Sexual violence prevention initiatives for disabled people in New Zealand

Literature review, stocktake and assessment

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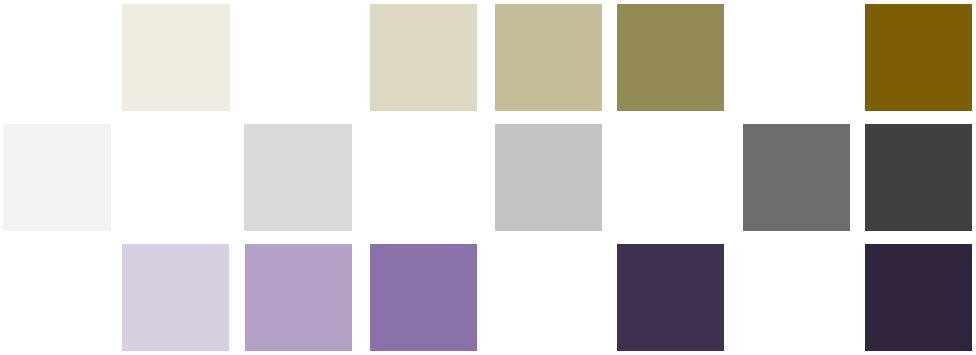

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The views in this report are the authors' based on their research, engagement with stakeholders and review of literature. The views in this report do not necessarily represent those of ACC.

Acknowledgments

We would to acknowledge the large number of stakeholders that have helped us with this project. We interviewed and/or received information from over 30 organisations. These individuals were passionate about sharing their experiences, views, expertise and ideas about sexual violence prevention for disabled people with our team. We thank all those that gave up their time during their busy work schedules to engage with us.

Sapere partnered with Ruth Gammon (clinical psychologist) for this project. Ruth was previously the director of Massey University's Psychology Clinic (2010–2018) and an ACC clinical psychologist provider for their psychological services and sensitive claims services for over eight years.

We would also like to thank Martine Abel-Williamson who, as a representative of Disabled People's Organisations, provided advice and guidance throughout the project.

Glossary

Abbreviation	Stands for
DPO	Disabled People's Organisation(s) Organisations that comprise the DPO Coalition have a history of working together under the United Nations Convention of the Rights of Persons with Disabilities. DPO coalition members include: • Association of Blind Citizens New Zealand • Balance Aotearoa • Deaf Aotearoa • Disabled Persons Assembly NZ • Kāpō Māori Aotearoa • Muscular Dystrophy Association of New Zealand Inc • People First New Zealand Ngā Tāngata Tuatahi
TOAH-NNEST	Te Ohaaki a Hine – National Network Ending Sexual Violence Together

Summary and recommendations

The purpose of the project was to identify and assess sexual violence prevention initiatives that are available for disabled people in New Zealand, to identify any gaps, and to provide advice on what is needed for disabled people in the future.

We completed over 30 interviews, held a hui and ran a survey for organisations and individuals from the disability and sexual violence sectors. These informed our stocktake of sexual violence prevention initiatives for disabled people and allowed us to identify gaps, future priorities, and enablers and barriers to service. We also completed a rapid review of literature to determine key success elements for sexual violence prevention initiatives for disabled people. These were used to assess the initiatives identified in the stocktake.

General agreement about risk factors and broad skills for preventing sexual violence

There appears to be general agreement about risk factors and the broad skills that need to be taught to prevent sexual violence against disabled people. Many of the risk factors identified for the general population are prevalent among people with learning disabilities. In addition, some academics identified that the severity of the cognitive impairment and associated characteristics are a risk factor for abuse. Both the literature and stakeholder engagement emphasised that the best ways to reduce sexual harm for disabled people are through:

- high-level changes that create a safer environment through a safeguarding approach
- building the resiliency skills of those at risk
- robust evaluation of evidence-based initiatives to better inform effectiveness and future initiative development.

A 'safeguarding approach', as described in the literature, includes a range of activities and responses that promote and protect human rights, health, wellbeing and culture; and prevent or reduce harm, abuse and neglect. Stakeholders described this to us as including the creation of strong social networks around a disabled person, supporting them to live a positive and fulfilling life, and also making it more difficult for someone to harm them. We emphasise that initiatives specifically designed for disabled people are just one part of the picture of sexual violence prevention for disabled people.

The literature identified three broad personal protective skills that can be taught to individuals to provide an added layer of protection against sexual violence.

- Identify the situation is dangerous.
- Respond to escape the situation quickly.
- Disclose the confrontation to an appropriate individual(s).

Beyond this the evidence is less clear.

Eleven sexual violence prevention initiatives specifically designed for disabled people were identified

We identified a limited number of sexual violence prevention initiatives catering for disabled people. We encountered some difficulty achieving full engagement with the sector, despite multiple attempts, so there may be some initiatives we have not identified. We do not believe any omissions to be significant. A table detailing these initiatives is given below.

The initiatives we identified primarily cater to those with mild to moderate learning disabilities. Stakeholders thought this may be because there is a historical perspective that people with learning disabilities are asexual and that people with cognitive disabilities require a different approach to learning. At the hui there was a general view that people with other disabilities, that do not have cognitive impairments, may to some extent have been able to access mainstream more easily.

Provider name	Initiative name	Prevention level	Disability type
People First	Keeping Safe Feeling Safe	Primary, secondary	Learning (mild–moderate)
Empowerment Trust	fullpower™ Healthy relationships	Primary	Learning (mild–moderate)
Sexual Abuse Prevention Network	Friends, whānau and flirting	Primary	Learning (not specified)
Disability Connect – Parent and Family Resource Centre	'Safe relationships and sexuality' for people with disabilities, their family and whānau	Primary	Any
	Information and advisory service	Primary	Any
ToBeFrank	A range of group and individual initiatives and services	Primary, secondary (including perpetrators)	Learning and autism
The Personal Advocacy and Safeguarding Adults	Safeguarding adult's response through bespoke training	Primary, secondary	Any one at risk
Health Click	A range of seminars and webinars	Primary	Learning (mild–moderate) and autism
	Me	Primary	Learning (mild–moderate)
Family Planning	Safe relationships; safer sex	Primary	Learning (mild–moderate)
	All about growing up	Primary	Learning (mild–moderate)

Limited research and evidence about the effectiveness of interventions

Limited evidence-based literature about the effectiveness of sexual violence prevention initiatives for disabled people hampered our ability to identify strong findings. Much of the literature did not show robust methodologies. This made it challenging to present a sound assessment. Specifically, there is:

- a lack of evidence-based initiatives
- weak research and/or evaluation methodologies
- a lack of research on actual violence outcomes (a strong focus on risk measurement factors).

A framework of key success factors, to be able to move forward

From the literature we identified common key success elements for sexual violence prevention initiatives for disabled people (Russell, 2008; Barger, Wacker, Macy, & Parish, 2009; Harvey, Garcia-Moreno, & Butchart, 2007; Wissink, van Vugt, Moonen, Stams, & Hendriks, 2015; McEachern, 2012; Verlinden, Scharmanski, Urbann, & Bienstein, 2016; Martinello, 2014).

Key success elements for sexual violence prevention initiatives for disabled people

Element	Description
Audience	• **Co-designed, tailored and accessible** to participants specific needs (e.g. developmental level, learning styles, culture, disability). • **Flexible and adaptable** to be inclusive of and able meet individual needs (e.g. strategies to engage with people different disabilities and from different cultures). • **Appropriately timed** to ensure exposure to the initiative is available during the appropriate developmental stage (i.e. when it will have the most impact). • **Inclusive** of perpetrators as part of the solution (e.g. include in design, delivery and receipt of initiatives).
Content	• **Evidence based** on research and theoretical evidence of how behaviours develop and can be changed. • **Clearly defined initiative goals** that can be measured. • **Comprehensive:** target multiple risk factors in multiple settings and linkages between them; promotes healthy behaviour, positive relationships and skill building with opportunities to practice and implement the new skills; focus on empathy not blaming. • **Challenge cultural norms** that normalise sexual violence against disabled people (e.g. target attitudes and beliefs about disability and sexual violence).
Delivery	• **Teaching methods:** Use varied and interactive teaching methods including participatory education and training approaches (e.g. skill-development components and interactive or 'hands-on' methods) and practical application and material to teach knowledge, improve attitudes and increase skills. • **Dosage (the amount of intervention):** Participants at greater risk require a greater dosage of intervention (e.g. it may be necessary to provide more contact with participants through longer sessions, multiple sessions, and follow-up). • **Reinforcement:** Repeated exposure to content overtime is necessary to achieve long lasting attitude and behavioural changes as well as reinforcement of learnings and behaviours outside of the learning environment. • **Facilitators:** Delivery should be by well-trained staff who are sensitive, competent, supported and supervised. A high turnover negatively affects the continuity and effectiveness of initiatives. Peers as educators can be successful in addressing behaviours such as bystander apathy and they can deliver information in a way that appeals to their peers. • **Disclosure strategy:** Ensure that facilitators are equipped to deal with disclosures and have a robust disclosure policy in place (e.g. provide information about resources and support mechanisms).

Evaluation	• Evaluation strategies should be integrated into initiatives at the time of inception. • Results should be documented against the initiative goals and outcome evaluation should include measures beyond participant satisfaction.
Funding	• Adequate resourcing is required to ensure initiatives are well supervised, have well trained facilitators and that they can operate over sufficient timeframes so that outcomes can be evaluated. Evaluation should be included in the resourcing.

In summary, our assessment of current initiatives found the following:

- The audience is primarily limited to those with mild to moderate learning disabilities.
- The content is focused on keeping safe and healthy relationships. We did not identify any initiatives focused specifically on sexual violence prevention for disabled people.
- Delivery is largely through group workshops run by trained facilitators. The dosage (or amount of intervention) of initiatives varied greatly.
- Only one initiative has been formally evaluated.
- Funding is primarily from grants provided by charitable organisations. There is a level of uncertainty among providers about their ongoing ability to deliver their initiatives or to update their resource material.

Our recommendations

The voice of the stakeholders is clear and consistent that sexual violence against disabled people is a significant issue. There is evidence that those with disabilities are more likely to encounter violence and abuse generally, and sexual violence specifically.

A set of recommendations emerge from the cross-cutting themes discussed in this report as well as its acknowledged limitations. In summary, we recommend the following:

1. Cross-agency leadership is developing and requires an ongoing concerted effort. On a practical level, we think the next steps under this coordinated effort are to:
    a) develop campaigns promoting acceptance of all disabled people, but with an emphasis on more complex impairments including communication difficulties
    b) actively promote the full range of initiatives on offer to ensure different agencies and providers know what is available
    c) coordinate funding of initiatives and support for evaluation.
2. Cross-agency partners jointly commission further research, needs analyisis and co-design of initiatives. Priorities for further research are:
    a) targeted engagement with Māori and Pacific peoples to deepen the understanding of cultural needs and appropriate service/initiative design
    b) targeted engagement with particular disability groups to balance the focus on mild to moderate learning disabilities in the existing body of knowledge.

    We recommend involving community leaders in the design of engagement with Māori and Pacific peoples, as well as particular disability groups.

3. Further research and/or service design should be progressively tailored (e.g. content and teaching methods) to the different settings in which disabled people live, learn, work and play, at different stages of life.

4. Support practical adaptations of mainstream initiatives to ensure they are inclusive and access is consistent across locations. This could include development of accessibility features (e.g. sub-titles) as well as human resources (e.g. teacher aides) that support disabled people to participate.

5. Investigate common training of initiative facilitators, and possibly credentialing, to ensure a common language, consistency and quality of initiatives.

6. Funding that ensures sexual violence prevention initiatives are well designed, achieve sufficient dosage, and endure to enable evaluations of outcomes and continuous sector learning.

1. About this report

This report is focused on sexual violence prevention for disabled people. This section provides an overview of the context, purpose, objectives and scope of the research.

1.1 Context

The definition of sexual violence given by the World Health Organization is as follows.

> ...any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic or otherwise directed against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work (World Health Organization, 2011).

The New Zealand Crime and Victims Survey 2018 (Ministry of Justice, 2019) estimated that 192,500 sexual assault incidents happened to around 87,500 adults in the previous 12 months. Women made up 71 percent of the victims and two-thirds of sexually assaulted people were between 15 and 29 years old.

The New Zealand Disability Strategy describes disability as:

> ...not something individuals have. What individuals have are impairments. They may be physical, sensory, neurological, psychiatric, intellectual or other impairments...Disability is the process which happens when one group of people create barriers by designing a world only for their way of living, taking no account of the impairments other people have (Minister for Disability Issues, 2001).

In the context of this project, the term 'disabled people' is used broadly and includes people of all ages with a range of impairments. Disability is commonly divided into the following five categories:

- sensory (e.g. impairment of sight or hearing)
- physical (e.g. mobility or agility impairments)
- intellectual (e.g. impairment of cognitive function)
- psychiatric/psychological (e.g. people with long-term emotional, psychological or psychiatric conditions)
- other (e.g. people with other long-term conditions and health problems).

We recognise that disabled people are not a homogenous group, that there are many terms used to identify disability and that individuals have different views on this. Throughout this report we use the term 'disabled people' in line with the New Zealand Disability Strategy (Office for Disability Issues, 2016).

The 2013 New Zealand Disability Survey estimated that one in four people (1.1 million) in New Zealand identify as having an impairment that results in disability (long-term limitation in a person's ability to carry out daily activities). Furthermore, that disability increases with age (11% of children have a disability compared to 59% of people aged over 65 years). After adjusting to account for the

different age profiles of ethnic groups, the rate of disability for Māori was 32% compared to Pacific peoples (26%) and European (24%) (Statistics New Zealand, 2014).

Research shows that disabled people are more likely to be abused both as children and adults than non-disabled people (World Health Organization, n.d.). Reliable statistics on the prevalence of sexual violence against disabled people are not readily available; however, two systematic reviews found that adults with disabilities were 1.5 times more likely to be victims of violence of any type than non-disabled adults (Hughes, et al., 2012). These reviews also found that children with disabilities were 2.9 times more likely to be victims of sexual violence compared to non-disabled children while those with cognitive impairments were 4.6 times more likely to be victims (Jones, et al., 2012).

1.2 Purpose and objectives

The Sexual Violence Prevention Advisory Board endorsed a proposal commissioning research to identify and understand what dedicated and/or mainstream sexual violence prevention initiatives are available for disabled people in New Zealand. The Sexual Violence Prevention Advisory Board comprises officials from agencies involved in the funding, management and delivery of sexual violence prevention activities, as well as sector representatives and independent representatives from key population groups. ACC funded the research on behalf of the Sexual Violence Prevention Advisory Board and through a competitive process, ACC engaged Sapere to undertake the research.

The purpose of the project was to understand what sexual violence prevention programmes or initiatives are available for disabled people in New Zealand, including both those that are specifically for disabled people and general ones which can cater for disabled people. In addition, the project will assess the effectiveness of these programmes or initiatives and how they perform against best practice as identified in the literature. The research findings will be used to inform and strengthen future design and development of programmes and initiatives.

The objectives of the research project were to:

1. understand what mainstream sexual violence prevention programmes and initiatives are currently available and accessible to disabled people, as well as any specifically for disabled people
2. assess the existing initiatives and their effectiveness and how they perform against best practice (as identified in the literature review)
3. understand the gaps and identify opportunities in relation to sexual violence prevention initiatives
4. provide recommendations and advice on gaps in the current provision of services and what is needed in the future for disabled people.

1.3 Scope

The scope of this project was to look at sexual violence prevention programmes and initiatives that are accessible to disabled people with a focus on primary and secondary prevention.

Sexual violence prevention strategies, from a public health perspective, can be classified into three approaches (World Health Organization & London School of Hygiene and Tropical, 2010):

- Primary: approaches that aim to prevent sexual violence before it occurs.
- Secondary: approaches that focus on treating immediate injury or harm from sexual violence.
- Tertiary: approaches that focus on a range of activities aimed at addressing the medium to long-term effects of sexual violence. This includes therapy and other rehabilitation efforts that attempt to lessen trauma and reduce long-term disability.

Throughout this report we use the following terms:

- 'Mainstream' when referring to initiatives that are aimed at everyone in the general population.
- 'Specifically designed for disabled people' when referring to initiatives that are directed toward disabled people.

Out of scope for this project:

- Assessment of mainstream sexual violence prevention initiatives for the wider population that are not inclusive of disabled people and do not include any disability specific content.
- Interviewing programme or initiative participants and/or sexual violence survivors about their experiences with programmes or outcomes for them. However, outcomes and impacts may be identified if the programmes have participant feedback processes (e.g. satisfaction surveys).
- Programmes or initiatives for people who may have caused sexual harm.
- Financial or cost analysis of programmes or initiatives.

1.4 Ethics

Following discussions with ACC it was decided that no ethics approval was required. This was primarily due to the fact that we were not intending to interview any individuals who may have been on a programme and/or encountered sexual violence. If a disclosure occurred during interviews with organisations, Sapere's Disclosure Policy would have been adhered to (for the safety of both interviewers and interviewees). However, this was not required.

1.5 Approach and methods

This section outlines our approach and methods for meeting the research purpose and objectives above in Section 1.2. Below we identify the three key components of the research and describe the combination of methods we used to address the research objectives.

- **The stocktake of sexual violence prevention initiatives.** We used a combination of desk-based research, interviews and a survey to identify what sexual violence prevention initiatives are currently available and either accessible to disabled people or specifically designed for disabled people.

- **The assessment of the effectiveness of the initiatives identified in the stocktake.** We undertook a literature review to identify 'best practice' and supplemented this with expert and clinical advice to assess the initiatives.
- **Identification of opportunities and recommendations for future provision of services.** We used a combination of methods including a hui, interviews, a survey and literature to gather information about gaps in research and barriers to providing services, and what stakeholders would like to see in the future.

The desk-based research, literature review, survey, hui and interviews all provided information about the key themes, gaps and future priorities for the sexual violence primary prevention initiatives for disabled people. We triangulated information gathered through each of our methods to identify the key themes these are discussed in Section 4.

1.5.1 Interviews informed the stocktake, gaps and priorities

We interviewed (in person or by phone) over 35 individuals from 32 organisations. They included a range of both disability and sexual violence prevention organisations. People and organisations, we talked to were identified initially by our knowledge and contacts in both the sexual violence and disability sectors. We used a snowball recruitment method where the initial list was extended as we talked to people and more suggestions of individual names and organisations were shared with us. Although we observed limited coordination across the services and initiatives that are in place, interviewees tended to know of additional service providers or disability agencies that were important for us to talk to. Some were providing initiatives and others were sector experts in either disability or sexual violence prevention or therapy. We engaged with Pasifika organisations by interview but to date, we were not able to engage with any Māori organisations.

A list of interviewee organisations is included in Appendix A.

The interviews were face-to-face where possible and semi-structured in nature. Although we had a script and a set of questions, the interviews allowed for considerable variety of response due to the varying experiences of those we spoke with. The topics explored included:

- understanding and experience of initiatives
- target audience of those initiatives including number attending
- delivery methods, including where and how and by who
- outcomes of the initiative, and evaluation of outcomes
- cost and funding of initiatives
- enablers, barrier and future priorities.

1.5.2 Hui feedback focused on priorities for the future

We facilitated a national hui in Wellington on 4 February 2020 for representatives from organisations in the disability and sexual violence sectors. The purpose of the hui was to gather information from the disability and sexual violence sectors about priorities for the future along with enablers and barriers to providing sexual violence prevention initiatives.

The hui was not for survivors of sexual violence.

Twelve individuals, representing seventeen organisations attended the hui. Some of the individuals represented more than one organisation. In addition to four representatives for ACC and four members of the Sapere project team. A list of organisations participating in the hui is included in Appendix A.

1.5.3 The survey sought to expand our reach

We developed an survey in collaboration with ACC staff and the Sexual Violence Prevention Advisory Board's independent representative. The Disabled People's Organisation coalition and TOAH-NNEST were also given the opportunity to comment on draft questions and format.

There were two purposes to the survey:

1. The primary purpose was to ascertain if there were other initiatives underway that we hadn't been able to identify through interviews and desk-based research, and if so, what they are delivering.
2. The secondary purpose was to gather people's thoughts on priorities for future developments of change for sexual violence prevention for disabled people along with any enablers and barriers to providing services.

The survey was run online via SurveyMonkey from 18 December 2019 until 9 February 2020. The survey link was distributed via individuals and organisations in both the sexual violence prevention sector and the disability sector. These individuals were identified when we carried out our interviews and they were asked to circulate the survey widely via their networks. Agencies that the survey was initially disseminated to were:

- ACC
- National Network of Stopping Violence and their member agencies
- District health boards, including mental health, child development services, psychological services and health of older people
- Platform Trust (mental health)
- Le Va
- Ministry of Social Development
- Ministry of Health's Disability Support Services
- Disabled People's Organisations
- Needs Assessment and Service Coordination Association
- New Zealand Disability Services Network.

We received 15 responses to the survey. This was a lower response rate than we had anticipated. There were two key factors that may have contributed to this. The first was the timing of the survey, as it was distributed during a holiday period. The second being we had already engaged with some of the survey recipients via other information gathering methods (i.e. the hui and interviews). A list of organisations that completed the survey is included in Appendix A.

Forty percent (6/15) of the respondents did not complete the survey beyond Question 2. Forty percent (6/15) of respondents answered yes to running an initiative, two fully completed and one partially

completed the survey. Fifty-three percent (8/15) of respondents completed the future focused section of the survey.

We asked the survey respondents whether there is a need for sexual violence prevention initiatives for disabled people. Of the eight respondents that answered this question, all responded 'yes'. We then went on to ask respondents to tell us their views on what they believe the top two priorities are, what would need to occur to address these priorities and what the barriers might be.

1.5.4 We drew from the literature to inform 'best practice'

We completed a rapid, non-systematic literature review of published academic and grey literature of sexual violence prevention initiatives for disabled people with the aim of identifying their effectiveness and to identify of 'best practice'. More detail on the search methods and literature is available in Appendix B.

The initial search identified 84 papers. Abstracts for these papers were reviewed and 43 papers were selected to be included in the review. The selected papers were published between 2002 and 2019 with the majority being published in 2010 or later.

We also undertook an assessment of the sexual violence prevention initiatives for disabled people that were identified in the stocktake. We assessed their effectiveness, and how they perform against 'best practice' (as it is identified in the literature).

1.6 Limitations of this research inform recommendations for the future

There are a number of limitations in the body of evidence informing this report.

We had some difficulty achieving full engagement will the range of disability and sexual violence sector stakeholders—most notably engagement with Māori providers. We acknowledge that this is an important gap and have recommended that further targeted engagement occur with Māori providers and communities. As was pointed out at the hui, there are different forums, settings and methods that could be used in further engagement.

As noted in section 1.5.3, the survey response was lower than expected however the commentary we received via the survey aligned with the interview data.

The literature highlights the limited number of evaluations assessing the effectiveness of initiatives to prevent sexual violence against disabled people. Therefore it is difficult to clearly identify 'best practice'. We have recommended that evaluation be built into the New Zealand system for sexual violence prevention for disabled people. Where research has been published, the methodological quality is often described as weak (e.g. small sample size, limited data on specific types of disability). Monitoring and evaluation of local initiatives and programmes may well suffer similar weaknesses. We note that evaluation is important but should be pragmatic and relevant to context. Service improvement does not need to rely on overly ambitious evaluations.

2. What the literature tells us

This section summarises the key themes from the literature and identifies, where possible, aspects of 'best practice' for sexual violence prevention for disabled people.

2.1 Limited research about sexual violence prevention for disabled people

Many of the authors identified that there is limited research on interventions to prevent violence against disabled people (Mikton & Shakespeare, 2014; Schaafsma, Kok, Stoffelen, & Curfs, 2015; Barger, Wacker, Macy, & Parish, 2009).

Where there is literature, it tends to be focused on women or children and those with mild to moderate cognitive disabilities (intellectual/learning/developmental). Literature also tends to be focused around behaviour change (Chodan, Häßler, & Reis, 2017) and deterrence interventions (i.e. an intervention (e.g. self-defence) that deflects the perpetrator away to another victim) rather than preventing perpetration from occurring (Barger, Wacker, Macy, & Parish, 2009).

2.2 Many sexual violence risk factors are prevalent among disabled people

There is an emerging body of literature that attempts to understand factors associated with the higher prevalence of abuse against disabled people compared to the general population.

There are numerous factors associated with sexual violence including:

- prior victimisation
- non-assertive behaviour
- socialisation to compliance
- low socioeconomic status
- acquaintance with the perpetrator
- social isolation
- a lack of knowledge of risk factors.

None of the risk factors are known causes of sexual violence. However, these factors are more common for people that have experienced sexual violence (Araten-Bergman, Bigby, & Ritchie, 2017; Barger, Wacker, Macy, & Parish, 2009). Many of the risk factors identified for the general population are prevalent among people with learning disabilities. In addition, some academics have identified that the severity of the cognitive impairment and associated characteristics are a risk factor for abuse (Araten-Bergman, Bigby, & Ritchie, 2017).

2.3 A full spectrum of prevention approaches

A range of prevention approaches were identified in the literature. (Barger, Wacker, Macy, & Parish, 2009; Schaafsma, Kok, Stoffelen, & Curfs, 2015; Mahoney & Poling, 2011; Doughty & Kane, 2010; Kim,

2016; McEachern, 2012; Phasha, 2009; Harvey, Garcia-Moreno, & Butchart, 2007). These range from structural and policy approaches to awareness campaigns to teaching behaviour change and abuse-protection skills.

The importance of creating a culture of protection for people at risk came through strongly in the literature. Several of the papers discussed the need for high-level change that creates a culture of prevention and protection for disabled people, particularly those with cognitive impairments. (Barger, Wacker, Macy, & Parish, 2009; Robinson & Chenoweth, 2011; Wissink, van Vugt, Moonen, Stams, & Hendriks, 2015; Araten-Bergman, Bigby, & Ritchie, 2017).

There were several other observations including:

- van der Heijden et al. (2019) discuss how the prevention of violence against women with physical disabilities needs to address the role of disability stigma that shapes the types of violence they experience, change gender norms, create accessible and safe environments and economic empowerment opportunities.
- Frohmader et al. (2015) discuss the need for a human rights approach that not only addresses inter-gender discrimination and inequality in violence prevention efforts, but also recognises the need for more holistic approaches that address intra-gender inequality and intersectional discrimination.

Others shared a view that a broader framework encompassing an individual's safety as part of their quality of life is needed, and that sexual violence should be treated as a public health problem (Stevens, 2012; Araten-Bergman, Bigby, & Ritchie, 2017).

Several other papers focused more on the importance of policies and guidelines. Some examples are given below.

- Explicit policy concerning how to deal with sexuality and sexual abuse within institutions, including schools with concrete behavioural guidelines for professionals (Wissink, van Vugt, Moonen, Stams, & Hendriks, 2015).
- Disability advocacy and sexual violence advocacy organisations working together (McEachern, 2012).
- Organisations incorporating abuse-prevention models into their management system. A comprehensive model would include training clients how to avoid and report abuse, training staff to identify signs of and reporting abuse, and ensuring rules and programmes are implemented (Mahoney & Poling, 2011).
- Highlighting that managerial, compliance-based systems may be deflecting attention from recognising and responding more effectively to abuse and neglect at individual, systemic and structural levels. Many current approaches fail to develop a culture of prevention and protection for people with intellectual disability (Robinson & Chenoweth, 2011).

2.3.1 Three broad personal protective skills

At the more specific behaviour change and abuse-protection skills end of the prevention approaches for disabled people, three broad personal protective skills were identified. These skills are highlighted below with examples of why there are challenges in teaching these skills to individuals with intellectual

disabilities and possible training methods to enhance these skills (Doughty & Kane, 2010; McEachern, 2012; Wissink, van Vugt, Moonen, Stams, & Hendriks, 2015; Walters & Gray, 2018).

2.3.1.1 Identify the situation is dangerous

Identifying a potential perpetrator or high-risk situation may be challenging for people with developmental disabilities due to a limited understanding about sexuality and healthy relationships. Adolescents and young adults with developmental disabilities often do not receive developmentally appropriate sexual health education, and this is associated with poor sexual health outcomes and increased rates of sexual abuse in this population. Therefore, promoting sexuality and reproductive health of adolescents and young adults with developmental disabilities, particularly for those with intellectual disabilities, is very much needed.

2.3.1.2 Respond to escape the situation quickly

It is necessary to establish an escape response when presented with an inappropriate situation. This response needs to overcome an extensive history of reinforcement for complying with requests from authority figures. Some authors emphasise teaching children defensive or self-protection and escape techniques. However, others have commented on how deterrence interventions deflect the perpetrator away to another individual that may not have these skills (Barger, Wacker, Macy, & Parish, 2009).

2.3.1.3 Disclose the confrontation to an appropriate individual(s)

The reporting of a perpetrator or potential perpetrator must occur despite impaired social skills, decision-making skills and communication skills. Literature indicates that many cases of sexual abuse of children with intellectual disabilities are not reported by the children themselves, but also not by their parents and care providers. Some authors emphasise the importance of behaviour-skills training, that includes reporting an incident to an appropriate individual(s), to address the previously mentioned challenges. Through instruction, demonstration, rehearsal, reinforcement and 'corrective' feedback behavioural-skills training, for those with intellectual disabilities, can enable development, maintenance and generalisation of skills (Doughty & Kane, 2010).

2.4 Limited evidence of initiative effectiveness and evaluation methodology is often weak

There is general agreement across the literature that there is scant research and few evaluations assessing the effectiveness of initiatives to prevent sexual violence against disabled people (Schaafsma, Kok, Stoffelen, & Curfs, 2015; Mikton & Shakespeare, 2014; Barger, Wacker, Macy, & Parish, 2009; Mikton, Maguire, & Shakespeare, 2014; Skarbek, Hahn, & Parrish, 2009).

Where research has been published, the methodological quality of the research or initiative evaluations is often described as weak (e.g. small sample size, limited data on specific types of disability or specific types of violence) and detailed descriptions of initiatives (e.g. materials, goals, methods) are lacking in publications. Conclusions about the effectiveness of initiatives are difficult to interpret because of the lack of rigorous planning, implementation and evaluation (Mikton &

Shakespeare, 2014; Mikton, Maguire, & Shakespeare, 2014; Schaafsma, Kok, Stoffelen, & Curfs, 2015; van der Heijden, 2014).

2.4.1 Participant satisfaction is often the only outcome measure

Most of the evaluated initiatives identified in the literature used participant satisfaction as their outcome measure. Some studies measured risk or protective changes such as behaviour change and skill acquisition (Mikton, Maguire, & Shakespeare, 2014). None measured changes in actual sexual violence outcomes such as a reduction in the incidence of sexual violence against disabled people (Barger, Wacker, Macy, & Parish, 2009; van der Heijden, 2014).

Below are papers we identified that presented some form of evaluation.

- Barger et al. (2009) found that of the four programmes they reviewed, only one had tested for outcomes other than participant satisfaction. This programme (Khemka 2000 cited in Barger et al. 2009) used a pre-test and post-test control group design to compare effects of two training conditions and a control condition (decision-making training, self-directed decision-making training and no training). They found that participants in self-directed decision-making training group held significantly more internal perceptions of control than participants in decision-making training and control groups (but participation in the decision-making training yielded a greater internal perception of control than did those in the control group). **This suggests that the ability of an individual with intellectual disabilities to make an effective decision against abuse is not only related to strategies being available but to factors related to self-motivation** (e.g. increased self-confidence and sense of empowerment) (Barger, Wacker, Macy, & Parish, 2009).
- A paper by Chodan et al. (2017) discusses their study protocol for conducting a randomised control trial to assess the effectiveness of a sexual abuse prevention programme for girls with intellectual disabilities. They assess preventive skills in terms of individual changes in measures of knowledge, verbal reports of anticipated behaviour, role plays, and in situ probes (Chodan, Häßler, & Reis, 2017). Results of the trial were not presented in the paper.
- A further study by Sullivan et al. (2017) looked at whether implementing an individual-level skill-building programme for school students could improve the impact of a universal intervention focused on improving the school climate and also whether these added benefits varied by disability status or gender. They found that among youth with disabilities there were greater increases in teacher-rated social skills for students in the combined intervention than students in the comparison condition at post-test (Sullivan, Sutherland, Farrell, Taylor, & Doyle, 2017).
- Schaafsma et al. (2015) found that in 13 articles they reviewed that included skills training, five of them focused on self-protection skills. Results from these **studies showed that the skills can be taught but generalisation of the skill to real life situations was often not achieved** (Schaafsma, Kok, Stoffelen, & Curfs, 2015).
- In addition, Klee (2016) noted that **people with higher cognitive abilities performed better on all test instruments at pre-test and post-test compared to people with lower cognitive abilities** (Klee, 2016).

2.4.2 Long-term effectiveness of initiatives is not known

In general, long-term maintenance of treatment effects has not been demonstrated or evaluated. However, there are indications that knowledge retention tends to deteriorate over time for people with cognitive disabilities and **they are likely to need more focus on maintenance of knowledge and skills over time** than people attending mainstream initiatives (Barger, Wacker, Macy, & Parish, 2009; Schaafsma, Kok, Stoffelen, & Curfs, 2015; Mahoney & Poling, 2011; Verlinden, Scharmanski, Urbann, & Bienstein, 2016).

2.4.3 Little guidance on specific interventions

Initiative evaluations tend to offer little guidance for practitioners and initiative commissioners when selecting specific interventions (Schaafsma, Kok, Stoffelen, & Curfs, 2015; Mikton & Shakespeare, 2014; Mikton, Maguire, & Shakespeare, 2014; Skarbek, Hahn, & Parrish, 2009).

In some circumstances, evidence from initiatives for the general population may provide insights. However, there is a need to keep in mind that in many instances adapted initiatives may be required (e.g. for people with cognitive impairments). It is also important to consider that people with severe disabilities will need different strategies (e.g. training for staff and caregivers) to those with mild to moderate disabilities (Mahoney & Poling, 2011).

2.5 Still many research gaps and recommendations

There are only a small number of sexual violence prevention interventions or initiatives for disabled people that have been rigorously evaluated, these all tend to relate to primary prevention strategies predominantly targeted at individuals with mild to moderate intellectual disability (Araten-Bergman, Bigby, & Ritchie, 2017).

Consistent with the findings of Mikton et al. (2014).

- We *did not* identify any literature on sexual violence prevention for people with mental illness, sensory impairments, severe intellectual or developmental disability.
- There was *very limited* literature (one study) on prevention for people with physical disabilities (van der Heijden, Abrahams, & Harries, 2019).

Research and interventions need to move beyond a response-to-risk approach to a broader framework that encompasses the individual's safety as part of their quality of life due to this lack of evidence (Araten-Bergman, Bigby, & Ritchie, 2017). Robinson & Chenoweth (2011) discussed how there are some systemic and structural preconditions in society (e.g. oppression, isolation and dehumanising of people with intellectual disabilities) which make abuse and neglect less likely to be prevented. In addition, legislation, policies and procedures are often predominantly focused on responding to individual instances of abuse, and fail to focus on changing environments and developing a culture of prevention and protection for people with intellectual disabilities (Robinson & Chenoweth, 2011). Wissink et al. (2015) highlight that there is still much to learn about the sexual development, sexual behaviour and effective methods for teaching sex education to children with intellectual disabilities.

It is largely undetermined if interventions for people with mild to moderate intellectual disabilities will work for people with severe intellectual disabilities (Mahoney & Poling, 2011).

In general, there is a need for more research and rigorous evaluations to better understand effective methods for preventing sexual violence against disabled people (Barger, Wacker, Macy, & Parish, 2009; Wissink, van Vugt, Moonen, Stams, & Hendriks, 2015). Programmes and evaluations need to provide more detailed descriptions of programme materials, programme goals, and methods used (Schaafsma, Kok, Stoffelen, & Curfs, 2015). There needs to be better collection and reporting of data for awareness and funding support and evaluation methods need to be incorporated to assess the impact of programmes beyond participant satisfaction (McEachern, 2012). The quality of the design and measurements that programmes use are particularly important as these can greatly influence the generalisability and credibility of the results (Schaafsma, Kok, Stoffelen, & Curfs, 2015).

2.6 Key success elements commonly identified

As discussed above, due to limited published research and robust evaluations about sexual violence prevention for disabled people, it is difficult to clearly identify 'best practice'. Table 1 below highlights the key success elements for sexual violence preventions initiatives for disabled people that were commonly identified in the literature (Russell, 2008; Barger, Wacker, Macy, & Parish, 2009; Harvey, Garcia-Moreno, & Butchart, 2007; Wissink, van Vugt, Moonen, Stams, & Hendriks, 2015; McEachern, 2012; Verlinden, Scharmanski, Urbann, & Bienstein, 2016; Martinello, 2014).

Table 1 Key success elements for sexual violence prevention initiatives for disabled people

Element	Description
Audience	• **Co-designed, tailored and accessible** to participants specific needs (e.g. developmental level, learning styles, culture, disability). • **Flexible and adaptable** to be inclusive of and able meet individual needs (e.g. strategies to engage with people different disabilities and from different cultures). • **Appropriately timed** to ensure exposure to the initiative is available during the appropriate developmental stage (i.e. when it will have the most impact). • **Inclusive** of perpetrators as part of the solution (e.g. include in design, delivery and receipt of initiatives).
Content	• **Evidence based** on research and theoretical evidence of how behaviours develop and can be changed. • **Clearly defined initiative goals** that can be measured. • **Comprehensive:** target multiple risk factors in multiple settings and linkages between them; promotes healthy behaviour, positive relationships and skill building with opportunities to practice and implement the new skills; focus on empathy not blaming. • **Challenge cultural norms** that normalise sexual violence against disabled people (e.g. target attitudes and beliefs about disability and sexual violence).
Delivery	• **Teaching methods:** Use varied and interactive teaching methods including participatory education and training approaches (e.g. skill-development components and interactive or 'hands-on' methods) and practical application and material to teach knowledge, improve attitudes and increase skills.

	• **Dosage (or amount of intervention):** Participants at greater risk require a greater dosage of intervention (e.g. it may be necessary to provide more contact with participants through longer sessions, multiple sessions, and follow-up). • **Reinforcement:** Repeated exposure to content overtime is necessary to achieve long lasting attitude and behavioural changes as well as reinforcement of learnings and behaviours outside of the learning environment. • **Facilitators:** Delivery should by well-trained staff who are sensitive, competent, supported and supervised. A high turnover negatively affects the continuity and effectiveness of initiatives. Peers as educators can be successful in addressing behaviours such as bystander apathy and they can deliver information in a way that appeals to their peers. • **Disclosure strategy:** Ensure that facilitators are equipped to deal with disclosures (e.g. provide information about resources and support mechanisms).
Evaluation	• Evaluation strategies should be integrated into initiatives at the time of inception. • Results should be documented against the initiative goals and outcome evaluation should include measures beyond participant satisfaction.
Funding	• Adequate resourcing is required to ensure initiatives are well supervised, have well trained facilitators and that they can operate over sufficient timeframes so that outcomes can be evaluated. Evaluation should be included in the resourcing.

3. Stocktake and assessment of initiatives

The stocktake of primary and secondary sexual violence prevention initiatives was primarily informed by desk-based research and interviews. A small amount of additional information about initiatives was received via the survey and hui. There may be others that we have missed because of the fragmented nature of provision but we don't believe any omissions to be significant.

We have used the key success elements for sexual violence preventions initiatives as an organising framework (Table 1) to assess the primary and secondary sexual violence prevention initiatives specifically designed for disabled people identified in the stocktake.

3.1 Stocktake

This section summaries the information we identified about the initiatives. A total of 24 initiatives were identified in the stocktake. Not all of these were sexual violence prevention specific, but they were included if they covered some content on sexual violence prevention or healthy relationships or keeping safe. Table 2 provides a summary of the 24 initiatives identified and their audience.

3.1.1 Mainstream initiatives

Thirteen mainstream initiatives were identified, of which, only three were specifically focused on sexual violence prevention.

Interviews informed us that mainstream initiatives are often not known about by, or accessible to, disabled people. However, we identified that four mainstream initiatives, although not specifically designed for disabled people may, to varying degrees, be accessible or adaptable to disabled people (primarily with those with mild learning or age-related impairments). These initiatives were:

- Atu-Mai (Le Va)
- Mates and Dates (multiple providers)
- Elder abuse prevention and support services (Age Concern)
- Empower to Pamper (TOA Pacific).

Two of the initiatives, run by Age Concern and TOA Pacific, are specifically for older people and therefore, are likely to be adaptable for people with age-related disabilities. Le Va advised us that Atu-Mai could cater for people with mild learning disabilities (reading age of 12 years). Mates and Dates is provided in the school environment. It may be accessible to some disabled people in the mainstream education environment, but this may vary.

3.1.2 Specifically designed for disabled people

Eleven initiatives specifically designed for disabled people were identified. None of these were specifically focused on sexual violence prevention. All were generally focused on developing knowledge and skills for keeping safe, healthy relationships or sexuality. All the initiatives had a primary prevention focus, with three also including secondary prevention.

In general, the initiatives tend to be focused around adolescents and adults with mild to moderate learning disabilities. This was consistent with findings in the literature. Several initiatives were more focused towards providing information to the families/whānau of disabled people or professionals and support workers.

During our sector engagement we asked why people thought initiatives were mostly focused on those with mild to moderate learning disabilities. Reasons they gave included:

- there is a historical perspective that people with learning disabilities are asexual
- that people with cognitive disabilities (learning disabilities, dementia and brain injury—traumatic and acquired) require a different approach to learning.

At the hui there was a general view that people with other disabilities (e.g. physical or sensory disabilities) that do not have cognitive impairments, have historically had more of a voice about their needs. This means that to some extent they have been able to access mainstream services with no or minimal need for these to be adapted. There were two material qualifications to this point of view.

- We heard from stakeholders that mainstream initiatives are not always accessible to, or adaptable to the needs of disabled people.
- In addition, we heard concerns from stakeholders that mainstream initiatives are already oversubscribed and therefore may not be able to accommodate disabled people.

No sexual violence prevention initiatives specifically designed for disabled people being run by Māori or Pasifika providers were identified in the stocktake. However, we did identify two mainstream initiatives run by TOA Pacific and Le Va that may be adaptable for some disabled people. Both initiatives are more generally focused on abuse or violence prevention.

We acknowledge that this does not necessarily mean there are no initiatives, rather during our stocktake we were not able to identify any.

Table 2 Summary of primary and secondary prevention initiatives identified in the stocktake and their audience

Category	Provider name	Initiative name	Prevention level	Age group targeted	Disability type
Specifically designed for disabled people	People First	Keeping Safe Feeling Safe	Primary, secondary	≥18 years	Learning (mild–moderate)
	Empowerment Trust	fullpower™ Healthy relationships	Primary	Teens and adults	Learning (mild–moderate)
	Sexual Abuse Prevention Network	Friends, whānau and flirting	Primary	≥16 years	Learning (not specified)
	Disability Connect - Parent and Family Resource Centre	'Safe relationships and sexuality' for people with disabilities, their family and whānau	Primary	Any (including parents and professionals)	Any
		Information and advisory service	Primary	Primarily for parents of children and adults with disabilities	Any
	ToBeFrank	A range of group and individual initiatives and services	Primary, secondary (including perpetrators)	Any (including parents and professionals)	Learning and autism
	The Personal Advocacy and Safeguarding Adults	Safeguarding adult's response through bespoke training	Primary, secondary	18–64 years	Any one at risk
	Health Click	A range of seminars and webinars	Primary	Young people, caregivers and professionals	Learning (mild–moderate) and autism
		Me	Primary	Adolescents and adults	Learning (mild–moderate)
	Family Planning	Safe relationships; safer sex	Primary	Any	Learning (mild–moderate)
		All about growing up	Primary	Young people and their families	Learning (mild–moderate)
Mainstream	Age Concern	Elder abuse prevention and support	Secondary	≥65 years	Age-related
	TOA Pacific	Empower to Pamper	Primary	≥65 years	Age-related
	Le Va	Atu-Mai	Primary	Young people and their families	Learning (mild)
	Multiple providers	Mates and Dates	Primary	13–17 years	Anyone in mainstream education
	Child Matters	A range of child protection courses	Primary, secondary	Children and young people	
	Family Planning	Navigating the Journey	Primary	9–11 years	
	Health Click	Sex Smart	Primary	Adolescents	
		Puberty changes	Primary	10–14 years	
	Ministry of Social Development	"It's not ok"	Primary	Any	
	New Zealand Rugby	Headfirst Being Men	Primary	Youth and adults	
		'Who are you?'	Primary	14–25 years	

	Sexual Abuse Prevention Network	'Who are You?' campaign	Primary	Any	
	WellStop	Prevention strategies for children or youth at risk of concerning or harmful sexual behaviour	Primary, secondary	Children and youth	

3.2 Assessment of sexual violence prevention initiatives for disabled people

As discussed in the literature review, there is limited published research and a lack of methodologically robust evaluations about sexual violence prevention for disabled people. Due to this, it is difficult to clearly identify what is effective and could, therefore, be considered 'best practice'. Both the literature and stakeholder engagement emphasised that the best ways to reduce sexual harm for disabled people are through:

- high-level changes that create a safer environment through a safeguarding approach
- building the resiliency skills of those at risk
- robust evaluation of evidence-based initiatives to better inform effectiveness and future initiative development.

We take the key success elements for sexual violence prevention initiatives for disabled people identified in the literature (Table 1) and assess initiatives specifically designed for disabled people, identified in the stocktake (Table 3).

3.2.1 Audience is mainly those with mild to moderate learning difficulty

Most of the initiatives identified are focused around young people and adults with mild to moderate learning disabilities. This was consistent with findings in the literature.

Two initiatives ('Keeping Safe Feeling Safe' and 'Healthy Relationships') were clearly identified to us as being co-designed with disabled people.

> With school programmes, for physical disabilities we don't really have to adapt the course, and for sensory we can provide the resources differently. But we run a whole different programme with different learning techniques for those with learning disabilities.
>
> Inclusion is one of the main barriers. [There is a saying that] the only disability is loneliness…so if we want to stop sexual violence, we need to support inclusion.
>
> Each disability is different—there is a need for more one on one so that questions can be answered.
>
> Our programme is accessible for different disability types as the online resources have sound so they can be accessible to blind as there is narration etc. For deaf people…we have taught with an interpreter.

None of the initiatives specifically designed for disabled people were designed exclusively for one ethnic group. However, the 'Healthy Relationships' resources were designed with advice from Māori and/or Pasifika so that the resources are culturally relevant. Disability Connect specialises in providing information for Chinese and Indian ethnic groups in Auckland.

> When we designed our resources, we had advice from Māori and Pasifika, and we made sure the names and situations were culturally relevant. We don't have resources available in different languages, but we can change the sound files into different languages, if that was requested.
>
> Our specialist areas are Chinese and Asian groups in Auckland. We have support groups primarily aimed for Indian people (broadening that now) and also a group for Chinese". There are differences between cultures on how they prefer to receive information.

Several initiatives were focused towards providing information to the families/whānau of disabled people or professionals and support workers working with disabled people.

- 'Safe relationships and sexuality'
- Group sessions provided by ToBeFrank
- 'Safeguarding Adults from Abuse'
- Seminars and webinars provided by Health Click.

> What about those with severe disability? The main point is that if people don't relate to others, they will not need this programme. It is the professionals and supporters that will need the programme.
>
> There is a need for information about sexuality and relationships and disabilities. Most prominent needs are for families with a person with intellectual disability.
>
> People around the disabled people need to be educated also. It is these people that are unintentionally not creating safe environments.

Although out of scope for the work, including perpetrators as part of the solution (e.g. include in design, delivery and receipt of initiatives) was recommended. We did not hear of any initiatives specifically designed for disabled people that included perpetrators.

> Disabled people as perpetrators…If you do a sexual violence prevention programme it needs to include perpetrators. It is not just about the victims but also about stopping perpetrators. If you are putting people down, you will lose people but if they are getting the training also, they will learn.

3.2.2 Content focused on keeping safe and healthy relationships

None of the initiatives were focused specifically on sexual violence prevention. They were more generally focused on keeping safe, sexuality or healthy relationships. Most of the initiatives cover a comprehensive range of topics or are specifically tailored to the information needs of the participants. The range of topics covered include information about sexuality, promoting healthy behaviour and relationships and building resiliency skills to prevent bullying, violence and abuse.

> A main priority that you can see with our programme is that we are focusing on skills development…that means we are making things safe for disabled people which is important around sexual violence,

> violence and relationships. There are lots of good meaning people that don't do it well.

3.2.3 Delivery largely through group workshops

In general, the initiatives are delivered via group workshops with specifically designed resources. These are commonly provided in community settings at provider premises as they are accessible to disabled people they represent. However, the dosage (or amount of intervention) of initiatives varied greatly.

Two initiatives provide multiple sessions over multiple weeks:

- 'Keeping Safe Feeling Safe' 30 hours (10 sessions over 10 weeks)
- 'Friends, whānau and flirting' 6 hours (4 sessions over 4 weeks)

Three initiatives tailor the dosage to individual needs:

- 'Healthy Relationships'
- Individual sessions by ToBeFrank
- 'Safeguarding Adults from Abuse'

Three providers deliver one-off workshops:

- Disability Connect
- ToBeFrank
- Health Click

Three initiatives provided resources only:

- 'Me'
- 'Safe relationships; safer sex'
- 'All about growing up'

From the literature and sector engagement it is clear that dosage, repetition and refreshers are essential for reinforcing and building skills over time particularly for people with cognitive impairments (Barger, Wacker, Macy, & Parish, 2009; Russell, 2008; Schaafsma, Kok, Stoffelen, & Curfs, 2015; Mahoney & Poling, 2011; Verlinden, Scharmanski, Urbann, & Bienstein, 2016). However, we did not identify any clear evidence or recommendations for what the optimal dosage is. The optimal dosage is likely to vary depending on individual needs and participants at greater risk are likely to require a greater dosage of intervention.

> People with learning disabilities can't be taught a concept except if high functioning…it is through coaching in the moment. They need to practice the skills and they don't have to know why, like teaching children to wash hands before eating, they don't need pictures of germs they just need to learn to do it.
>
> [There is a] need to be more fluid in teaching approaches for [people with] learning disabilities.

> Our programme is good as it 1. focuses on skills development, 2. makes sure to continue the process after the initial programme, 3. uses kinesthetics and practices that are carefully coached so that everyone is successful, 4. uses visual and non-verbal ways of teaching so that everyone can participate (as many have more than one disability). It's important to know that if it is done wrong, you can do damage.

Most of the initiatives identified are delivered by trained facilitators and have disclosure strategies. The 'Healthy Relationships' initiative is unique in that it is delivered by 'supporters' who are people that know the learners well. The resources for this initiative include a guide for facilitators with information about responding to disclosures.

> Users [people that have done the programme] have the ability to coach others also…We have started an ambassador project where they teach other groups, coaching and helping others and we are working on expanding this. They get paid for their work too.

> Disclosures…the programme user/teacher has a booklet and poster on what should be done…so part of the programme is about how to deal with disclosures. We teach a lot about getting help…also need to make sure you don't put too much on it at the start as they can exploit the attention they may get. Support people often know the difference.

3.2.4 Only one initiative has been formally evaluated

Sector engagement told us that there is currently a small number of initiatives specifically designed for disabled people that are operating and are well received. However, most have not been formally evaluated. This indicates that evaluation strategies are generally not being integrated into initiatives at the time of inception.

We heard of some initiatives that measure participant satisfaction ('Keeping Safe Feeling Safe', 'Safe Relationships and Sexuality') but we only identified one initiative (fullpower™ Healthy Relationships) that had been formally evaluated (five time since 2009) and one initiative (Safeguarding Adults from Abuse) that was formally evaluated at the pilot stage, we summarise these evaluations below.

The fullpower™ Healthy Relationships programme was most recently evaluated in 2014 (Wilson, 2015). This was a quantitative evaluation of the programme using a pre- and post-test research design. Eighteen people completed the pre-test, post-test and post-post-test (6-months after completing the programme). Testing criteria were six vignettes or stories depicting problem situations that were not part of the Healthy Relationship programme. Participants were asked to say what they would do, and responses were graded.

- The results indicated that there were significant improvements in scoring rates for all six vignettes combined for pre-test and post-test and that these were maintained 6-months later at the post-post-test.

- The evaluators found that 80 percent of participants were generalising healthy relationship skills to situations not encountered during the programme, meaning some people may be applying the skills in real life.
- However, it was noted that the programme seemed to be most effective for people teaching adults with mild to moderate learning disabilities.
- In particular, those who are living relatively independently or in a semi-supported environment as the programme does require a degree of cognitive ability, especially the ability to move from concrete learning environments to abstract generalised situations (Wilson, 2015).

The Waitematā 'Safeguarding Adults from Abuse' pilot evaluation was published in 2017 (Appleton-Dyer & Soupen, 2017). This was an interagency safeguarding approach to reporting, investigation and responding to alleged or identified family harm and other forms of abuse, neglect or harm to vulnerable adults. The pilot ran for six months in the Waitakere, North Shore and Rodney district policing areas. The review used a mixed-methods approach bring together stakeholder interviews and service data. The reviewers found that overall the 'Safeguarding Adults from Abuse' pilot offered an approach that supports Police to achieve their key priorities, such as reducing victimisation, ensuring people are safe and feel safe, and fostering trust and confidence (Appleton-Dyer & Soupen, 2017).

3.2.5 Funding

We heard in interviews that most of the initiatives are primarily resourced by funding from grants provided by charitable organisations. Interviewees told us that this reliance on grants impacts the provision of initiatives in the following ways.

- Limits how widely initiatives can be implemented. Several initiatives we identified are available nationally, but to varying degrees, while others are only available at one specific location where the provider is located (e.g. Nelson).

  > The number of courses we run a year and where is totally dependent on funding…Funding of programmes is based on grants, we would like to do a lot more, but the resources are limited.

- Creates uncertainty for providers about their ongoing ability to provide an initiative.

  > We rely on philanthropic funding, but they say this should be Government work and we may not get it in the future, yet we have been turned down for Government funding.

  > Funding is a bit of a problem now. MSD used to fund $30,000 a year for this and other programmes but now that contract has changed to go to Oranga Tamariki, which means we have to focus more on children so now we don't have funding. Now the workshops need to be paid for by the users and hard copies can be covered by grants, it is about 50% by grants and 50% user fees. This is a big problem. We need to find at least $50k a year.

- Limits ability to undertake evaluations.

Table 3 Assessment of sexual violence prevention initiatives for disabled people

Initiative (Provider)	Audience	Content	Delivery	Evaluation	Funding
Keeping Safe Feeling Safe (People First)	People ≥18 years with mild to moderate learning disabilities. Co-designed with disabled people.	Aims to help safeguard disabled people from bullying, abuse and neglect. Topics include: the law and your rights, what abuse is, keeping safe, healthy relationships, what to do and how to report abuse.	• Group workshops and resources (easy read format workbook, cards, booklets reporting form, find out more sheets). Also use a ripple effect for further dissemination of information by giving participants multiple copies of the resources so they can be shared with family and friends. • Dosage: 30 hours over 10 weeks • Delivered by trained facilitators. Staff training includes recognising and responding to abuse and neglect.	End of course participant feedback	Grants
fullpower™ Healthy Relationships (Empowerment Trust)	Teens and adults with a wide range of disabilities including autism/Asperger's, Down's syndrome, other learning disabilities. Co-designed with disabled people.	Aims to provide tools to build resiliency and to prevent bullying, violence and abuse. Topics include healthy relationships; saying stop and stopping; getting help	• Interactive resources including workbooks, posters, animated stories and a facilitators guide. • Dosage can be tailored to needs. • Delivered by 'supporters' who are people that know the learners well. The resources include a guide for facilitators that includes information about responding to disclosures.	Formally evaluated x5 (last in 2014) using pre-/post-/post-post-test	Grants
Friends, whānau and flirting (Sexual Abuse Prevention Network)	People ≥16 years with learning disabilities.	Use fullpower™ Healthy Relationships resources	• Workshop • Dosage: 6 hours over 4 weeks	Indirectly (see above)	
'Safe relationships and sexuality' (Disability Connect with ToBeFrank)	• Family/whānau of disabled people • Professionals and support workers • Disabled people (learning and ASD)	Aims to provide information for different groups about sexuality and disabled people. Topics include sexuality and disabled people including safety in relationships; sexuality—what it means; intimate support;	• Workshop • Dosage: 2 hours • Delivered by a trained facilitator. • Disclosure strategy: Refer on as appropriate	Informal end of workshop feedback	Grants, Course fee

Initiative (Provider)	Audience	Content	Delivery	Evaluation	Funding
		touch; contraception; legal aspects and consent			
Information advisory service (Disability Connect - Parent and Family Resource Centre)	Members of Disability Connect Support groups, primarily parents of children and adults with disabilities.	A variety of topics tailored to the needs of the groups	• Support group • Topic specialists are brought in • Disclosure strategy: Refer on as appropriate	Run a survey for members to understand their priorities	DHB contract
Group and individual workshops (ToBeFrank)	• Disabled people (learning and ASD) • Family/whānau of disabled people • Professionals and support workers	Aims to provide a disability advisory service that provides general information, advice, and resources that include seminars, support groups and community conversations. Topics that may include sexuality and disabled people.	• Workshop and individual sessions • Dosage is tailored to educational needs • Delivered by a trained facilitator • Disclosure strategy: Refer on as appropriate	No	
Safeguarding Adults from Abuse (The Personal Advocacy and Safeguarding Adults Trust)	Adults (18–64 years) at risk and families and organisations. Use a person-led approach	Aims to coordinate an inter-agency response to referrals of harm, abuse or neglect for Adults at Risk. The safeguarding approach includes a range of activities and responses that promote and protect human rights, health, wellbeing and culture, and prevent or reduce harm, abuse and neglect.	• Bespoke training tailored to needs • Dosage is tailored to training needs of organisation or individual • Delivered by trained facilitators • Disclosure strategy: Refer on as appropriate	Waitematā pilot only	Grants
Seminars and webinars (Health Click)	Anyone educating people with learning disabilities	Tailored to audience covering topics about sexuality and health education.	• Seminar or webinar • Dosage: 1.5 hours • Delivered by trained facilitators	No	Course fee for professional
Me (Health Click)	A collection of resources (book, e-book, CD Rom, wall chart) to teach adolescents and adults with mild to moderate learning disabilities (such as ASD, Down's syndrome, brain injury or other learning disabilities) about hygiene, relationships and intimacy.			No	Resource fee

Initiative (Provider)	Audience	Content	Delivery	Evaluation	Funding
Safe relationships; safer sex (Family Planning)	A booklet for people with mild to moderate learning disabilities that covers personal and private body parts, places, behaviours, relationship types and safer sex.			Resources go through a research, testing and development phase before production.	
All about growing up (Family Planning)	A booklet for young people with mild to moderate learning disabilities and their families that covers information and activities for families to use with young people about the emotional, physical and social aspects of puberty.				

4. Themes from our engagement

This section brings together information gathered from the literature and sector engagement (interviews, survey and hui). There was considerable agreement in the themes, from all sources.

4.1 There is an important backdrop to the development of initiatives

Although the scope of this work was primarily a stocktake and assessment of initiatives for the prevention of sexual violence against disabled people, we heard consistent feedback on the importance of societal attitudes and increasing understanding of disabled peoples' experiences. Increasing the value placed on disabled people within their communities is the starting point for a culture that protects people from harm. In addition, there was a strong call for increased cross-sector leadership and a coordinated approach to service development.

> There is a saying that culture will trump policy any day of the week.
>
> It's about values, and the value we place on every human being.
>
> [We] need to start with changing attitudes and values about age and disability.

4.1.1 A safeguarding and situational prevention response is needed

The need to take a wider safeguarding approach—and not just a response to risk approach—was a strong theme in both the literature and our stakeholder engagement. It requires the creation of strong social networks around a disabled person and vetting of carers so that it is more difficult for someone to harm them. Stakeholders also talked about situational crime, the body of evidence around situational crime and the role of environments (e.g. safety features of public spaces, observation in residential facilities) that makes it harder for people to cause harm, even if there may be ideation. A safeguarding approach is not necessarily specific to sexual violence.

> Sometimes we don't need to be sexual violence specific, as long as your safeguarding approach is wide enough to take it into account.
>
> Why are people targeting people with disabilities—because it's easier. So, we need to make it harder. Look at situational things, without reducing the environment that people live within. It is a balance.

4.1.2 Cross-agency coordination effort is required

There is a strong call for cross-agency leadership and a coordinated approach to further service development in this area. Key sectors cited included Education, Social Development and Health. In practical terms, we think this coordinated effort could focus on:

- campaigns promoting acceptance of all disabled people, irrespective of age, stage and disability type, but with an emphasis on more complex impairments including communication difficulties
- joint commissioning of research, needs analysis and co-design of initiatives
- awareness raising—promoting the full range of initiatives that are on offer and ensuring that different agencies and providers know what is available
- coordinated funding of initiatives and support for evaluation.

A system wide approach in the future would need to consider all these factors, as well as an end-to-end system response from policy to practical front-line programme or initiative level.

4.2 Initiatives must be culturally relevant

Culturally relevant approaches are key to ensuring equity of access to sexual violence prevention initiatives and reduction in harm. This applies equally to needs analysis and design, which should apply a cultural lens, as well as delivery of initiatives. Meaningful engagement with Māori and Pasifika and other ethnic groups is required at each step. There is also a need to consider diversity between cultures but also within each culture.

> When we say Māori or Pacific need to remember that there is variation within culture also. Agree that a holistic approach is needed.

4.3 Developing healthy sexuality supports prevention of harm

Stakeholders pointed out that disabled people are often viewed as asexual and that there is a cultural reticence to address sexuality and relationships. There is need to take a human rights-based approach to education (i.e. individuals know their rights and are supported to participate in and make decisions about things that affect their lives) that supports disabled people to have positive sexual experiences and relationships—if that is what they want. Keeping safe is a core part of this but the narrative is around 'what you can do' and not solely focused on 'what you can't do' and fear of abuse.

> From a historical perspective perhaps that people with learning disabilities have been seen as more asexual in the past. With physical and sensory disabilities there may not be cognitive disability, so they may be able to access more mainstream programmes. In the past people with sensory disabilities and physical disabilities have been able to voice themselves. Cognitive disability needs different approaches as they are not able to self-find information.

Although not within the scope of this work, stakeholders were clear that primary prevention needs to be considered alongside secondary and tertiary prevention and all approaches need to be inclusive and consider perpetration as part of the solution. Harm can be caused by one young person to another, highlighting the need for education that allows people to explore their sexuality in a safe way. Prevention of perpetration should focus on settings rather than individuals that may cause harm.

> There is some evidence that 'primary prevention' based on prevention of victimisation doesn't work.

> If you do a sexual violence prevention programme it needs to include perpetrators because it is not just about the victims but also about stopping perpetrators.
>
> Prevention of perpetration—it's not about identifying who is a perpetrator, because we don't know who the perpetrators are. If we go on the literature, we will miss groups of people. Prevention of perpetration—the focus needs to be on settings (rather than individuals).

4.4 A multi-pronged approach that responds to different needs

Stakeholders felt that disabled people need easily accessible education and information including sexuality and sexual health, consent and autonomy, their individual rights and how to make complaints.

However, one size does not fit all. A successful prevention strategy must be multi-pronged, with strong consideration of different cohorts and a variety of learning and education options, across different settings, to meet different needs. This includes coverage across geographical locations, adaptations and specific initiatives for people with different disability types, different settings (e.g. schools, community settings, maraes), and a variety of providers.

Approaches need to consider age, stage and living circumstances, such as residential facilities or people having intimate personal cares at home. Early intervention is important, as abuse in childhood often continues into adulthood and leads to poor outcomes throughout the life course. At the same time, initiatives aimed at prevention of sexual violence amongst older people must respect that discussing this openly with older adults may not be comfortable or acceptable.

Some stakeholders felt that mainstream initiatives were well intentioned but can overlook the specific needs of disabled people. We heard from the Deaf community who are clear there is a pressing need for them to access education and support, but that initiatives need to be led by people who understand their needs and culture.

4.5 Smart and accessible delivery formats

Disabled people need to receive information in a manner that is appropriate for them—experiential learning in accessible formats is important. Examples include the use of illustrations/graphics, videos, physical demonstrations of body language/actions to demonstrate safe and unsafe intimate behaviours.

Accessibility features such as sub-titles, use of hearing loops and sign language interpreters are important to ensure people are not excluded from education. Initiatives, including mainstream ones, should be accessible for those with impaired mobility. Speech language therapists can support people with limited verbal communication to participate.

Some stakeholders felt that there are initiatives that could be easily adapted for disabled people but that it is highly dependent on funders and/or settings. For example, an individual school might provide an interpreter or teacher aide to enable a disabled student to participate in an initiative.

Stakeholders are thinking beyond traditional formats for delivery of education including digital content. We were given examples of video-based resources used in education sessions, but these are not able to be taken home. Greater availability of online resources and content could support learning in the 'classroom'.

Stakeholders are also considering the impact of the growing influence of social media and the pornography and sex industries.

4.6 Dosage is an important initiative success factor

The literature is clear that 'dosage', that is, the amount of intervention an initiative delivers, is important to embed learning and behaviours. However, we did not identify any clear evidence or recommendations for what the optimal dosage is and it is likely to vary depending on individual needs. Unfortunately, many initiatives are not resourced to deliver the length of sessions, or multiple sessions and follow up that may be desirable. It appears that one-off initiatives don't work as well as when there is repetition within the initiative and refreshers are offered later. This not only assists with reminding people about what they have previously learnt, but also can build on experiences and possible questions people might have.

> Research says you need a certain amount of 'dosage'. Programmes less than 4 hours are not effective and they can't just be one-off either.

Some people we spoke with pointed out that education doesn't always translate into real life, highlighting the need for reinforcement of messages on multiple occasions and in different settings. 'Age and stage' of people means that different topics may be covered and built on over time.

4.7 Well-trained facilitators ensure consistency of messaging

There was a call to ensure that initiatives are run by well-trained facilitators to ensure consistency of messaging as the current system is fragmented and based on individual preferences and knowledge. Common training, and possibly credentialing, would ensure a common language, consistency and quality of initiatives.

4.8 Educating whānau and wider workforces is equally important

Stakeholders were clear there is a need to educate the wider workforce (e.g. teachers, carers, health care professionals) and whānau to support the messages delivered through formal initiatives as well as act to keep disabled people safe.

Many stakeholders noted that when an initiative is brought into a school, for example, as a one off, and parents and teachers are not involved, then there is no continuity for the disabled person or ability to ask questions later. There are mixed views as to whether sessions should be joint with disabled people and parents/teachers or be separate but cover similar topics. Most likely, a combination of both approaches would be appropriate.

There is likely to be a level of discomfort from both parents and their disabled children, knowing and talking about their child's sexuality. In addition, there may be different cultural sensitivities to talking about sexuality that need to be respected.

Professional development for support workers doesn't seem to be readily available. Healthcare professionals may not receive child protection and sexual education in their undergraduate training.

4.9 Getting the basics right

Stakeholders emphasised the importance of system-level factors however, there is clearly also a need to 'get the basics right' in terms of initiative development and sustainability. They have expressed the following:

- Don't reinvent the wheel for sexual violence prevention initiatives. It was noted that there is a significant lead in time for the development of new initiatives, therefore we should build on the gems that already exist.
- Existing initiatives including mainstream initiatives have limited capacity and additional resourcing is required to meet the known demand.
- Funding is fragmented and can be hard to come by. There are a variety of funders such as ACC, Oranga Tamariki, Ministry of Social Development, councils and grants from charitable organisations. Many of the initiatives identified are run solely by funding grants from charitable organisations.
- Funding should be specifically targeted for designing, delivering and evaluating initiatives for disabled people, their families and those who work with them (including relationships and sexuality).
- Evaluation should be built into the system but needs to be pragmatic. Smaller scale initiatives may only require simple evaluations so that we don't lose good work waiting for overly ambitious evaluations.

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Appendix A: List of engagement

The organisations invited to participate in the research—either via interviews, invitations to the hui or the survey—is listed in the table below.

We interviewed (in person or by phone) over 35 individuals from 32 organisations. A majority of organisations on the list below were invited to the hui and 12 individuals representing 17 organisations attended (some individuals represented more than one organisation). Fifteen individuals from nine organisations submitted a survey response.

Table 4 Organisations invited to participate in the research

Organisation	Interview completed	Attended hui	Survey response
Disabled People's Organisations Coalition • Association of Blind Citizens New Zealand • Balance Aotearoa • Deaf Aotearoa • Disabled Persons Assembly NZ • Kāpō Māori Aotearoa • Muscular Dystrophy Association of New Zealand Inc • People First New Zealand Ngā Tāngata Tuatahi	Attended coalition meeting	Coalition representative	
Sexual Violence Prevention Advisory Board		Y	
The Personal Advocacy and Safeguarding Adults Trust	Y		
Empowerment Trust	Y		
Family Planning	Y		
Health Click	Y	Y	
ToBeFrank	Y	Y	
TOAH-NNEST	Y		
TOAH-NNEST Tauiwi caucus		Y	
TOAH-NNEST (Ngā Kaitiaki Mauri whare)		Y	
Te Pou o te Whakaaro Nui	Y	Y	
Age Concern New Zealand	Y	Y	
Child Matters	Y		
Le Va Pasifika	Y		
Advocate for disabled people with high and complex needs, ex-Board of Complex Carers NZ	Y		
MSD (Sexual Violence Team)	Y		
ACC (Behaviour Management and Sensitive Claims)	Y		
IHC	Y		
Platform Trust	Y		
Aged Residential Care expert	Y		
NZ Spinal Trust	Y		
NZ Women's Refuge	Y		

Organisation	Interview completed	Attended hui	Survey response
Auckland Sexual Abuse HELP	Y		
Rape Crisis NZ	Y		
TOA Pacific	Y		
Le Va	Y		
Oranga Tamariki	Y		
Aged nursing care	Y		
CCS Disability Action	Y		
Cavit ABI	Y		
NZ Carers Alliance	Y		
Complex Carers Group	Y		
Deaf Action NZ	Y		
Disability Connect	Y		Y
Sexual Abuse Prevention Network		Y	Y
Te Ao Taurima			
Te Roopu Taurima			
Office of Disability Issues, Ministry of Social Development			
Department of Corrections			Y
Lesley Ayland & Associates		Y	
Human Rights Commission		Y	
Ministry of Health - DSS		Y	
Ministry of Education			
Disability Women's Forum			
Police (School Community Policing team)			Y
Spectrum Care Trust			Y
Northland District Health Board			Y
Ministry of Justice			Y
Te Taitokerau Tangata Whai Ora Network			Y
Yes Disability			Y

Appendix B: Literature search methods

Search strategy

In consultation with ACC, sexual violence and disability experts we developed a formal search strategy. This included a list of search terms, items to be included, items to be excluded, and other search parameters such as language, location and publication date. Sources for the search for peer reviewed literature included:

- PubMed
- ABI Inform
- ProQuest Research Library
- Business Source Premier
- Google Scholar.

Sources for the search for grey literature included:

- A scan of information repositories such as the Family Violence Clearinghouse, Social Sciences Research Network, and university research sources.
- Disability and sector specific sites and organisations such as the Office of Disability Issues, People First, the Disabled Peoples' Organisations Network, Age Concern and other peak bodies and non-governmental organisations and sexual violence providers. (Note: This list will also be a component of our qualitative fieldwork process).
- Government and recognised quasi- and non-governmental organisations such as the Vera Institute of Justice, Organisation for Economic Co-operation and Development, World Health Organization, European Union and United Nations.
- Relevant international sources such as Australian Policy Online, the Sexual Violence Research Initiative, and disability networks and alliances.

Search terms were used in a combination of field, command and key word searches, using both the basic and advanced techniques available in each database. Boolean operators, truncation and wildcard commands were used as required.

An iterative approach was used, taking into consideration the results of searches, and new terms may be added to the strategy if they were identified during the search process.

A bibliographic software tool (EndNote) was used to manage references.

Search terms

The following list is the example starting point for search terms. The MeSH thesaurus was used to check for other terms and subheadings that may be useful.

Table 5 Literature search terms

Terms grouped by subject	
Sexual violence	Rape
Sexual abuse	Domestic violence
Sexual offense	Family violence
Sexual harm	Intimate partner violence
Sexual assault	Harmful sexual behaviour
Disability*	Handicapped persons
Disabled persons/persons with disability/ies	* Optional terms to capture mainstream information as well
Physical disability/persons with	Older people/elder abuse
Mental disability/persons with	Indigenous/Māori
Sensory disability/persons with	Autism spectrum disorder
Intellectual/brain injury disability/persons with	Long term chronic health disability/persons with
Prevention programme/education programme	Initiative
Treatment programme	Pilot
Effectiveness	Review
Best/good practice	Analysis
Benchmarking	Outcome(s)
Success	Results
Evaluation	Methodology/ies/modalities/components of programmes

Characteristics of the literature

Table 6 Summary of literature characteristics

Characteristics		Number of papers (n=43)
Publication type	Published article	22
	Report	17
	Website	2
	Thesis	1
	Book chapter	1
Disability	All or not specified	18
	Intellectual/developmental/special needs	17
	Physical	1
	Mainstream (i.e. not disability specific)	7
Country of origin	United States	11
	New Zealand	10
	Australia	6
	South Africa	4
	Canada	2
	Germany	2
	The Netherlands	2
	South Korea	1
	Switzerland	1
	United Kingdom	1
	Other	3

Table 7 Included literature

Reference	Literature type	Disability type	Violence type	Initiative or prevention approach
ACC. (2019). Making a difference: Sexual violence primary prevention toolkit. [https://svpptoolkit.nz/]	Website	Not disability specific	Sexual	Prevention
Araten-Bergman, T., et al. (2017). Literature Review of Best Practice Supports in Disability Services for the Prevention of Abuse of People with Disability: Report for the Disability Services Commissioner.	Review	Intellectual	All	Prevention
Barger, E., et al. (2009). "Sexual assault prevention for women with intellectual disabilities: A critical review of the evidence." Intellectual and Developmental Disabilities 47(4): 249-262.	Review	Intellectual	Sexual	SVP programmes
Chiamulera, C. (2016). Children with Disabilities and Sexual Abuse: Risk Factors and Best Practice. Child Law Practice Today (April 2016). [https://www.americanbar.org/groups/public_interest/child_law/resources/child_law_practiceonline/child_law_practice/vol-35/april-2016/children-with-disabilities-and-sexual-abuse--risk-factors-and-be/]	Website	All	Sexual	Risk factors and best practice
Chodan, W., Häßler, F., & Reis, O. (2017). A randomized controlled trial on the effectiveness of a sexual abuse prevention programme for girls with intellectual disabilities: study protocol. Translational Developmental Psychiatry, 5(1), 1407192.	RCT Single programme study	Intellectual (mild)	Sexual	Group programme: behavioural therapeutic exercises and also contain psychoeducational elements.
Department of Communities. (2013?). Preventing and responding to the abuse, neglect and exploitation of people with a disability: Tips and resources for disability service managers and staff.	Resource for disability service managers and staff	All	Abuse and neglect	

Reference	Literature type	Disability type	Violence type	Initiative or prevention approach
Dickson, S. & Willis, G. (20105). Primary prevention of sexual violence in Aotearoa New Zealand: A survey of prevention activities. Sexual Abuse: A Journal of Research and Treatment, 29(2): 128-147.	Survey	Not disability specific	Sexual	
Doughty, A. H., & Kane, L. M. (2010). Teaching abuse-protection skills to people with intellectual, disabilities: a review of the literature. *Res Dev Disabil, 31*(2), 331-337.	Literature review	Intellectual (mild to moderate)	Sexual, physical, verbal	Teaching abuse-protection skills
Dowse, L., et al. (2013). Stop the Violence: Addressing Violence Against Women and Girls with Disabilities in Australia: Background paper.	Symposium report	All	All	
Fitzsimons, N. M. (2017). Partnering with People with Disabilities to Prevent Interpersonal Violence: Organization Practices Grounded in the Social Model of Disability and Spectrum of Prevention. In Religion, Disability, and Interpersonal Violence (pp. 45-65).	Book chapter	All	All	
Frohmader, C., et al. (2015). "Preventing violence against women and girls with disabilities: Integrating a human rights perspective." Hum. Rts. Defender 24: 11.	Discussion document	All	All	
Harvey, A., Garcia-Moreno, C., & Butchart, A. (2007). Primary prevention of intimate-partner violence and sexual violence: Background paper for WHO expert meeting May 2–3, 2007. Geneva: World Health Organization, Department of Violence and Injury Prevention and Disability, 2007.	Prevention approaches	Not disability specific	Sexual and intimate partner	
Julich, S. J., et al. (2015). The sustainable delivery of sexual violence prevention education in schools, Massey University.	Literature review	All	Sexual	School-based prevention programmes
Kim, Y. R. (2016). Evaluation of a sexual abuse prevention program for children with intellectual disabilities. *Behavioral Interventions, 31*(2), 195-209.	Single programme review	Intellectual (mild-moderate)	Sexual	Prevention
Klee, K. E. (2016). Evaluation of an Abuse Prevention Education Program for Adults with Developmental Disabilities. Faculty of Education, Wilfrid Laurier University. Master of Education.	RCT: Single programme review	Intellectual and Developmental	All	

Reference	Literature type	Disability type	Violence type	Initiative or prevention approach
Krisch, M., et al. (2015). Global strategies to reduce violence by 50% in 30 years: findings from the WHO and University of Cambridge Global Violence Reduction Conference 2014.	Conference proceedings	Not disability specific	All	Global strategies
Lund, E. M., & Hammond, M. (2014). Single-session intervention for abuse awareness among people with developmental disabilities. Sexuality and Disability, 32(1), 99-105.	Single programme review	Intellectual	Abuse	SAFE - Stopping Abuse For Everyone: one-session abuse psychoeducation programme
Mahoney, A., & Poling, A. (2011). Sexual abuse prevention for people with severe developmental disabilities. Journal of Developmental and Physical Disabilities, 23(4), 369-376.	Literature review	Developmental (severe)	Sexual	
Martinello, E. (2014). Reviewing strategies for risk reduction of sexual abuse of children with intellectual disabilities: A focus on early intervention. *Sexuality and Disability, 32*(2), 167-174.	Literature review	Intellectual	Sexual	Prevention/early intervention
McEachern, A. G. (2012). Sexual Abuse of Individuals with Disabilities: Prevention Strategies for Clinical Practice. *Journal of Child Sexual Abuse, 21*(4), 386.	Review	All	Sexual	
McPhillips, et al. (2002). Preventing Sexual Violence: A Vision for Auckland/Tamaki Makaurau. Report presented to ACC by Auckland Sexual Abuse HELP with contributions from community groups.	Literature review	All	Sexual	Community Injury Prevention and Safety Promotion Project
Mikton, C. & T. Shakespeare (2014). "Introduction to special issue on violence against people with disability." Journal of interpersonal violence 29(17): 3055-3062.	Literature review	All	All	Public health approach
Mikton, C., et al. (2014). "A systematic review of the effectiveness of interventions to prevent and respond to violence against persons with disabilities." Journal of interpersonal violence 29(17): 3207-3226.	Systematic review	All, esp intellectual and developmental	All	
Ministry of Health. (2016). The Prevention and Management of Abuse: Guide for services funded by Disability Support Services.	Services guide	All	Al	

Reference	Literature type	Disability type	Violence type	Initiative or prevention approach
Ministry of Women's Affairs. (2013). Current Thinking on Primary Prevention of Violence Against Women.	Report	Not disability specific	All	Primary
Nyokangi, D., & Phasha, N. (2016). Factors contributing to sexual violence at selected schools for learners with mild intellectual disability in South Africa. Journal of applied research in intellectual disabilities, 29(3), 231-241.	Qualitative research	Intellectual (mild)	Sexual	Focus groups
Origin Research Charitable Trust. (2019). Identifying, Preventing, and Responding to Abuse against Disabled People: Literature Review	Literature review	All	Abuse	
Percival, T., et al. (2010). Pacific pathways to the prevention of sexual violence.	Report	All	Sexual	Prevention
Phasha, N. (2009). Responses to situations of sexual abuse involving teenagers with intellectual disability. Sexuality and Disability, 27(4), 187.	Qualitative research; Single study	Intellectual	Sexual	
Robinson, S., & Chenoweth, L. (2011). Preventing abuse in accommodation services: From procedural response to protective cultures. Journal of Intellectual Disabilities, 15(1), 63-74.	Review	Intellectual	Abuse and neglect	Prevention in accommodation services
Russell, N. (2008). What works in sexual violence prevention and education: A literature review prepared for the Ministry of Justice.	Literature review	All	Sexual	Prevention and education
Schaafsma, D., et al. (2015). Identifying effective methods for teaching sex education to individuals with intellectual disabilities: A systematic review. Journal of sex research, 52(4), 412-432.	Systematic review in sex education programmes	Intellectual	None	Sex education
Skarbek, D., Hahn, K., & Parrish, P. (2009). Stop sexual abuse in special education: An ecological model of prevention and intervention strategies for sexual abuse in special education. *Sexuality and Disability, 27*(3), 155-164.	Review	All	Sexual	Prevention and intervention programmes based on Bronfenbrenner's Ecology of Human Development and the three categories of

Reference	Literature type	Disability type	Violence type	Initiative or prevention approach
				prevention: primary, secondary, and tertiary
Smith, N. & S. Harrell (2013). "Sexual abuse of children with disabilities: A national snapshot."	Overview of principles	All	Sexual	
Stevens, B. (2012). Examining emerging strategies to prevent sexual violence: Tailoring to the needs of women with intellectual and developmental disabilities. *Journal of Mental Health Research in Intellectual Disabilities, 5*(2), 168-186.	Synthesis of workshop information	Intellectual & Developmental	Sexual	Three strategies: protective and promotive factors, bystander intervention, and working with men and boys.
Sullivan, T. N., et al. (2017). Evaluation of violence prevention approaches among early adolescents: Moderating effects of disability status and gender. Journal of child and family studies, 26(4), 1151-1163.	Single programme review: RCT	All	All	School-based prevention programme
Urbis Keys Young. (2004). National Framework for Sexual Assault Prevention.	National framework	Not disability specific but disability section	Sexual	
van der Heijden, I. (2014). What works to prevent violence against women with disabilities. Pretoria: What Works To Prevent VAWG.	Review	All	All	
van der Heijden, I., et al. (2019). "Additional Layers of Violence: The Intersections of Gender and Disability in the Violence Experiences of Women with Physical Disabilities in South Africa." Journal of interpersonal violence 34(4): 826.	Qualitative research	Physical	All	
Verlinden, K., et al. (2016). Preventing Sexual Abuse of Children and Adolescents with Disabilities–Evaluation Results of a Prevention Training for University Students. International Journal of Technology and Inclusive Education (IJTIE), 5(2), 859-867.	Single programme review: RCT	Special needs	Sexual	Special prevention training for children and adolescents with disabilities

Reference	Literature type	Disability type	Violence type	Initiative or prevention approach
Walters, F. P., & Gray, S. H. (2018). Addressing sexual and reproductive health in adolescents and young adults with intellectual and developmental disabilities. *Curr Opin Pediatr, 30*(4), 451-458.	Review	Intellectual & Developmental	Sexual	Promoting sexuality and reproductive health and sexual abuse prevention
Wharewera-Mika, J. M. & K. M. McPhillips (2016). Good Practice Responding to Sexual Violence Guidelines for 'mainstream' crisis support services for survivors - Round two.	Guidelines	Not disability specific and survivors	Sexual	Support for survivors
Wissink, I. B., et al. (2015). Sexual abuse involving children with an intellectual disability (ID): a narrative review. Res Dev Disabil, 36, 20-35.	Literature review	Intellectual	Sexual	

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