Support for survivors of sexual violence: the rape crisis response

Report prepared for Rape Crisis Scotland by

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1 Background

1.1 The Rape Crisis Scotland (RCS) helpline offers an initial and crisis support and information service across Scotland. It is open from 6pm to midnight every day. As a first point of contact for many survivors who want support from rape crisis, the helpline works with RCS member centres (RCCs). This includes signposting and referring callers to their local centre for continuing support, including face-to-face and group support, whether short-term or long-term. The helpline also provides crisis support to those who are already being supported by their local centre.

1.2 Local centres offer various support services including face-to-face and group support, phone, email and text support, information, advocacy and accompaniment.

1.3 The helpline is fully funded by the Scottish Government which also funds RCS member centres through the Rape Crisis Specific Fund and the Violence Against Women Fund. The Scottish Government has indicated that, given the financial climate, it may require more provision for the same or less funding.

1.4 RC England and Wales, in conjunction with RCS, has produced national service standards which recognise the specific needs of survivors of sexual violence and which benchmark the specialisms needed to provide services.

1.5 The national service standards are currently being adopted by RCS member centres and by centres across England and Wales. They aim to assure that all survivors receive a quality service regardless of their location. They will also provide funders with evidence on the quality of services purchased.

Aims and objectives of study

1.6 The aims of the study are overlapping and were specified by RCS as to:

- Establish the nature of the rape crisis support services available to survivors in Scotland
- Assess the effectiveness of these services
- Identify any gaps in rape crisis service provision

1.7 The objectives specified by RCS were to:

- Identify the extent, quality and diversity of rape crisis support services currently available to survivors of sexual violence
- Identify any gaps in existing rape crisis service provision
- Assess the impact and effectiveness of rape crisis service provision

- Assess to what extent the national helpline and local rape crisis centres provide integrated support to survivors

Methodology

1.8 The study is quantitative and qualitative. It builds on an earlier literature review, evidence gathered for the funding model, and the national service standards. It referred to the RCS evaluation toolkit when designing questions for interviews and focus groups.

1.9 The study involved:

1. Briefing with RCS on the background to this study and the terms of reference

2. Semi-structured interviews with the RCS national coordinator and the helpline manager to gain an overview

3. Desk research: analysis of calls to RCS helpline and referrals to member centres; national database report; and evaluations conducted by member centres

4. Semi-structured telephone interviews with RCS member centres to assess the nature of support services; their quality and effectiveness; and any gaps; the extent, quality and diversity of support; and the relationship with the national RCS helpline. Respondents were:

   - Alison Black, coordinator, Argyll and Bute
   - Caroline Burrell, manager, Edinburgh
   - Angela Campbell, coordinator, Western Isles
   - Norma Downie, support services coordinator, Dundee
   - Isabelle Kerr, centre manager, Glasgow
   - Anne McGuire, centre manager, Lanarkshire
   - Maggie McVean, development manager, Perth and Kinross
   - Shannon Milne, volunteer coordinator and outreach support, Aberdeen
   - Dawn Osborne, service coordinator, Scottish Borders
   - Cathy Steele, manager, Central
   - Jan Swan, manager, Fife
   - Anne Thompson, coordinator, East Ayrshire

   It was not possible to interview anyone at South West Rape Crisis and Sexual Abuse Centre.

5. Discussion workshop for member centres about improving integrated support to survivors.

6. Interviews and focus groups with survivors (including those who have used the national helpline and then received continuing support from a

local rape crisis centre) to find out their assessment of the service they have received; the difference it has made; and its quality. 18 service users from five RCCs took part in these discussions – two by phone and the rest in groups (these were support groups already taking place in centres). They involved a mix of rural, urban and suburban centres

7. Report writing

Outcomes

1.10 The outcomes for the study were specified by RCS as:

1. The difference, if any, that rape crisis support has made to survivors of sexual violence will be established

2. The current level of integration between the RCS Helpline and member centre support services will be described

3. Gaps, if any, in rape crisis support will be identified

4. Recommendations about integrating services and enhancing support to survivors of sexual violence will be made

5. Recommendations about integrated services for repeat callers to the RCS Helpline who experience continuing crisis will be made

Report

1.11 The findings are organised according to the aims and objectives of the study. The conclusions and recommendations are organised according to the outcomes.

Chapter 2 establishes the nature of the rape crisis support services available to survivors and identifies the extent, quality and diversity of rape crisis support services available to survivors.

Chapter 3 assesses the effectiveness of these services and their impact.

Chapter 4 assesses to the extent to which the national helpline and local rape crisis centres provide integrated support to survivors.

Chapter 5 identifies gaps in rape crisis service provision.

Chapter 6 makes conclusions.

Chapter 7 makes recommendations.

2 Nature of rape crisis support services available to survivors

2.1 This chapter outlines the nature of rape crisis support services available to survivors and comments on its extent, quality and diversity.

Overview of support services

2.2 Table 1 below gives an overview of the support services provided by local centres and the RCS helpline to survivors.

X denotes that a service is provided.

Table 1

	Tel[1]	Text	Email	One to one	Group	Advocacy	Accompan-iment[2]	Drop-in	Complementary/ art therapy	Psycho-educational groups	Other
Aberdeen	x		x	x		x	x (limited)		x		
Argyll and Bute	x		x	x	x	x	x				Have received funding to offer CBT on a one-to-one basis with those experiencing 'complex trauma or who find it difficult to move on'
Central Scotland	x		x	x		x	x				
Dundee	x		x	x	x	x	x				Vice versa support for women involved in street prostitution; SARN partnership with health and police to support survivors of recent assault (7 days)
East Ayrshire	x		x	x	x	x	x		x		Resource library
Edinburgh	x	x	x	x	x	x	x		x		Seminars on personal safety; seminar for women affected by their own or another's alcohol use

[1] Telephone contact or support or helpline
[2] Accompanying survivors to appointments with other services/police/court

Fife	x		x	x	x	x	x			x	Counselling
Glasgow	x		x	x	x	x	x	x	x		About to pilot a support group for family members; just received funding to start a young women's (17 and under) group
Lanarkshire	x			x		x	x (if nec but tend to link up with Witness Service)	(previously)			
Perth	x		x	x	x	x	x (limited)				
Scottish Borders	x	x (if survivor in crisis)		x	(planning to pilot in autumn)	x (limited 'bridging' - 'refer gently to other agencies'	x				
South West	No info	No info	No info	No info	No info	No info	No info	No info	No info	No info	No info
Western Isles	x	x		x	x	x	x		x		Relaxation workshops
RCS Helpline	x		x								

Notes

2.3 The above is based on information provided by centres in telephone interviews. It may not be complete as some interviewees may have omitted to mention some services but, nevertheless, it shows the range on offer. Survivors mentioned the range and appreciated being able to move between different forms of support for example, from one-to-one to group support or drop-in.

2.4 All centres reported limitations in services. See below for more information and discussion. For example, Aberdeen offers advocacy and accompaniment but says that this may not always be possible, depending on the notice given and whether any volunteers are available. Other limitations may be geographical (e.g. distance to cover) or physical (lack of space).

2.5 One-to-one support is provided variously in centre offices, on an outreach basis, for example, in health centres and through home visits. It is mostly provided face-to-face, but occasionally it involves ongoing phone support. How such support is provided works differently in different centres, which means that access to support also differs for survivors living in different areas.

2.6 If ongoing support is provided in the form of a home visit, or outreach, or out of hours, typically it involves two workers. Centres may not be able to afford this, so that means that not all centres can provide adequate ongoing support to all survivors who would benefit from or who need it, for example elderly or disabled people.

2.7 Rural centres such as Western Isles may have to be more circumspect in the support they offer. For example, WIRCC offers home visits under the 'guise of healing' or general relaxation workshops so that women are not identified as 'clients' of WIRCC. Privacy, as opposed to confidentiality, is more difficult to ensure in rural areas and small communities.

2.8 Several centres said that they provide education and prevention work with young people. Although not strictly speaking a 'support service' many young people come forward for support though this contact.

2.9 Dundee provides face-to-face support to (women) friends and family (three sessions). Glasgow is about to pilot group support for family members.

2.10 Complementary therapies and classes mentioned included stress management; anger and aggression; relaxation; art; crafts; guided meditation; and healing.

2.11 Two centres (Glasgow and Edinburgh) said that they offer self-directed/peer support groups.

Limitations on support services

2.12 All centres said that they were limited by funding, staffing and other factors. To try to quantify that, the study looked specifically at 'long-term' face-to-face

support. Some survivors do not want or need long-term support. They may be content with some phone or email contact, literature or other assistance. However, face-to-face support is one of the main methods of supporting survivors of sexual violence. It is generally provided one-to-one but is also provided in groups.

2.13 Some centres limit ongoing support to a fixed number of sessions. This is commonly to manage waiting times and waiting lists although all try to accommodate survivors who ask for, or are assessed as needing, support for longer. But it may also be associated with the distances which a centre needs to cover. For example, supporting a woman in Barra from the Stornoway base would entail the one paid support worker to make a regular, time-consuming and expensive flight. A couple of centres mentioned that they also limit ongoing support in order to avoid 'creating dependency'.

2.14 The difficulty with limiting ongoing support, however, is that survivors may not think they are able to (or should need to) ask for more; may be aware than in asking for more they are depriving other survivors of support; and it also suggests that there is a set time by which a survivor may be expected to have 'moved on'. Several survivors in this study indicated that, even after many months of support, they had barely started to speak about what had happened to them.

2.15 All centres, regardless of waiting lists/times, aim to provide survivors with an initial meeting as soon as possible after they first make contact. All try to provide an immediate response for survivors who have experienced very recent assault. However, most survivors contact centres because of historical rather than very recent assault. It is not known whether this is because of the lack of capacity in local centres (e.g. they may not be open when a survivor phones in an emergency). However, referrals from the RCS national helpline and the national police referral scheme to local centres may, over time, affect the profile of those supported by local centres.

Availability of ongoing support to survivors

2.16 Table 2 below describes the duration of face-to-face (ftf) support and details of waiting lists and waiting times.

Table 2

	Duration of ftf support	Waiting list for ftf support	Waiting time for ftf support
Aberdeen	6 sessions with a possible 2 further sessions	8 survivors	5 months (20 weeks)
Argyll and Bute	15 weeks (but would continue if beneficial)	0	0
Central Scotland	Not limited	0	0
Dundee	Not limited (have set limits previously but not for the past 5/6 years	5+	12 weeks+ ('and climbing')
East Ayrshire	3 months	Not known	Not known
Edinburgh	21 sessions (but looking to become open-ended)	60+ survivors	8 months (32 weeks)
Fife	Not limited	20 ('biggest it's been')	12-16 weeks
Glasgow	10 weekly sessions and a further 5 if required	8 survivors	4-5 weeks
Lanarkshire	Not limited. Usually offer 8-12 sessions and then review	3 survivors plus further 10 survivors waiting for assessment	3 months (12 weeks)
Perth	Not limited	0 at moment – had 9 but managed to reduce	1 week
Scottish Borders	2 introductory sessions and then 10 sessions at whatever interval suits the survivor (possible to return after a break)	1	4 weeks
South West	No information	No information	No information
Western Isles	Not limited (if provided in office)	0	Would vary depending on location of survivor

Notes

2.17 Centres are as flexible as possible, juggling both their own capacity and the varying needs of survivors. Most manage the waiting lists by keeping in touch with survivors as best they can, providing introductory sessions, phone calls, and crisis support. However, the interviews with service users suggest that this can break down, and interviews with national staff suggest that the RCS helpline often helps to plug the gap.

2.18 Comments included:

'We try not to go over the limits in order to keep the waiting list down; we are stretched because we are losing staff funding. But if more needed to be done, we would extend…'

2.19 Glasgow offers 10 one-to-one sessions by telephone.

2.20 Fife limits group work to 8 weeks and Glasgow and East Ayrshire limit groups to 12 weeks although all say they would like to run these for longer, the last on a rolling programme without breaks.

Availability of helpline support to survivors

2.21 Most local centres run a 'helpline'. The helplines are used by survivors who are already receiving support and who need additional telephone contact if they are not coping or in crisis; survivors who are waiting for one-to-one or group support and require some contact in the interim; and new contacts. There is no breakdown of this data available.

2.22 Table 3 below shows helpline opening hours and highlights the times which overlap with the RCS helpline.

Table 3

Centre	Helpline opening times	Timings which overlap with the RCS helpline
Aberdeen	Monday to Thursday 7-9pm	Monday to Thursday 7-9pm
Argyll and Bute	Women: Monday-Friday 10am-12noon; Monday-Sunday 7-9pm; Men: Thursday 2-4pm and Friday and Saturday 7-9pm	Monday-Sunday 7-9pm; and Saturday 7-9pm
Central Scotland	8.30am-4pm weekdays; Thursday 7-9pm; Sunday 1-3pm	Thursday 7-9pm
Dundee	10 hours per week; Monday 12noon-2pm and 2-4pm; Tuesday 10am-12noon; Wednesday and Friday 7-9pm	Wednesday and Friday 7-9pm
East Ayrshire	Weekdays 9am-7pm (but to be reduced because of lack of capacity)	Weekdays 6-7pm
Edinburgh	27 hours per week, running every day at different times including weekends ('but not always a steady system')	Every day at different times?
Fife	No helpline: RCS Helpline number provided	
Glasgow	Two-hour shifts every day; four-hour shifts on a Monday, Tuesday, Thursday and Sunday.	Currently overlaps with RCS Helpline on Monday 6-8pm; Tuesday 5.30-7.30pm and Sunday 6-8pm
Lanarkshire	Monday and Wednesday 1-3.30pm; Tuesday and Thursday 6-8.30pm; Friday 10.30am-1pm	Tuesday and Thursday 6-8.30pm
Perth	Monday to Friday 9am-4.30pm; Tuesday and Sunday 7-9pm	Tuesday and Sunday 7-9pm
Scottish Borders	Tuesday 10am-12noon; Wednesday 12noon-2pm; Saturday 10am-12noon	
South West	9am-9pm; 7 days per week (according to publicity)	6-9pm; 7 days per week
Western Isles	Monday, Tuesday, Wednesday 10am to 9pm; Thursday 10am-4pm and 6-9pm; Friday 6-9pm	Monday to Friday 6-9pm
RCS Helpline	Daily, 6pm-midnight	

Notes

2.23 Argyll and Bute is the only centre to offer separate times to men and women.

2.24 Fife does not run a helpline at all but provides the RCS national helpline number on its answering machine.

2.25 Several centres have set their helpline times to complement the national helpline because, as they reason, at least survivors can get support from somewhere at those times.

2.26 Other than Fife, the only centre which runs with no overlap with the national helpline is Scottish Borders.

2.27 The total hours of overlap (highlighted above) across Scotland per week are roughly: 79.5 hours plus the Edinburgh hours. This is equivalent of at least two full-time workers and probably represents far more than that as there will be more than one worker present at helpline times.

2.28 Several centres use a call divert system outwith office hours which is not generally considered good practice either for callers or for workers. Some centres struggle with their helpline hours which are heavily dependent on staff or volunteer availability. Most centres close their helplines down completely over the Christmas period.

2.29 The current system of helplines is not consistent within or across centres. Also, the study found that local helplines were not always available at the advertised times. This is not a criticism of individual centres but a reflection of under-capacity and being over-stretched. This means, that for phone contact, there is also a 'postcode lottery' for survivors.

Extent and diversity of support

2.30 The above information shows that the extent and diversity of support for survivors is wide but varies considerably across centres. Although not all survivors need the same and, because of the type of areas they serve, not all centres can offer the same, there is a sense of disparity overall.

2.31 Most centres want to do more for survivors; whether this is doing more of the same or doing different things to respond to demand (e.g. home visits or drop-ins) but are struggling. Most talk about having to set some kind of limit on their services whilst noting unmet need and significant gaps.

2.32 Access to rape crisis support may present problems for some survivors. RCS is about to conduct an access audit but generally, services are not universally accessible. Several centres said that they could not offer home visits which may exclude disabled or older women or those with caring responsibilities. Office opening hours may be difficult for women who are employed. Women who are Deaf or whose first language is not English may be excluded. There are few specific services for young women. However, this is a changing picture and the RCS helpline and local centres are working hard to ensure

that services are keen to improve access to the diversity of survivors. Good examples in Dundee are the Vice Versa project for women involved in prostitution and the Sexual Assault Referral Network; while Glasgow has an established Rosey project supporting young women. A couple of centres are considering how to support families better.

2.33 Table 1 above shows that there are at least 11 different support 'products' such as telephone support; drop-ins; complementary therapies; advocacy and information services. This means that survivors are likely to find support which suits them and their circumstances, at least at a basic maintenance level. Several survivors who took part in this study valued the different ways in which they could be supported.

2.34 Statistics collected from ten centres in the year 2010/211 indicate that they received 12,418 calls. Over the year, centres provided 5,112 support meetings; 916 group support sessions; and 278 advocacy/accompaniment times.

2.35 Not all areas have rape crisis centres (and this is discussed below) although the RCS helpline can provide an initial and crisis response to survivors anywhere in the country.

2.36 The extent and diversity of support are discussed further in the next chapter.

Quality of support

2.37 It is difficult to get a clear idea of quality of support services in local centres. National standards have now been agreed and all centres are beginning the process of ensuring that they meet these. These will provide a way to benchmark and evidence quality.

2.38 The 2010 external evaluation of the RCS helpline comments, 'The evidence is that the service is consistently high quality. There is a stable pool of well-trained, experienced and highly skilled volunteers. …There are thorough and clear systems and procedures supporting the service and good management from within the RCS national office. There is some feedback from service users and this is overwhelmingly positive. Local centres are generally positive about the quality of the helpline.' The evaluation also recommends that there needs to be a more systematic way of gathering evidence of quality so it is heartening to see that positive steps have been taken to do so, for example through the evaluation toolkit and national standards.

2.39 The evidence from online surveys of the RCS helpline and email service suggests that survivors continue to rate these services highly. Comments on survey monkey about the new email service include:

'I was struggling to talk but the workers were very helpful.'

'It was a fast response.'

'The response was quick and extremely helpful and caring.

'It gave me the advice I was seeking and the support I needed to help my friend.'

2.40 For centres generally, strict recruitment and selection procedures; the focus on a high standard of volunteer training; the experience of many years; and the 'empowerment' and 'trauma-led' support model, are all features which indicate high service standards. The interviewees from centres rated the quality of support highly. However, several centre staff said that limitations in funding, and therefore on support, must have an impact on quality. Funding issues affect direct services, staff training, staff and volunteer recruitment, support and turnover, burnout – all with a consequent impact on quality. And this is borne out by the literature.

2.41 Survivors in this sample also rated rape crisis support highly albeit these are survivors who are happy with the service. However, some survivors described the (negative) impact of having to wait for a service and others how that would be likely to affect other survivors.

2.42 Quality is discussed further in the next chapter.

3 Effectiveness of support services

3.1 For the reasons already stated, there are challenges in evaluating the overall effectiveness of rape crisis services; although the evidence which does exist suggests that they are very effective indeed.

3.2 The national database project means that, for the first time, there is a now a clearer picture across Scotland of the numbers of survivors contacting services and what they are looking for. There is a full set of data for 2010/11 with a subsequent year about to be published.

3.3 The 2010 evaluation of the RCS helpline showed that it is a very effective and competent service with a strong focus on quality.

3.4 To date, there has been little in the way of formal qualitative evaluations of support services in local centres. Centres themselves vary in the extent to which they monitor their work and when they do, it tends to focus on the 'progress' of individual survivors. Although some centres do conduct reviews at different stages with individual survivors, this information tends to remain in 'case files' and is for the benefit of the individual service user, rather than to evidence the effectiveness of the service overall.

3.5 However, centres have been required by funders to provide evidence of their effectiveness and funding applications from local centres provide a good picture of the work they achieve. Edinburgh Women's Rape and Sexual Assault Centre (EWRASAC), in conjunction with Rape Crisis Scotland, has developed an evaluation toolkit. This describes outcomes for rape crisis centres to use with women to measure the difference made. It includes suggestion for gathering baseline information against which to measure this. EWRASAC has probably the most developed systems, but is only now beginning to collect baseline information from survivors. It also uses worker observations and case studies, and most centres collect testimonials from survivors. See appendix 1 for evidence gathered by EWRASAC and sample methods; and appendix 2 for evidence gathered by Western Isles through testimonials and evaluation forms.

3.6 No centres have undertaken any long-term tracking to see whether the support they have provided has made any long-term difference to survivors. This is not seen as feasible given the nature of sexual violence and because survivors do not usually want to remain in contact with or be contacted by centres after support has finished; and there may be risks to survivors in doing so. However, gathering baseline information is at least a start in the right direction.

3.7 In the course of this study, survivors were asked for their opinions of rape crisis support and what, if any, difference it has made to them. However, this is a self-selecting group of women who are, generally happy with the service. There is no direct feedback from women who were unhappy with a service, could not get a service; or did not want a service (for some reason connected to how services are offered).

3.8 With these caveats, the following section provides a good indication of the effectiveness of support services from the point of view of survivors, local centres, national staff; and the observations of the evaluator.

Feedback from survivors

3.9 18 women took part in interviews and focus groups. They came through five centres – two rural; two urban; and one suburban. Because it is unusual to get this amount of testimony, it has been presented in detail, although some may not be directly relevant to the study outcomes. Findings have not been quantified as percentages because the sample size is too small.

How survivors found out about local centres

3.10 Women found out about local centres in various ways. This included:

- Looking online
- Looking in the phone book
- Being told by other agencies, notably police, mental health and addictions services
- Seeing an advert in the local press

3.11 Two women had contacted the RCS helpline. One had been referred to her local centre by the RCS helpline.

Coming forward

3.12 Most women found it difficult to make the first step of picking up the phone. Part of this was because they did not necessarily see themselves as being 'in crisis' or 'raped'. As one woman said, *'I didn't know I was in crisis until the worker told me I was.'* Others said:

'What happened to me wasn't rape as it happened so long ago. I didn't equate what happened to me with the rape crisis logo.'

'I had issues about the name – it was quite extreme.'

3.13 Other women had been effectively silenced by other services or by those to whom they had tried to disclose. One woman said, 'I had seen five psychiatrists. You give your soul to them and you don't want to start all over again with someone else. I didn't want to go through it all again. Then they wonder why you do silly things. I self-harmed and was treated nastily in the hospital. I let my teeth rot and didn't go to the dentist but none of the other professionals I saw ever asked me about that.'

3.14 Other comments included:

'I was throwing up before I got in touch.'

'What triggered me to pick up the phone was that I had been in psychiatric help and one of the staff nurses there in the hospital suggested that it (CSA) should be addressed in order to move forward. I'd had a lot of mental health support.'

'It was really hard [to make contact].'

'It took me decades but it was quite straightforward when I phoned.'

'I was frightened to get in touch as I blamed myself and I hadn't ever spoken about what happened.'

'I went to a group for carers and got talking about my issues and the group worker thought I should get in touch [with rape crisis]. It was just a fluke that [the rape crisis worker] was in. I was quite anxious about phoning. It was horrendous. I had cold sweats, was feeling sick, feeling faint and couldn't talk.'

'I didn't want to report to the police. I didn't want the ordeal of being dragged through the court. I didn't see the person – it was too dark. I just needed to talk to someone about it.'

Views of the initial response from rape crisis

3.15 Given that contacting a centre is a major step, first impressions made an enormous impact on the women and emphasise how important it is that centres, and the RCS helpline get this as right as possible.

3.16 Most women had got through to their local centre without difficulty. One woman had emailed but did not get a response. She said *'I was not up to talking so was prompted to contact the email. I didn't get a response until two months later. It was a mistake - human error - but at the time it was hard not to get a reply.'*

3.17 Survivors were asked to describe their first impressions or think of words that sprang to mind. These were overwhelmingly positive:

'I was glad it was all women. I needed to feel safe. I would not want to hear a man's voice.'

'Nice gentle Scottish voices.'

'She said she would not judge me and that filled me with confidence. She was amazing. She talked me though. She told me all that I could expect and that it was totally up to me.'

'Relief'

'Safety'

'They did everything possible to help.'

'They were really supportive.'
'It was good there was no sign on the door. I would not want anyone to know I was going to a centre and it was not obvious.'

'I was listened to.'

'I clicked with her. You have to click.'

'I was dubious about coming but their attitude was great. They don't ask if it was your fault.'

'I would not speak about it. I felt I could talk here…trust.'

Waiting for services

3.18 Survivors were asked how long they had to wait to be seen by their local centres and the impact of this. The comments below illustrate the importance of being seen quickly, at the very least, for an initial service. Having to wait for a service is likely to result in women 'dropping out' or thinking they are not important. Being kept informed about progress would be a minimum courtesy, and at best, could reduce the negative impact of having to wait.

3.19 The length of time survivors waited for a service varied. Some did not have to wait; some were able to manage the wait (with or without support) and others found waiting difficult. Negative consequences of waiting included feeling dispirited and coming off the waiting list; not turning up for the eventual appointment; one survivor left university because she could no longer cope; turning to or continuing to use other (negative) coping mechanisms.

3.20 Some women who received support quickly said:

'I had to wait for two weeks to see someone and then was offered a support service starting the week after. My aunt came with me to the first one just to get me though the door. It would have been hard to wait for months. But because I had been on my own dealing with it I was seen quite quickly.'

'I was quick to be seen – it was hard to phone and I remember it was so different to anyone I had spoken to before. If I'd had to wait it would have put it me back.'

'When I first rang I was seen in the first week and they sent me stuff.'

'It was really quick. I was seen the next day.'

3.21 Some who had to wait said:

'It was ages between the first contact and the group – months. I got in touch in the Easter and the group didn't start until the following January. I was

surprised by how long it took. It was not such a problem as I had support but it could be really hard to wait that long if you had nothing. I thought that they had lost my number as I didn't hear anything from them.'

'I had to wait from May to September and by then I took cold feet. But then I phoned to apologise and went back on the waiting list. Maybe if I had been seen quicker I would not have taken cold feet.'

'I got telephone support until I could get face-to-face support but I didn't find it easy to talk over the phone.'

'They phoned me and it was helpful to knowing where I was in the queue.'

Some women speculated how waiting or not might affect other women:

'If I had been attacked recently it would be a horrendous thing having to wait. It would be hard to wait for months. But because I had always lived with it, I was strong.'

'If I'd had to wait I would have chickened out.'

'Being seen quickly reinforces that you are being taken seriously.'

'*You may not normally have to wait that long. It was not so much of a problem as I was waiting for a group and I had some support but it could be really hard to wait with nothing.'*

'The earlier you get support the better. It would save so much money and lives.'

Quality of support

3.22 Survivors were asked to rate the quality of support they had received on a five-point scale ranging from 'poor' to 'very good'. The responses were overwhelmingly positive ('very good') with comments ranging from the dry 'I'm not dead' to 'fabulous', 'amazing' and 'excellent'.

3.23 Comments included:

'It's the difference between having quality of life and not.'

'Nothing was forced and it made me feel very much at ease. I will never be able to talk about the incident but it has helped.'

'I would not have continued if I didn't feel comfortable. I connected with the support worker who was very comforting, reassuring and friendly.'

'It is hard to be in people's company. But you can come here and not worry about being judged. You don't have to wear your mask here.'

Difference support has made

3.24 Survivors were asked what difference rape crisis services had made to them. They were asked to rate this on a four-point scale ranging from 'none' to 'a lot' and to give reasons for their rating.

3.25 They were overwhelmingly positive and comments included:

'Emotional, practical and psychological'

'How to go about changing my life'

'It's been a lifeline – they are always there at the end of the phone. They gave me techniques to use to deal with flashbacks. I will never get rid of that in my mind but I've learned to focus on the positive and the things I enjoy. I've joined a choir. I keep busy. I read, I listen to music, I do art.'

'Two things. I can now be present with my emotions in the group. Also when I first got in touch I would swing between believing nothing had really happened and knowing something had happened. It's helped me put that in perspective and accept that my dealing with what happened involves uncertainty.'

'I can now manage to keep going. I know now that nothing bad is going to come out of it. One weekend I was frantic and really, really low. I texted their mobile and she phoned me and we talked.'

'If you have years of things happening to you it becomes normal. You become so used to it. But being here helped me understand that it was so wrong. You have to learn to be a person again.'

'More confident in myself and getting stronger.'

'It has made me believe in myself.'

'I've had help with health problems – mouth problems and cysts. Someone came with me to the [GP] meetings and it meant I got treatment.'

'It's improved my thinking ability and I am able to understand my feelings. It helps you function again. You are all mixed up – it helps you to use your brain. You get an insight into why you do certain things and knowing the difference between thinking as a child and thinking as an adult.'

'It surprised me that so many people have the same story. There is no stigma and that has helped me get back my self-respect.'

'Building of confidence is very important.'

I don't get as drunk as I used to.'

'Years ago I was just a poor wee soul. For the first time in my life I feel I've grown. I will be seeing [rape crisis support worker] tomorrow probably for the last time but will still see the CPN and consultant psychiatrist. But before I would never have questioned what they prescribed to me. I've done my research now and I hope my recovery will continue. I know that I can get in touch with rape crisis now. I will pick up the phone. I can't crumble. I worked through so much with [rape crisis] in the past year.'

What survivors particularly liked about rape crisis support

3.26 Survivors particularly liked the following features of rape crisis support:

'Finding my voice. I had silenced myself and it has taken a very long time to start talking – it is a very slow process.'

'Advice on how to handle the flashbacks – they were so terrifying and sleep was nigh impossible.'

'Sense of belonging: nothing is too much trouble. I have a Motability scooter and every time I go the ramp is out for me. There are other places I go and that does not happen. They are very thoughtful.'

Many women compared their experience of rape crisis support favourably to other services with comments including:

'It was so much better than the hospital. I didn't feel I had to 'qualify' for the service. They were not making an assessment. I didn't have to say everything to prove that I was 'properly traumatised'. The letter that came from the hospital said that if I didn't come, they wouldn't ever see me again. They are not very understanding of post-traumatic stress. You are a person who they have to move on and you have to tell them things in front of other people. Here you just see one person, the same person.'

'I have definitely benefited here. I had never met someone who had experienced the same kind of abuse as me. It's very rare and it left me wondering whether it had really happened. Finding out there was someone else in the group made me realise that it could happen and had happened.

'*You can talk about what you want. They won't force you to say.'*

'The kettle was always on and you can make yourself at home. I knew it would be hard and I quite looked forward to going.'

3.27 One survivor also mentioned that her aunt had gone with her to the final support session and that this had been helpful both for her and for her aunt.

What survivors did not like about rape crisis support

3.28 There were very few criticisms of rape crisis support, and none to do with the quality of the support. The criticisms were as follows:

- Several women would have liked support for longer.
- Several said that it was difficult to have to wait for a service: *'I had to hang on – that was a nightmare – I almost gave up.'*
- One woman did not like the worker allocated to her. She found her too forceful. She would have preferred a choice, or to have known that she could ask for someone different.
- One woman was concerned about a lack of communication about who would phone her. *'I saw two different girls and I got an unknown call [from a worker] on the mobile. I said I would prefer to know who was calling.'*
- Two said that their group would have benefited from a mid-way review. *'We decided what the group would discuss at the first meeting. It was very gentle but there were things we did not touch on and I think we could have if we'd been asked by the worker a bit later on in the group if there was anything else we wanted to talk about. We avoided the harder stuff. It would have been too soon to do it early on. But as soon as we were on our own – the first meeting with no worker – that's what we talked about.'*
- One woman, who lived in a rural area, was unhappy about the location of the centre. *'I didn't like that it was in a different town. I didn't want to be seen coming up. But then began to enjoy the travel across.'*

Suggestions for improving rape crisis services

3.29 There were few suggestions for improving rape crisis support. One woman commented, 'They have kept it about right. Very courteous. They came down to meet me – it was no problem for them to meet me. I still have issues going out when it's dark – it's a total impossibility – a bridge I still have to cross.'

3.30 The aspects which women did not like (above) suggest where improvements might be made.

3.31 Survivors made the following suggestions:

- 'Communication – make sure that women know what is happening. If they are waiting for a group, keep in touch with them while they are waiting.'

- '[Teach] self-defence. I'd maybe feel safer if I had a few techniques up my sleeve.'

- One woman suggested setting up a buddy system so that survivors would have someone to meet for a coffee. 'You would leave your name if you wanted to buddy or be buddied. You'd go to the cinema, a walk in the park, for a cup of tea. Not all focused on the rape or abuse.

- She also suggested changing the name 'definitely emphasise the fact that I would never have picked up the phone to ring a rape crisis centre. It was […] that pushed me to phone'. In the course of discussions several women said they had been put off by the words 'rape' and 'crisis'

- The same woman said she would like it if her centre offered group support in order to be with women in the same circumstances [the centre is intending to set up group support]

- She also suggested that leaflets should explain 'what it will be like when you go to a centre'

- One woman suggested that more people needed to come forward. She linked this to improving how centres encourage or inform survivors. 'I used to go to that phone box but I couldn't do it. I wish I could turn back time. I started on the drink and got really low and was close to committing suicide.'

- One woman suggested that other agencies needed to be trained or informed 'my GP didn't even know about it'. Although not a comment about rape crisis support, it indicates other important work required, particularly to support those who never reach a rape crisis centre

- One woman suggested that rape crisis should 'link into places where women could get spiritual help as there are no female clergy and so many of us can only speak when we are here. When you do speak out it's a big relief as we can't tell family, friends, colleagues.'

3.32 Several women commented that rape crisis centres should have more funding so they can offer more of the same, including drop-in services at the point of need.

3.33 A couple of women were very keen to get involved in the work of centres as a way of saying thank you. Wanting to 'give something back' was the main motivation for survivors taking part in this study and indicates the strength of their appreciation, as it was not an easy thing for them to do.

Awareness of the RCS national helpline

3.34 Survivors were asked whether or not they had heard of the RCS national helpline and what they knew about it. A few had heard of the national helpline before they were in touch with their local centre; most were not aware of it; and some still did not know about it despite receiving support from the local centre.

3.35 It was clear that not all centres routinely tell survivors about the national helpline, or if they do so, not in a way which survivors remember. This is an omission, not only for survivors themselves, but also because word of mouth is an effective way of promoting the national helpline.

3.36 When asked, most women would prefer to contact a local centre. The reasons for this included that they would not need to 'repeat the same story'; knowing that they wanted to find local support; not wanting to phone at all (preferring text or email or not wanting support by phone but a face-to-face service).

3.37 One said that it did not make a difference to her whether she phoned the national helpline or the local centre – the location was not important for helpline support. One woman said that she had not phoned the national helpline but that it was *'good to know that it was there'.*

3.38 Commenting generally on the national helpline, two women thought it was good that the helpline was there because it's *'nice to phone somewhere you have no history'; 'it is anonymous' and that' often you have a crisis at an awkward time'.*

3.39 Another woman said that she was aware of a woman in the Highlands who *'phones the RCS Helpline all the time as there is nothing for her in her area'.*

Experience of phoning the national helpline

3.40 A few women had phoned the national helpline. One had been referred to the local centre for support.

3.41 Comments on the experience of phoning the national helpline were positive and negative:

'The girls were amazing. It's a fantastic service and was very helpful to me.'

''I had phoned and they sent me stuff which I found useful.'

'I had phoned, and no disrespect but I felt she did not have enough time to speak. She was wanting me to speak to [xx] rape crisis centre.'

Understanding the purpose of the national helpline

3.42 When asked whether they thought that other women understood the difference between 'crisis' and 'ongoing' support, survivors said that this distinction is not clear. One woman said. *'I hadn't realised I was in crisis until the worker told me I was. What happened, happened when I was a child.'*

3.43 The comment from the woman who said that the RCS helpline operator wanted to refer her to the local centre, also suggests some confusion.

3.44 Clearly, when women take the enormous step of phoning for the first time, they are not thinking about how organisations configure their services! Also, they may have very high or very low expectations. This may be for many reasons, including sense of self-worth, belief, trust, their level of desperation or trauma and how they have been treated by other services. Comments included:

'I knew nothing about the RCS service and how it was organised.'

'I knew that there was a helpline and that there were local centres. I would not have cared which one I contacted and it's good to have both.'

Other comments

'The RCS website was really good as it has loads of info.'

Feedback from centres

3.45 This section summarises the views of managers and coordinators from rape crisis centres about the effectiveness of support services. They comment on the strengths and weaknesses of support services; the main gaps; and the difficulties of filling these.

Strengths of support services

3.46 Interviewees identified many strengths. All those mentioned are noted below (with frequency of response in brackets). These strengths are consistent with the features survivors liked about rape crisis support.

3.47 Not all 'strengths' apply to all centres.

Workforce

- Skills and commitment of workers (5)
- Small organisation that values volunteers

Approach

- Services are flexible and responsive to feedback from staff and service users (3)
- Survivor-led approach (2)
- Being able to build good and trusting relationships through talking face-to-face with survivors
- Returning control to survivors
- Level and quality of support
- Person-centred, non-judgemental, flexible, accessible 'we really listen to women'
- Having a feminist analysis because women can make more sense of what has happened and understand that it is not about their pathology
- Structure and giving women responsibility – they are responsible for their own recovery
- Safe and welcoming environment
- Known to be trustworthy and confidential (important in rural area)
- Work is trauma-informed with a move to a counselling-informed model

Range

- Range of services for women to dip in and out of
- Diversity of approaches
- Group support which meets women's needs
- Popular drop-in service

Availability

- Helpline is a constant – available most days
- Initial appointments are fairly quick (within a week)
- Crisis support for recent assault can be provided immediately
- Being able to go that extra mile

Networks

- Positive links with local partners – not trying to do things on our own – sharing information and training

Weaknesses of support services

3.48 All but one centre identified weaknesses with their support service. All those mentioned are noted below (with frequency of response in brackets). These show that centres are working with great uncertainty and indicate how this affects staffing, training, the availability of support and the ability to plan ahead or develop. This has implications for quality standards.

Workforce

- Lack of training because of cost (2)
- Lack of staff and premises
- Lack of experienced workers
- Funding is a stress on workers. Have never been well-enough staffed and is now even worse
- Lack of sustainability – workers on temporary contracts from different short-term funding sources
- 'There is a lack of staff capacity and some more experienced workers are asking for a break. We have trained seven more staff but still in the process of moving them in.'
- Lack of funding and capacity 'we have just lost two staff and are cutting hours' and 'at a time when we should be cutting the service because of capacity issue, we don't'

Availability

- Waiting list and waiting times (3)
- Limiting ongoing support in order to manage the waiting list
- Limited capacity to do home visits as this requires 2 workers – but is very excluding of those who are housebound
- Lack of capacity 'which affects quantity although not necessarily quality'. 'We are a victim of our own success. Quality suffers because we have to create a waiting list and can't meet demand. Then we have to find a way to manage that – for example by offering telephone support to women waiting for face-to-face support'
- Not inclusive enough of disability or other aspects
- Lack of coverage (large rural area)
- Lack of space to run groups (down-sized to save money)

Planning and development

- Lack of resources to take development forwards (2)
- Lack of money to train workers to run training for other agencies
- 'Internally – there is a lot of uncertainty as we are lurching. It's difficult for long-term planning and everything is piecemeal. We are the poor relations.'
- 'We are a bit stuck between the current service and needing to develop'
- Uncertainty of funding affects long-term planning

Approach

- Lack of consultation with service users

Gaps in support services

3.49 All but one centre noted gaps in support services. These are in addition to the points raised under 'weaknesses' above:

- Lack of volunteers
- Difficulty of covering large rural area and getting to remote islands
- Support to friends and family
- Men looking for support
- Lack of helpline hours (no cover in the 'early hours')
- Lack of drop-in facilities ('is helpful for women to be reassured')
- No service at times that survivors would find useful, for example Saturday mornings or evening appointments for those in paid work
- Not able to provide a good enough service for minority groups; disabled people; outreach support to those in residential care or sheltered housing
- Struggle to provide what survivors ask for
- Difficult to provide support outwith the centre
- Difficult to accompany women to clinics and precognitions

Unmet need

3.50 In addition to the above gaps, various centres noted other unmet need including:

Services

- Advocacy and accompaniment (Aberdeen)
- Group work – but trying to set up (Borders)
- Local SARC or forensic examination and storage facilities (Fife)
- Self-help group (Perth)
- More local helpline cover in the evenings (Perth)
- Lack of capacity to accompany women to appointments – but there is a growing need for advocacy because of the welfare benefits changes and need for medical assessments (Edinburgh)

Survivors

- No services for male survivors (2)
- Young people and BME women (Dundee)
- Work with young people (Edinburgh)

Geographical areas

- Some communities are hard to reach (Aberdeen)
- Particular geographical areas (Argyll and Bute)
- Rural area and definitely not meeting the needs of every woman (WI)

Difficulties in filling gaps

3.51 Centres identified various difficulties in filling the gaps, mostly associated with lack of funding and the consequences of this:

- Lack of funding (many)
- Lack of staff
- Lack of volunteers
- Lack of staff capacity to reach people in 'hard-to-reach' areas
- Distance (and transport)
- Lack of space to provide support work

3.52 Comments included:

'The biggest problem is the lack of resources. We have a skilled workforce but we need paid staff. For example, outreach home visits needs two workers for ten sessions and that is just impossible.'

'Volunteers are transient – in this area women tend to have to move elsewhere to work.'

Impact of this on survivors

3.53 Interviewees were asked how the above affects survivors. There was considerable consensus indicating that deficiencies in support services have a considerable (negative) impact on survivors both immediately at the point of contact/need and in the long-term. Waiting for a service inevitably leads to drop outs; limiting the length of support may leave survivors and staff feeling 'short-changed'; and limiting the type of support means that many survivors are simply excluded. Interviewees recognised, and survivors also noted this, that this may mean that some survivors continue to use negative strategies to cope with the effects of the abuse with the personal, familial and societal consequences of that. Centres clearly try hard to mitigate this, for example, by keeping in contact with women on waiting lists, and offering an initial appointment very quickly, but interviewees said that this is far from ideal.

3.54 Comments included:

'The impact is huge – there is no other service for women unless they go down the mental health route for which there is a long waiting list and they are not mentally ill anyway. If you pick up that phone then you are ready so they do not want to wait for weeks and drop off. We see a lot of women but not as many as ask for help. So, they go back to negative coping mechanisms – alcohol, drugs, self-harm, they make less contribution to society; it is difficult to hold down a job; their education suffers; right down to mothering skills - the damage and stress is huge – and not just for women but their family, children and not to mention the stress on the NHS for depression or on welfare benefits; the knock on effect is massive. It's not good enough.'

'It feels that the service isn't meeting need at the point of need. With long-term support the sense of an ending is being imposed on women. They have taken courage to make contact but can't get the support (hope we can offer some helpline/email and complementary therapies) but guess that at the worst there is unaddressed trauma and all the ways that manifests - physical, mental - and becomes more embedded. Women drop off the list and some do not get back in touch or don't want a service.'

'It can be devastating to start off with. They can be very upset especially in trauma. We explain this to them in a 'contract of support' but it often results in women not turning up for appointments and leaving contact. We offer one emergency appointment within 24 hours and if someone is in crisis this can take off a bit of the pressure.'

'If they are isolated, for example in a remote area, they face massive isolation. In some areas the transport is poor and there is a general lack of services of any kind. So the isolation is magnified. It continues to silence them and they use negative coping strategies such as alcohol, drugs, prescribed and non-prescribed. The only service they might be able to access is mental health and that is encased in the belief of illness.'

'Having a waiting list is difficult. It can take a long time for women to pick up the phone and there is a knock on effect when they have to wait. A lot of women don't show up for appointments when they eventually get one. They may decide not to come because the impetus is lost.'

'We have never had a waiting list before now. I am glad we have not because particularly for young women, it could make a significant difference for someone in crisis.'

'We miss the boat with some of them. This has an impact on their mental and physical health and also how they function as mothers, wives, workers.'

'It is very hard for women to make contact. The initial assessment is quick but women plummet when told that they have to wait. Some women disappear because of that. We say to them they can come back any time but women often feel they have burnt their bridges.'

'When we have had a waiting list we have lost a few women who did not engage when space became available. It is also difficult to have no-one to talk to when in crisis. When a woman has given lots of information to one worker, it is difficult for her then to phone a helpline and have to speak to another worker.

'Some women disappear. They may not like talking on the phone and we lose them while they wait. It has to make a big impact as women may not be able to manage their lives and it's restricting their choices, opportunities, family relationships, ability, work and health.'

'The fact that women don't have continuity and don't know if or when they will get a service. When someone is ready for a service and has to wait, it creates anxiety. They feel short-changed and that they won't bother.'

Support services which centres would like to improve or develop

3.55 Interviewees were asked whether there were any aspects of their support service which they would like to develop or improve. The responses indicate that, in addition to meeting the gaps and unmet needs specified above, centres are keen to improve what they do. Their aspirations are modest:

Aberdeen

- Outreach work
- Helpline open for longer
- More art therapy courses (funding issue)
- Develop outreach and work to target particular groups

Argyll and Bute

- Extend reach
- Group work
- Youth work service
- To be more proactive and less reactive

Central

- Services for men

Dundee

- Face-to-face support group
- Capacity to expand existing services e.g. Vice Versa (with women involved in prostitution
- More staff to work with young people and BME women

Borders

- Groupwork on self-esteem issues
- Community engagement – with youth groups and schools
- Training for trainers – so that agencies would be more capable at responding to survivors
- Advocacy

Fife

- More staff in order to run groups and offer more one-to-one support

Glasgow

- More outreach. 'We know from experience that if we can get into an area, we fill up immediately. We would like to get into more areas, both in Glasgow and around.'

Perth

- Outreach support
- Support for young people
- Support for young men
- Groups
- Peer support
- Befriending

Lanarkshire

- Advocacy
- Work with young people
- Awareness raising about drugs and alcohol
- More work with the police
- More involvement in partner agencies

Western Isles

- Greater availability
- More choices e.g. art classes and holistic healing
- A wider range of workshops

Edinburgh

- It would be helpful to think about what the journey is for survivors. For example, we are thinking about psycho-education work while women are waiting and looking at a self-help booklet designed to begin to help women to self-manage anger, flashbacks, panic and to normalise those
- More long-tern support
- Having short-life groups for specific issues
- Programme of seminars on trauma – how it works and how it might make women feel and what might help them to look after themselves; eating disorders; managing anger; anxiety; confidence
- Outreach support – have extended to East Lothian but would be good to extend to different areas of Edinburgh
- More helpline hours

East Ayrshire

- Question not appropriate as facing huge funding cuts.

4 The extent to which the national helpline and local rape crisis centres provide integrated support to survivors

4.1 This chapter considers the extent to which the national helpline and local rape crisis centres provide integrated support to survivors. It is based on interviews with local centres, RCS staff and a workshop discussion.

Respective roles

4.2 The RCS national helpline provides an initial and crisis response to anyone (women and men) affected by sexual violence. It is open every day from 6pm to midnight. It also provides email support to survivors and families, friends and workers. It has developed comprehensive information materials which are available on the RCS website and some are distributed widely across Scotland.

4.3 The helpline has been running for almost five years (since October 2007). The service was designed to complement the work of local centres and also to help survivors across Scotland, many of whom do not live in an area supported by a local centre.

4.4 The national helpline offers an initial response and limited (crisis) support to survivors. If survivors want long-term support, the helpline refers or signposts them to their nearest centre or to another agency in areas where there is no centre.

4.5 Since December 2010, the national helpline has managed a new police referral protocol. This means that anyone over the age of 16 who reports a sexual crime – recent or historic – to the police in Scotland, receives an automatic referral to the RCS helpline. When the helpline receives the referral, it contacts the survivor to offer initial and crisis support and information with the option of signposting or referral to local RCCs for longer-term support.

4.6 Between December 2010 and June 2012, the RCS helpline received 322 referrals through the protocol. Although the protocol is working well, according to a report from RCS, uptake remains lower than anticipated and this is under discussion. The protocol is still to be introduced in some areas.

Statistical overview

Local centres

4.7 Ten centres participated in the national database project which provides a summary of support provided for the period 1 April 2010 to 31 March 2011 (latest statistics not yet available).

4.8 This indicates that a total of 12,481 calls were received by local centres.

4.9 Most contacts were by phone (84%) with text 9.9% and email 5.8%.

4.10 Where known, most callers were female (96.8%) and most were from survivors rather than agencies or friends and family.

4.11 Where known, callers tended to phone about childhood sexual abuse (45.6%); rape (39.4%); and sexual assault (8.9%) with other forms of sexual violence making up the remainder.

4.12 These contacts converted to:

- 5,112 appointments for face-to-face support
- 916 group support sessions
- 278 advocacy/accompaniment appointments

Calls to the national helpline (2009-2012)

Telephone contacts

4.13 Since April 2009, there have been 10,832 calls to the national helpline of which 7,984 (74%) have been for support and information, representing 3,750 callers. The number of calls and callers has increased annually. The number of repeat calls has reduced in 2011/12 which means that more individuals are phoning the helpline. The percentage of support calls has decreased annually. Hang-ups (discounting year one) account for around a quarter of calls.

Table 4

	No of calls	No of callers*	Support and info calls	% support calls	Repeat calls**	Hang ups	Silent	Prank	Abusive
2009-2010	3,083	1,135	2,509	81%	1,374	347	136	64	27
2010-2011	3,822	2,216	2,763	72%	1,547	840	151	36	32
2011-2012	3,927	1,399	2,712	69%	1,313	1,054	135	23	3
Total	10,832	3,570	7,984	74%	4,234	2,241	422	123	62

* Silent, abusive and hang-up calls not included
** Of total calls

Email contacts

4.14 Since the national email support service opened in November 2011 until 30 June, there have been 200 email contacts for support. This represents 97 individuals.

Referrals and signposts from the national helpline to local centres (1 April 2011 to 31 March 2012)

Table 5

	Signpost	Direct referral	Total	Total (2009-2012)
Aberdeen	10	25	35	80
Argyll and Bute	3	0	3	16
Central Scotland	6	17	24	58
Dundee	11	6	17	41
East Ayrshire	11	12	24	42
Edinburgh	55	52	107	220
Fife	11	11	22	44
Glasgow	58	67	125	297
Lanarkshire	14	18	32	60
Perth	2	6	8	22
Scottish Borders	5	6	11	14
South West	2	0	2	12
Western Isles	2	2	4	7
Total	190	224	414	922 (514 SP and 408 DR)

Referrals and signposts from the national helpline email service to local centres (1 November 2011 to 30 June 2012)

Table 6

	Signpost	Direct referral
Aberdeen		1
Argyll and Bute		
Central Scotland		
Dundee		
East Ayrshire		2
Edinburgh		1
Fife		
Glasgow		2
Lanarkshire		1
Perth		
Scottish Borders	1	
South West		
Western Isles		
Total	1	7

4.15 These tables note the volume of signposts and direct referrals from the national helpline to local centres, and more recently from the email service. The national helpline has referred or signposted 26% of callers to local centres for support. The figures for the last year to March 2012 indicate that

the volume of signposting and direct referrals is increasing for most centres. There are decreased referrals/signposts to Argyll and Bute and South West. But this may not be significant – it may simply be that any callers from these areas to the helpline did not require further assistance.

4.16 Direct referrals are made verbally to local centres by the national helpline. RCS sends each centre a weekly report with the number of referrals and signposts made to the centre. There is not a written record of names of survivors referred or signposted. There is no system of feedback from local centres to the national helpline to see whether and how direct referrals converted into ongoing work with survivors. This would be useful information to collect and should not be difficult given that it is already being done for the police referral protocol scheme.

4.17 There is no record of calls, by location, which did not result in a direct referral/signposting so it is not possible to quantify, to what extent, the national helpline is alleviating pressure on local centres.

4.18 Interviews with centres suggested that, for the most part, the current volume of direct referrals is manageable and for some centres is negligible.

Signposting from local centres to the RCS helpline and RCS website

4.19 As part of the study, the consultant checked all centre answering machines and websites during the week beginning 25 June to see what information is provided by centres to survivors and others about the national helpline and Rape Crisis Scotland.

4.20 Centres vary considerably in the type of message they leave and the quality. Six centres do not give the national helpline number. Those which do give the number, do not all give the times or say that it is open every day. Oddly, several interviewees (see below) said they advertise this information but, in fact on checking, they do not.

4.21 None mention email support anywhere – either that they offer it or that the RCS helpline does.

4.22 This suggests that they need a script; and some centres need to consider the way they sound and the impression they give to callers. A few are exemplary and the RCS message is also a good example of how to do it well.

4.23 Not all local centres give the national helpline on their websites. Some do prominently; others list it but it is difficult to find – on one site it is two clicks away at the bottom of a page.

4.24 Not all link local sites to the RCS website which not only contains a huge amount of useful information; and access to email support; it also tells people about all the other centres in Scotland. So, not only are some centres not telling site users about the national resource, they are not telling people about other centres either. Given that some survivors may not want to contact their local centre, this is a huge omission.

4.25 In some cases, the link to the RCS website is just a link to the helpline and so visitors end up on the RCS site almost by accident.

4.26 Few mention that they are part of a network or even that there is one. Survivors might like to know this. Agencies, researchers and others certainly would.

4.27 This suggests a greater need for coordination and consistency with a focus on the point of view of survivors as well as others including family, friends and professionals.

Table 7

	Answering machine message gives the RCS helpline number (and its opening times)	Website gives the RCS helpline number	Website gives a link to RCS site
Aberdeen	Yes (but not days)	No	Yes
Argyll and Bute	No	Yes (in links section)	Yes
Central Scotland	No	No	No
South West	No	No	No
Dundee	No	Yes (at bottom of page – need to scroll to find)	No
East Ayrshire	Yes (but does not mention weekend times)	n/a: no website	n/a: no website
Edinburgh	Yes	Yes (in contact section)	Yes (under 'useful contacts' within certain topics e.g. ritual abuse, deaf women so not that easy to find)
Fife	Yes	Yes (on home page)	No
Glasgow	No	Yes (on home page, prominent)	No
Lanarkshire	Yes (good message but does not give times)	Yes (on home page, prominent and alongside local number)	No
Perth	Yes	Yes (in contact section)	Yes
Scottish Borders	Yes (but does not give opening times)	Yes (on home page)	Yes (in links section)
Western Isles	Yes	Yes (on contact page)	No

Views of centres on the extent to which local support is integrated with the national helpline

4.28 Interviewees from centres were asked about their work with the national helpline. Their comments are discussed below.

Capacity to respond to referrals and contacts from RCS helpline

4.29 Interviewees generally said they had capacity to deal with referrals/contacts from the national helpline and that these are 'just woven into' the support service. At 24%, the number is fairly low. A few centres said that it was difficult when they could not contact a survivor (i.e. no answer to phone call) who had been referred to them from the helpline. It is not known how many survivors this involves.

4.30 Comments included:

'Have always felt that the helpline should be better advertised. It's not very well known down here and needs more of an effort - not many people know it's there.'

'The capacity is good. If we get a referral from them we try to contact the survivor within two days and invite them to an exploratory session. So there is an immediate response but they may need to then go on the waiting list.'

'We just deal with it. We contact the survivor within 24 hours. Sometimes it's hard to get hold of people but we would be consistent and phone four or five times. The process has always been very straightforward and very clear.'

'So far we have been able to contact the survivor and get them an introductory meeting within a week.'

'We're noticing an increase overall.'

'It depends when the referrals come in whether we have the capacity. Once we had seven referrals in the one week but we just deal with it. It's difficult when you get a referral but you can't get in touch with the survivor.'

Impact of the police referral protocol

4.31 Interviewees said that the police referral protocol had not added significantly to their work. A few commented that as the protocol becomes more established this might change. Others said that, in their experience, survivors do not generally contact the police, so they do not anticipate many referrals in the future either. A few said that there were difficulties with the protocol. Comments included:

'Not yet, but think that there will be an increase.'

'Have noticed a small increase but not sure yet.'

'It all adds up.'

'[I have] a feeling that the system is more onerous than before and that referrals are going round the houses. Think the police are referring to other agencies and it has affected our referrals down the way.'

How local centres use the national helpline

4.32 The extent to which local centres use the national helpline varies. As the table above shows, not all centres actively tell survivors about the helpline. However, several centres see the helpline as a resource for all survivors in Scotland; for survivors they are currently supporting; and for their service more generally. For example, several centres encourage survivors they are supporting to phone the national helpline if they are not available and survivors need crisis support. Two centres said they encourage women to phone the helpline for 'top up' support. Fife does not run a local helpline and advertises the national helpline instead. Other centres rely on the helpline for cover when they are on holiday. Several centres plan their telephone opening hours around those of the national helpline. One centre mentioned that they refer male survivors to the national helpline as they do not provide a service for men. Some centres think they mention the RCS helpline on their answering machine, but on further investigation, do not actually do so. Comments included:

'I always let survivors know for emergency support and if women are very distressed that the national line is available.'

'We advise women if they want to speak to someone out of hours then to phone the RCS helpline. We also use it as a crisis back-up and divert our phone to the national helpline after 6pm.'

'We advertise it as much as possible and offer it to women whom come to us and say it is available seven days a week to them 'if they are struggling'.

'We tell women they can phone if they need top up to the support we are giving them when we are not available. We also give the helpline number if we are on annual leave or if women want to discuss issues when we are not there.'

'We advertise the helpline on our answering machine and website and use it when our own helpline is not active or on holidays and over the weekends – we always make sure that women know they can phone it if there is a crisis.'

'The RCS helpline is on our message so it is available to everyone. But because it is only for crisis support we tend not to give it out but would refer women to other local agencies.' [This message does not say RCS helpline is open every day.]

'It is on the answering machine and our website and particular when the office is closed, or public holidays or over Christmas when we are closed.' [There is nothing about the RCS helpline on the message.]

'We tell them to phone the national helpline if they feel they are in crisis and advertise it on our website and answering machine.' [There is nothing about the RCS helpline on the message.]

Views of the helpline

4.33 Centres were asked for their general views of the helpline. Most were very enthusiastic about the service and the additionality it brings to their own service. A few were concerned that it might threaten local services. Interviewees gave contradictory evidence. For example, one interviewee said that the helpline is straying into long-term support while another said that the helpline was very clear about only doing crisis support.

4.34 Several said that the helpline should be open for longer, particularly during the night.

4.35 Several commented on the value of having a service open when they are not; and having somewhere to refer both new and existing service users outwith their own opening hours.

4.36 One interviewee said she was confused about what the helpline can offer and said she understood that they could refer their service users to it if they needed to speak to someone in the evenings. But that feedback from those survivors has been that the helpline is for women in crisis. Other respondents said they thought that the helpline could provide 'top-up' support. This is/could be different from 'initial and crisis' support and suggests a need for more clarity in the light of experience. This is discussed further under 'remit' below.

4.37 Other comments included:

'It is really important to have the national helpline for survivors to access when they need it. Really important.'

'It seems to have taken a different direction to what we thought [comment stemmed from concern that the police referral protocol meant local police were directing survivors to the national helpline rather than the local centre]. But at the end of the day it's open every day of the year and that can only be positive. It's a central point for people to contact. It's well publicised and they are clear that they don't provide ongoing support and they do refer and signpost.'

'It's hard to say because women don't say if they have used it. But I think it is worthwhile.'

'I think it's been a long time coming. I think it was long overdue and that it should be 24 hours. There should be access to support whenever someone

needs it; everyone has different needs and times when they can phone – when kids are at school; on a break from work; when their partner isn't around; also in areas where there are no services it's invaluable. Folk don't have crisis between this and that time. Women talk about sleepless nights and needing someone to talk to.'

'It has been very positive – it has been really helpful especially out of hours as the majority of women have issues with flashbacks and nightmares and they think of things in the evenings so being open at those times is very positive.'

'It is a fantastic resource and has good coverage. It's consistently open seven days a week and it is very reassuring to be able to let women know that.'

'I think that the helpline is getting into ongoing support and that means that women are not coming to the local centre.'

'It is supplementary as it's open at times when we can't be available. This is valuable to survivors who are in crisis – but most of ours aren't.'

'Generally, very positive – it's a resource when we are not available and people also use it for information.'

'I think it's a very good resource. It's tapped into survivors and the feedback is really good. Only thing that's not good about it is that it's not open at night.'

Remit of the helpline

4.38 Interviewees were asked whether they thought that survivors were clear about the remit of the helpline (to offer initial and crisis support).

4.39 Responses varied. Some centres said that they had not heard anything to the contrary. Some said that they thought this was clear if they explained it to survivors. At least one centre was not clear itself about what the helpline offered ('is it first port of call or more top up?'). Others said that it would be difficult for some survivors to understand this. Comments included:

'Anyone I've spoken to is clear.'

'I think when someone is at the stage of phoning, it's almost impossible to understand. They are very expectant; there are dependency issues; and they can be shocked when they realise it's not ongoing.'

'On the whole yes, but when they are not really registering anything, it goes out the window.'

'Not sure what people pick up. Some survivors will use everything and every helpline the length and breadth of the country. But, if we explain, nine times out of ten they will understand.'

'No. They understand that there is support but not exactly what it is. They think it is all part of the one service. But don't think we have ever asked.'

Particular issues

4.40 Interviewees were asked if there were any particular issues about the helpline. There were very few and these are discussed below.

4.41 One interviewee mentioned an issue with a repeat caller who was phoning the local centre and the national helpline. She said that this was dealt with between both services in a way which was *'very straightforward and all very supportive'.*

4.42 One interviewee said that there was 'maybe' an issue about sharing information within the network with *'chance conversations making us realise that we were supporting the same person'*. She suggested the need for a national protocol to minimise disruption and the potential for inappropriate use of services. Another interviewee made a similar point and mentioned that confidentiality policies made it difficult to share information.

4.43 One interviewee said that there was an issue 'sometimes' if they were not able to contact a woman referred to them by the helpline. But she did not see this as a deficiency on the part of either service, rather a concern about doing the job well. It could be the case, however, that onward referrals and signposting may introduce an extra stage which may not suit all survivors.

4.44 Comments included:

'We have no concerns. There are no worries about stepping on toes. The national office is there to support local services and plug the gaps and make sure that there is a good service across the country. We are very heartened that there is a national helpline service.'

Local helplines

4.45 Interviewees were asked if they provide a local helpline service for initial/crisis support to survivors. All except Fife do [see table 3]. The highlighted text shows overlaps with the national helpline. Scottish Borders is the only centre which has chosen not to overlap opening times with the RCS national helpline in order to manage resources.

4.46 When asked about possible duplication, centres were keen to emphasise that their helpline was used both by new contacts as well as existing contacts. Anecdotally, most calls to centres are from existing service users although analysis of national database statistics indicates that most calls to ten local centres in 2010-2011, including Edinburgh and Glasgow which receive the most calls, are from new contacts (72.3%). But this figure appears to be flawed and it would be useful to find out the true picture, particularly at the overlap times highlighted below.

4.47 Comments included:

'We are keen to keep a local helpline because we think it's useful for local women.'

'We want to provide a helpline for new callers and crisis support to our own users – we think people may prefer a local service.'

'Most calls come during the day and the rest would be for ongoing support.'

'There is not enough demand for us to run a local helpline so we used the Rape and Abuse Line in Dingwall and then moved to the RCS national helpline.'

'There is no duplication as we offer our helpline at complementary times. The three sessions we offer are in the daytime and we need to keep those for local contacts. Our Saturday morning is a very busy session.'

'A lot of women who call our helpline are regular callers.'

'Our helpline is not busy and it's often new service users who call it. They may use it regularly and not want appointments for structured support.'

'Our helpline rings more during the day. It's a different type of service – more personalised and longer term.'

'We run our helpline until 7pm every night but we are stopping this in six weeks and will offer limited times only with referral to the RCS helpline at other times.'

Scope for closer working

4.48 Interviewees were asked whether there was scope for the RCS helpline to work more closely with their local support service. Responses varied. Six do not think there is any such scope. One said *'not really'* but thought it would be helpful to their centre if RCS could provide more daytime helpline cover. Two were open to the general principle but not sure what that would be. One said there was potential perhaps if there were more helpline cover at later times – but this response was more about extending national work rather than closer work.

4.49 Two were keen on the idea.

4.50 East Ayrshire, for example, is facing cut-backs so is looking for the RCS helpline to take calls at the times when they will no longer be able to offer their own helpline.

4.51 Another centre thought that it would be useful if there could be more 'case discussions' or discussions about issues arising.

'Yes – just being able to take the calls so we can cope.'

'Can't imagine how that would be. We have our own local helpline and don't see how we could integrate it any more than we do and [the RCS helpline] doesn't seem to be picking up calls from [our area] anyway.'

'We work well together already. But I can't imagine not embracing any new ways of working together.'

Pros and cons of a closer working relationship

4.52 Interviewees who saw benefits to a closer working relationship highlighted the following pros:

- Service for survivors outwith office hours, particularly during the night
- More scope to concentrate on other work e.g. complex advocacy issues
- RCS is a useful source of information and resources
- Local centres and the national helpline can be complementary

4.53 Interviewees noted various issues about closer working relationships including:

- Need for clarity about roles and confidentiality issues. ('It would be helpful to be able to discuss individual women but there are issues about confidentiality and we would have to agree how to do this. There is already precedent with child protection cases and it may be that we could proceed with the permission of the women and take a case management approach similar to Women's Aid.')
- Concern about losing local profile and how local women would react
- Concern about lack of resources in local centre to manage onward referrals
- Concern about losing knowledge and a very important first local point of contact

4.54 Comments included:

'There are no cons. We serve different functions. We have the same aim but do different things.'

Ideas for providing more support to more survivors at the point of need

4.55 Interviewees were asked whether they had any ideas, given current and likely future funding difficulties, about how existing resources across Scotland could be used to provide more support services to more survivors at the point of need. There was a mixed reaction to this question with some frustrated by any suggestion that they might be asked to do more for less.

4.56 Others thought that there might be some merit in trying to at least question how services are configured to ensure that the best possible use is made of limited and diminishing resources.

4.57 Three centres said that, were they to reduce helpline hours, they could offer more ongoing face-to-face and groupwork support.

4.58 One centre said there was scope for using, developing and sharing national resources such as information and training.

4.59 Comments included:

'If the helpline could take on our calls it may not impact that much as most calls are during the day.'

'At times we feel very pushed as we are trying to cover our helpline. If there was a national helpline running during the day it would help us.'

'The pressure of work is catching up. The pot is shrinking.'

'I'm not sure what we could do Scotland-wide. Every area is different and we have to fit with local demand. The helpline has freed up our staff considerably to let us focus on face-to-face support. If anything, if the helpline were to be extended and be open for longer, we'd encourage people to phone it.'

'We could do more face-to-face and group work if we did less helpline. There is definitely a demand for face-to-face and group work and I can see more uptake from family members. I think that we need to focus more on young women. There's still a place for a local helpline as that's how women come to us; but there needs to be more at weekends. As for resources, at the end of the day, I dare you to provide the service we do for what we get.'

'I am not keen for the voluntary sector to take on more. There needs to be quality and we can't have that if we water it down – it's disrespectful. We should give good quality or none at all.'

'We should discuss these issues at a development day in world café style and look at how best to share what we have in common, for example information resources, training resources. We will be struggling to recruit a trainer; could we look to have a national pool of trainers to free up centres to focus on support? The evaluation toolkit is a good example of how we can work together and the national prevention materials to be developed will also be really important.'

Other comments

4.60 Interviewees also commented:

'We would like to run our own helpline from 9am to 6pm and then have a seamless transition to the national line, but we have not been able to achieve that.'

'There is not parity of service for all women. Some women ask for home visits – there may be issue with agoraphobia and mobility but they have to wait longer for a service.'

'There is a significant increase in income advocacy-based work and we think that will continue. There is also increasing involvement in adult protection case conferences and the organisation's involved in that are also stretched and it falls back on us.'

'A lot of service users would benefit from advocacy.'

Home visits are difficult and we often have to link with another worker e.g. CPN as we cannot provide two from our service.

'The helpline is a great resource and very helpful. Our trainees go to it to listen in on calls and it's been really helpful.'

'We hope that it continues to develop. The national voice is growing; the service standards are excellent; the Rape Crisis Specific Funding has been fantastic.'

'It's a matter for us to let all service users know that the helpline is there.'

Views of RCS staff on extent to which support is integrated

4.61 This section highlights some key points which emerged from discussions with national staff and includes the researcher's observations.

General overview of provision

4.62 There have been significant developments since 2004 when the Scottish Government increased funding to rape crisis centres and RCS. The geographical coverage of centres has greatly improved since then with centres established in Argyll and Bute, Perth and Kinross, Western Isles and Scottish Borders. There are also now services in West Lothian (though the local authority) and East Lothian (through Edinburgh Women's Rape and Sexual Assault Centre). As yet, there is no specialist coverage, linked to RCS, in Orkney, Shetland and Highland.

4.63 Changes to the membership structure have also enabled more centres to be members of the national network and the national standards will be important for quality assuring provision overall.

4.64 Within local centres, there are capacity issues and so survivors do not universally get support at the point of need. Through the combined efforts of the RCS helpline and local centres, survivors have to wait for less time before speaking to a rape crisis worker. Although there is no coverage during the night, after midnight, there is not a clear demand for this, although this is under constant review, particularly the 5-6pm and 12-1am slots and weekends during the day. Research indicates that women want proactive contact after recent rape or sexual assault and the new police referral protocol aims to provide that. There are various initiatives to reach some excluded 'groups' of survivors including the Scottish Refugee/UKBA referral process for refugees and asylum seekers who have experience sexual violence (see below).

4.65 The general sense is that centres and the national helpline together provide a 'package' of support for survivors across Scotland. The helpline is an established element of this. It is contacted by callers from all over the country and recent work on inclusion, for example, with Deaf women and BME women and the police referral protocol, is likely to increase referrals, and potentially increase the type of services required.

4.66 Recent evidence indicates that more people are phoning the national helpline shortly after an attack. Monitoring information from the RCS log book, survey monkey and cards and letters from survivors indicates that service user feedback is good. The national helpline has commissioned two external evaluations to date, and staff have been responsive to the recommendations, using these to help with ongoing planning and development.

4.67 There is a strong focus on quality though the training and supervision systems with close regard to service standards for rape crisis and for helpline operators. The evidence is that the national helpline is providing a high quality service; that it is very important for survivors to have first point of contact with a specialist service; and there is a good and increasing response to the new email service. In addition, the national helpline offers a safe forum for survivors on Facebook.

4.68 The national helpline is limited to providing initial and crisis support to survivors with callers referred or signposted to local services, including rape crisis centres, if they want longer-term support. Staff noted the following key points, which centre staff also mentioned in interviews, including:

- Survivors value the support of local centres
- There is a variety of support in local centres; this is very good 'but there is just not enough'
- Local support services are being eroded because of budget cuts
- Some centres are running with waiting lists or restricting the length of ongoing support

- There is a lack of local services for male survivors who phone the helpline
- There is some confusion about what the helpline can offer
- Linked to this, there are some issues with repeat callers – to the helpline and local centres (about 5% of callers to the national helpline)
- Information sharing and confidentiality protocols between the national helpline and local centres need discussed
- National publicity: national initiatives and increased referrals must have a knock on effect on centres

The current process

4.69 The current process for survivors using the national helpline varies according to the circumstances but one model is:

1. Survivor contacts the helpline
2. They receive initial support - they might phone three or four times at this stage, partly to test out the helpline and to build confidence
3. The call handler works with the survivor to build their confidence to approach a local service. This is mainly a rape crisis service but, depending on the survivor's experience or location it might be Women's Aid or a support organisation such as Say Women or a generic service
4. The focus is on 'signposting' because this fits with the rape crisis 'empowerment' approach but the survivor may not want this or may be struggling e.g. with mental health issues
5. So, if the survivor wishes this, the helpline will make a direct referral to the local centre which will then contact the survivor directly
6. The survivor might contact the helpline again at a later stage, if they are in crisis

4.70 For survivors who are in ongoing crisis, it may be difficult for them to understand the difference between when an ongoing crisis should be directed to the RCS helpline and their local centre.

4.71 Some survivors also call the national helpline as 'top-up' in the evenings, and local centres do encourage some women to phone the helpline when they are not available. But this survey indicates that there is a grey area about what the RCS helpline can actually offer, probably linked to what constitutes 'crisis support', and this may account for the dissatisfaction/confusion expressed by some centres and survivors.

Strengths of the approach

4.72 The main strengths of the current approach are:

- The helpline is open every night of the year (and since it opened has only closed twice in very heavy snow)
- It has a proven track record

- For a survivor in crisis, they are a maximum of 18 hours away from the national helpline (and hopefully less if they can get in touch with a local service)
- Survivors can get support wherever they live
- It has freed up centres to concentrate on face-to-face support
- It provides a back-up to local centres
- It provides choice to survivors who may not want to contact a local centre (and vice versa)

Weaknesses of the approach

4.73 The weaknesses of the current approach are:

- Survivors may be confused about service boundaries (national and local)
- Some centres are concerned about capacity to respond should referrals from the helpline increase
- Local centres vary in what they offer so there is not a uniform local response and it may not be available quickly enough for the survivor

4.74 The study also noted that there are not procedures to monitor what happens locally after direct referrals are made, and a lack of accountability possibly about who 'holds' the survivor – this may be important given that there may be many survivors with severe mental health issues and facing other serious risks.

4.75 There are limitations associated with current rules about confidentiality and information sharing.

4.76 Local centres do not seem to be noting referrals consistently so it is not clear whether signposting is effective.

Issues of fragmentation

4.77 Although there is a general sense that the system of direct referrals and signposts to local centres is logical, it depends on strong communication systems which can support the service user and also the availability/capacity of local services to respond. The two main areas of concern, also mentioned by local centres, are:

1. A lack of a clear pathway for repeat callers who may find themselves in a referral loop or going between their local centre and national helpline. It can be difficult to provide a unified response because each service provider is limited by the confidentiality protocols.

2. There may not be local services, for example for male survivors; or for face-to-face support in some rural areas; or limitations on local services (such as waiting lists/no home visits and so on).

Working more closely with local centres

4.78 The national helpline has now been running for five years and is generally working well with local centres. So, an integrated approach is already in place, to some extent. The picture has changed in several ways since the helpline opened, both within the statutory sector e.g. new legislation on rape and sexual assault; and within the network e.g. new centres established such as the Borders Rape Crisis Centre. This centre came into the network with a national helpline in place so it saw the helpline as a resource which they and local survivors could use. Accordingly, the centre's telephone opening hours were organised to complement the national helpline. And the helpline is seen as a potential training resource for its volunteers (the call volumes in the Borders make it difficult for trainees to gain enough experience). Other, pre-existing centres have modified their service as the helpline has become established.

4.79 For other, long-established centres, there has been a period of 'settling in'. As the interviews with centres indicate, the helpline has mostly been embraced, as a resource for all survivors. A few see it as a possible threat to local funding and autonomy. Some centres clearly have a historical attachment to their own helplines. But the study indicated a willingness to review such arrangements in order to improve services to survivors.

4.80 National staff are keen to make sure the response to survivors is as good as possible, whether at national or at local level. There are various examples which illustrate how the national developments can benefit survivors across Scotland, and which both support and have a 'knock on' effect on local centres.

4.81 The police referral protocol is a significant development which is managed by the RCS helpline. Although there are some teething problems, it is hoped that it will particularly benefit survivors of recent rape or sexual assault who will be linked in more quickly to rape crisis support. In the past, local centres and the national helpline would have struggled to engage with this service user group.

4.82 Local centres have not noticed a significant increase in police referrals through the protocol; some have noticed a general decrease in police referrals; and in some areas the protocol is not working. Some centres anticipate no increase in referrals as a result of the protocol because the survivors they have previously worked with have rarely contacted the police. But, previously, centres have not worked with many survivors in the immediate aftermath of recent sexual violence, because they are not particularly accessible (for example local helpline is open sporadically; and service users are often met by answering machine messages). Also there may be increased referrals to the police in the future as a result of efforts within ACPOS and COPFS to improve the criminal justice response to survivors.

4.83 The RCS helpline has focused on improving access in various ways, aware that the helpline has not reached particular groups. The new email service is being well used with good feedback. There are plans to increase uptake from

male survivors. Other initiatives have included joint work with the Scottish Refugee Council with a view to establishing a protocol to support refugees and asylum seekers who are survivors of sexual violence; liaising with organisations which support black minority ethnic people; and improving access for Deaf survivors. For example, all RCS helpline leaflets have been translated into BSL and are on the RCS website. The helpline is piloting a 'sign-on screen' and is also looking for funding to assist centres with hardware requirements and interpretation so they can support Deaf survivors needing ongoing support. This is a good example of taking a national approach; adding value to local centres; and also helping centres cope with any additional demand. This also improves the capacity of local centres to respond to local survivors who approach them directly.

4.84 The RCS helpline has developed information materials which local centres can use with survivors, for example, recent information to support survivors who are raped abroad. (However, there may be some issues with duplication across the network as a whole with centres and the helpline each producing and translating their own materials.)

Feedback from survivors to the helpline

4.85 The RCS helpline has limited feedback from survivors about how they perceive the constituent national and local elements of the support offered. This is not surprising because survivors themselves are not likely to understand or even care about how a service is organised and structured behind the scenes.

4.86 There has been some 'critical' feedback, although this emphasises that the helpline is providing a service which survivors value and want more of:

- Anger at about being 'moved on' to local centres. Some survivors who have appreciated the level of acceptance and understanding shown to them by the helpline have found the 'boundaries' of an 'initial and crisis service' frustrating

- Not being happy with the local service to which they have been referred, whether a local centre or another agency such as a GP. With the latter, they have found that RCS has provided a level of understanding and support which is probably not available in many other agencies, and not within the limits of a GP appointment, no matter how well-intentioned the GP

- Returning to the RCS helpline for ongoing support because, for example, the ten support sessions given by their local centre have not been enough. (It has not been possible to quantify this and it would be useful if this could be collected.)

4.87 Feedback to the helpline indicates that:

- Survivors are very pleased to be able to get local support
- Survivors want ongoing support from local centres (for example, beyond ten weeks)
- Survivors want advocacy support, for example, for housing and accompaniment to court (and this can make a significant difference to them) but centres really struggle to provide it
- Centres are doing their best but the resources are simply not there

Best use of resources

4.88 National staff also report that an issue for the helpline is 'repeat callers'. Some callers phone the national helpline while they are waiting for a local service; while they are receiving a local service; and after they have left a local service. Some survivors do not want the support of a local service; and some do not have a local service.

4.89 However, on investigation, the main issue seems to relate to a small number of callers (5%) who phone the line repeatedly; and probably other helplines too. Typically, these callers are experiencing continual crisis and other issues such as poor mental health. The helpline is working hard to manage this and keep the lines open for other survivors.

4.90 Repeat calls as a percentage of all calls has reduced over the past three years from 46% to 41% to 34%.

4.91 Given the restrictions on resources overall in local centres, national staff are keen to explore any ways to help to provide better services; more of what survivors want; and less duplication.

Options for development

4.92 National staff suggested some options both to support survivors and to respond to capacity issues in centres:

- Refocus services across Scotland so that local centres focus mainly on ongoing, face-to-face work with survivors, including home visits; accompaniment and increased advocacy
- Local centres offer telephone support to their existing service users only

4.93 Other options suggested by the study include:

- RCS helpline takes all calls

- Local centres do not run helplines when national helpline is open – i.e. not in the evenings after 6pm

4.94 The advantage may be to free up some time for local staff to do more face-to-face and ongoing work, but there could be associated staffing issues, such as training.

4.95 However, while some centres would be positive about such an approach, others are not and would see the above options as very controversial.

4.96 It is for RCS and member centres to discuss whether the risks of service reconfiguration outweigh the benefits (for service users). But there are risks in not doing so both to centres and the national helpline and, the consequential risks to survivors.

Feedback from discussion workshop

4.97 The discussion workshop provided an opportunity to:

- Reflect on how the RCS helpline and member centres work together
- Consider how local centres and the helpline might work together more closely in order to enhance support for survivors
- Consider how to respond to repeat callers

4.98 Participants were asked to plot an example of a support pathway looking at where a survivor might come into the support process: RCS helpline; specific centre; other centre in the network; other agency; and to consider what happens next.

4.99 They discussed what works well; barriers/difficult points and gaps; and what could be improved locally and nationally, both at the beginning of the process and the 'end' of the process.

4.100 The following example summarises one 'pathway' and highlights some of the issues.

1. Survivor contacts RCS helpline; receives initial support and, depending on circumstances of the call, discussion moves to what the survivor might want to do or where they might go for further help
2. RCS helpline refers or signposts the survivor to a local centre. Referral is made by phone to the local centre
3. In the case of a direct referral, the local centre phones the survivor; if signpost, the survivor phones the local centre herself
4. Local centre offers a first appointment, usually within one week

5. If no waiting list, the survivor should start to receive support immediately

6. If waiting list, then survivor is told what will happen and when. Survivor may phone the local centre or the RCS helpline while waiting for a service

7. If the survivor is receiving ongoing support, she may phone her local centre outwith support sessions and she may also contact the RCS helpline for ongoing support if she is struggling or, for example, her support worker is unavailable/on holiday

8. When local support ends, she may continue to phone the local centre; often, at this point, survivors go back to the RCS helpline

4.101 The particular challenges in this pathway are:

- How to support women who are waiting for ongoing support. The RCS helpline receives many calls while women are waiting for support and if the wait is as long as eight months, then there are questions about whether that is sustainable or fits within the current remit of the helpline

- How to provide support by phone/email to survivors who are already receiving long-term support

- What happens to women at the end of the support 'term' (particularly if support duration is very limited)

4.102 The challenges may be greater in responding to those who have particularly acute mental health issues or when there is ongoing abuse. It can entail 'massive' use of the service and difficulties for services in setting boundaries.

4.103 The picture that emerged is one of some service users bouncing between the RCS helpline and local centres. This is difficult to manage, particularly as the confidentiality/information sharing procedures do not allow for joint working; there are not reporting back systems for direct referrals; and those who phone most frequently are likely to be those dealing with complex issues.

4.104 The following points were noted:

- There needs to be further discussion in the network about information sharing and confidentiality, particularly when there is risk (e.g. of suicide) but also more generally in order to provide better support to survivors

- The national helpline has capacity in the evenings; could this help to alleviate pressure on local services?

- It would be useful to know from local centres: who is using their helplines – current clients or new referrals

4.105 The workshop also discussed how the RCS helpline and local centres might work together more closely. The following points were noted:

- Practical assistance to local centres for aspects such as negotiating interpreting services, current work on access including Deaf access
- Ongoing work on the police referral protocol to ensure it works smoothly in all areas
- Sharing resources e.g. materials/leaflets/translated materials so that RCS and local centres are not all reproducing their own/the same information or all having the same information translated into community languages
- Training: national training resource (staff) to train in local centres and external agencies (to respond better to survivors)
- Need for more discussion on joint work; confidentiality and information sharing; referral processes

5 Gaps in rape crisis service provision

5.1 The previous sections highlight gaps in rape crisis service provision.

5.2 Broadly, gaps are identified in:

- Services tailored to people with particular needs e.g. men; young people; older people; BME people; disabled people
- Access to services
- Range of services
- Level of service

5.3 Mostly, they are attributed to capacity issues (lack of funding, staff).

5.4 It is evident from this report that there gaps in the service but it is difficult to be precise about their size and shape. This chapter explores some reasons for that and describes some over-arching issues.

1. Lack of benchmarking for support services

5.5 The literature review shows that there is a limited evidence base to show what works; for how long; and even what rape crisis support services should be.

5.6 Although there are now national service standards, these focus on general principles, and do not specify what a rape crisis support service actually is. So there is no benchmarking of, for example:

- What should be available (e.g. one-to-one support service/counselling/advocacy and so on)
- How long survivors should have to wait for a service
- What the service duration should be
- How referrals are managed

5.7 This makes it difficult to say what exactly, overall, the gaps/shortfalls are; to what extent individual centres are exceeding, meeting or falling short of a minimum service; and how the shortfall/gaps might be met.

2. Lack of co-ordination

5.8 The nature of the network in Scotland is that each of its constituent elements, by and large, does its own thing. There is no overall co-ordination and where co-ordination does occur, this is variable and it seems to be based on individual centres wanting to do so, rather than on the basis of procedure.

3. No 24-hour service

5.9 There is no 24-hour rape crisis service for survivors in Scotland. Although the longest a survivor may have to wait to speak to someone, somewhere in rape crisis in Scotland is now reduced to 9 hours (say from the RCS helpline closing at 12 midnight a centre, somewhere in Scotland, opening, perhaps, at 9 in the morning) this is not good given the nature of sexual violence. It would also be hard for a survivor to find out which centre might be open at 9am and that centre might not be in a position to support them or know what support is available nearby, depending on the survivor's location.

4. Patchwork of services

5.10 Across the network, there is obviously very good work being done. The testimony of service users indicates that clearly. However, the picture is of individual centres struggling with their own decisions about what they can provide and, as the tables in chapter two show, above and beyond the issues of geography, size of premises, number of volunteers, and so on, it is a patchwork. Most centres are doing most things, but not everyone is doing everything.

5. Differing views of closer working

5.11 Linked to this, there are differing views about integrated working and this is a barrier to survivors. This would require a shift in perception and thinking about all survivors rather than the particular survivors who manage to contact a particular local centre. That is, for all survivors in Scotland:

1. What does the rape crisis support service look like from the point of view of the service user?

2. How can we work behind the scenes to find the best way to make this service as effective as possible?

6 Conclusions

6.1 This is a wide-ranging report. Interviewees provided very valuable feedback. Not all of it is concerned with the specific aims of this report but it has been included because it is rare to receive this kind of testimony.

6.2 However, this section sets out main conclusions in accordance with the study outcomes.

6.3 It is worth noting also that this report links to a previous literature review, and that its general findings are consistent with the research. As far as it is possible to tell, rape crisis centres provide a very good service to survivors of sexual violence. Rape crisis centres excel in the nature and type of support they give to those needing help and they provide a service which is not provided by any other agencies. There is a paucity of evidence on those elements which might lead to evidence-based services, but what evidence there is, is overwhelmingly positive.

The difference that rape crisis support makes to survivors of sexual violence

6.4 Rape crisis centres in Scotland provide a broad range of support services to survivors including one-to-one support, group support, counselling, complementary therapies, advocacy and more. Access is by phone, email, drop in, appointment, home visits, web, and there are both urban and rural models for providing services. There is considerable variation across centres both in the level and type of support offered. Most centres provide most of the above but not all centres provide all of them.

6.5 Although there are limitations with monitoring and evaluating support services, according to the observations of staff and some service user feedback, support services are very effective.

6.6 There is no tracking of survivors who move between the RCS helpline and local centres or between local centres; and there is no evidence from survivors who have not used rape crisis centres or who have been unhappy with the service.

6.7 EWRASAC and RCS have produced an evaluation toolkit, and along with the new service standards, this is enabling local centres to look at monitoring, evaluation and quality standards and the need for evidence both to improve services and to inform funders.

6.8 As the literature review shows, research and experience indicate that survivors of sexual violence benefit from specialist services which do not pathologise them or their experience and which understands that how they present, for example though self-harming, flashbacks, or whatever, is a natural response to trauma. Feedback from survivors and through research is that rape crisis centres make a significant difference to the people they work

with, and to society in general. This is consistent with the feedback received during the course of this study.

6.9 Service users who were interviewed for this study liked the choice and the flexibility of rape crisis support. They remarked on the (positive) difference between rape crisis support and other services, notably mental health and police. Their first impressions were favourable; they liked meeting others with similar experiences; they preferred the anonymity; the fact that they were given a voice, were not pressured and that there were no expectations on them. They also said that 'recovery' takes a very long time – most said that they had only just begun this process.

6.10 The difference this made to survivors described in this report include speaking about abuse for the first time; finding coping mechanisms to help deal with trauma; being able to resume education and employment; being helped to get welfare benefits and health services; improved self-confidence and self-esteem; preventing suicide and self-harm and much more. These differences have brought positive and long-term benefits to individual survivors and their partners, children, families, employers and also public services such as the NHS.

Gaps in rape crisis support

6.11 Although all local centres in Scotland are founded on common principles and have adopted national service standards, there is no specification of an 'overall rape crisis support service'. There is an autonomous national service and autonomous local services which are notionally linked in a national network.

6.12 It is difficult to specify gaps precisely because there is no specification for a rape crisis support service. But the following could be considered as gaps:

- Clear information about the service itself is not always readily available to people seeking help
- 24-hour access to a rape crisis support service is not available, whether through the RCS helpline or the network of member centres
- There is a lack of consistency across Scotland in what is offered by different centres and what is available in different areas. Waiting lists vary from 0 to 60 individuals; waiting times vary from 0 to 32 weeks; and the duration of one-to one support varies from six sessions to unlimited time. Clearly survivors' needs vary, but these differences are not about survivors' needs; they are about capacity
- There are limits to centres' effectiveness and concerns about quality because of capacity issues. These include lack of opportunity to develop, lack of planning and training; worker and volunteer turnover; worker burnout; problems covering rural populations and also large populations. Interviews with centres suggest that they are working very

hard, but are limited; and know they should be doing more, and would like to do more, but cannot. One centre was facing imminent and severe cutbacks because a major funder was diverting funding elsewhere

6.13 The gaps/shortfall may increase e.g. through police referrals; through benefits changes which require more advocacy work; and ongoing work to improve access by the RCS helpline.

6.14 The gaps in service were noted by survivors. The consequences of not getting a service or enough of a service include drop out; reliance on negative coping methods; internalising problems, and are long-term and serious.

Level of integration between the RCS helpline and member centre support services

6.15 Local centres and the RCS national helpline are all working to provide support to survivors of sexual violence. There is clear evidence of good collaboration but there are difficulties and also aspects which could be improved.

6.16 There is a lack of overall co-ordination, partly for historical reasons and partly because of the nature of the network and a focus on autonomy but this means that there is a patchwork of services and approaches with each centre doing its own thing. The RCS helpline is also autonomous.

6.17 The RCS helpline is seen by most centres as very beneficial. It is open every day of the year and at times and on days which local centres do not cover. Centres use the helpline as back-up and one centre only advertises the RCS helpline number (not its own).

6.18 The RCS helpline is referring and signposting survivors to local centres and vice versa. This looks likely to increase.

6.19 There is a lack of clarity about what happens once women are referred to local centres by the RCS helpline as there is no reporting back requirement. There is no written referral and signposting procedure.

6.20 There is some confusion about what the national helpline offers to survivors who are receiving ongoing support from local centres.

6.21 The above may stem from the current policies for confidentiality and information sharing which may need to be re-visited. A couple of centres are keen on a case management approach to discuss, and share information about, individual service users in order to given them a better service.

6.22 Issues for the national helpline include survivors returning to the helpline while waiting for a local service and after receiving a local service which has ended. So, by default, it is providing, although trying to resist, ongoing/short-term support for some survivors.

6.23 Most local centres are also committed to their own helplines and opening times although many seem to be struggling to cover these because they need significant staff time. They do not see this as duplicating efforts. But this study suggests that it is. More information about who is using local helplines is required.

6.24 Examples of good collaboration between the RCS helpline and local centres include information materials for survivors and agencies; training for local centres; referral processes; and access improvements e.g. Deaf access. There is duplication of resources and it will be important to avoid e.g. RCS helpline and all centres producing translated leaflets. These are all areas where a closer working relationship would be productive and would help survivors and centres, and make effective use of resources.

6.25 The vast majority of contacts to rape crisis are made by phone. So, it is obvious that phone access is very important. Both the RCS helpline and local centres offer initial and crisis support by phone. But only local centres can provide face-to-face support. However, many are struggling to do the latter, running both waiting lists and waiting times – some of which are worryingly long. This is an area where closer working could minimise the gaps which have a known and detrimental effect on survivors. This would mean a closer focus on:

- What the service looks like to the service user
- How rape crisis can work behind the scenes, jointly, to see how best to make the support as effective as possible to survivors across Scotland

6.26 It is worth noting that Fife already increases its own capacity by using the national helpline; other centres have done so in the past because of service shut down and still do, for example holiday and weekend cover. A few centres are interested in exploring how the national helpline might free them to provide more ongoing and face-to-face support.

7 Recommendations

7.1 This section makes recommendations in accordance with the study outcomes.

Integrating services and enhancing support to survivors of sexual violence

7.2 RCS should circulate this research in order to encourage further discussion of the issues. It is hard to take stock, and centres, for good reasons, are often focused on immediate service delivery. Rape crisis has always been good at providing what survivors need. This is what differentiates it from other services. However this is a changing environment; more and 'different kinds of' survivors are coming forward with different and changing needs e.g. for advocacy. It is important to rethink 'access' from the point of view of survivors and not the interests of individual centres and their staff, and to consider what could be provided by the network as a whole with increased collaboration.

7.3 Coordination needs to be improved, albeit within the limits of autonomy. The current referral and signposting systems should be improved (see below) between RCS and local centres and also among local centres.

7.4 This would also include 'requiring' all centres, possibly as a condition of membership, to provide recorded information on their answering machines and written information on their websites which refers survivors to the national helpline and the RCS website (as a source of information). (There should be a script for telephone answering machines, and guidance about the tone, speed and delivery of the message.)

7.5 Given that not all survivors in the sample were aware of the national helpline, despite being existing service users of local centres, local centres should be strongly encouraged to provide this information as a matter of course, whether for the benefit of that survivor or other people she may be in contact with (all survivors in the sample knew many others and word of mouth is an important method of publicity).

7.6 RCS should write a specification for a rape crisis support service to accompany the service standards and to be a benchmark against which gaps (and progress) can be measured.

7.7 This should include specifying a 'universal' support package detailing the expectations of both local and national elements and the relationship (for providing support) between local centres as well as between the RCS helpline and local centres.

7.8 RCS should review and clarify the role of the national helpline given the experience of the past five years. Options for discussion which might provide a more integrated approach and better service to survivors include:

- Broadening the helpline remit to provide 'short-term' support

- Formalising the support provided for survivors who are 1) waiting for local support; 2) receiving local support and 3) who have 'completed' local support
- Formalising the referral and signposting systems and introducing a report back system
- Reviewing the policy for information sharing and confidentiality between the RCS helpline and local centres and among local centres
- Considering the possibility of a case management approach for survivors who call the helpline and local centre(s)
- Considering joint discussions of practice

7.9 The area where there is greatest scope for integration is the phone as the RCS helpline has a daily presence and the systems and hardware and processes to add on to what is already there, within limits. Many centres are struggling both to run phone lines and provide the level of ongoing face-to-face support which survivors would find helpful. It would not be taking anything away from service users, or from centres, were the RCS helpline to cover more calls. Quite the reverse. Given that a few centres are at least interested in this as a possibility, it is recommended that RCS works with the willing to develop this as a trial, for example at times when phone lines are overlapping. The network is such that neither RCS nor member centres can prescribe what is done, but there is always the possibility of leading by example.

7.10 The new RCS helpline email service could be part of this.

7.11 Other aspects where there is potential duplication or need for support at local level include training (internal and external); information services; and access arrangements.

7.12 It may also be helpful for some survivors to have the option of web-based support with practical materials/exercises to use while waiting for face-to-face support, for example to manage flashbacks; or information on welfare and housing rights (advocacy support) and so on. Also, some survivors may prefer web-based support (it may appeal to male survivors for example). There is already good material on the RCS website and some local sites. A first step would be to ensure that both the RCS helpline and local centres let people who are waiting for services know about this.

Integrated services for repeat callers to the RCS helpline who experience continuing crisis

7.13 The recommendations above are also relevant to integrating services for repeat callers who experience continuing crisis. However, RCS will also need to specify how it can, and whether it should provide ongoing telephone and email support to callers who have no local rape crisis service or suitable local support service.

Next steps

7.14 RCS should organise a development day to enable local centres and national staff to discuss this report in more depth.

7.15 From this, RCS should establish a short-term focused working group comprising a small number of centres who would be willing to trial a new form of support package.

Post script

7.16 Although not directly relevant to the above outcomes, discussions with survivors resulted in some learning points which the consultant agreed to pass on to centres and RCS:

- Words such as ‘rape’ and ‘crisis’ may not be understood in the same way that the network understands them and may put survivors off contacting them
- Survivors want to know what is happening or have some contact while they are waiting for a service
- Survivors may want to know the phone number of who will be in touch with them (so they are not scared by an unknown number)
- In groupwork, what survivors want to cover at the beginning of a programme may be different several weeks in, so reviews are important
- Survivors may not gel with their allocated worker, so centres need to provide a choice/review and find a way of wording that which enables survivors to state their preference
- All survivors knew of (many) other women who would find rape crisis centres helpful and thought that there should be more publicity about the organisation

8 Appendices

Appendix 1: Evidence from Edinburgh Women's Rape and Sexual Abuse Centre

Evidence collected via visual 'house' tool

(At the start of support women are invited to indicate where they identify themselves in an image of a house and to say a bit about why. This is repeated at the end of support, and women are invited to comment further on any changes that have taken place for them over the course of their support)

Survivor	Where self-identified before support began	Issues that came up during support	Where self-identified at end of support	Additional comments
1	Wants to relax more- feel more calm and collected and more confident.	Lack of drive Feelings of dread Self-dislike Feeling over-sensitive to others Tired Unable to think or talk about the rape Worrying about friends	Taking career in slower steps, not so overwhelmed. No feelings of dread. Happier with self Stronger with boundaries More energy Able to talk about the rape whilst feeling present and comfortable in self.	Sessions most helpful, even more than realised. A real feeling of getting somewhere, feels very positive.
2	Feeling very alone, doesn't know what life is anymore; lots of change; waiting for something better; doesn't know how to find what might be better; doesn't know who she is anymore.	Feeling very alone Lack of direction in life Painful relationship break-up Feeling desperate Not feeling safe at home or outdoors Worries about being able to cope with starting work Deep sadness and grief	Work going very well, flowing naturally- providing a focus for now, really helpful. Taking some time to consider what she really wants. Not feeling as desperate about self or life anymore at all. Feels safe at home now.	Sessions have been fantastic, really helpful. Both the remedies and the insight of the therapist.
3	Lonely, isolated. Angry and trapped	Eating disorder; feeling lonely and isolated; feeling angry; finding it hard to relax; depression; very sensitive to other people's mood and behaviour; emotions overwhelming;	Got things a lot clearer, got more confidence in own perception of events, doesn't feel own thoughts are 'silly' any more. Talking about feelings has really helped to start to address them. Able in last few weeks	Has been good to have someone who understands what she is experiencing.

		extremely difficult to talk or show feelings to others.	to fight off low moods, rather than being floored by them. Feeling like it ok to have the feelings she has. Able to ask her partner for more support.	

Survivor stories and artwork:

With the permission of survivors accessing the service, we continued to extend of Wall of Healing in the centre, which is a dedicated space for survivors stories, art, poetry and messages of hope for others. Some survivors have also given us permission to include their stories, poetry and art work on our website. This can be found at http://www.ewrasac.org.uk/Survivors-stories/ .

Survivors have also given us permission to use some of their stories as case studies to submit to funders and for lobbying purposes.

Young persons' worker and project

Over the past year we have collected a range of evidence to show how we are achieving [these] indicators and working towards our project aims, including case studies, monologues written by young survivors, support evaluation forms completed by young women, art work and anecdotal feedback young women have granted us permission to record. The following are some examples of this evidence:

Monologues written by young women:

'Rachel'

'The support I received has helped me to get my life back on track, I often found it difficult to function before, even in normal everyday situations but the support helped with all that, and coping with life is a lot easier.

The sessions were helpful in that I could use the time the way I wanted. I could talk or draw, whichever I found useful. It helped to let me have a bit of control, it was not something that I really had over my life before, it was nice to know that I could take control every once in a while.

Before the support I wasn't coping with my life, I hadn't laughed in months and smiling was a thing of the past. I had just been put on anti-depressants and it seemed like my life was falling apart. The support helped me get back on track, I started smiling again, and laughing and I am still doing so now, even though I am not receiving counselling right now. My life after the counselling is very different, and much better to the life before, I am a changed person and I am starting to heal and put the difficulties of the past behind me.

I think that anyone who has gone through the same or similar as me will find any support useful. Just to be listened to, without judgement is the most anyone could hope for, but to receive care and attention on top of that, makes it easier for us to get through the painful thing we call day-to-day life. The support the centre gave me, has without a doubt gave me a reason to live again and I hope it continues to do so.'

Rachel's feedback provides evidence of the following indicators:

- Young survivors are more able to cope with flashbacks and intrusive memories
- Young survivors feel they have a voice at STAR/ EWRASAC and that they are listened to and consulted with.
- Young survivors feel less anxious
- Young survivors report improved mood
- Young survivors report feeling more confident
- Young survivors report feeling less isolated
- Young survivors express a sense of hope for the future

'Karen'

'It's complicated to explain… to explain how you feel. How do you go on…

How do you get your head round the idea?

All these questions going round and round in your head, and you wonder why it happened to you? You try and work out why you deserved to …. well, you know, how you deserved to have your freedom taken away from you. But it just happens.

The worker I see at the STAR project tells me it's not my fault but everyday I wake up I still have a bit of guilt in me: "You could have done something!" But you know that it's his fault. He's done it to me, he messed up my head and took my trust away from people.

I think the hardest part in all this is telling my mum. Telling your mum that her little girl was sexually assaulted.

Every day is a struggle and sometimes I feel like I can't go on and just want to end it right there and then. But why put my family through that just because of what he did to me on that cold and dark February night?

And the thing that hurts me the most is he is still walking the streets, getting on with his life like he is just another citizen in this democracy of a country. I'd love to tell him what I think of him. Not face-to-face… I couldn't handle that. But to say how angry I am… for leaving this dark cloud over me just so you could get your enjoyment of taking my innocence and hurting me physically and most of all emotionally.

But he isn't going to stop me. Because that would just give him even more pleasure. To think he has ruined my life forever. So now I go for 1-2-1 sessions at the STAR project and it helps me… it really does.

I still get those dreaded nightmares and flashbacks and sometimes I feel that he is around me… I see his disgusting face in my head. But my worker at the STAR project has helped me through it and still is. '

‘Karen’s’ feedback provides evidence of the following indicators:

- Young survivors feel less fear
- Young survivors can name the abuse they experienced
- Young survivors are more able to cope with flashbacks and intrusive memories
- Young survivors cope with anger more positively

Appendix 2: Feedback from survivors to Western Isles RCC

> *'Women feel safe to approach our service without the fear of being identified as survivors within their close knit communities, and no stigma attached and no fear of giving themselves away.*

The most important feedback we receive is the one of survivors feeling they have been given a lifeline and no longer have to struggle alone with no support or anyone to help them make sense of how and why they act and feel the way they do.

Survivors have commented on the difference our service makes to their life in terms of feeling understood and they say what a difference it makes not having to tie themselves up in knots and have the frustration of trying to make themselves understood.

The support survivors have identified they receive is one of genuine empathy and they feel validated and feel confident in working with us and being able to be honest with how they feel, especially those who feel suicidal.

Women say that they find that their new ways of coping strategies to deal with stress has made them feel confident in their own ability to take control back of their lives.

Being offered individual request sessions i.e. asking them what they would benefit from as an individual, survivors say is imperative in their healing and recovery from the trauma of abuse as it is their story in their life history and they have become very confident in asking and saying what their needs are, they also like the idea that they can all try out each others' choices and that because everyone gets their 'own turn so it's ok to say what I'd like.'

One survivor who was able to confide that she cannot read, says she appreciates and enjoys on two different levels having the stories of other women's experience read out aloud to her, firstly so she knows she is not the only one and secondly it makes her feel important when the time is taken to read for her as she suffered severe emotional neglect as part of her childhood abuse, and as a child she always longed for her mum to read her a story.'