Intervention type Comparator Outcome types	Gender Age Ethnicity Specific population
		residency programme without a pre-existing SANE programme			
3	Becker (2014)	To examine the feasibility of an integrated CBT and AT group treatment for adult CSA survivors	USA Victim-Survivors Sexual abuse as a child Public healthcare	Before and after Therapy – Other NA Scales – PTSD; Depression or Anxiety; Dissociation	Mixed gender Aged 18 and over only Mixed ethnicity PTSD
4	Belleville (2018)	To evaluate the efficacy of a combination of CBT and nightmare therapy (imagery rehearsal therapy; IRT) compared with CBT alone for the treatment of PTSD	Canada Victim-Survivors Rape/abuse at any age Not stated	RCT Therapy – IRT No treatment or waiting list control Scales – PTSD; wellbeing and functioning. Sleep quality & other sleep related symptoms	Mixed gender Aged 18 and over only Not stated PTSD
5	Bohus (2013)	To assess the effects of dialectical behaviour therapy for PTSD (DBT-PTSD) on PTSD	Germany Victim-Survivors	RCT Therapy – DBT	Women only

	Author	Aim	Country Population Type of sexual violence Service setting	Study Design Intervention type Comparator Outcome types	Gender Age Ethnicity Specific population
		symptoms in people with CSA-related PTSD with or without borderline personality disorder, compared with usual care	Sexual abuse as a child Residential care	Usual care control Scales – PTSD; wellbeing and functioning; Depression or Anxiety	Mixed age (aged 16 – 18 and over) Not stated PTSD
6	Bongaerts (2017)	To determine the safety and effectiveness of an intensive EMDR programme for CSA patients suffering from severe PTSD	Netherlands Victim-Survivors Rape/abuse at any age Public healthcare	Before and after Therapy – EMDR NA Scales – PTSD; wellbeing and functioning	Mixed gender Mixed age (aged 16 - 18 and over) Not stated PTSD
7	Britton (2013)	To evaluate the implementation of a standardised order set, for the care of adult sexual assault patients, that provided clinicians with treatment recommendations consistent with CDC guidelines	USA Professional Staff Rape/abuse at any age University/education	RCT Service – SANE Control not described Scales – PTSD; wellbeing and functioning; Depression or Anxiety	Women only Aged 18 and over only Mainly Caucasian Older or elderly

	Author	Aim	Country Population Type of sexual violence Service setting	Study Design Intervention type Comparator Outcome types	Gender Age Ethnicity Specific population
8	Brotto (2012)	To compare the efficacy of a cognitive behavioural or mindfulness-based group treatment to address sexual distress	Canada Victim-Survivors Sexual abuse as a child Public healthcare	Before and after Therapy – Mindfulness NA Adherence to guidelines	NA NA NA No specific population
9	Bowland (2012)	To evaluate the effectiveness of an 11-session, spiritually focused group intervention with older women survivors of interpersonal trauma (child abuse, sexual assault, or domestic violence) in reducing PTSD	USA Victim-Survivors Sexual abuse as a child University/education	RCT Therapy – holistic/residential Active control Scales – wellbeing and functioning. Sexual arousal or interest	Women only Aged 18 and over only Mainly Caucasian No specific population
10	Calvert (2015)	To investigate the effectiveness of 24 sessions of group cognitive analytic therapy (GCAT) delivered in routine practice for female survivors of CSA	UK – England Victim-Survivors Sexual abuse as a child Public healthcare	Non-randomised controlled Therapy – CAT No treatment or waiting list control	Women only Aged 18 and over only Mainly Caucasian No specific population

	Author	Aim	Country Population Type of sexual violence Service setting	Study Design Intervention type Comparator Outcome types	Gender Age Ethnicity Specific population
				Scales – wellbeing and functioning; Depression or Anxiety	
11	Campbell (2012)	To assess the impact of the SANE programme on criminal justice case outcomes	USA Victim-Survivors Rape/abuse as an adult – perpetrator not specified Specialist sexual violence services	Before and after Service – SANE NA Legal	Not stated Aged 18 and over only Not stated No specific population
12	Campbell (2014)	To assess how implementation of SANE programmes affects adult sexual assault prosecution rates	USA Victim-Survivors Rape/abuse as an adult – perpetrator not specified Specialist sexual violence services	Before and after Service – SANE NA Legal	Not stated Aged 18 and over only Not stated No specific population
13	Cash (2009)	To examine the efficacy of the Seeking Safety intervention in reducing trauma-related symptoms and improved	USA Victim-Survivors Sexual abuse as a child	RCT Therapy – Seeking Safety Usual care control	Women only Aged 18 and over only Mixed ethnicity

	Author	Aim	Country Population Type of sexual violence Service setting	Study Design Intervention type Comparator Outcome types	Gender Age Ethnicity Specific population
		drug abstinence among women in residential chemical dependence treatment	Residential care	Scales – PTSD. Drug/hormone test	Substance abuse
14	Clifford (2018)	To examine the efficacy of a 12-session Emotion- and Memory-Processing Group Programme on PTSD	UK – England Victim-Survivors Rape/abuse as an adult – perpetrator not specified Specialist sexual violence services	Before and after Therapy – STAIR Scales – PTSD; Depression or Anxiety	Women only Aged 18 and over only Mixed ethnicity PTSD
15	Cloitre (2010)	To evaluate the benefits and risks of a treatment combining an initial preparatory phase of skills training in affect and interpersonal regulation (STAIR) on PTSD	USA Victim-Survivors Sexual abuse as a child Not stated	RCT Therapy – STAIR Active control Scales – PTSD; wellbeing and functioning; Depression or Anxiety; Other mood states; Social support	Women only Aged 18 and over only Mixed ethnicity PTSD
16	Dombo (2014)	To test the effects of The Feminist-Cognitive-	USA	RCT	Women only

	Author	Aim	Country Population Type of sexual violence Service setting	Study Design Intervention type Comparator Outcome types	Gender Age Ethnicity Specific population
		Relational Social Work Intervention (FCRSWI) on relational health in CSA survivors	Victim-Survivors Sexual abuse as a child Voluntary services	Therapy – feminist cognitive Usual care control Scales – wellbeing and functioning	Aged 18 and over only Mixed ethnicity No specific population
17	Dorrepaal (2012)	To test the efficacy of a behavioural stabilising group treatment on PTSD severity in people with history of childhood abuse (physical and sexual abuse)	Netherlands Victim-Survivors Sexual abuse as a child Public healthcare	RCT Therapy – general CBT Usual care control Scales – PTSD; wellbeing and functioning	Mixed gender Aged 18 and over only Not stated PTSD
18	Duberstein (2018)	To compare Interpersonal Psychotherapy-Trauma (IPT-T), for depressed women with child abuse histories, with clinic psychotherapy (CP)	USA Victim-Survivors Sexual abuse as a child Public healthcare	RCT Therapy – psychotherapy Usual care control Scales – PTSD; wellbeing and functioning; Depression or Anxiety; Social support; Physical health.	Women only Aged 18 and over only Mixed ethnicity Depression

	Author	Aim	Country Population Type of sexual violence Service setting	Study Design Intervention type Comparator Outcome types	Gender Age Ethnicity Specific population
				Knowledge, attitudes or skill assessment	
19	Dutton (2017)	To evaluate the preliminary effectiveness of the JHF Holistic Healing Retreat for improving wellbeing and resilience among counsellors, advocates and lawyers who deliver services to survivors of child abuse, domestic violence, and sexual assault	USA Professional Staff Rape/abuse at any age A mixture of settings	Before and after Therapy – holistic/residential NA Scales – PTSD; wellbeing and functioning; Depression or Anxiety. Sleep quality & other sleep related symptoms. Knowledge, attitudes or skill assessment.	NA NA NA No specific population
20	Earley (2014) Follow-up study, at 2.5 years, to Kimbrough 2010	To examine the long-term effects of a mindfulness-based stress reduction (MBSR) programme on PTSD for adult survivors of CSA	USA Victim-Survivors Sexual abuse as a child Public healthcare	Before and after Therapy – Mindfulness NA Scales – PTSD; wellbeing and functioning; Depression or Anxiety	Not stated Aged 18 and over only Mainly Caucasian No specific population

	Author	Aim	Country Population Type of sexual violence Service setting	Study Design Intervention type Comparator Outcome types	Gender Age Ethnicity Specific population
21	Elkjaer (2014) Follow-up study, at one year, to Lau, 2007	To ascertain the durability of gains achieved one year after treatment completion by the women in Lau & Kristensen, 2007	Denmark Victim-Survivors Sexual abuse as a child Public healthcare	RCT Therapy – CAT Active control Scales – wellbeing and functioning	Women only Aged 18 and over only Not stated No specific population
22	Elklit (2015)	To investigate the changes in psychological and social domains associated with treatment in survivors of CSA	Denmark Victim-Survivors Sexual abuse as a child Public healthcare	Before and after Therapy – STAIR NA Scales – PTSD; wellbeing and functioning	Mixed gender Includes people aged <16 All Caucasian No specific population
23	Ellis (2012)	To demonstrate the effectiveness of the Butterfly Programme (a group therapy programme) for adult survivors of CSA	UK – England Victim-Survivors Sexual abuse as a child A mixture of settings	Before and after Therapy – Other NA Scales – wellbeing and functioning; suicide	Women only Aged 18 and over only Not stated No specific population
24	Embregts (2017)	To evaluate a five-day training programme for psychologists to detect	Netherlands Professional Staff	Before and after	NA NA

	Author	Aim	Country Population Type of sexual violence Service setting	Study Design Intervention type Comparator Outcome types	Gender Age Ethnicity Specific population
		and assess (alleged) sexual abuse among people with intellectual disabilities who have been either the victim or the perpetrator of sexual abuse	Rape/abuse at any age Public healthcare	Education – for professionals NA Knowledge, attitudes or skill assessment	NA Learning disabilities
25	Fitzpatrick (2012)	To evaluate the competence of advanced registered nurse practitioner (ARNP)s in performing examinations independently, after attending state-wide sexual assault nurse examination training using simulation technology	USA Professional Staff Rape/abuse at any age Public healthcare	Before and after Education – for professionals NA Knowledge, attitudes or skill assessment	NA NA NA Health professionals
26	Fletcher (2017)	To assess the effectiveness of personalised psychotherapy (including cognitive, psychodynamic, and	Denmark Victim-Survivors Sexual abuse as a child Public healthcare	Before and after Therapy – psychotherapy NA	Mixed gender Includes people aged <16 All Caucasian PTSD

	Author	Aim	Country Population Type of sexual violence Service setting	Study Design Intervention type Comparator Outcome types	Gender Age Ethnicity Specific population
		behavioural treatments) on PTSD in CSA survivors		Scales – PTSD; wellbeing and functioning	
27	Gerardi (2010)	To examine changes in salivary cortisol levels in response to EMDR treatment in female rape victims with PTSD	USA Victim-Survivors Rape/abuse at any age Public healthcare	RCT Therapy – EMDR Active control Scales – PTSD; Depression or Anxiety. Drug/hormone test	Women only Aged 18 and over only Not stated PTSD
28	Glass (2017)	To test the effectiveness of a tailored online safety information and safety planning aid for women experiencing intimate partner violence	USA Victim-Survivors Rape/abuse as adult by intimate partner Online	RCT Therapy – By computer or video No treatment or waiting list control Scales – PTSD; wellbeing and functioning; Depression or Anxiety	Women only Aged 18 and over only Mixed ethnicity No specific population
29	Gooch (2019)	To examine relational group psychotherapy processes including group cohesion and bond	USA Victim-Survivors	Before and after Therapy – general CBT	Women only Aged 18 and over only

	Author	Aim	Country Population Type of sexual violence Service setting	Study Design Intervention type Comparator Outcome types	Gender Age Ethnicity Specific population
		with the group leaders as vital components in treatment for sexual trauma	Rape/abuse at any age Voluntary services	NA Scales – PTSD; wellbeing and functioning	Mixed ethnicity No specific population
30	Gutner (2013)	To examine the impact of Cognitive Processing Therapy (CPT) and Prolonged Exposure (PE) on subjective measures of sleep disturbance among female rape victims	USA Victim-Survivors Rape/abuse at any age Not stated	RCT Therapy – CPT Active control Scales – PTSD. Sleep quality & other sleep related symptoms	Women only Aged 18 and over only Mixed ethnicity PTSD
31	Ha Neul (2019)	To examine the therapeutic effects of forgiveness writing therapy in victims of sexual abuse	South Korea Victim-Survivors Rape/abuse as an adult – perpetrator not specified Not stated	RCT Therapy – Writing No treatment or waiting list control Scales – PTSD; wellbeing and functioning; Depression or Anxiety	Mixed gender Aged 18 and over only Not stated University/college students
32	Habib (2013)	To assess the effectiveness of Structured	USA	Before and after	Mixed gender

	Author	Aim	Country Population Type of sexual violence Service setting	Study Design Intervention type Comparator Outcome types	Gender Age Ethnicity Specific population
		Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS)	Victim-Survivors Rape/abuse at any age Residential care	Therapy – psychotherapy NA Scales – PTSD; wellbeing and functioning	Includes people aged <16 Mixed ethnicity No specific population
33	Harper (2009)	To assess the effectiveness of CSA group treatment in survivors with and without histories of eating disorders	USA Victim-Survivors Sexual abuse as a child A mixture of settings	Alternative population comparison Therapy – general CBT NA Scales – wellbeing and functioning; Depression or Anxiety	Women only Aged 18 and over only Mainly Caucasian No specific population
34	Hassija (2011)	To evaluate the effectiveness and feasibility of providing evidence-based, trauma-focused treatment via videoconferencing to rural survivors of domestic violence and sexual assault	USA Victim-Survivors Rape/abuse at any age Voluntary services	Before and after Therapy – By computer or video NA Scales – PTSD; wellbeing and functioning; Depression or Anxiety	Women only Aged 18 and over only Not stated PTSD

	Author	Aim	Country Population Type of sexual violence Service setting	Study Design Intervention type Comparator Outcome types	Gender Age Ethnicity Specific population
35	Hemma (2018)	To evaluate the efficacy of the Warrior Renew intervention for treating sexual trauma in a substance abuse residential programme for women	USA Victim-Survivors Sexual abuse as a child Residential care	Before and after Therapy – Warrior Renew NA Scales – PTSD; wellbeing and functioning	Women only Aged 18 and over only Mixed ethnicity Substance abuse
36	Hill (2011)	To examine the efficacy of a brief mindfulness-based programme in reducing rates of sexual assault and re-victimisation in college women	USA Victim-Survivors Sexual abuse as a child University/education	Non-randomised controlled Therapy – Mindfulness Control not described Scales – wellbeing and functioning. Re-victimisation. Knowledge, attitudes or skill assessment	Women only Aged 18 and over only Mixed ethnicity University/college students
37	Holliday (2014)	To assess the effects of cognitive processing therapy and present-centred therapy on negative conditions	USA Victim-Survivors Military sexual trauma	RCT Therapy – CPT Active control	Mixed gender Aged 18 and over only Mixed ethnicity

	Author	Aim	Country Population Type of sexual violence Service setting	Study Design Intervention type Comparator Outcome types	Gender Age Ethnicity Specific population
		among veterans diagnosed with MST	Military medical	Scales – PTSD	Military
38	Holliday (2015)	To examine the effectiveness of CPT in addressing psychosocial, health, and quality of life in veterans with MST-related PTSD	USA Victim-Survivors Military sexual trauma Military medical	RCT Therapy – CPT Active control Scales – PTSD; wellbeing and functioning	Mixed gender Aged 18 and over only Mixed ethnicity Military with PTSD
39	Holliday (2017) Secondary analysis of: Suris et al. (2013)	To evaluate the effectiveness of CPT for Black and White female veterans with MST-related PTSD	USA Victim-Survivors Military sexual trauma Military medical	Alternative population comparison Therapy – CPT NA Scales – PTSD	Women only Aged 18 and over only Mixed ethnicity Military with PTSD
40	Holliday (2018)	To examine the effectiveness of CPT in reducing suicide-specific beliefs among veterans with MST-related PTSD	USA Victim-Survivors Military sexual trauma Military medical	Before and after Therapy – CPT NA Scales – suicide	Mixed gender Aged 18 and over only Mixed ethnicity Military with PTSD

	Author	Aim	Country Population Type of sexual violence Service setting	Study Design Intervention type Comparator Outcome types	Gender Age Ethnicity Specific population
41	Jepsen (2009)	To examine the changes in psychiatric symptoms and interpersonal problems in adults with a history of CSA and post-traumatic stress disorder who attended an inpatient treatment programme	Norway Victim-Survivors Sexual abuse as a child Residential care	Alternative population comparison Therapy – holistic/residential NA Scales – PTSD; wellbeing and functioning; Depression or Anxiety	Mixed gender Aged 18 and over only Not stated PTSD
42	Jung (2013)	To examine the efficacy of Cognitive Restructuring and Imagery Modification (CRIM) for the treatment of PTSD and the feeling of being contaminated following CSA	Germany Victim-Survivors Sexual abuse as a child Public healthcare	RCT Therapy – CRIM No treatment or waiting list control Scales – PTSD; Depression or Anxiety; Other mood states; contamination	Women only Aged 18 and over only Mainly Caucasian PTSD
43	Katz (2014)	To assess the effectiveness of Renew for women Veterans with complex issues including sexual trauma, PTSD, medical problems,	USA Victim-Survivors Military sexual trauma	Before and after Therapy – Warrior Renew NA	Women only Aged 18 and over only Mixed ethnicity

	Author	Aim	Country Population Type of sexual violence Service setting	Study Design Intervention type Comparator Outcome types	Gender Age Ethnicity Specific population
		chronic pain, and histories of homelessness and substance abuse	Military medical	Scales – PTSD; wellbeing and functioning; Other mood states	Military
44	Katz (2014)	To assess whether holographic processing (HR) and PE reduce symptoms related to trauma more so than person-centred (PC) therapy	USA Victim-Survivors Military sexual trauma Military medical	RCT Therapy – Other Active control Scales – PTSD; Other mood states	Women only Aged 18 and over only Mixed ethnicity Military
45	Katz (2015) Follow-up, at one year, to Katz (2014)	To (re)-evaluate the effectiveness of the Renew sexual trauma treatment programme for female veterans and assess results at one year follow-up	USA Victim-Survivors Military sexual trauma Military medical	Before and after Therapy – Warrior Renew NA Scales – PTSD; wellbeing and functioning	Women only Aged 18 and over only Mixed ethnicity Military
46	Katz (2016)	To examine the change in perceived attachment style in relationships in graduates of the Warrior	USA Victim-Survivors Military sexual trauma	Before and after Therapy – Warrior Renew NA	Women only Aged 18 and over only Mixed ethnicity

	Author	Aim	Country Population Type of sexual violence Service setting	Study Design Intervention type Comparator Outcome types	Gender Age Ethnicity Specific population
		Renew programme for sexual trauma treatment	Military medical	Scales – wellbeing and functioning; Other mood states	Military
47	Katz (2019)	To determine whether a brief version of Warrior Renew delivered in Veteran Affairs (VA) primary care is feasible and effective in reducing negative cognitions, anxiety, depression, and post-traumatic symptoms	USA Victim-Survivors Military sexual trauma Military medical	Before and after Therapy – Warrior Renew NA Scales – PTSD; wellbeing and functioning; Depression or Anxiety. Views	Women only Aged 18 and over only Mixed ethnicity Military
48	Kearns (2010)	To assess the effectiveness of Pennebaker's emotional disclosure paradigm with sexual assault survivors	USA Victim-Survivors Rape/abuse as an adult -perpetrator not specified University/education	RCT Therapy – Writing Active control Scales – PTSD; wellbeing and functioning; Other mood states; Physical health	Women only Aged 18 and over only Mainly Caucasian University/college students

	Author	Aim	Country Population Type of sexual violence Service setting	Study Design Intervention type Comparator Outcome types	Gender Age Ethnicity Specific population
49	Kimbrough (2010) Linked to Earley 2014	To assess the efficacy of mindfulness meditation-based stress reduction (MBSR) on PTSD among adult CSA trauma survivors	USA Victim-Survivors Sexual abuse as a child University/education	Before and after Therapy – Mindfulness NA Scales – PTSD; Depression or Anxiety. Side-effects; Knowledge, attitudes or skill assessment; Views	Mixed gender Aged 18 and over only Mainly Caucasian No specific population
50	Kip (2015)	To compare the effectiveness of Accelerated Resolution Therapy (ART) for the treatment of symptoms of PTSD and sexual trauma between civilian and military adults	USA Victim-Survivors Rape/abuse as an adult – perpetrator not specified A mixture of settings	Alternative population comparison Therapy – ART NA Scales – PTSD; wellbeing and functioning; Depression or Anxiety; Other mood states. Sleep quality & other sleep related symptoms; Behaviour including service use	Mixed gender Aged 18 and over only Mainly Caucasian Military

	Author	Aim	Country Population Type of sexual violence Service setting	Study Design Intervention type Comparator Outcome types	Gender Age Ethnicity Specific population
51	Kruger (2014)	To explore the course of an exposure-based treatment programme for female patients suffering from PTSD related to CSA who also show severe comorbidity	Germany Victim-Survivors Sexual abuse as a child Residential care	RCT Therapy – DBT No treatment or waiting list control Scales – PTSD	Women only Aged 18 and over only Not stated PTSD
52	Kumar (2017)	To compare two, three, and four-drug regimens, and their associated outcomes for patients at a sexual assault care facility	Canada Victim-Survivors Rape/abuse as an adult – perpetrator not specified Public healthcare	Non-randomised controlled Secondary prevention – HIV Active control Side-effects; Behaviour including service use	Mixed gender Includes people aged <16 Not stated No specific population
53	Lange (2013)	To confirm the effects of online treatment (therapist-assisted Web-based treatment) of adolescent victims of sexual abuse	USA Victim-Survivors Rape/abuse at any age A mixture of settings	Before and after Therapy – Other NA Scales – PTSD; wellbeing and functioning; Social support	Women only Aged 18 and over only Mainly Caucasian No specific population

	Author	Aim	Country Population Type of sexual violence Service setting	Study Design Intervention type Comparator Outcome types	Gender Age Ethnicity Specific population
54	Lee (2019)	To develop an inter-professional simulation event that would foster sexual assault interview skills, foster effective communication with patients, and increase learner confidence in assessing sexual assault patients	USA Professional Staff Military sexual trauma Military medical	Before and after Education – for professionals NA Knowledge, attitudes or skill assessment	NA NA NA Military
55	Littleton (2016)	To compare the efficacy of the From Survivor to Thriver programme with a self-help psycho-educational website among a sample of college women who met full diagnostic criteria for rape-related PTSD	USA Victim-Survivors Rape/abuse as an adult – perpetrator not specified Online	RCT Therapy – By computer or video Active control Scales – PTSD; Depression or Anxiety; suicide. Knowledge, attitudes or skill assessment; Behaviour including service use	Women only Aged 18 and over only Mixed ethnicity PTSD
56	Loucks (2019)	To examine the use of virtual reality exposure	USA	Before and after	Mixed gender

	Author	Aim	Country Population Type of sexual violence Service setting	Study Design Intervention type Comparator Outcome types	Gender Age Ethnicity Specific population
		therapy (VRE) in the treatment of MST-related PTSD	Victim-Survivors Military sexual trauma Military medical	Therapy – By computer or video NA Scales – PTSD; Depression or Anxiety. Psychophysiological assessment	Aged 18 and over only Mixed ethnicity Military with PTSD
57	Matulis (2014)	To evaluate the feasibility and efficacy of Developmentally Adapted Cognitive Processing Therapy (D-CPT)	USA Victim-Survivors Sexual abuse as a child Public healthcare	Before and after Therapy – CPT NA Scales – PTSD; Depression or Anxiety; Other mood states; Dissociation	Mixed gender Includes people aged <16 Mainly Caucasian PTSD
58	Meade (2010)	To test the effects of a coping group intervention for HIV-positive adults with CSA histories on alcohol, cocaine and marijuana use	USA Victim-Survivors Sexual abuse as a child A mixture of settings	RCT Therapy – general CBT Active control Behaviour including service use	Mixed gender Aged 18 and over only Mainly minority ethnicity HIV+

	Author	Aim	Country Population Type of sexual violence Service setting	Study Design Intervention type Comparator Outcome types	Gender Age Ethnicity Specific population
59	Miller (2015)	To examine the efficacy of a nine-minute video-based intervention that provided psycho-education and modelling of coping strategies	USA Victim-Survivors Rape/abuse as an adult – perpetrator not specified Public healthcare	RCT Therapy – By computer or video Usual care control Scales – PTSD; Depression or Anxiety	Women only Aged 18 and over only Mixed ethnicity No specific population
60	Mouilso (2011)	To explore the effects of participating in a sexual assault risk reduction programme on distress in women who were later re-victimised	USA Victim-Survivors Rape/abuse as an adult – perpetrator not specified University/education	RCT Therapy – Other No treatment or waiting list control Scales – PTSD; wellbeing and functioning; Other mood states; Coping/avoidant coping strategies. Re-victimisation	Women only Aged 18 and over only Mainly Caucasian University/college students
61	Munsey (2018)	To examine the GenerateHope residential programme and provide early	USA Victim-Survivors	Before and after Therapy – Other	Women only Aged 18 and over only

	Author	Aim	Country Population Type of sexual violence Service setting	Study Design Intervention type Comparator Outcome types	Gender Age Ethnicity Specific population
		outcome results for residents living at the GH programme for six to 12 months	Trafficked sex slavery Residential care	NA Scales – PTSD; wellbeing and functioning; Depression or Anxiety	Mixed ethnicity No specific population
62	Nixon (2016) Initial trial: Nixon, 2012	To evaluate the efficacy of Cognitive Processing Therapy, in a wholly sexual assault sample, delivered by non-CBT oriented, non-selected therapists within a community sexual assault centre	Australia Victim-Survivors Rape/abuse at any age Specialist sexual violence services	RCT Therapy – CPT Usual care control Scales – PTSD; Depression or Anxiety	Mixed gender Aged 18 and over only Mainly Caucasian Acute Stress Disorder
63	Poleshuck (2009)	To examine whether clinically significant pain is associated with worse depression and functioning outcomes among women with CSA histories treated with interpersonal psychotherapy	USA Victim-Survivors Sexual abuse as a child Public healthcare	RCT Therapy – psychotherapy Usual care control Scales – wellbeing and functioning; Depression or Anxiety	Women only Aged 18 and over only Mixed ethnicity Depression

	Author	Aim	Country Population Type of sexual violence Service setting	Study Design Intervention type Comparator Outcome types	Gender Age Ethnicity Specific population
64	Pulverman (2017)	To examine changes in theme prominence after an expressive writing treatment for seven themes: family and development, virginity, abuse, relationship, sexual activity, attraction, and existentialism	USA Victim-Survivors Sexual abuse as a child University/education	Before and after Therapy – Writing NA Writing themes	Women only Aged 18 and over only Mixed ethnicity No specific population
65	Robjant (2017)	To assess NET in treating 10 women who had been trafficked for sexual exploitation who were diagnosed with PTSD	UK – England Victim-Survivors Trafficked sex slavery Specialist sexual violence services	Before and after Therapy – Writing NA Scales – PTSD	Women only Aged 18 and over only Mainly minority ethnicity PTSD
66	Rothbaum (2012)	To test an early intervention to modify memory to prevent the development of PTSD before memory consolidation	USA Victim-Survivors Rape/abuse as an adult – perpetrator not specified Public healthcare	RCT Therapy – PE No treatment or waiting list control Scales – PTSD; Depression or Anxiety	Mixed gender Aged 18 and over only Mainly minority ethnicity No specific population

	Author	Aim	Country Population Type of sexual violence Service setting	Study Design Intervention type Comparator Outcome types	Gender Age Ethnicity Specific population
67	Rousseau (2018)	To investigate how an exploratory measure of self-efficacy could mediate IRT's effectiveness	Canada Victim-Survivors Rape/abuse at any age A mixture of settings	RCT Therapy – IRT Active control Scales – PTSD. Sleep quality & other sleep related symptoms	Mixed gender Aged 18 and over only Not stated PTSD
68	Scher (2017)	To examine the relationships between trauma-related cognitions and PTSD symptoms from pre-treatment through a long period following CBT and whether these relationships were affected by treatment type	USA Victim-Survivors Rape/abuse as an adult – perpetrator not specified Not stated	RCT Therapy – CPT Active control Scales – PTSD	Women only Aged 18 and over only Not stated PTSD
69	Schiff (2015)	To test the feasibility of PE, delivered by a social worker, for female patients in methadone programme clinics who	Israel Victim-Survivors Rape/abuse at any age	Before and after Therapy – PE NA	Women only Aged 18 and over only Not stated

	Author	Aim	Country Population Type of sexual violence Service setting	Study Design Intervention type Comparator Outcome types	Gender Age Ethnicity Specific population
		were survivors of CSA or rape, and to examine its effects on PTSD, depression, and illicit drug use, before and after treatment and one year later	Public healthcare	Scales – PTSD; Depression or Anxiety. Behaviour including service use	Substance abuse
70	Sharma-Patel (2012)	To examine emotional activation and cognitive processing, across narrative writing sessions, with undergraduate sexual assault survivors	USA Victim-Survivors Rape/abuse as an adult – perpetrator not specified University/education	Before and after Therapy – Writing NA Scales – PTSD; Depression or Anxiety. Behaviour including service use	Women only Aged 18 and over only Mixed ethnicity University/college students
71	Signal (2013)	To evaluate and compare the efficacy of an adjunct EFT programme for the reduction of depressive symptoms across three age cohorts of CSA victims	Australia Victim-Survivors Sexual abuse as a child Specialist sexual violence services	Before and after Therapy – Other NA Scales – Depression or Anxiety	Women only Aged 18 and over only Not stated No specific population

	Author	Aim	Country Population Type of sexual violence Service setting	Study Design Intervention type Comparator Outcome types	Gender Age Ethnicity Specific population
72	Sikkema (2013)	To examine whether Living in the Face of Trauma (LIFT) significantly reduced traumatic stress, at one-year follow-up, more than an attention-matched support group, and whether reductions in avoidant coping mediated reductions in traumatic stress	USA Victim-Survivors Sexual abuse as a child A mixture of settings	RCT Therapy – Other Active control Scales – PTSD; Coping/avoidant coping strategies	Mixed gender Aged 18 and over only Mixed ethnicity HIV+
73	Spinhoven (2009)	To examine the impact of childhood abuse on the outcome of cognitive-behavioural therapy for young people who recently engaged in Deliberate Self-Harm (DSH)	Netherlands Victim-Survivors Sexual abuse as a child Not stated	RCT Therapy – general CBT Usual care control Behaviour including service use	Mixed gender Includes people aged <16 Not stated Deliberate self-harm
74	Steil (2011)	To evaluate CRIM's feasibility and efficacy in reducing the feeling of	Germany Victim-Survivors	Before and after Therapy – CRIM	Women only Aged 18 and over only

	Author	Aim	Country Population Type of sexual violence Service setting	Study Design Intervention type Comparator Outcome types	Gender Age Ethnicity Specific population
		being contaminated in adult survivors of CSA	Sexual abuse as a child University/education	NA Scales – PTSD; contamination	All Caucasian PTSD
75	Steil (2011)	To examine the acceptance, safety, and efficacy of DBT-PTSD	Germany Victim-Survivors Sexual abuse as a child Residential care	Before and after Therapy – DBT NA Scales – PTSD; Depression or Anxiety	Women only Aged 18 and over only All Caucasian PTSD
76	Steil (2018)	To investigate the feasibility, acceptance and safety of Dialectical Behaviour Therapy for PTSD in an outpatient treatment setting by therapists who were novice to the treatment	Germany Victim-Survivors Sexual abuse as a child University/education	Before and after Therapy – DBT NA Scales – PTSD; Depression or Anxiety; Dissociation; borderline personality symptomatology	Women only Aged 18 and over only Not stated PTSD
77	Suris (2013)	To evaluate the effectiveness of individual CPT in the treatment of post-traumatic and depressive	USA Victim-Survivors Military sexual trauma	RCT Therapy – CPT Active control	Mixed gender Aged 18 and over only Mixed ethnicity

	Author	Aim	Country Population Type of sexual violence Service setting	Study Design Intervention type Comparator Outcome types	Gender Age Ethnicity Specific population
		symptoms related to MST, compared with present-centred therapy (PCT)	Military medical	Scales – PTSD; Depression or Anxiety	Military with PTSD
78	Talbot (2011)	To compare interpersonal psychotherapy with usual care psychotherapy among women in a Community Mental Health Centre	USA Victim-Survivors Sexual abuse as a child Public healthcare	RCT Therapy – psychotherapy Usual care control Scales – PTSD; wellbeing and functioning; Depression or Anxiety	Women only Aged 18 and over only Mixed ethnicity Depression
79	Tarquinio (2012)	To test the effectiveness of a new type of early treatment (URG-EMDR) on the consequences of rape	France Victim-Survivors Rape/abuse as an adult – perpetrator not specified A mixture of settings	Before and after Therapy – EMDR NA Scales – PTSD; Other mood states. Sexual arousal or interest	Women only Aged 18 and over only Not stated No specific population
80	Tarquinio (2012)	To evaluate the effects of Eye Movement Desensitisation and Reprocessing (EMDR), in	France Victim-Survivors	Before and after Therapy – EMDR	Women only Aged 18 and over only

	Author	Aim	Country Population Type of sexual violence Service setting	Study Design Intervention type Comparator Outcome types	Gender Age Ethnicity Specific population
		reducing PTSD, anxiety, and depressive symptoms, for female victims of intimate partner rape	Rape/abuse as adult by intimate partner University/education	NA Scales – PTSD; Depression or Anxiety	Not stated PTSD
81	Voelkel (2015)	To explore the effectiveness of CPT in treating full or subthreshold PTSD, comparing US veterans with MST versus those without MST	USA Victim-Survivors Military sexual trauma Military medical	Alternative population comparison Therapy – CPT NA Scales – PTSD; Depression or Anxiety	Mixed gender Aged 18 and over only Mixed ethnicity Military with PTSD
82	Wachen (2014) Follow-up to Galovski et al. (2005)	To examine the complete LTFU data from the parent study, to assess overall functioning, symptoms, and trajectory of change between CPT and PE treatment groups	USA Victim-Survivors Rape/abuse at any age Not stated	RCT Therapy – CPT Active control Scales – PTSD; wellbeing and functioning; Depression or Anxiety	Women only Aged 18 and over only Mixed ethnicity PTSD
83	Wagenmans (2018)	To test the hypothesis that a history of CSA would have a detrimental	Netherlands Victim-Survivors	Alternative population comparison	Mixed gender Aged 18 and over only

	Author	Aim	Country Population Type of sexual violence Service setting	Study Design Intervention type Comparator Outcome types	Gender Age Ethnicity Specific population
		effect on the outcome of intensive trauma-focused treatment for those suffering from PTSD	Rape/abuse at any age Specialist sexual violence services	Therapy – Combined PE & EMDR NA Scales – PTSD	Not stated PTSD
84	Walter (2014)	To examine pre-treatment PTSD and depression severity, as well as treatment outcome, between female veterans who reported experiencing MST, with and without a history of CSA	USA Victim-Survivors Military sexual trauma Military medical	Alternative population comparison Therapy – CPT NA Scales – PTSD; Depression or Anxiety	Women only Aged 18 and over only Mixed ethnicity Military with PTSD
85	Wilson (2012)	To examine if a stress-management education programme was effective in improving coping skills as measured by the Ways of Coping	USA Victim-Survivors Sexual abuse as a child Specialist sexual violence services	Before and after Education – for victims NA Scales – wellbeing and functioning	Women only Aged 18 and over only Mainly Caucasian No specific population
86	Witt (2015)	To describe an educational method for SANEs, based on adult	USA Professional Staff	Before and after	NA NA

	Author	Aim	Country Population Type of sexual violence Service setting	Study Design Intervention type Comparator Outcome types	Gender Age Ethnicity Specific population
		learning principles and constructivist learning theory, and to provide preliminary quantitative evaluation data	Rape/abuse at any age University/education	Education – for professionals NA Knowledge, attitudes or skill assessment; Views	NA SANEs
Outcomes and processes					
87	Ades (2017)	To evaluate group education sessions (GESs) for preventive health interventions for women with prior sexual violence	USA Victim-Survivors Rape/abuse at any age Military medical	Before and after Education – for victims Knowledge, attitudes or skill assessment; Views	Women only Aged 18 and over only Mainly minority ethnicity Military
88	Auringer (2011)	To determine the feasibility and effectiveness of a brief hypnotic intervention for hyperarousal PTSD symptoms in women who have experienced sexual trauma	USA Victim-Survivors Rape/abuse at any age Specialist sexual violence services	RCT Therapy – Hypnosis Usual care control Scales – PTSD; Depression or Anxiety; Other mood states. Sleep quality & other sleep related symptoms; Views	Women only Aged 18 and over only Mixed ethnicity PTSD

	Author	Aim	Country Population Type of sexual violence Service setting	Study Design Intervention type Comparator Outcome types	Gender Age Ethnicity Specific population
89	Decker (2017)	To examine the efficacy of INSPIRE (Integrating Safety Promotion with HIV Risk Reduction) to improve safety and reduce HIV risk among drug-involved female sex workers (FSWs)	USA Victim-Survivors Sex Workers A mixture of settings	Before and after Education – for victims NA Scales – PTSD; Depression or Anxiety. Re-victimisation; Knowledge, attitudes or skill assessment; Views; Behaviour including service use	Women only Aged 18 and over only Mixed ethnicity Substance abuse
90	Du Mont (2017)	To pilot and evaluate a novel Elder Abuse Nurse Examiner Curriculum and materials for their efficacy in improving SANEs' knowledge of elder abuse and competence in delivering care	Canada Professional Staff Rape/abuse as an adult – perpetrator not specified Specialist sexual violence services	Before and after Education – for professionals NA Knowledge, attitudes or skill assessment; Views	NA NA NA SANEs
91	Harding-Jones (2018)	To gauge the effectiveness of trauma-focused cognitive	UK – England	Before and after Therapy – general CBT	Women only Aged 18 and over only

	Author	Aim	Country Population Type of sexual violence Service setting	Study Design Intervention type Comparator Outcome types	Gender Age Ethnicity Specific population
		behavioural therapy (TF-CBT) with adult women who had been trafficked into the sex industry	Both professional and voluntary staff Trafficked sex slavery Specialist sexual violence services	NA Scales – PTSD; wellbeing and functioning. Views	Not stated No specific population
92	Holder (2018)	To examine the effect of therapist treatment fidelity on patient outcomes for veterans receiving CPT for MST-related PTSD	USA Victim-Survivors Military sexual trauma Military medical	Alternative population comparison Therapy – CPT NA Scales – PTSD; Depression or Anxiety	Mixed gender Aged 18 and over only Mixed ethnicity Military with PTSD
93	Karatzias (2014)	To assess the effectiveness and acceptability of a new brief psycho-educational group intervention for managing mental health and behavioural problems associated with a history of CSA	UK – Scotland Victim-Survivors Sexual abuse as a child Public healthcare	Before and after Education – for victims NA Scales – PTSD; wellbeing and functioning; Depression or Anxiety; Dissociation.	Mixed gender Aged 18 and over only Not stated No specific population

	Author	Aim	Country Population Type of sexual violence Service setting	Study Design Intervention type Comparator Outcome types	Gender Age Ethnicity Specific population
				Views; Behaviour including service use	
94	Lange (2010)	To examine the session-to-session change in symptom severity and social bonding ability in the participants of group treatment for survivors of sexual trauma	Netherlands Victim-Survivors Rape/abuse at any age Online	Non-randomised controlled Therapy – By computer or video Active control Scales – wellbeing and functioning; Depression or Anxiety. Views	Not stated Includes people aged <16 Not stated No specific population
95	Macdonald (2018)	To assess the efficacy of training to improve competence to address sexual assault among Emergency Department (ED) staff, and to compare in-person and online training modes	Canada Professional staff Rape/abuse at any age Public healthcare	Alternative population comparison Education – for professionals NA Knowledge, attitudes or skill assessment; Views	NA NA NA Health professionals

	Author	Aim	Country Population Type of sexual violence Service setting	Study Design Intervention type Comparator Outcome types	Gender Age Ethnicity Specific population
96	MacIntosh (2018)	To assess the outcomes of the first two years of the Skills Training in Affective and Inter-personal Regulations (STAIR) model at the Cedar Centre for individuals who have experienced CSA	Canada Both professional and voluntary staff Sexual abuse as a child Public healthcare	Before and after Therapy – STAIR NA Scales – PTSD; Other mood states; Dissociation; Interpersonal problems. Views	Mixed gender Aged 18 and over only Not stated No specific population
97	Pence (2014)	To explore the efficacy of iRest to reduce trauma-related symptoms in women with sexual trauma, including MST; and to monitor how well iRest was tolerated in a VA setting	USA Victim-Survivors Military sexual trauma Military medical	Before and after Therapy – Mindfulness NA Scales – PTSD; wellbeing and functioning; Depression or Anxiety. Side-effects; Views	Women only Aged 18 and over only Mixed ethnicity Military
98	Rumney (2019)	To compare a specialist (Operation Bluestone) and non-specialist policing response to rape	UK – England Both professional and voluntary staff Rape/abuse at any age	Non-randomised controlled Service – police Usual care control	Mixed gender Includes people aged <16 Mainly Caucasian

	Author	Aim	Country Population Type of sexual violence Service setting	Study Design Intervention type Comparator Outcome types	Gender Age Ethnicity Specific population
			Police or legal	Legal; Views; Referrals to specialist support services	Law enforcement/legal
Process only					
99	Brooks (2017)	To evaluate an innovative advocacy model introduced in Scotland to assist reporting rape to the police	UK – Scotland Victim-Survivors Rape/abuse as an adult – perpetrator not specified Specialist sexual violence services	Process evaluation Service – advocacy NA Views	Women only Aged 18 and over only Not stated No specific population
100	Brooks-Hay (2018)	To evaluate Rape Crisis Scotland's National Advocacy Project (NAP)	UK – Scotland Both professional and voluntary staff Rape/abuse at any age Specialist sexual violence services	Process evaluation Service – advocacy NA Views	Mixed gender Includes people aged <16 Not stated No specific population
101	Donohoe (2010)	To describe the impact of the Department of Health's Victims of Violence & Abuse	UK – England Professional Staff Rape/abuse at any age	Process evaluation Education – for professionals	NA NA NA

	Author	Aim	Country Population Type of sexual violence Service setting	Study Design Intervention type Comparator Outcome types	Gender Age Ethnicity Specific population
		Prevention Programme one-day education and training course, on mental health professionals' practice and attitudes in UK Health Trusts	Public healthcare	NA Knowledge, attitudes or skill assessment; Views; Behaviour including service use	Health professionals
102	Donovan (2011)	To evaluate the Grace project (Rape Crisis) in Northumberland	UK – England Both professional and voluntary staff Rape/abuse at any age Specialist sexual violence services	Process evaluation Service – support and advocacy NA Views	Women only Aged 18 and over only Not stated No specific population
103	O'Neill (2016)	A process evaluation of the Basis Yorkshire Supporting Historic Victims/Survivors of Child Sex Exploitation in Leeds project	UK – England Both professional and voluntary staff Sexual abuse as a child Specialist sexual violence services	Process evaluation Service – support and advocacy NA Views	Women only Aged 18 and over only Not stated No specific population

	Author	Aim	Country Population Type of sexual violence Service setting	Study Design Intervention type Comparator Outcome types	Gender Age Ethnicity Specific population
104	Saha (2011)	To explore how the sense of self evolves through the recovery process after intensive therapy that focuses on issues pertaining to CSA	UK – England Victim-Survivors Sexual abuse as a child Specialist sexual violence services	Process evaluation Therapy – Other NA Views	Women only Aged 18 and over only All Caucasian No specific population
105	Van Staden (2010)	To establish whether or not a dedicated unit improved the services provided to victims of sexual assault	UK – England Professional Staff Rape/abuse at any age Police or legal	Process evaluation Service – police NA Views	NA NA NA Law enforcement/legal
106	Williams (2017)	To explore in depth the lived experience of women attending a specialist psychotherapy service for survivors of CSA	UK – England Victim-Survivors Sexual abuse as a child Specialist sexual violence services	Process evaluation Therapy – Other NA Views	Women only Aged 18 and over only Not stated No specific population

Appendix H: List of included systematic reviews n=21

Note that we used included systematic reviews published in 2014 or later.

Abayomi O, Chibuzor MT, Okusanya BO, Esu E, Odey E, Meremikwu MM (2017) Supportive psychotherapy or client education alongside surgical procedures to correct complications of female genital mutilation: A systematic review. *International Journal of Gynaecology & Obstetrics* 136 Suppl 1: 51-55.

Adelufosi A, Edet B, Arikpo D, Aquaisua E, Meremikwu MM (2017) Cognitive behavioral therapy for post-traumatic stress disorder, depression, or anxiety disorders in women and girls living with female genital mutilation: A systematic review. *International Journal of Gynaecology & Obstetrics* 136 Suppl 1: 56-59.

Bello S, Ogugbue M, Chibuzor M, Okomo U, Meremikwu MM (2017) Counselling for deinfibulation among women with type III female genital mutilation: A systematic review. *International Journal of Gynaecology & Obstetrics* 136 Suppl 1: 47-50.

Berry V, Stanley N, Radford L, McCarry M, Larkins C (2014) *Building Effective Responses: An Independent Review of Violence against Women, Domestic Abuse and Sexual Violence Services in Wales.* Welsh Government Social Research.

Chen R, Gillespie A, Zhao Y, Xi Y, Ren Y, McLean L (2018) The Efficacy of Eye Movement Desensitization and Reprocessing in Children and Adults Who Have Experienced Complex Childhood Trauma: A Systematic Review of Randomized Controlled Trials. *Frontiers in Psychology* 9: 534.

Dawson A, Homer CS, Turkmani S, Black K, Varol N (2015) A systematic review of doctors' experiences and needs to support the care of women with female genital mutilation. *International journal of gynaecology and obstetrics: the official organ of the International Federation of Gynaecology and Obstetrics* 131: 35-40.

Deming ME, Bhochhibhoya A, Ingram L, Stafford C, Li X (2018) HIV/STI Interventions targeting women who experience forced sex: A systematic review of global literature. *Health care for women international*: 1-31.

Dworkin ER, Schumacher JA (2018) Preventing Posttraumatic Stress Related to Sexual Assault Through Early Intervention: A Systematic Review. *Trauma Violence & Abuse* 19: 459-472.

Ezebialu I, Okafo O, Oringanje C, Ogbonna U, Udoh E, Odey F, Meremikwu MM (2017) Surgical and nonsurgical interventions for vulvar and clitoral pain in girls and women living with female genital mutilation: A systematic review. *International Journal of Gynaecology & Obstetrics* 136 Suppl 1: 34-37.

Fraley HE, Aronowitz T, Stoklosa HM (2019) Systematic Review of Human Trafficking Educational Interventions for Health Care Providers. *Western Journal Of Nursing Research*: 193945919837366.

Hamid A, Grace KT, Warren N (2018) A Meta-Synthesis of the Birth Experiences of African Immigrant Women Affected by Female Genital Cutting. *Journal of Midwifery & Women's Health* 63: 185-195.

Korotana LM, Dobson KS, Pusch D, Josephson T (2016) A review of primary care interventions to improve health outcomes in adult survivors of adverse childhood experiences. *Clinical Psychology Review* 46: 59-90.

Menon B, Van D, Awerbuch A, Caddell L, Roberts K, Stoklosa H, Potter J (2018) Informing Human Trafficking Clinical Care Through Two Systematic Reviews on Sexual Assault and Intimate Partner Violence. *Trauma Violence & Abuse*: 1524838018809729 (p1524838018809721-1524838018809714).

O'Driscoll C, Flanagan E (2016) Sexual problems and post-traumatic stress disorder following sexual trauma: A meta-analytic review. *Psychology & Psychotherapy: Theory, Research & Practice* 89: 351-367.

Okomo U, Ogugbue M, Inyang E, Meremikwu MM (2017) Sexual counselling for treating or preventing sexual dysfunction in women living with female genital mutilation: A systematic review. International *Journal of Gynaecology & Obstetrics* 136 Suppl 1: 38-42.

Parcesepe Angela M, Martin Sandra L, Pollock McLean D, Garcia-Moreno C (2015) The effectiveness of mental health interventions for adult female survivors of sexual assault: A systematic review. *Aggression and Violent* Behavior 25: 15-25.

Parry S, Simpson J (2016) How Do Adult Survivors of Childhood Sexual Abuse Experience Formally Delivered Talking Therapy? A Systematic Review. *Journal of Child Sexual Abuse* 25: 793-812.

Platt L, Grenfell P, Meiksin R, Elmes J, Sherman Susan G, Sanders T, Mwangi P, Crago A-L (2018) Associations between sex work laws and sex workers' health: A systematic review and meta-analysis of quantitative and qualitative studies. *PLoS Medicine* 15: 1-54.

Toon C, Gurusamy K (2014) Forensic Nurse Examiners versus Doctors for the Forensic Examination of Rape and Sexual Assault Complainants: A Systematic Review. *Campbell Systematic Reviews*.

Wilen Jessica S (2015) A systematic review and network meta-analysis of psychosocial interventions for adults who were sexually abused as children. *Dissertation Abstracts International* Section A: Humanities and Social Sciences 75: No Pagination Specified, UMI No. 3619714.

Zurynski Y, Sureshkumar P, Phu A, Elliott E (2015) Female genital mutilation and cutting: a systematic literature review of health professionals' knowledge, attitudes and clinical practice. *BMC international health and human rights* 15: 32.

Appendix I: Study details of the systematic reviews

Author/year	Review characteristics	Date range searched	Included studies/ publication date	Type of interventions	Type of data synthesis	Outcomes
Female genital mutilation: victim-survivors						
Abayomi 2017	Population: Women and girls Study Designs: RCTs and NRCTs	Not stated	0	Supportive psychotherapy or client education	n/a	Post-op care, stigma, patient satisfaction, sexual dysfunction, medico-legal complaints
Adelufosi 2017	Population: Women and girls Study Designs: RCTs and NRCTs	Inception - 2015	0	Cognitive behavioral therapy CBT	n/a	PTSD, depression, or anxiety disorders
Bello 2017	Population: Women and girls Study Designs: RCTs and NRCTs	Inception - 2015	0	Counselling prior to deinfibulation	n/a	Patient satisfaction, marital satisfaction, and requests for re-infibulation
Ezebialu 2017	Population: Women and girls	Inception - 2015	0	*Surgical and nonsurgical interventions	n/a	Vulvar pain, adverse events

Author/year	Review characteristics	Date range searched	Included studies/ publication date	Type of interventions	Type of data synthesis	Outcomes
	Study Designs: Mixed methods					
Okomo 2017	Population: Women and girls Study Designs: Mixed methods	Inception - 2015	0	Sexual counselling	n/a	Sexual functioning
Hamid 2018	Population: Somalian women and girls settled outside Africa (age not stated) Study Designs: Qualitative	Inception - 2016	14 (published 2000-2016 [3 UK studies])	Views of services	Thematic	Labour and birth experiences: pain, anxiety, provider knowledge and support
Female genital mutilation: Healthcare professionals (HCP)						
Dawson 2015	Population: Nurses, midwives, doctors, gynaecologists Study Designs: Mixed methods	2004-2014	10 (published 2003-2013 [2 UK studies])	Views and perceived training needs	Narrative	Experience and needs in supporting women with FGM

Author/year	Review characteristics	Date range searched	Included studies/ publication date	Type of interventions	Type of data synthesis	Outcomes
Zurynski 2015	Population: Nurses, midwives, obstetricians, social workers, psychologists Study Designs: Mixed methods	2000-2014	18 (published 2002-2014 [3 UK studies])	Views of services	Narrative	Knowledge and attitudes of FGM in clinical practice
Sexual abuse and violence: victim-survivors						
Berry 2014	Population: Adult women (age not stated) Study Designs: Mixed methods	2000-2014	10 (published 2001-2013 [1 UK study)	ɫ Mental health/psychological interventions	Narrative	PTSD, anxiety, depression, satisfaction
Parcesepe 2015	Population: Adult women (age not stated) Study Designs: RCTs and NRCTs	1985-2012	9 (published 1991-2012)	ɫ Mental health/psychological interventions	Narrative	PTSD, anxiety, depression, distress-fear
Dworkin 2018	Population: Adult men and women (age not	Not stated	15 (published 1995-2014 [2 UK studies])	Timing of response/ Interventions	Narrative	PTSD

Author/year	Review characteristics	Date range searched	Included studies/ publication date	Type of interventions	Type of data synthesis	Outcomes
	stated) Study Designs: Mixed methods					Help-seeking experiences
Deming 2018	Population: Adult women (age not stated) Study Designs: Mixed methods	2007-2017	17 (published 2003-2015)	HIV/STI intervention	Narrative	Safe sexual practices
Platt 2018	Population: Men, women and trans gender people sex workers (age 14-68 years) Study Designs: Qualitative	1990-2018	46 (published 1995-2017 [1 UK study])	Views of services	Thematic	Safety, health and access to services related to criminalisation of sex work
Sexual abuse and violence: HCP						
Toon 2014	Population: SANEs	Inception – 2014	6 (published 1997-2012 [1 UK study])	SANE care vs non-SANE care	Meta-analysis	Efficacy (STI, pregnancy and HIV prophylaxis;

Author/year	Review characteristics	Date range searched	Included studies/ publication date	Type of interventions	Type of data synthesis	Outcomes
	Study Designs: RCTs and NRCTs					prosecution /conviction rates)
Sexual abuse as children: victim-survivors						
Wilen 2015	Population: Adult survivors (mean age 36 years) Study Designs: RCTs	Not stated	18 (published 1989-2013)	ǂ Mental health and psychological interventions	Meta-analysis	PTSD, anxiety, depression, suicide
Parry 2016	Population: Adult men and women (age < 48 years) Study Designs: Qualitative	Not stated	23 (published 1997-2013 [2 UK studies])	Views on trauma-focused talking therapies	Thematic	Experience of healing, connecting with others, discovering hope for the future
O'Driscoll 2016	Population: Adult women (age not stated) Study Designs: RCTs	Inception-2015	4 (published 2003-2013)	ǂǂ Psychological interventions	Meta-analysis	Sexual dysfunctions and concerns

Author/year	Review characteristics	Date range searched	Included studies/ publication date	Type of interventions	Type of data synthesis	Outcomes
Korotana 2016	Population: Adult men and women (age not stated) Study Designs: RCTs and NRCTs	Not stated	99 (published 1985-2014)	ⱡ Mental health and psychological interventions	Narrative	PTSD, anxiety, depression, emotional functioning
Chen 2018	Population: Adult men and women (age 18-65 years) Study Designs: RCTs	Inception-2017	3 (published 1999-2007)	EMDR intervention	Narrative	PTSD, anxiety, depression
Human trafficking: victim-survivors						
Human trafficking: HCP						
Menon 2018	Population: Adult women (age not stated) Study Designs: RCTs	Inception-2017	10 (published 2001-2015)	ⱡ Mental health interventions	Narrative	PTSD, anxiety, depression, self-reported health-related quality of life

Author/year	Review characteristics	Date range searched	Included studies/ publication date	Type of interventions	Type of data synthesis	Outcomes
Fraley 2019	Population: Medical doctors, nurses, social workers, mental health providers, health educators Study Designs: Pre- and post-test	2000 -2018	7 (published 2009-2019)	Educational intervention (one-to-one, web-based)	Narrative	Awareness of and attitudes toward HT victims, confidence in identifying trafficking victims

*deinfibulation and reconstruction, analgesic medication

ǂ CBT, supportive psychotherapy and counselling, Imagery rehearsal therapy, EMDR, coping skill/assertiveness training, stress inoculation therapy, and others

ǂǂ Trauma Affect Regulation: Guide for Education and Therapy, Supportive group therapy, Trauma focus expressive Writing, Sexual schema-focused expressive writing, Cognitive-processing therapy, Prolonged exposure, Minimal attention condition, Prolonged exposure, Present-centred therapy.

Sexual Assault Nurse Examiner (SANE)

Appendix J: Protocol

Adult Specialist Services for Victim-Survivors of Sexual Violence and Abuse: Systematic Map protocol

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1 Background

The Crime Survey for England and Wales found 24.4% of women, and 4.5% men aged between 16 and 59 have experienced some form of sexual violence since the age of 16 (Office for National Statistics, year ending March 2018). The true extent of the prevalence of sexual violence, including child sexual abuse, remains largely unknown. Owing to a range of personal, social, and cultural factors, such as the persistence of rape myths, victim-blaming (Waterhouse et al. 2016), extremely low conviction rates (Kelly et al. 2005), and the risk of worsening victimisation if the perpetrator is known to them, many victim-survivors do not report their experiences, or delay their disclosures for many years.

The yearly figures from the Crime Survey of England and Wales reveal that while the prevalence of sexual violence and abuse had halved between March 2006 and March 2014 (from 3% of 16-59 year old victims once or more in 2006 to 1.5% in 2014), the

percentage is now on the rise again (2.7% in March 2018, see graph).

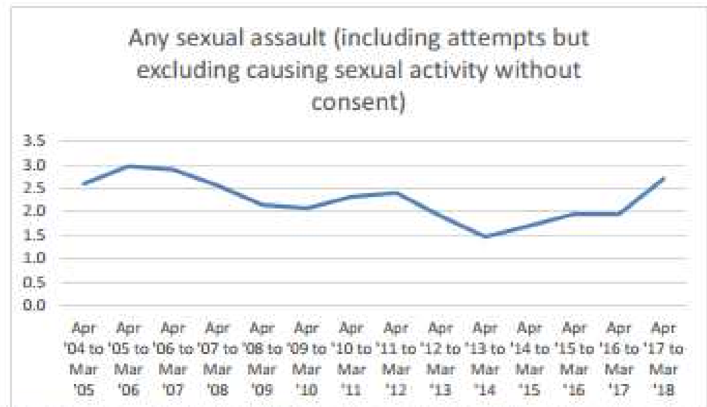

Figure 1: The Crime Survey of England and Wales figures for percentage of 16-59 year olds who have been victims of any sexual assault once or more in the last year

Despite the hidden nature of a lot of sexual violence crimes, there has been an unprecedented increase in demand for sexual violence and abuse services in recent years. In the last year alone (2017-18) there was a 17% increase in the number of people who accessed Rape Crisis specialist services in England and Wales compared with the previous year (Rape Crisis England & Wales website).

A cultural shift, engendered in part by high-profile child sex abuse cases in the media, and the magnitude of the #MeToo and #TimesUp social media campaigns, has emboldened people to speak out about their experiences of assault or abuse, sometimes dating back years or even decades.

This surge in demand has come at a time when commissioning for services has been largely devolved to a local level. Changes in commissioning responsibilities have produced many challenges for services in terms of maintaining the stability and consistency necessary to support victims and survivors of sexual violence and abuse (APPG report 2018).

In a recent report, specialist sexual violence support services described themselves as being at crisis point. They are under-commissioned to meet the demand, and have to divert efforts to repeatedly apply for short-term grants in order to survive (APPG report 2018). A complex and competitive commissioning landscape has led to the loss of experienced staff; pressure to merge or broaden population focus; and soaring, or closed, waiting lists. Thousands of victim-survivors have been left without adequate services, or completely unsupported, at a time when they are particularly vulnerable and in need of ongoing dedicated support. On the current trajectory of increased demand and scant

resources, there is little prospect of fulfilling the Government's pledge that every victim of sexual violence 'gets the help they need when they need it' by 2020 (p.10, VAWG strategy, 2016).

NHS England's Strategic Direction for sexual assault and abuse services: Lifelong care for victims and survivors: 2018-2023 presents a vision of the radical reform needed to improve services and care for victim-survivors.

Given the current policy priority for specialist sexual violence and abuse services, commissioners need guidance on the kinds of interventions which have been found to be effective or not, as well as the appropriateness of these services to meet victim-survivors' needs. We will, therefore, carry out a systematic map of evidence to answer the following research question: What is known about the effectiveness and appropriateness of specialist adult services for people who have experienced sexual violence and abuse?

1.1 Policy Context

The Ending Violence against Women and Girls (VAWG): strategy 2016-2020 (HM Government, 2016) details the government's pledge to reform services to help women and girls rebuild their lives after experiencing violence or abuse. Working with local commissioners the government aims to ensure that prevention and early intervention, rather than crisis support, are the norm by 2020.

Ensuring a secure future for rape support centres, Female Genital Mutilation (FGM) and Forced Marriage Units is one way they intend fulfil their promise that 'victims [and survivors] get the help they need when they need it.' (p.10). While acknowledging that sexual violence and abuse disproportionately affects women and girls, a complementary piece of work to the VAWG strategy, the Male Victims Position Statement, issued in March 2019, sets out the government's commitments to supporting male victim- survivors. One of these commitments states that £24 million will be provided to services providing advice and counselling to all victims of sexual violence, including men and boys over the next three years.

The Victim's Strategy vows to increase spending from £31m, in 2018, to £39m, in 2020/21, to improve services and pathways for victim-survivors of sexual violence and abuse, who seek support, to and from Sexual Assault Referral Centres. It claims that national rape services will be funded for a minimum of two years, and that there will be further local commissioning of services by Police and Crime Commissioners (PCCs) to improve support for victims of sexual violence. The government claim that they will work with the police to increase awareness of Sexual Assault Referral Centres (SARCs) for lesbian, gay, bisexual and transgender (LGBT) victims, and consider how to improve support for people identifying as non-binary or intersex.

1.2 Definitions

1.2.1 Victim-survivor

While legally the term victim is used to describe those who have experienced sexual violence and abuse, individuals may prefer to identify themselves as survivors (McNaughton et al. 2012). In recognition of the stark differences between these terms and the ways in which people may self-identify over time, the term victim-survivor will be used throughout our work.

1.2.2 Sexual violence

Throughout our work we use the term sexual violence to refer to sexual violence and abuse. In line with NHS England's Strategic direction for Sexual Assault and Abuse our definition of sexual violence covers any non-consensual act or attempt to obtain an act of a sexual nature, regardless of the context and the relationship between perpetrator and the victim. It covers marital rape and rape.

Examples of offences include (but are not exclusive to):

- *sexual acts involving a child, sexual harassment, forced marriage, honour-based violence*, female genital mutilation, human trafficking, sexual exploitation and ritual abuse; or*
- *any unwanted sexual activity with someone without their consent or agreement.*

Sexual assault and abuse can happen to anyone; men, women and children; at any age, and may be a one-off event or happen repeatedly. In some cases it can involve the use of technology such as the internet or social media which may be associated with grooming, online sexual harassment and trolling. (p.7, NHS England , 2018)

1.2.3 Specialist services

We are using 'specialist' to denote services which are provided by staff and volunteers with the appropriate skills and expertise specifically tailored to support adult victim-survivors of sexual violence and abuse. We acknowledge that this may be delivered within services for domestic abuse, and violence against women and girls services. Where this is the case we will verify that the services are, at least in part, aimed at providing support to victim-survivors of sexual violence and abuse.

2 Methods

2.1 Aim

To provide a systematic map of available evidence on specialist adult services for victim-survivors of sexual violence and abuse. We will develop a coding tool to capture data within the following broad categories:

We will also conduct reference list harvesting from any relevant systematic reviews, contact topic experts, and search relevant websites.

2.5 Screening

Inclusion Criteria:
To be included in the systematic map, studies will have to:

- be about adult specialised services for victim-survivors of sexual violence and abuse (including statutory, third-sector and voluntary organisations);
- provide findings about the effectiveness and/or appropriateness of these services*;
- be about services aimed at adults, of any gender, over the age of 16 years who have experienced sexual violence and abuse at any point in their life;
- be published in or after 2009; and
- be published in the English language.

* in terms of study designs, the review will seek:

- Evaluations of the outcomes of interventions that
    a) use a comparative design (cost-effectiveness, RCTs, controlled trials and before- after studies, as well as systematic reviews of these kinds of studies), and
    b) are conducted in OECD countries;
- Evaluations conducted in the UK of intervention processes (process evaluations); and qualitative studies conducted in the UK of the views and experiences of people seeking or providing specialist adult services .

An initial sample of 10% of abstracts will be screened independently by two reviewers and differences resolved by discussion. If agreement at this stage is over 90% remaining abstracts will be screened by a single reviewer.

The full texts of all references meeting the criteria, or where it is unclear whether they meet the criteria, will be retrieved and screened against the same criteria. Depending on the nature and volume of the evidence located at abstract screening stage, we may adopt further inclusion criteria at this stage. For example, see 'outcomes' section below.

2.6 Outcomes

We will not exclude studies on account of the outcomes assessed. However, we are interested in physical and mental health (e.g., suicide, depression and anxiety), and well-being (e.g., quality of life, self-esteem, self-efficacy) outcomes including any adverse or unintended consequences of the intervention. We will look for evidence relating to appropriateness of specialist services to victim-survivors' needs, such as their views on accessibility and acceptability of services, and satisfaction with care.

3 References

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4 APPENDIX A: EXAMPLE SEARCH STRATEGY

Database: Ovid MEDLINE(R) ALL <1946 to April 05, 2019>
Search Strategy:

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1 exp Sex Offenses/ (22337)
2 Rape/ (6139)
3 (sexual adj2 (assault$ or aggress$ or coercion or harass$ or violen$)).ti,ab. (10529)
4 rape.ti,ab,kw. (7267)
5 exp Domestic Violence/ (42114)
6 exp Intimate Partner Violence/ (8641)
7 ((abus$ or battered or violen$) adj2 (boyfriend$ or girlfriend$ or husband$ or partner$ or spousal or spouse$ or wife$ or wive$)).ti,ab. (8434)
8 "Adult Survivors of Child Abuse"/ (1909)
9 (historic$ adj6 abuse).ti,ab. (158)
10 (survivor$ adj10 sexual abuse).ti,ab,kw. (556)
11 Sex Work/ (5836)
12 (prostitution or sex work$).ti,ab. (7235)
13 (sex$ adj2 (exploit$ or traffick$)).ti,ab. (680)
14 Human trafficking/ (306)
15 Coercion/ (4389)
16 Marriage/ (22698)
17 15 and 16 (50)
18 forced marriage$.ti,ab. (87)
19 ((honor or honour) adj killing$).ti,ab. (31)
20 Circumcision, Female/ (1241)
21 (FGM or female genital mutilation).ti,ab. (1443)
22 breast ironing.ti,ab. (1)
23 Erotica/ (1690)
24 pornograph$.ti,ab. (1053)
25 revenge porn$.ti,ab. (4)
26 sexting.ti,ab. (133)
27 Stalking/ (175)
28 ((harmful or inappropriate) adj6 sexual behavio$).ti,ab. (193)
29 1 or 2 or 3 or 4 or 5 or 6 or 7 or 8 or 9 or 10 or 11 or 12 or 13 or 14 or 17 or 18 or 19 or 20 or 21 or 22 or 23 or 24 or 25 or 26 or 27 or 28 (79376)

30 Community Health Services/ (30461)
31 Community Mental Health Services/ (18058)
32 "Delivery of Health Care"/ (83560)
33 Health Services Accessibility/ (68345)
34 Mental Health Services/ (31501)
35 Primary Health Care/ (71351)
36 Social services.ti,ab. (6104)

37 (voluntary organi?ation$ or voluntary sector$ or third sector$).ti,ab. (1258)
38 Women's Health Services/ (3745)
39 30 or 31 or 32 or 33 or 34 or 35 or 36 or 37 or 38 (284275)

40 29 and 39 (3567)

41 (sexual abuse adj6 (center$ or centre$ or effective$ or evidence or intervention$ or prevent$ or program$ or project$ or service$ or support$ or treatment$ or unit$)).ti,ab. (1355)
42 (sexual assault adj6 (center$ or centre$ or effective$ or evidence or intervention$ or prevent$ or program$ or project$ or service$ or support$ or treatment$ or unit$)).ti,ab. (1020)
43 (sexual trauma adj6 (center$ or centre$ or effective$ or evidence or intervention$ or prevent$ or program$ or project$ or service$ or support$ or treatment$ or unit$)).ti,ab. (120)
44 (sexual violence adj6 (center$ or centre$ or effective$ or evidence or intervention$ or prevent$ or program$ or project$ or service$ or support$ or treatment$ or unit$)).ti,ab. (483)
45 (rape adj6 (center$ or centre$ or effective$ or evidence or intervention$ or prevent$ or program$ or project$ or service$ or support$ or treatment$ or unit$)).ti,ab. (832)
46 41 or 42 or 43 or 44 or 45 (3599)

47 (sexual abuse adj6 (access$ or collaborat$ or commission$ or integrat$ or joint$ or partner$ or pathway$ or refer or refers or referring or referral$ or statutory or third or voluntary)).ti,ab. (401)
48 (sexual assault adj6 (access$ or collaborat$ or commission$ or integrat$ or joint$ or partner$ or pathway$ or refer or refers or referring or referral$ or statutory or third or voluntary)).ti,ab. (257)
49 (sexual trauma adj6 (access$ or collaborat$ or commission$ or integrat$ or joint$ or partner$ or pathway$ or refer or refers or referring or referral$ or statutory or third or voluntary)).ti,ab. (26)
50 (sexual violence adj6 (access$ or collaborat$ or commission$ or integrat$ or joint$ or partner$ or pathway$ or refer or refers or referring or referral$ or statutory or third or voluntary)).ti,ab. (339)
51 (rape adj6 (access$ or collaborat$ or commission$ or integrat$ or joint$ or partner$ or pathway$ or refer or refers or referring or referral$ or statutory or third or voluntary)).ti,ab. (268)
52 47 or 48 or 49 or 50 or 51 (1234)

53 Assertiveness/ (1675)
54 assertiveness.ti,ab. (1606)
55 Brief behavioural intervention$.ti,ab. (23)
56 Brief behavioral intervention$.ti,ab. (73)
57 Clinician assisted emotional disclosure.ti,ab. (3)

Comoros or Comoro Islands or Comores or Mayotte or Congo or Zaire or Costa Rica or Cote d'Ivoire or Ivory Coast or Croatia or Cuba or Cyprus or Djibouti or French Somaliland or Dominica or Dominican Republic or East Timor or East Timur or Timor Leste or Ecuador or Egypt or United Arab Republic or El Salvador or Eritrea or Ethiopia or Fiji or Gabon or Gabonese Republic or Gambia or Gaza or Georgia Republic or Georgian Republic or Ghana or Gold Coast or Grenada or Guatemala or Guinea or Guam or Guiana or Guyana or Haiti or Honduras or India or Maldives or Indonesia or Iran or Iraq or Isle of Man or Jamaica or Jordan or Kazakhstan or Kazakh or Kenya or Kiribati or Korea or Kosovo or Kyrgyzstan or Kirghizia or Kyrgyz Republic or Kirghiz or Kirgizstan or Lao PDR or Laos or Lebanon or Lesotho or Basutoland or Liberia or Libya or Macedonia or Madagascar or Malagasy Republic or Malaysia or Malaya or Malay or Sabah or Sarawak or Malawi or Nyasaland or Mali or Malta or Marshall Islands or Mauritania or Mauritius or Agalega Islands or Micronesia or Middle East or Moldova or Moldovia or Moldovian or Mongolia or Montenegro or Morocco or Ifni or Mozambique or Myanmar or Myanma or Burma or Namibia or Nepal or Netherlands Antilles or New Caledonia or Nicaragua or Niger or Nigeria or Northern Mariana Islands or Oman or Muscat or Pakistan or Palau or Palestine or Panama or Paraguay or Peru or Philippines or Philipines or Phillipines or Phillippines or Puerto Rico or Romania or Rumania or Roumania or Russia or Russian or Rwanda or Ruanda or Saint Kitts or St Kitts or Nevis or Saint Lucia or St Lucia or Saint Vincent or St Vincent or Grenadines or Samoa or Samoan Islands or Navigator Island or Navigator Islands or Sao Tome or Saudi Arabia or Senegal or Serbia or Montenegro or Seychelles or Sierra Leone or Sri Lanka or Ceylon or Solomon Islands or Somalia or South Africa or Sudan or Suriname or Surinam or Swaziland or Syria or Tajikistan or Tadzhikistan or Tadjikistan or Tadzhik or Tanzania or Thailand or Togo or Togolese Republic or Tonga or Trinidad or Tobago or Tunisia or Turkmenistan or Turkmen or Uganda or Ukraine or Uruguay or USSR or Soviet Union or Union of Soviet Socialist Republics or Uzbekistan or Uzbek or Vanuatu or New Hebrides or Venezuela or Vietnam or Viet Nam or West Bank or Yemen or Yugoslavia or Zambia or Zimbabwe or Rhodesia).hw,kf,ti,ab,cp. (2612841)
92 90 not 91 (9070)

93 limit 92 to (english language and yr="2009 -Current") (4093)

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