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Identifying Existing Provisions That Improve Health Outcomes for Adolescents Who Experienced Sexual Harm: A Rapid Review

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ABSTRACT

Sexual harm is an urgent public health concern for adolescents, with profound and lasting health consequences. This rapid review aimed to identify interventions that improve health outcomes for adolescents aged 11–18 following sexual harm. Five databases and grey literature were searched for quantitative or qualitative studies published between January 2020 and February 2025 that reported at least one health outcome. Of 3595 publications screened, 10 studies ($n = 723$ participants) were included. Seven evaluated psychosocial interventions, one assessed pharmacological treatment and two focussed on multi-agency or first-responder protocols. Short-term improvements were reported for trauma symptoms ($k = 4$), anxiety ($k = 2$), depression ($k = 2$), suicidal ideation ($k = 1$), health service utilization ($k = 2$), general functioning ($k = 1$) and well-being ($k = 3$). No study reported physical health outcomes, and only two spanned a 12-month follow-up. Although evidence remains constrained by limited long-term evidence and heterogeneity of outcomes, promising cross-cutting characteristics included wrap-around and multidisciplinary support, co-production of interventions and research with adolescents, and involvement of the wider family. Future research should focus on establishing a shared outcomes framework and leveraging linked administrative data to examine long-term trajectories.

1 | Introduction

Rising incidence of sexual harm is a pressing global public health problem for adolescents, requiring urgent action (UNICEF 2017). Although prevalence rates vary considerably and are limited by under-reporting, the Centre of Expertise on Child Sexual Abuse (CSA) posits that in England and Wales alone at least 15% of girls and 5% of boys experience sexual harm before the age of 16 (Karsna and Kelly 2021).

In the United Kingdom, there is no single definition of CSA (Karsna and Kelly 2021). The government published its ambition 'to tackle child sexual abuse in all its forms' and the Centre of Expertise on CSA has cautioned research against having a narrow focus on particular contexts of abuse (Dean 2021). Reflecting this, our review adopts the broader umbrella term 'sexual harm' to consider all forms of sexual abuse (e.g., exploitation and assault), across contexts (e.g., digital or offline) and involving any perpetrator (e.g., extra- or intra-familial).

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Key Practitioner Messages

- Several studies demonstrated the feasibility of co-located services spanning forensic, social care, advocacy, third-sector and health provision to deliver wrap-around, holistic support for adolescents.
- Diversity of adolescents' needs was reflected in the range of outcomes across studies. Developing a shared outcomes framework, grounded in survivor-defined concepts of recovery, may support learning across practitioners and services.
- Studies that involved adolescents in the design of interventions concluded that co-production improves the relevance and meaningfulness of support.

The effects of sexual harm in adolescence are profound and often persist into adulthood. Hailes et al.'s (2019) umbrella review, with over 4 million participants, associated childhood sexual harm with a range of adverse long-term mental health outcomes including substance abuse, post-traumatic stress disorder and suicide. A recent Lancet publication using UK BioBank data from 156,968 participants found childhood sexual abuse to be associated with 10 physical disease categories in adulthood, ranging from common conditions such as back pain and headaches to blood, respiratory and circulatory diseases including anaemia, hypertension, heart disease, arrhythmias and chronic bronchitis (Frank et al. 2024). The World Health Organization has therefore urged for evidence on interventions that improve health outcomes for young people who seek support following sexual harm (García-Moreno et al. 2013).

Adolescence is a critical developmental stage when appropriate interventions (in education, healthcare and other settings) can deliver a triple dividend: improved current health, improved future health and better health for the next generation (Patton et al. 2016). To date, several reviews have examined the effectiveness of mental health interventions for children and young people who have experienced sexual harm, but these have primarily focused on psychological outcomes, potentially overlooking broader health impacts (Caro et al. 2023; Macdonald et al. 2012; McTavish et al. 2021; Tichelaar et al. 2020). The majority of evidence suggests that cognitive behavioural therapy (CBT), including trauma-focused CBT, may lead to small but significant improvements in mental health outcomes (Macdonald et al. 2012; McTavish et al. 2021; Tichelaar et al. 2020). More recently, Caro et al.'s (2023) meta-analysis found tentative support for CBT and child-centred therapy but noted that other less-evaluated interventions could be promising but are under-researched. Additionally, inconsistencies in outcome measures, differences in interventions and short-term and/or absence of follow-up periods have meant the evidentiary support remains largely uncertain (Caro et al. 2023; Macdonald et al. 2012; McTavish et al. 2021; Tichelaar et al. 2020).

Notably, past reviews also span large age ranges, for example, 2–18 years (Caro et al. 2023), 3–18 years (Macdonald et al. 2012; McTavish et al. 2021) and 4–18 years (Tichelaar et al. 2020), making it difficult to establish whether findings apply equally to younger children and adolescents. Caro et al. (2023), among

others, have argued that having a wide range of ages affects the way interventions are delivered and received, which could in turn impact outcomes. Adolescents have distinct developmental and therapeutic needs that differ from both younger children and adults, highlighting a crucial gap in the evidence base (Patton et al. 2016).

To address this research gap, we conducted a rapid review to address the research question: What interventions exist for improving health outcomes for adolescents (aged 11–18) who have experienced sexual harm? Our rapid review focuses specifically on adolescents aged 11–18. The impact of sexual harm is wide ranging and requires a multi-faceted approach to optimize support (Vera-Gray 2023). Accordingly, this review expands the scope of inquiry beyond psychological outcomes and mental health interventions to include physical and general health outcomes, as well as broader service provisions.

2 | Methods

2.1 | Search Strategy

Five electronic databases were searched between 31st January and 3rd February 2025: PubMed, Web of Knowledge, ProQuest, Medline & Embase, Scopus. Details of the search terms and counts are provided in Appendix A in the [Supporting Information](#).

To reflect the scope of a rapid review and to ensure relevance to recent policy developments (e.g., Home Office 2021) and calls for more holistic systems of support (e.g., Home Office 2025), only studies published after 1st January 2020 were included in the review. Given the timeframe for this evidence synthesis, a formal protocol was not prospectively registered; however, to support transparency and comprehensive reporting, eligibility criteria were developed prior to study selection using Cochrane's Population, Intervention, Comparison, Outcome and Study design (PICOS) framework.

In conjunction, grey literature was searched (i.e., literature published outside of academic journals) for relevant publications. This included searching policy documents (e.g., from the Department for Education) and websites from UK organizations either focused on safeguarding young people and children (e.g., NSPCC) or populations that have experienced sexual harm (e.g., Rape Crisis England & Wales and Centre of Expertise on CSA).

2.2 | Inclusion and Exclusion Criteria

The rapid review included quantitative and qualitative primary empirical studies on service provision, treatments, interventions and programmes for adolescents who have experienced sexual harm. Studies with and without comparison groups were considered.

As the review focused on adolescents, only studies in which the mean participant age was between 11 and 18 years at the time of intervention were included. This age range was chosen to align with existing UK service structures, such as secondary schools.

One study (Louison Vang et al. 2020) combined their adult and adolescent samples in the main analysis; however, as the authors ran a moderation analysis to determine if age group moderated the effectiveness, it was still included.

Studies were eligible if they reported any health outcome, including, but not limited to, economic evaluations, measures of health service activity (e.g., counts of emergency care use), psychological or physical health, well-being, or general functioning. In contrast, studies were excluded if they did not evaluate an intervention or provision and lacked health outcomes, including those focused solely on patient satisfaction or professional perceptions of service delivery.

Only English-language studies conducted within Australia, Canada, Europe, Turkey, the United Kingdom, the United States and New Zealand were included. These countries were selected following consultation with members of the study team, comprising clinical practitioners from social work, education and health. Consultations aimed to ensure the rapid review's relevance to UK policy and practice, while maximizing comparability across high-income countries and their respective health, education and social care landscapes in which interventions are delivered. Other high-income countries were excluded to maintain the feasibility of a rapid review.

The decision flow chart which aided the decision-making process can be found in Appendix B in the [Supporting Information](#).

2.3 | Title and Abstract Screening

A total of $k=12,562$ studies were identified in the search, of which $k=8967$ duplicates were detected, resulting in $k=3595$ citations for title and abstract screening. For the PRISMA flow diagram, see Figure 1.

Title and abstract screening were completed by five reviewers using Rayyan (J.M., T.M., D.P., S.P., F.D.S.S.). Each reviewer independently screened between 10% and 25% of records. Records marked as 'maybe' ($k=28$) were reviewed by J.M., who made the final inclusion decision. A minimum of 15% of records from each reviewer was double screened by J.M. Percent agreement ranged from 94% to 99%. Prevalence-adjusted-bias-adjusted Kappa (PABAK) values were also calculated, ranging from 0.88 to 0.98, indicating consensus (Byrt et al. 1993).

2.4 | Full-Text Screening and Data Extraction

A total of 155 full-text articles were included in the review ($k=143$ from the database search; $k=12$ from grey literature). J.M. screened all articles ($k=155$), with a second researcher (F.D.S.S.) screening a subset of 15% ($k=23$). Three disagreements arose, which were resolved through discussion with the wider group. A total of $k=10$ studies met the inclusion criteria for the review. J.M. extracted data on (a) the study design and sample characteristics (e.g., mean age and sample size), (b) intervention characteristics (e.g., duration and the provider(s)) and (c) health-related outcomes (qualitative and quantitative).

Extracted data were subsequently checked by N.M. to verify accuracy. Non-health-related outcomes were not extracted. Data were synthesized narratively.

2.5 | Quality Assessment

Quality appraisal of included full-text papers was conducted by two independent researchers (A.H. and J.M.; see Appendix C in the [Supporting Information](#)). Because of the heterogeneity of methodologies in included studies, we used a variety of quality appraisal tools as appropriate. These included the CASP Cohort Study Checklist, CASP Randomized Controlled Trial Checklist, CASP Qualitative Study Checklist (Critical Appraisal Skills Programme 2024a, 2024b, 2024c), the JBI Case Series Checklist (Munn et al. 2020) and the Mixed Methods Appraisal Tool (Hong et al. 2018).

3 | Results

3.1 | Overview

The final 10 studies included in the review comprised data from 723 adolescents (see Table 1). The studies varied by type of sexual harm experienced by the adolescents. Five studies focused on survivors of CSA ($N=245$), two on commercial sexual exploitation ($N=306$), two on rape or sexual assault ($N=157$) and one study on survivors of technology-assisted sexual abuse ($N=15$).

Adolescents' mean ages ranged from 13.0 to 16.33. Across studies reporting gender ($k=9$; 627 adolescents), 6.2% of adolescents were male. Seven studies reported on ethnicity (523 adolescents), in which 41.47% were from Black and minority ethnic backgrounds. In terms of study design, one was qualitative, one was mixed methods, and eight were quantitative. The studies were conducted across six countries: three in the United States, two in the United Kingdom, two in Canada and one each in Turkey, France and Denmark. Of the three studies that reported attrition, the dropout rate between pre- and post-intervention ranged from 11.1% to 54.8% (Brown et al. 2020; Louison Vang et al. 2020; Reeson et al. 2020).

3.2 | Intervention Characteristics

Ten distinct interventions to support adolescents who had experienced sexual harm were identified across 10 studies. Although two studies assessed the same intervention programme (Reeson et al. 2020, 2022), one study assessed two separate psychosocial interventions (Brown et al. 2020). Altogether, interventions varied in type, scope/breadth, duration and setting (see Table 2). Seven comprised psychosocial interventions, one assessed a pharmacological treatment, and two focused on multi-agency or first responder protocols. Most interventions were delivered in clinical settings ($k=8$), one in the third sector ($k=1$), none in educational settings and one was digital and therefore not setting-specific ($k=1$). Although non-offending caregivers were not included as study participants, support for them was integrated in four interventions: Two included family therapy (Demirgoren et al. 2020;

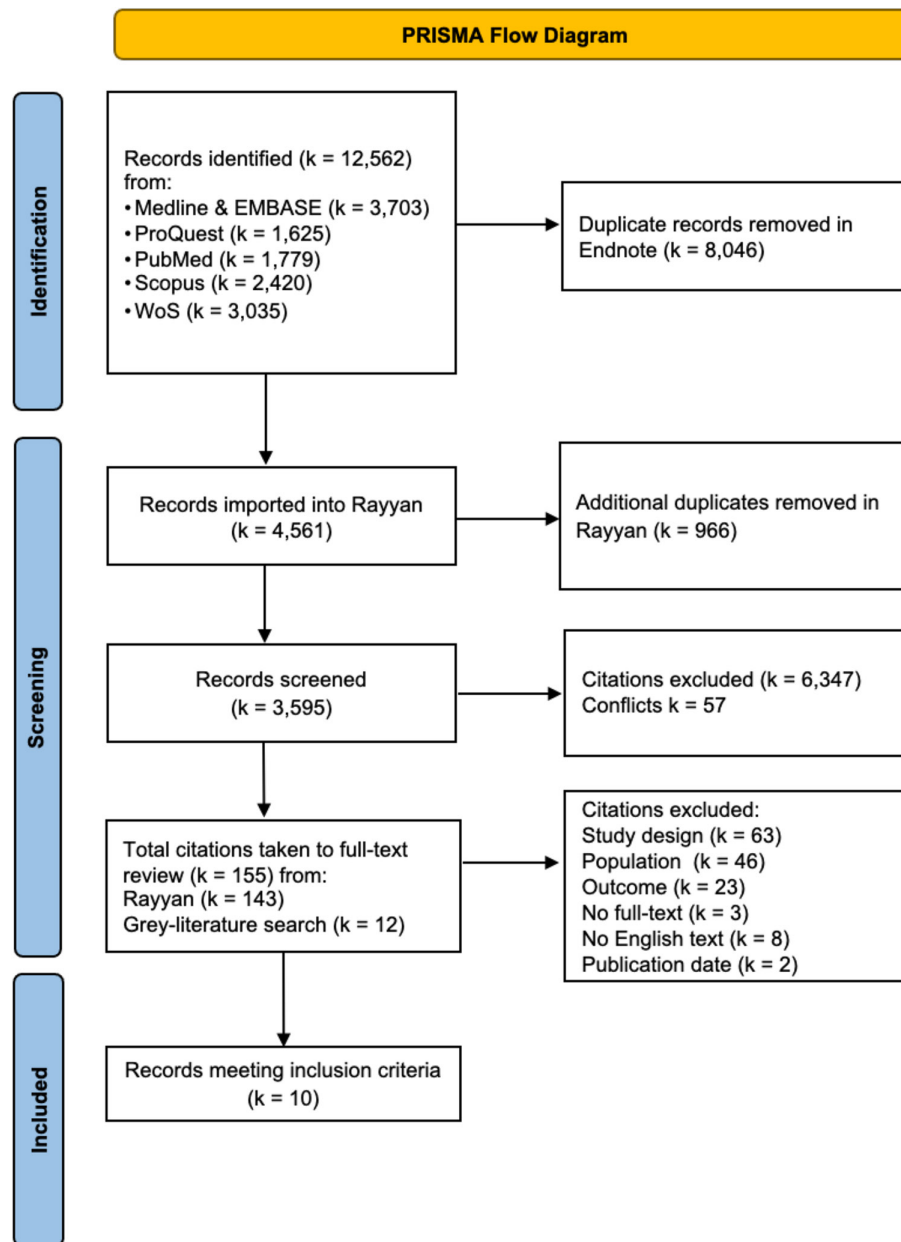


FIGURE 1 | PRISMA flow diagram.

Reeson et al. 2020, 2022), whereas two provided parallel support groups for caregivers (Louison Vang et al. 2020; Parker et al. 2021). Two interventions involved adolescents in designing or evaluating the intervention (Parker et al. 2021; Quayle et al. 2024), and two tailored interventions to individual adolescents by adjusting therapy modules or treatment goals through clinician-led processes (Reeson et al. 2020, 2022; Louison Vang et al. 2020). Five interventions were classified as multidisciplinary; details of the professional backgrounds involved in intervention delivery are provided in Table 2. Professions involved spanned mental health (e.g., therapists), health (e.g., paediatricians), youth justice (e.g., police), social work (e.g., social workers) and advocacy (e.g., advocates).

3.3 | Outcomes

All 10 included studies reported health outcomes. Most studies on psychosocial interventions evaluated mental health

outcomes, including posttraumatic stress symptoms, anxiety, depression, suicidal ideation, global functioning and general well-being. The single pharmacological intervention evaluated posttraumatic stress symptoms, whereas the two cross-sector service models primarily assessed health service utilization and broader well-being, rather than symptom change. None reported physical health outcomes. Only Parker et al. (2021) involved adolescents in selecting measured outcomes. All findings, including information on who assessed outcomes, can be found in Appendix D in the [Supporting Information](#).

3.4 | Posttraumatic Stress Symptoms

Four studies evaluated posttraumatic stress symptoms and/or posttraumatic stress disorder (PTSD) severity. Two studies derived from the same intervention, a 2–4 week intensive, multimodal psychosocial residential programme named the BeBrave

TABLE 1 | Population characteristics of included studies.

Author(s)	Country	Study design	Intervention type	Target population	Total (N)	Mean age (SD)	Age range	Male (%)	Mental health condition (%)	Black and minority ethnic background (%)	Attrition (%)
Brown et al. (2020)	USA	RCT	CCT or PE-A	Rape survivors aged 13–18	61	15.3 (1.5)	NR	0	NR	75.4	NR
Demigoren et al. (2020)	Turkey	Pre-post intervention	Milieu therapy	CSA survivors aged 8–18	43	14.51 (2.39)	8–18	14	100	NR	NR
Ferrafiat et al. (2020)	France	Pre-post intervention	Prazosin	Youth with CSA-related PTSD	18	13.0 (1.8)	9–15	44.4	100	11.1	NR
Hershberger (2022)	USA	Qualitative	EAP	Commercially sexually exploited youth	6	14.5 (1.26)	13–16	0	NR	33.3	NR
Louison Vang et al. (2020)	Denmark	Pre-post intervention	CBT	Sexual assault survivors aged 13–18	96	16.33 (1.44)	13–37	NR	75	NR	NR
Miller et al. (2020)	USA	Observational	First responder protocol	Commercially sexually exploited youth	300	15.9 (NR)	11–18	0.6	NR	89	NR
Parker et al. (2021)	UK	Non-Randomized comparative evaluation	Barnahus model	Survivors of CSA and child sexual exploitation	88	11 (NR)	NR	20	NR	50	NR
Quayle et al. (2024)	UK	Qualitative	DHI	TASA survivors aged 12–18	15	15.3 (NR)	12–18	6.7	NR	0	NR
Reeson et al. (2020)	Canada	Pre-post intervention	Multimodal CBT-TF	CSA survivors aged 13–18	27	14.3 (1.0)	13–16	0	92.6	32.3	11.10
Reeson et al. (2022)	Canada	Pre-post intervention	Multimodal CBT-TF	CSA survivors aged 13–18	69	14.3 (1.5)	NR	5.8	NR	40.6	NR

Abbreviations: CBT = cognitive behavioural therapy; CBT-TF = cognitive behavioural therapy–trauma focused; CCT = client-centred therapy; CSA = childhood sexual abuse; DHI = Digital Health Intervention; EAP = equine-assisted psychotherapy; N = number; NR = not reported; PE-A = prolonged exposure for adolescents; PTSD = posttraumatic stress disorder; RCT = randomized controlled trial; SD = standard deviation; TASA = technology-assisted sexual abuse.

TABLE 2 | Intervention characteristics of included studies.

Author(s)	Intervention	Target population	Intervention duration	Intervention setting	Intervention cost	Delivered by	Outcomes measured	Follow-up
Brown et al. (2020)	PE-A or CCT. PE-A includes psychoeducation, in vivo and imaginal exposure and relapse prevention.	Rape survivors aged 13–18	14 30- to 90-min sessions	NR	NR	Therapists	Suicidal ideation	Post-intervention 3 months; 6 months; 12 months
Demirgoren et al. (2020)	Milieu therapy within a multidisciplinary team inpatient unit. Services include individual and group therapy, family therapy, medication management, community meetings and education via an on-site school.	CSA survivors aged 8–18	85.74 ± 30.54 days (min–max: 30–184 days)	Inpatient Child and Adolescent Mental Health Unit	NR	Multidisciplinary team led by consultant psychiatrist	General functioning	Post-intervention
Ferrafiat et al. (2020)	Prazosin, an alpha-1 adrenergic receptor antagonist	Youth with CSA-related PTSD	1 month with a mean dose of 2.16 (±0.6) mg/day	Inpatient Child and Adolescent Mental Health Unit	NR	Psychiatrists	Trauma symptoms	Post-intervention
Hershberger (2022)	Weekly EAP sessions at a residential therapeutic working ranch. It includes rhythmic riding while following therapeutic prompts from a trained social worker.	Sex trafficked youth	4 weeks	Residential facility	NR	Social worker, horse handler	General mental health and well-being	Post-intervention

(Continues)

TABLE 2 | (Continued)

Author(s)	Intervention	Target population	Intervention duration	Intervention setting	Intervention cost	Delivered by	Outcomes measured	Follow-up
Louison Vang et al. (2020)	STEPS: Individual or group-based CBT involving (i) psychoeducation provided by psychologists, forensic doctors and police officers; (ii) in sensu and in vivo exposure; (iii) cognitive restructuring; (iv) relapse prevention. It includes a parallel six-session parent support group.	Sexual assault survivors aged 13–18	8 weeks	Centre for sexual assault survivors	NR	Forensic doctors, police officers, psychologists	Trauma symptoms	Post-intervention 6 months; 12 months
Miller et al. (2020)	A rapid-response, multidisciplinary intervention. Within 90 min, a social worker or probation officer and a community advocate meet the youth to address immediate needs and safety planning. Within 72 h, youth receive medical and mental health assessments. Advocates provide ongoing support, case management and crisis intervention for at least 90 days.	Commercially sexually exploited youth	90 days	Paediatric clinic	NR	Police officers, probation officers, social workers, advocates	Health service utilization	Post-intervention

(Continues)

TABLE 2 | (Continued)

Author(s)	Intervention	Target population	Intervention duration	Intervention setting	Intervention cost	Delivered by	Outcomes measured	Follow-up
Parker et al. (2021)	A Barnahus model that brings together (i) social care, (ii) medical, (iii) police, (iv) advocacy and (v) therapeutic support under one roof. Includes a parallel parent support group	Survivors of CSA and child sexual exploitation	≤2 years	Centre for CSA and child sexual exploitation survivors	£6860 per young person	Paediatricians, social care liaison officers, play advocates, police specialists, police liaison officers, mental health professionals	General mental health and well-being	Post-intervention
Quayle et al. (2024)	<i>i-Minds</i> —a digital mentalisation-based health intervention. Self-led modules delivered via smartphone. Four content areas: (i) mentalisation, (ii) psychoeducation about TASA, (iii) emotional and mental health and (iv) trauma. No restrictions on session number or content navigation	TASA survivors aged 12–18	6 weeks	Digital (no limits on where the app was used)	NR	Self-led via smartphone app	General mental health and well-being	Post-intervention

(Continues)

TABLE 2 | (Continued)

Author(s)	Intervention	Target population	Intervention duration	Intervention setting	Intervention cost	Delivered by	Outcomes measured	Follow-up
Reeson et al. (2020)	A residential multimodal treatment programme including daily TF-CBT. This is supplemented with (i) group and individual therapy, (ii) EMDR, (iii) yoga and meditative therapy, (iv) art therapy, (v) cultural activities, (vi) recreational therapy, (vii) animal-assisted therapy and (viii) combined child–caregiver sessions. The distribution of therapy and intervention schedules is individualized.	CSA survivors aged 13–18	2 weeks	Residential facility	NR	Therapists	Trauma symptoms; anxiety; depression	Post-intervention

(Continues)

TABLE 2 | (Continued)

Author(s)	Intervention	Target population	Intervention duration	Intervention setting	Intervention cost	Delivered by	Outcomes measured	Follow-up
Reeson et al. (2022)	A residential multimodal treatment programme including daily TF-CBT. This is supplemented with (i) group and individual therapy, (ii) EMDR, (iii) yoga and meditative therapy, (iv) art therapy, (v) cultural activities, (vi) recreational therapy, (vii) animal-assisted therapy and (viii) combined child–caregiver sessions. The distribution of therapy and intervention schedules is individualized.	CSA survivors aged 13–18	Two 12-day treatment rounds	Residential facility	NR	Therapists	Trauma symptoms; anxiety; depression	Post-intervention

Abbreviations: CBT = cognitive behavioural therapy; CBT-TF = cognitive behavioural therapy–trauma focused; CCT = client-centred therapy; CSA = childhood sexual abuse; DHI = Digital Health Intervention; EA P = equine-assisted psychotherapy; NR = not reported; PE-A = prolonged exposure for adolescents; PTSD = posttraumatic stress disorder; TASA = technology-assisted sexual abuse.

ranch (Reeson et al. 2020, 2022). One study evaluated a structured trauma-focused cognitive behavioural therapy (TF-CBT) (Louison Vang et al. 2020) and the other an atypical psychotropic drug, Prazosin (Ferrafiat et al. 2020). All reported significant post-treatment improvements in posttraumatic stress symptoms or PTSD severity.

At the *BeBrave Ranch*, Reeson et al. (2020) found average Child PTSD Symptom Scale (CPSS) scores reduced from moderate (29.7) to mild (23.6) levels after 2 weeks (mean change = -6.1, adjusted $p=0.009$). Reeson et al. (2022) extended these findings, showing sustained improvement after 12 and 24 days of treatment. The study's pre-coronavirus (COVID) cohort improved from severe to mild (28.1% reduction, $p=0.007$), and the COVID-impacted group from moderate to mild severity (25.4% reduction, $p=0.041$) in CPSS scores. Although symptoms remained clinically relevant, both studies indicate meaningful short-term improvements.

Similarly, Louison Vang et al. (2020) found significant reductions in PTSD severity (Harvard Trauma Questionnaire) and other trauma-related symptoms (Trauma Symptom Checklist) in the STEPS programme, a structured, individual or group-based TF-CBT. No significant differences were found between intervention conditions (individual vs. group therapy). Age group did not significantly moderate the decline in total symptoms, except for negative affectivity, where adults had significantly improved scores compared with adolescents post intervention ($F(1, 180)=6.65$, $p=0.011$). Improvements across all measures of posttraumatic stress sequelae were maintained at 12-month follow-up.

Ferrafiat et al. (2020) evaluated the impact of Prazosin using the UCLA Child/Adolescent PTSD Reaction Index (UCLA-PTSD-RI). After 1 month of treatment within an inpatient unit, adolescents experienced a significant reduction in total posttraumatic stress symptoms as well as reductions in the severity of PTSD based on the clinician-rated Global Impression-Severity scale. Notably, authors recommended using Prazosin in conjunction with other psychosocial and multidisciplinary interventions rather than as a standalone treatment; although a comparison between these conditions was not evaluated.

3.5 | Anxiety

Two studies from the *BeBrave Ranch* evaluated anxiety outcomes using the Hospital Anxiety and Depression Scale to measure anxiety. Reeson et al. (2020) found a significant decrease after two weeks ($p=0.014$), with clinical levels of anxiety falling from 81.5% to 66.6%. In Reeson et al. (2022), pre-COVID adolescents showed significant reductions after both 12 days ($p=0.006$) and 24 days ($p=0.003$). COVID-impacted adolescents also improved at 12 days ($p=0.007$), but not at 24 days ($p=0.32$).

3.6 | Depression

Reeson et al. (2020, 2022) also assessed depression outcomes. Reeson et al. (2020) reported a significant reduction in mean Patient Health Questionnaire for Adolescents scores from 15.6

(moderate) to 11.9 (mild), a 23.8% decrease ($p=0.001$) after 2 weeks. In Reeson et al. (2022), pre-COVID adolescents showed significant reductions at both 12 days ($p=0.001$) and 24 days ($p=0.026$), whereas COVID-impacted adolescents showed no significant change across both time points.

3.7 | Suicidal Ideation

One study assessed suicidal ideation among adolescents receiving prolonged exposure therapy (PE-A), a manualised intervention involving in vivo and imaginal exposure, or client-centred therapy (CCT), a counselling-based intervention centred on discussing adolescents' experiences of betrayal, stigmatization and powerlessness (Brown et al. 2020). The authors assessed suicidal ideation during treatment and at 12-month follow-up. They found that adolescents who received PE-A or CCT experienced a significant reduction in suicidal ideation over the course of treatment. The decline in symptoms was more pronounced in the PE-A group compared to CCT, with a small-to-moderate effect size ($d=0.52$). At follow-up, suicidal ideation symptoms remained stable, with no significant further change from end-of-treatment levels in either group, and no significant difference between PE-A and CCT ($d=0.09$). Additionally, greater reductions in depressive symptoms (Beck's Depression Inventory) and posttraumatic stress symptoms (The CPSS-Self Report) during follow-up were significantly associated with reductions in suicidal ideation ($d=0.82$ and $d=0.54$, respectively). These associations were not significantly moderated by treatment condition.

3.8 | Health Service Utilization

Two studies evaluating system-level, multi-agency service models measured health service utilization. Miller et al. (2020) evaluated a law enforcement first responder protocol that coordinated rapid multidisciplinary assessment and referral of health needs for suspected victims of commercial sexual exploitation. Of 509 identified adolescents, 300 (59%) received a medical evaluation within 72 h. Placement context significantly influenced evaluation rates. Children placed back in their homes on the day of identification had significantly lower rates of evaluation ($p<0.0001$). However, those placed at home and evaluated within 72 h were more likely to return for follow-up care than those who were placed out-of-home ($p<0.043$).

Parker et al. (2021) evaluated the Lighthouse, a community-based service model that co-locates physical and mental health care, social care, police and advocacy services under one roof. Interviews with 11 children and four parents highlighted that co-location facilitated access to health services (e.g., in-house nurses) and joined-up responses when children had a range of mental health, physical health, social care, justice and advocacy needs.

3.9 | Global Functioning

One study evaluating a psychosocial intervention measured global functioning. Demirgoren et al. (2020) found significant improvements in clinician-rated functioning among adolescents

receiving inpatient 'milieu therapy', a structured therapeutic environment that facilitates reparative social interactions with family, peers and staff through daily routines and therapeutic interventions. Children's Global Assessment Scale (CGAS) scores increased from 40.65 to 61.04 ($p < 0.001$), and the Health of the Nation Outcome Scales for Children and Adolescents scores decreased from 27.16 to 15.80 ($p < 0.001$). Although these changes indicate clinical improvement and enhanced functioning, the final average CGAS score reflects some persistent difficulties. The authors attributed improvements to the 'structured community environment' within the milieu therapy inpatient unit between parents, peers and practitioners, although no comparison condition was reported.

3.10 | General Mental Health and Well-Being

Two qualitative studies evaluating psychosocial interventions reported that adolescents experienced improved emotion regulation. Quayle et al. (2024) examined a self-led digital app, with a mandatory mentalisation module, for adolescents exposed to technology-assisted sexual harm. Deductive analysis of 11 semi-structured interviews, coded for perceived effectiveness, suggested that the app reduced feelings of isolation and helped to recognize and manage feelings, although some content was experienced as triggering and adolescents expressed a preference for connecting with other peers with similar experiences.

Hershberger (2022) used interpretative phenomenological analysis of six semi-structured interviews with adolescents who had experienced sex trafficking, exploring their participation in equine-assisted psychotherapy within a residential setting. All adolescents described increased distress tolerance, emotion regulation and confidence and self-worth as a result of rhythmic riding. Adolescents reported feeling understood by the horses (e.g., through body language), which they had not experienced in other therapeutic settings.

In the co-located Lighthouse service model, Parker et al. (2021) reported that 89% of well-being goals, set by adolescents themselves, were fully or partially achieved as a result of Lighthouse support. It is unclear at what time point data were collected, whether they were self or clinician reports and exactly what configuration of support adolescents received. Authors compared this to 47% at a 'business as usual' CSA unit, although notably the comparison unit used different outcome measures.

4 | Discussion

This review set out to identify recent studies assessing interventions to improve health outcomes among adolescents who have experienced sexual harm, building on a pre-existing evidence base predominantly focusing on psychological interventions. The search found 10 studies evaluating distinct forms of interventions, which may be grouped into broader categories of psychosocial interventions ($k = 7$), pharmacological ($k = 1$) and cross-sector collaborations ($k = 2$). All interventions showed short-term improvements in at least one health outcome. Notably, no studies reported physical health outcomes. Given the wide-ranging impacts of sexual harm, future research

should widen its scope to consider physical health outcomes alongside mental health outcomes.

Adolescents who have experienced sexual harm present with diverse and often complex health needs. It is therefore unsurprising that the review identified a wide range of interventions using different measures to evaluate a variety of needs. This review illuminates some encouraging opportunities across modalities, notable persistent challenges and important directions for future research.

4.1 | Opportunities

4.1.1 | Wrap-Around Support

A recurrent theme was the provision of wrap-around support, addressing a variety of needs ($k = 6$). The Centre of Expertise on CSA (Parkinson and Steele 2024) has urged greater investment in holistic support services that address a range of needs that adolescents and families have. Three studies described services that included co-located multidisciplinary support (Demirgoren et al. 2020; Miller et al. 2020; Parker et al. 2021). This involved cross-sector collaborations spanning forensics, social care, advocacy, third sector and health services. A fourth study, although not specifying physical co-location, featured multidisciplinary input from forensic, medical and therapeutic professionals (Louison Vang et al. 2020). Parker et al. (2021) compared their multidisciplinary, co-located model with a 'business as usual' CSA hub, in which children received weekly support from co-located paediatricians and play therapists, alongside non-co-located mental health provision. Although the authors asserted that there was a significant difference in outcomes achieved by the Lighthouse intervention compared to the comparison hub (89% vs. 47%, $p < 0.05$), the two services used different outcome measures, making this conclusion tentative. One intervention, evaluated across two studies (Reeson et al. 2020, 2022), was not multidisciplinary but included a comprehensive therapeutic package of 10 different therapies, centred around daily TF-CBT. Although it is not possible to determine which model of support is most effective, the range of approaches reflects an encouraging responsiveness to the complex and diverse needs of adolescents affected by sexual harm. These findings highlight an opportunity to further develop and evaluate wrap-around support that can address multiple dimensions of adolescents' health.

4.1.2 | Involvement of Adolescents

Two studies involved adolescents in the design of the intervention and/or in shaping how outcomes were assessed, concluding that co-production made the intervention more effective and meaningful for adolescents (Parker et al. 2021; Quayle et al. 2024). The findings of Parker et al. (2021) and Quayle et al. (2024) therefore highlight opportunities for future research and service design to involve adolescents more systematically throughout both the development and evaluation of interventions to shape meaningful support. We acknowledge that such involvement requires specific professional skills, time and resources, attending to diverse support needs and a focus on both formal and dynamic ethical considerations that occur in the moment to ensure adolescents

are empowered to participate meaningfully and/or withdraw from research (Ellis et al. 2023; Hagell 2023). However, these challenges do not diminish the importance of involving adolescents in research to ensure their priorities are not excluded from the interventions intended to support them (Ellis et al. 2023).

4.1.3 | Involvement of the Family/Wider Network

Several of the interventions involved non-offending caregivers in some capacity, whether through child-caregiver intervention sessions (Demirgoren et al. 2020; Reeson et al. 2020, 2022), requiring parental buy-in as a criterion for inclusion (Reeson et al. 2020, 2022), or offering supplementary parent support groups (Parker et al. 2021; Louison Vang et al. 2020). Miller et al. (2020) noted non-offending caregivers as a potentially important lever or barrier to adolescents accessing timely health care. Parker et al. (2021) highlighted that the development of a parent psychoeducation course emerged in response to both a lack of broader support services for parents and increasing reports from parents about their own experiences of sexual harm. Existing research also underscores the detrimental impact of sexual harm on secondary victims, including friends, family members and partners (Christiansen et al. 2012). Although no direct comparisons were made between interventions with and without parental support, the consistent involvement of non-offending parents across studies suggests an opportunity for future research to explore the impact that holistic, family-centred support can have on adolescents' outcomes. Macdonald et al. (2012) likewise highlighted that multiple CBT studies have involved non-offending caregivers. The authors concluded that trials should consider which subgroups benefit (or not) from child vs. parent-child interventions. This consideration is particularly important given that MacDonald et al. (2012) did not distinguish between children and adolescents, and adolescents may require different approaches due to their developmental stage and greater autonomy in relation to caregiver involvement. We echo this recommendation.

4.2 | Persistent Challenges and Future Directions

4.2.1 | Heterogeneity of Outcomes and Interventions

In keeping with previous reviews, we encountered the challenge of comparing diverse interventions, assessed using a wide range of metrics and outcomes (Caro et al. 2023; McTavish et al. 2021; Tichelaar et al. 2020). To achieve uniformity across studies and enable comparison of interventions (or intervention components), it would be beneficial to develop a shared outcomes framework. This framework could be applied across interventions and, crucially, be designed in a survivor-led manner to ensure metrics are meaningful and not solely medicalised constructs of health. A research priority-setting exercise with adult (including childhood) survivors similarly highlighted the need for co-produced, valid recovery measures that could support future recovery-promoting interventions (Varese et al. 2023).

Additionally, studies should report not only on the overall effectiveness of the intervention but also on its specific components. For example, Louison Vang et al. (2020) found no significant

difference between group and individual TF-CBT. Such insights are valuable and could inform adaptations across different types of interventions. Currently, the diversity of interventions and under-reporting of specific components within them complicate cross-comparisons. Notably, although most studies reported some demographic information (e.g., gender and ethnicity), none considered how these factors may shape outcomes or influence the acceptability of interventions. Future research could undertake a Delphi study with practitioners, adolescents and their families to identify which components of interventions are essential for adolescents with experiences of sexual harm. These components could then be examined across diverse interventions to enable more meaningful comparisons in the future.

4.2.2 | No Long-Term Follow-Up or Comparison Group

Finally, although short-term benefits were reported across all studies ($k=10$), only two included follow-up assessments, limiting conclusions about long-term effectiveness. Louison Vang et al. (2020) and Brown et al. (2020) evaluated TF-CBT and PE-A, respectively, at 12-month follow-up. Both found sustained improvements in trauma symptoms (Louison Vang et al. 2020) and suicidal ideation (Brown et al. 2020), suggesting potential long-term benefit. As both interventions involved *in vivo* and *in sensu* exposure, this may tentatively support the role of exposure-based techniques in maintaining treatment gains. However, Brown et al. (2020) also found that differences between PE-A and the non-exposure-based CCT diminished over time, limiting conclusions about the unique contribution of exposure. Future research would benefit from incorporating extended follow-up periods and comparator conditions to more clearly assess the durability of treatment effects and effectiveness of interventions. Alternative data sources, such as linked administrative data, may offer one way to map adolescents' trajectories over time across health, social care and education domains (Devaney et al. 2023).

4.2.3 | Lack of Physical Health Outcomes

A notable finding of this review was the absence of studies evaluating physical health outcomes. Childhood sexual harm is associated with a wide range of adverse physical health outcomes across the life course, including longer-term effects such as blood, respiratory and circulatory diseases in adulthood (Frank et al. 2024). Adolescents who have experienced sexual harm report higher levels of somatic symptoms—including headaches, fatigue, abdominal pain and dizziness—which are associated with significant functional impairment and reduced quality of life (Saunders et al. 2020). Although these symptoms can be assessed in this population using validated paediatric measures (Raza et al. 2025), no included intervention study evaluated physical health. Given the broad health impacts of sexual harm, this represents an important gap in the evidence base. Future research should evaluate physical health outcomes alongside mental health to provide a more comprehensive understanding of intervention effectiveness.

The absence of physical health outcomes is particularly noteworthy in the context of pharmacological interventions. Ferrafiat

et al. (2020) reported promising reductions in PTSD symptomatology following prazosin treatment, although an adverse effect of hypotension was observed in one participant. Given the small sample size and uncontrolled pre-post design, these findings require replication. Future pharmacological research should incorporate a broader range of physical health outcomes, alongside routine monitoring of adverse physical effects, to further improve understanding of treatment safety and effectiveness, thereby informing evidence-based decisions in clinical practice.

4.3 | Strengths and Limitations

A key strength of this review is its broad scope, extending consideration beyond psychological outcomes and mental health interventions to include physical health outcomes and wider service provision. In doing so, it advances prior systematic reviews that focused exclusively on psychological effects (Caro et al. 2023; Macdonald et al. 2012; McTavish et al. 2021; Tichelaar et al. 2020). Although no physical health outcomes were identified, this absence underscores a critical gap in the evidence base and points to an important direction for future research.

The scope of the rapid review was restricted by country, publication year and the inclusion of English-language texts only. These parameters may have resulted in an overrepresentation of evidence from Anglophone and Western, high-income contexts, thereby limiting the cultural breadth and global applicability of the findings. Excluding other high-income countries may have resulted in the omission of relevant intervention models or service approaches. Although such methodological constraints represent pragmatic trade-offs to ensure the timeliness of a rapid review to inform UK-based policy and practice, they inevitably reduce comprehensiveness. Future research should seek to extend this work by examining general health outcomes following interventions for sexual harm across broader temporal ranges and more diverse geographical settings.

5 | Conclusion

Overall, this review synthesizes recent literature on interventions that aim to improve health outcomes for adolescent survivors of sexual harm. Consistent with previous reviews, methodological limitations including heterogeneity in outcome measures, short or absent long-term follow-up, variability in intervention types and a lack of appropriate comparison groups remain serious constraints on the evidence base (Caro et al. 2023; Macdonald et al. 2012; McTavish et al. 2021; Narang et al. 2019; Tichelaar et al. 2020). By highlighting these persistent challenges, future research areas of focus have been suggested, including a shared outcomes framework and the use of alternative data sources including administrative records to examine long-term trajectories.

Although not a specific intervention, a component that cuts across our diverse set of interventions and which warrants further attention is multidisciplinary working and wrap-around support for adolescents and their families. Given calls for increased investment in interventions that serve adolescents' multiple needs (e.g., Parkinson and Steele 2024), a priority for future

research is to understand which configurations and aspects of holistic support are most effective for adolescents who have experienced sexual harm using both physical and mental health outcome measures.

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Ethics Statement

No ethical review or consent procedure was required as the research project did not involve human participation or personal data.

Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

All articles included in this systematic review, along with the outcomes extracted from them, are available in the [Supporting Information](#).

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Supporting Information

Additional supporting information can be found online in the Supporting Information section. **Table A1:** The search terms and record counts for each electronic database. **Table A2:** Search string and limits for each electronic database. **Table C1:** CASP RCT quality appraisal tool. **Table C2:** CASP cohort quality appraisal tool. **Table C3:** CASP qualitative quality appraisal tool. **Table C4:** Mixed Methods Appraisal Tool (MMAT). **Table C5:** JBI case series quality appraisal tool. **Table D1:** Trauma. **Table D2:** Anxiety. **Table D3:** Depression. **Table D4:** Suicidal ideation. **Table D5:** Quality of life. **Table D6:** Clinician-rated general functioning. **Table D7:** Self-esteem and emotional well-being. **Table D8:** Health service utilization and behavioural outcomes.