



HEALTH IN MIND

COUNSELLING AND PSYCHOTHERAPY SERVICE PROVISION FOR MALE SURVIVORS OF CHILDHOOD SEXUAL ABUSE: A SCOPING EXERCISE OF STATUTORY AND VOLUNTARY SECTOR SERVICES IN SCOTLAND



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Foreword

The National Strategy for Survivors of Childhood Abuse SurvivorScotland : Supporting Male Survivors of Childhood Sexual Abuse

The Sexual Abuse Service Development Fund (SASDF) was established as part of a range of measures within the overall Strategy to deliver improved support for adult survivors. Between 2007 and 2009 funding was awarded to twenty five organisations to develop services for survivors. These services were independently evaluated. We also held a Communication Strategy National Workshop to inform future service development. This identified a number of areas where further service development was required.

Male survivors was one of the priority areas for future funding. The National Reference Group who oversee the work of the SurvivorScotland Strategy agreed that work should be commissioned to scope what services there are for male survivors across Scotland in both statutory and voluntary sectors to provide an accurate a picture as possible of what was currently available. Health in Mind was funded to undertake this task on behalf of SurvivorScotland.

The main outcome of this important scoping exercise is to enable us to promote and increase awareness of the prevalence and effects of male childhood sexual abuse and their needs to health and social care practitioners and wider society.

The National Reference Group and the SurvivorScotland Team will consider the findings of this Report and discuss with our relevant stakeholders ways forward to ensure the needs of male survivors are considered and responded to positively.

**SurvivorScotland Team
Scottish Government**



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Summary

Background

This audit was undertaken in response to issues raised by research into 'The Care and Support Needs of Men Who Survived Childhood Sexual Abuse (2009)', undertaken by Health in Mind and the University of Edinburgh (Sarah Nelson CRFR) and sponsored by the Big Lottery. It was funded by the Scottish Government, through SurvivorScotland, a National Strategy for Survivors of Childhood Abuse, and is intended to inform future planning by the SurvivorScotland's National Reference Group with regard to counselling and psychotherapy service provision for male survivors in Scotland.

Information was collected via the internet, telephone interviews, followed by more in-depth telephone interviews. The former focused on gathering quantitative data, the latter on qualitative data.

All NHS Boards, Local Authorities, the Scottish Prison Service and appropriate Voluntary Sector services were approached to identify those providing counselling and psychotherapy services to adult male survivors of CSA in Scotland (eligibility criteria). *It should be noted that none of the fourteen (of thirty two) Local Authorities who responded within the timeframe met the eligibility criteria. However, a number of Local Authorities fund Voluntary Sector services who responded to this research.*

Quantitative Analysis

Respondents to the quantitative analysis comprised twenty nine of the fifty seven voluntary organisations approached (51%), offering nine specialist CSA services and twenty generic services; ten of eighteen Health Boards responded (56%) comprising four specialist CSA services and six generic services; one person from the Scottish Prison Service (SPS) was also interviewed for this audit. Overall, the majority of services responding (26 of 39) were generic counselling or psychotherapy services.

This response rate needs to be borne in mind when considering the implications outlined below.

Service Provision

Referrals

All NHS services took NHS referrals; 50% took Local Authority referrals; 30% took Voluntary Organisation referrals; 10% took self referrals. In contrast, 89.5% of Voluntary Organisations took NHS referrals; 83% took Local Authority referrals; 86% took voluntary Organisation referrals; 93% took self referrals.

Specialist Training for staff

All NHS and most voluntary sector specialist services felt that their staff were sufficiently trained to deliver CSA services. However, when it came to generic services, only 10% of NHS and 35% of the generic voluntary sector services received specialist training. Most said they would welcome additional specialist training, with different types of training for generic and specialist services.

Resourcing

There was a huge disparity across Board areas in the ratio of staff to CSA survivors. Most specialist CSA services were provided by the voluntary sector. Generic services showed a similar lack of consistency.

In terms of workforce, voluntary organisations employed 14.2 staff on average, comprising 3.1 full time equivalents (FTE's), whilst an NHS service employed 8.6 staff, comprising 4.1 FTE's.

Waiting lists for NHS services were an average of 17.3 weeks, whilst those for Voluntary Organisations were 7.3 weeks. There were no figures around referral numbers to correlate this with evidence of demand.

Skills and accreditation

NHS respondents stated that 95% of their counselling staff were accredited and they were all considered to be sufficiently skilled to offer counselling to male survivors; this contrasted with 26% of voluntary sector counsellors being accredited while 67% of voluntary sector respondents felt they were sufficiently skilled to offer sessions to male survivors.

Qualitative Analysis

This highlighted that:

- Demand for counselling services to male survivors seems to be on the increase, but there is a need for further evidence to correlate this with the need.

Clinical skills and approaches

Staff in both statutory and voluntary sector offered a wide range of approaches,. The majority of CSA specialist agencies, both statutory and voluntary sector, had provided specialist training to their staff. This was considerably less so in generic counselling services in both sectors. Although not part of this audit, services also reported that staff may be likely to experience vicarious traumatisation, with staff supervision seen as particularly important.

Advantages and disadvantages of specialist and gender-specific services

There was a range of advantages (e.g. specialist services develop expertise in working with psychological trauma) and disadvantages (e.g. too great a focus on a person's trauma history may miss the importance of a person's whole life experience) of each, for both survivors and staff.

Training Needs

Some staff said that trauma informed services were vital; therefore developing staff awareness of trauma issues was paramount. Staff also identified unique to male survivors' issues such as male sexuality and identity following abuse.

Further points

Some interviewees thought that there was a need for more clinical evidence of the impact abuse has on both men and women and what the most effective approaches are.

Implications

Implications are wide ranging and highlight: how referrals are accepted within the statutory and voluntary sector and how these are processed has implications for service accessibility; slightly higher staffing levels and longer waiting lists in the NHS than the voluntary sector requires further investigation in terms of referral rates; the negative impact which CSA work can have on staff was mentioned as well as the importance of having supports to minimise this; the value of specialist training; the lack of specialist training for generic services; the need for a flexible approach, rather than a particular type of approach; the seemingly disparity between NHS and voluntary sector services in relation to counsellor accreditation could benefit from further investigation and clarification; a significant geographical inconsistency in service provision across Scotland.

Recommendations

Recommendations focus on: the need to review referral policies; a need to increase the availability of training for both specialist and generic services; the adoption of common quality and core standards; the need for a more consistent approach to resourcing specialist and generic provision across all Board areas; a need to research the links between prevalence and demand.

Introduction

Following research into the Care and Support Needs of Men Who Survived Childhood Sexual Abuse (2009), undertaken by Health in Mind and the University of Edinburgh (Sarah Nelson, CRFR) and sponsored by the Big Lottery, the Survivor Scotland National Reference Group identified the need to scope current specialist services for male survivors of childhood sexual abuse (CSA) in Scotland, across both the statutory and voluntary sectors.

This scoping study addresses the following recommendations of the above Report:

- Recommendation 24: Better access is needed to free or low-cost therapies addressing childhood sexual abuse.
- Recommendation 34: Support agencies need to ensure that skilled advice and discussion on issues of sexual identity is available to male survivors.
- Recommendation 37: An increase in therapeutic and support services is urgently needed for male survivors in both voluntary and statutory sectors across Scotland, in both single-sex and mixed settings. These should include opportunities for counselling, group work and a range of therapies including safe bodywork: no single therapeutic approach suits, or is appropriate, for everyone, and there need to be choices. These could be a mix of new services and expansion of existing support agencies. Survivor self – help projects require professional support, training support and financial backing. Specialist CSA phone support could be attached to, e.g. telephone lines such as Breathing Space. Funding for services for male survivors should be in addition to, and not competing with, those for female survivors, which are also scarce in most areas of Scotland.

Since there was no data available with regard to counselling and psychotherapy service provision for male survivors of CSA across Scotland, this audit was commissioned, with the intention that the results would inform future service development and planning.

The predominant aim of this scoping exercise was to identify both geographical and service specific gaps. Where gaps were identified, suggestions for future service provision are made, with a view to these gaps in service provision and staff training needs in the conclusion section of this report being addressed.

Aims of the scoping exercise

This scoping project comprises the following elements:

1. Scoping of current statutory and voluntary sector counselling and psychotherapy services in Scotland which are explicitly for male survivors of CSA; these may be in either single sex or mixed settings.
2. Review of current specialist counselling and psychotherapy services for male survivors in Scotland.

3. Scoping of training and awareness needs relating to male CSA issues, amongst staff working in the voluntary and statutory sectors delivering counselling and psychotherapy explicitly for male survivors.
4. Identification of gaps in service delivery and staff training.

Methodology

Type of services included

The following services were included in the scoping project:

- Local Authorities: The Health and Social Care departments in each of the thirty-two Local Authority areas in Scotland were approached for information regarding the availability of counselling and psychotherapy services exclusively funded by the relevant Local Authority.
- All fourteen NHS Boards were approached and managers of psychological services within each Board were identified and invited to participate.
- The Scottish Prison Service was contacted and invited to participate.
- Voluntary Sector: Relevant organisations were identified through Office of the Scottish Charity Regulator records, COSCA organisational membership, the service directories of web based mental health information resources Edspace and Midspace, as well as the national and local provider lists provided by SurvivorScotland. This exercise produced a potential contact list of fifty-seven potential voluntary organisations.
- No attempt was made to contact the Armed Forces. We recognise that a significant number of Scottish men serve in the Armed Forces and that a number of these may receive support through the Mental Health Team within the MOD. We propose a similar scoping project to identify the level of counselling and psychotherapy provision for male survivors of CSA who serve within the Armed Forces.

Project Stage 1: Telephone interview

Procedure

All services fulfilling inclusion criteria were invited via email to participate in an initial telephone interview to provide information with regard to: counselling and psychotherapy service availability, referral volume and routes, as well as staff specialist training and perceived training needs. Services were provided with Project Information forms (Appendix 1) and Endorsement forms (Appendix 2) from SurvivorScotland in their initial contact email. A record of refusal and reasons for not participating was kept, where provided.

Services that agreed to take part in the Scoping Project were then provided with Telephone Interview Questionnaires (Appendix 3) and appointments for interviews were arranged. The detail of the contact procedure is provided in Appendix 4.

Inclusion criteria:

1. The service must explicitly provide counselling and psychotherapy services.

2. The service must be provided in Scotland.
3. The service must be available to adults (18 years and above).
4. The service must be available for men.

Exclusion criterion:

Services that provide counselling and psychotherapy only to people who are 16-21 years of age.

No Local Authority provided a service that fitted the inclusion criteria. Thus no further quantitative or qualitative data were collected from Local Authorities.

Project Stage 2: In-depth interviews.

Procedure

In-depth telephone interviews were also conducted with a subsample of services in order to identify training and awareness needs relating to male CSA issues amongst staff, as well as identifying possible gaps in staff training needs.

The services invited to participate in interviews were first provided with an In-Depth Interview Participant Information Sheet (Appendix 5), Consent Form (Appendix 6) and a list of the questions used for this stage (Appendix 7). Interview dates were arranged after positive replies regarding participation. Formal consent was obtained before each interview. Interviews were semi-structured and recorded using a digital voice recorder. The electronic data was transferred onto a computer for transcription and data analysis.

Inclusion Criteria

The targeted sample reflected the variability in types of services (e.g. voluntary, statutory, generic / specialist) and geographical spread. Representatives from three voluntary and five statutory sector services were invited to participate.

Quantitative Data Analysis

Quantitative data were collected from all participating organisations regarding the number of full time equivalent (FTE) counsellors/psychotherapists, accreditation, availability of service to male survivors, specialist training, referral routes and the current length of their waiting lists. Analysis of data was conducted using the Statistical Package for the Social Sciences (SPSS).

In order to estimate service needs across different geographical areas, further information regarding percentage of males and age band per area was obtained from the Scottish Government 2001 Census Report. To enable recommendations for service provision for male CSA survivors, an estimation of the adult male population in each NHS board area was calculated, based on epidemiological data from the literature and current population estimates for each area.

Qualitative Data Analysis

Qualitative data were collected at both stages one and two of the project. Telephone interview questionnaires at stage one enquired about the perceived training needs of counsellors and psychotherapists who work with adult male CSA survivors. In depth qualitative interviews were also conducted at Stage two. The in-depth interviews were transcribed verbatim.

All qualitative data was subject to thematic analysis (Braun & Clarke, 2006), where materials were coded and categorised to reflect emergent themes. The interpretation of the identified themes was guided by interview questions and project aims. Quotes in this report were selected from interview materials as appropriately representing emergent themes.

Telephone Interview Results

Response Rate

Twenty-nine (50.9%) of the fifty-seven (100%) voluntary organisations contacted agreed to take part in the initial telephone interview. Four of organisations (7%) refused to take part, with only one organisation stating that the project was irrelevant to the service. A total of six organisations did not provide a reason for non-participation. A further four organisations (7%) were excluded, since they identified themselves as not fulfilling the project inclusion criteria. A total of twenty voluntary organisations (35.1%) did not respond within the timeframe of the scoping project.

Of the eighteen (100%) statutory services identified within the fourteen NHS Scotland Board areas, two did not fulfil inclusion criteria (11%). Ten services (55.6%) participated in the initial telephone interview. Only one NHS Board (5.6%) did not wish to take part, providing no reason. The other five NHS services (27.8%) did not respond within the time frame of the scoping project.

Fourteen of the thirty-two Local Authorities (43.8%) responded to the invitation to participate in the Scoping Project. Six Local Authorities (18.8%) refused to take part without providing a reason. The remaining twelve Councils (37.4%) did not respond within the time frame of the Scoping Project. One individual from The Scottish Prison Service (SPS) also contributed to the data collection at both project stages.

The project recruitment and response distributions are illustrated in Figure 1.

Figure 1 –Recruitment & response rates

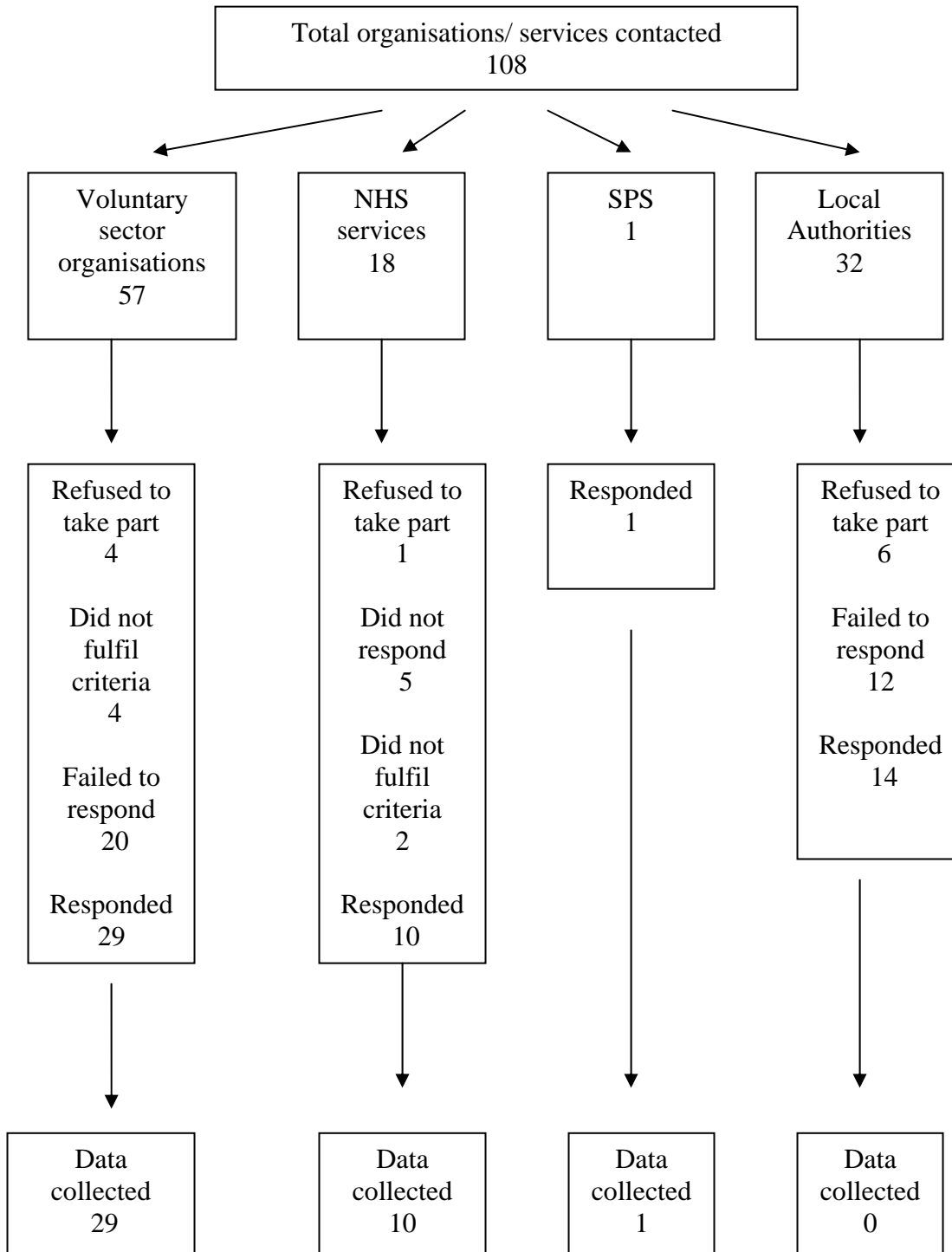


Table 1 below shows the response rates for each sector and type of service.

Table 1. Statutory and voluntary services

Sector	Number of Organisations Contacted			Number of Participants			Response Rate
	<i>Generic</i>	<i>Specialist</i>	<i>Total</i>	<i>Generic</i>	<i>Specialist</i>	<i>Total</i>	
Voluntary	48	9	57	20	9	29	50.9%
NHS	13	5	18	6	4	10	55.6%
Local Authorities	32			14			43.8%
SPS	1			1			100%
Total	108			54			50%

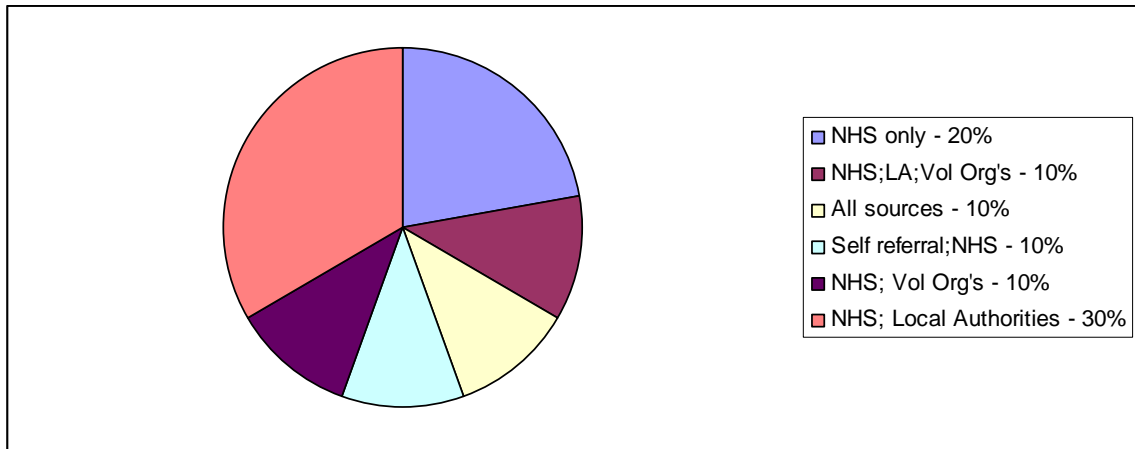
Referral Agencies

In summary, all NHS services took NHS referrals; 50% took Local Authority referrals; 30% took Voluntary Organisation referrals; 10% took self referrals. There were overlaps and combinations as shown in figure 2 on page 17.

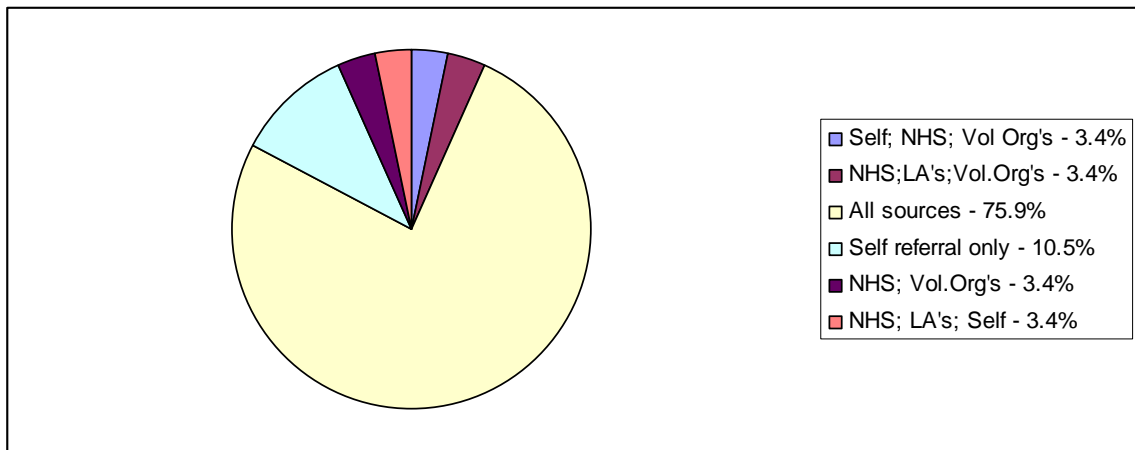
A proportion of 89.5% of Voluntary Organisations took NHS referrals; 83% took Local Authority referrals; 86% took voluntary Organisation referrals; 93% took self referrals. There were overlaps and combinations as shown in figure 2 on page 17.

Figure 2 Referral agencies

NHS referrals



Voluntary Organisations referrals



Of the ten NHS services (100%) which answered the question on referral routes, three of the services (30%) reported that they accept referrals from both NHS services and local authorities. Two NHS services (20%) only accepted referrals from NHS services, and a further two services (20%) accepted referrals from NHS services, Local Authorities and voluntary organisations. Only one NHS service (10%) accepted self-referrals, as well as referrals from other NHS services, voluntary sector organisations and Local Authorities. Only one NHS service (10%) accepted self-referrals and referrals from other NHS services. One other NHS service (10%) accepted referrals from other NHS services and voluntary sector organisations.

Twenty two (75.9%) of the twenty-nine (100%) participating voluntary sector organisations reported that they accept referrals through all possible routes, including self-referrals, NHS, Local Authorities and voluntary sector organisations. Three voluntary organisations (10.5%) only accepted self-referrals;

one organisation (3.4%) accepted referrals from NHS services, Local Authorities and other voluntary sector organisations; one organisation (3.4%) accepted referrals from Local Authorities and other voluntary organisations as well as self-referrals; one organisation (3.4%) accepted self-referrals, referrals from NHS services and other voluntary sector organisations; and one other organisation (3.4%) only accepted referrals from NHS services and other voluntary sector organisations.

Training Needs

The participating organisations and services were asked whether their staff had received any specialist training on the mental health issues of male survivors of CSA.

In summary, specialist training was provided to all four of the NHS specialist services and to 78% of the nine voluntary sector specialist services; however, when it came to generic services, only 10% of staff of the remaining six NHS services and only 35% of the generic voluntary sector services received specialist training.

When asked about the training needs of staff to enable them to work with male survivors, most organisations said that they would welcome additional specialist training. There was a general concern about how this provision would be funded.

Proposed training content fell into two main categories, with different suggestions made by generic and specialist services: the former included awareness training –re CSA issues; how to raise the issue sensitively with clients; how to undertake assessments; the latter suggested the inclusion of issues around male culture, gender based violence, sexuality and transference.

Of the ten NHS services (100%), all four specialist services (40%) reported that their staff had received specialist training. However, among the six generic services (60%), only one (10%) reported that their staff had received specialist training.

Amongst the twenty-nine (100%) participating voluntary organisations, there are nine specialist services (31%) and twenty generic services (69%). Seven specialist services (24.1%) had staff who had received specialist training. The staff of the remaining two specialist services (7%) did not receive specialist training. Seven generic voluntary organisations (24.1%) also received specialist training, whereas the staff of the remaining thirteen generic services (44.8%) did not receive specialist training.

The details are described in Table 2 below:

Table 2. Specialist Training Received

Service Type	NHS 10		Voluntary 29	
	Yes	No	Yes	No
Specialist	4 (40%)	0	7 (24.1%)	2 (7.0%)
Generic	1 (10%)	5 (50%)	7 (24.1%)	13 (44.8%)

Voluntary Sector

Three themes relating to training were identified from voluntary sector responses: current training levels of staff, further training needs and training identified by type or content

Theme 1: current training levels

Some organisations responded that their staff had received some form of training on sexual trauma and/or offering support to men.

Comments included:

- *'All staff underwent additional training on male support'* (Organisation 2)
- *'(Staff) Have received training on sexual abuse from a Stirling Agency, but it was too focused on female survivors.'* (Organisation 23)

Theme 2: further training needs

Some organisations recognised the importance of and need for specialist training on issues around CSA survivors and male survivors in particular. Participating organisations welcomed the possibility of additional training in this area.

- *'Training at all levels is needed, from the basic knowledge to how to incorporate therapeutic approaches. More training material and information is needed.'* (Organisation 8)
- *'Specific training for male survivors would be beneficial. The training received so far has been female oriented.'* (Organisation 10)
- *'Training courses (that are) related to the subject (are needed) to increase (staff) understanding. Not necessarily to diploma level, but to add to current knowledge.'* (Organisation 15)
- *'Staff should look into CPD to update knowledge and the awareness towards the anger issues in male.'* (Organisation 19)

- *There is (a) great need for training focused on male survivors.* (Organisation 27)
- *'There should be more emphasis on the hidden needs of male survivors to raise staff awareness towards male culture and the possible sense of shame when talking about CSA history.* (Organisation 28)

A few organisations said that specialist training for issues relevant to male survivors was not their current priority or there was little current need for this in their organisations.

- *'Training for male survivors is not a current priority for the service. (The service) has only come across one case so far.'* (Organisation 4)
- *'Staff training is adequate. There are no immediate needs.'* (Organisation 9)

Finally, a few specialist services provide their own training programme for their therapists and to other organisations.

- *'CPD (of staff) is very important and (the service) has their own training programmes.'* (Organisation 21)
- *'(The service) has their own in-house training, whereas some organisations do not have the same access.'* (Organisation 27)

Theme 3: training identified by type or content

A few representatives expressed views on the content of childhood sexual abuse training. They suggested that training should focus on raising staff awareness of CSA; how to approach this issue sensitively with clients and how to undertake assessments in relation to CSA.

- *'(There is a) need to raise staff sensitivity in CSA and the anxiety in sexuality (and) relationship difficulties that may occur in later adult life. (We would) also like to see more relevant training courses available.'* (Organisation 5)
- *'(Training) needs to be up to date on the latest development in this field. (There) also need (to be) more ways for assessment of individuals.'* (Organisation 18)

Specialist services appeared to provide more specific training for male CSA survivors. They said that relevant training should tackle male culture, gender based violence, sexuality and transference. Organisation 14 suggested the inclusion of the following areas of training:

- *Training on gender differences*
- *Specific issues relating to male survivors, e.g. the impact of societal expectation in relation to acceptable male emotions.*

- *Training on types of abuse perpetrated by a man or by a woman, and the effect of such difference.*
- *Consideration about the gender of the therapist in relation to male survivors and sexuality issues that relate to the working relationship (including) erotic transference.*
- *Training to raise awareness of male abuse in care.*

NHS training provision

Similarly, two key themes, current training levels and further training by type or content, were identified in responses received from NHS services.

Theme 1: current training levels

Some NHS services considered staff training levels to be adequate in dealing with the mental health issues of male survivors.

- *'(We have) adequate staff training levels. The team has a 16 year service history and are considered the expert in the field. They provide training to (our) own (NHS) staff and other professionals'* (NHS Service 4)
- *'(There is) sufficient and adequate (staff) training within the Board.'* (NHS Service 7)
- *'Many (staff) in practice would have received relevant training in the process of obtaining their qualification.'* (NHS Service 8)

Theme 2: further training by type or content

Others identified a need for further training. Comments included the following:

- *'(Staff) need training and updates on generic issues with working with survivors, (and) male sexuality issues in particular.'* (NHS Service 1)
- *'(There is a need for) workshops providing information (and) training on gender based violence or similar, to add on to current knowledge.'* (NHS Service 2)
- *'(We) would like to see more accredited training courses become available.'* (NHS Service 9)
- *'(We) would like to have easy access to training and information, i.e. addition to the content of NHS Online Knowledge Bank.'* (NHS Service 10)
- *'Training in relation to trauma in general is needed, especially for those with multiple trauma. (Training) should see traumatic experience as an entity, not just focusing on a certain aspect of trauma.'* (NHS Service 11)

Some services mentioned specific training needs, including a focus on the association between CSA and mental health, different types of intervention and on issues that specifically relate to male identity.

- *'(There is a) need to raise awareness to the link between CSA experiences and mental health complications.'* (NHS Service 5)
- *'Awareness (training) of difficulties that male survivors face in particular, (including) expression of emotion.'* (NHS Service 5)
- *'(Training is needed on) better understanding of the differences between trauma intervention and supportive counselling.'* (NHS Service 5)
- *'(Training is needed on) what it means to be a man in this society, (and) the traditional role as a man; CSA history (and the) impact on relationships and sexuality; men's coping strategy and its difference from that of females; male experience in a position as a victim.* (NHS Service 6)

Service Provision

Resourcing

With regard to staffing, completed information was received from eight of the fourteen NHS services responding to this question and nine of the fourteen Voluntary Organisations. The ratios below are based on an estimated range of 3% - 21.6% prevalence of men presenting with a history of childhood sexual abuse in Scotland. Unfortunately, combined information was only available from both for five of the fourteen NHS Board areas. These showed overall ratios of specialist CSA counsellors to the estimated population of male survivors as zero in two areas and in the range 1:424 -1:3,051; 1:806 – 1:5,803 and 1:2,424 – 17,453 in the remaining three areas. Only one of the eight responding NHS services offered a specialist service, the remainder were provided by responding Voluntary Organisations.

In the same areas, the ratio of generic counsellors to the estimated population of male survivors for the NHS and Voluntary Organisations combined included the following: 1:36 – 1:256; 1:110 – 1:791; 1:468 – 1:3,371; 1:806 – 1:5,803; 1:1,673 – 1:12,045.

In terms of workforce, voluntary organisations employed 14.2 staff on average, comprising 3.1 full time equivalents (FTE's), whilst an NHS service employed 8.6 staff, comprising 4.1 FTE's.

Waiting lists for NHS services were an average of 17.3 weeks, whilst those for Voluntary Organisations were 7.3 weeks. There were no figures around referral numbers to correlate this with evidence of demand.

Skills and accreditation

NHS respondents stated that 95% of their counselling staff were accredited and they considered them all to be sufficiently skilled to offer counselling to male survivors; this contrasted with 26% of Voluntary Organisation counsellors being

accredited and 67% of respondents felt they were sufficiently skilled to offer sessions to male survivors.

Organisations and services also provided information regarding their current service provision. The questionnaires gathered data relating to the number of FTE counsellors/psychotherapists in the service, the number of accredited counsellor/psychotherapists, the number of those who are sufficiently skilled to offer sessions to male survivors and the length of waiting lists.

The results showed that on average, an NHS service employs 8.6 counsellor/psychotherapists, comprising 4.1 FTEs. All of them are sufficiently skilled to offer sessions to male survivors. The average waiting list for NHS services is 17.3 weeks.

On the other hand, a voluntary sector organisation on average employs 14.2 counsellors/ psychotherapists, comprising 3.1 FTEs. Of those, 3.7 counsellor/psychotherapists are accredited and 9.2 are sufficiently skilled to offer sessions to male survivors. The average waiting list for voluntary sector organisations is 7.3 weeks.

Table 3 illustrates the results reported above.

Table 3. Service Provision Variables

Variables	Sector	Mean (Standard Deviation)
Number of Counsellors/Psychotherapists	NHS	8.6 (11.1)
	Voluntary	14.2 (15.2)
FTE	NHS	4.1 (5.8)
	Voluntary	3.1 (4.4)
Number of Counsellors/Psychotherapists Accredited	NHS	8.2 (11.2)
	Voluntary	3.7 (4.1)
Skilled to Offer Counselling to male survivors	NHS	8.6 (11.1)
	Voluntary	9.2 (8.3)
Waiting List in Weeks	NHS	17.3 (9.5)
	Voluntary	7.3 (6.9)

Scottish Prison Service Provision

The Scottish Prison Service provided the following information on staff employed:

- 40 FTE Forensic Psychologists
- 1 CBT nurse
- 2 Psychotherapists who provide supervision to the team

No information relating to specific presenting issues or specialist CSA counselling/psychotherapy was provided.

Service need

In order to illustrate the geographical spread of generic and specialist counselling and psychotherapy services across Scotland, the adult male populations in the areas covered by each NHS Scotland Board were collated and the therapist / client ratio was calculated for each Board area. The details are shown in Table 4 below. Although data were not available for some areas, the information collected by the project highlights the gaps in counselling/ psychotherapy services for male survivors.

Whilst the table shows that some areas are better served than others, this analysis also provides some preliminary evidence that practicing psychotherapists and counsellors in both the NHS and voluntary sector, across all geographical areas in Scotland, are potentially faced with large case loads of male survivors.

From this analysis we can also conclude that relevant services in the NHS and the voluntary sector will potentially have to deal with very long waiting lists if the staff / male survivor ratio does not improve in future. This relates particularly to highly populated areas of Scotland or in areas with no specialist provision.

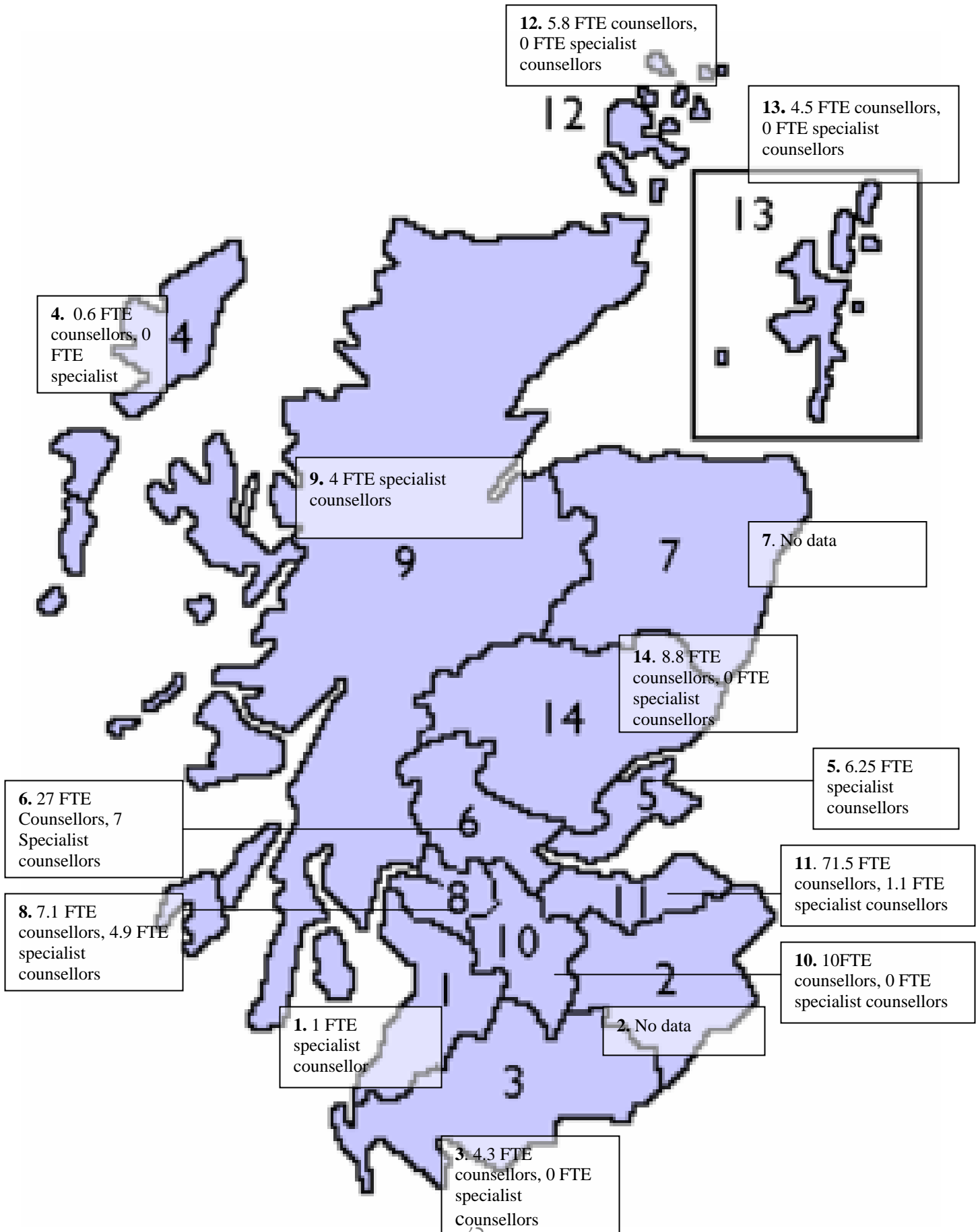
Note: It should be noted that Table 4 was populated by the data provided to the Scoping Project. No data relating to the Scottish Prison Service has been included as the prison population comes from across Scotland.

Table 4. Service volume in population context

NHS Boards	Adult Male Population Total (16-74 yrs) ¹	Estimated Male Survivor Prevalence ²	NHS Services FTEs	Voluntary Services FTEs	NHS Specialist Services FTEs	Voluntary Specialist Services FTEs	FTEs Total	FTEs Specialist Total	Estimated Number of Male Survivors per FTE	Estimated Number of Male Survivor per Specialist FTE
NHS Ayrshire & Arran	128,123	3844- 27,675	Missing data	1	Missing data	1	1	1	3,844- 27,675	3,844- 27,675
NHS Borders	37,111	1,113-8,016	Missing data	Missing data	Missing data	Missing data	Missing data	Missing data	Missing data	Missing data
NHS Dumfries & Galloway	51,818	1,555-11,193	4.3	Missing data	0	Missing data	4.3	0	362-2603	Missing data
NHS Fife	122,179	3,665-26,391	Missing data	6.25	Missing data	6.25	6.25	6.25	586- 4,223	586- 4,223
NHS Forth Valley	98,880	2,966- 21,358	19.5	7.5	0	7	27	7	110- 791	424- 3,051
NHS Grampian	195,023	5,851- 42,125	Missing data	Missing data	Missing data	Missing data	Missing data	Missing data	Missing data	Missing data
NHS Greater Glasgow & Clyde	395,934	11,878-85,522	4.9	2.2	4.9	0	7.1	4.9	1673-12,045	2424-17,453
NHS Highlands	107,452	3224- 23,210	0	4	0	4	4	4	806- 5,803	806- 5,803
NHS Lanarkshire	220,291	6,609- 47,583	Missing data	10	Missing data	0	10	0	661-4,758	Missing data
NHS Lothian	282,542	8,476- 61,029	Missing data	71.05	Missing data	1.1	71.05	1.1	119- 859	7,705- 55,481
NHS Orkney	6867	206- 1,483	0	5.8	0	0	5.8	0	36- 256	0
NHS Shetland	7905	237- 1,707	4.5	Missing data	0	Missing data	4.5	0	53- 379	Missing data
NHS Tayside	137,336	4,120- 29,665	6.8	2	0	0	8.8	0	468- 3,371	0
NHS Western Isles	9,353	281-2,020	0.6	Missing data	0	Missing data	0.6	0	468- 3,367	Missing data

1. Scottish Census 2001, Scotland's Census Result Online www.scrol.gov.uk
2. Estimated prevalence at 3.0% (Kercher & Meshane, 1984) – 21.6% (Fromouth & Burkhart, 1987)

The map below illustrates the distribution of FTE counsellors in both specialist and generic services within the statutory and voluntary sectors across Scotland.



NHS Areas

1. NHS Ayrshire and Arran
2. NHS Borders
3. NHS Dumfries and Galloway
4. NHS Western Isles
5. NHS Fife
6. NHS Forth Valley
7. NHS Grampian
8. NHS Greater Glasow and Clyde
9. NHS Highland
10. NHS Lanarkshire
11. NHS Lothian
12. NHS Orkney
13. NHS Shetland
14. NHS Tayside

In-depth Interview Results

The in-depth interviews captured the views and opinions on the demand for counselling and psychotherapy services, volume and range of service provision and staff training needs from service providers. Their views fall into the following six themes: demand for counselling and psychotherapy services; clinical skills and approaches; reward and challenges for staff; staff supervision; advantages and disadvantages of the provision of specialist services and gender specific CSA services and staff training needs.

1. Demand for Counselling and Psychotherapy Services

1.1 Perceived and increasing demand

Most services participated said there is a current demand for counselling and psychotherapy services from male survivors in their areas and they expected this to increase. One service also said that the length of their waiting lists had increased.

- *'There will be a number of people who would need longer term counselling and psychotherapy, and we have limited funding. That actually limits us in providing the service to more people.'* (Interviewee 1)
- *'It would be quite a big demand, in terms of new survivors, which is growing all the time. ... (In our new service) about 405 – 50% are male survivors. So we've seen a huge (increase in) demand there.'* (Interviewee 2)
- *'I think potentially there is a high demand. We've had about a six month waiting list, recently it has gone to between 6 to 9 month.'* (Interviewee 3)
- *'We are always not going to have enough specialist services, so it is more important that general staff felt more able, more equipped and confident to deal with most of the needs.'* (Interviewee 4)
- *'My impression is that, possibly over the last year, there have been more referrals of male childhood sexual abuse, than we would normally have received in the previous 12 months.'* (Interviewee 5)
- *'We have coped, but the waiting list sometimes gets to 6 months. And I think that's inadequate. And we try to keep it round to 3 months. But the waiting lists do get too long. And that's quite hard for vulnerable people.'* (Interviewee 6)

1.2 Lack of accurate data on service need

Although the majority of services did experience demand for counselling and psychotherapy, they also reported a lack of research/ audit to determine the extent of the problem.

- *'We have considerable difficulty, measuring... What I don't have a sense of, is how many people within, psychology and wider mental health are male survivors. ... But obviously what that isn't capturing is all the men, for whom there isn't a disclosure. We really don't know what the demand out there is at the moment. I mean we've got the prevalence stats, how you would then work out what you expect the demand to be. But until we have any way of (how to do) routine inquiries, and more, we are really going to struggle to really pin down what the demand is.'* (Interviewee 4)
- *'It's actually quite difficult to quantify, because we don't routinely collect the data in terms of gender. We do have a database of what the referring problem is, but particularly in relation to sexual abuse, the problem ultimately the GP refers the individual with is not necessarily the problem that you are dealing with.'* (Interviewee 5)

2. Clinical Skills and Approaches

2.1 Integrating different approaches

Most services employed counsellors and psychotherapists using a range of approaches for counselling and psychotherapy for male survivors. Approaches mentioned include working with the inner child; EMDR; sensory-motor psychotherapy; CBT and attachment based approaches.

- *The staff are trained in (the service) model of working, which is pretty much working with the inner child.'* (Interviewee 2)
- *'We are trying slowly put different members of staff in different training programmes to see what the impact is on working with the clients. (We have) one member of staff (who has) finished EMDR training and another member of staff (is doing) sensory-motor psychotherapy (training).'* (Interviewee 3)
- *'The present modality would probably be cognitive behavioural, although one or two (staff) go on to develop a more interpersonal, or attachment based, developmental based approach.'* (Interviewee 5)
- *We have a mixture of therapists, who work between person-centred, CBT, Gestalt, and Integrated. So we have all the models in our team.'* (Interviewee 6)
- *'I think an eclectic mix of skills is the best way of putting it. We require to have therapeutic skills and an approach or model of understanding trauma. That could be a very cognitive model (or) a very analytical model. They have to have that theoretical background, underpinning. It's also extremely useful to have staff who are skilled in different types of therapy.'* (Interviewee 7)
- *'There isn't a blanket of approaches through all our individualised care planning process. Someone (may) require basic level psychological support, or they may require high intensity psychological intervention,*

Cognitive Behavioural Therapy for example, or EMDR. It depends on individualised, assessed need.' (Interviewee 8)

2.2 Matching different skills to different needs

Most service providers acknowledge that whilst not all survivors require either generic or specialist psychological intervention, it should be available to those who feel they would benefit. The need to tailor the service to individual needs was also raised.

- *'I don't think there is anyone, particular approach that is more suited in working (with male survivors), because it depends on the individual client what the suitable intervention is.'* (Interviewee1)
- *'I would see myself as offering an individualised plan based on the person's needs and presentations, how they live their lives and you would use a range of different therapeutic approaches at different times depending on the needs of the client.'* (Interviewee 4)
- *'Not everyone who has experienced childhood sexual abuse, not every male required special psychology or, psychological service. But those who do, still have the right to access that.'* (Interviewee 7)
- *'Because someone has a history of childhood sexual abuse, doesn't mean they necessarily require specialist clinical interventions.'* (Interviewee 8)

2.3 Focus on the here and now

Some services identified that it was important to deal with the current life experience of survivors and focus on the 'here and now', instead of focusing only on the traumatic experience.

- *'In psychotherapy and counselling, there can be dangers of too much focus on the past, and too little emphasis on the future. It is how to help the individual to actually also get in touch with that they have survived and they have strengths and they have lots of qualities and abilities.'* (Interviewee 1)
- *'We are working with the depth, into the aspects of what's happened to the child, but we are also dealing with the here and now. And with a lot of men, they like to work with the here and now, much more than they like to go back, and walk in the past. That's just my experience that I think.'* (Interviewee 2)
- *'You very much deal with the here and now so you have your pre-disposing factors, triggering influences. It's what actually happens in the here and now. Now the traumatic experiences of here and now, even to work with that.'* (Interviewee 8)

2.4 Trust and hope in the therapeutic relationship

Finally, a few services highlighted the importance of building a therapeutic relationship based on trust and hope between the counsellor/ therapist and the service user.

- *'The relationship we build with the person that is the most significant... That, and hope and lots of other things you can't really measure, with a person.'* (Interviewee 1)
- *"Building up the trust is absolutely massive as well. Because we've got guys who come along, who don't even want to give you their names. They don't want anybody to know that they have actually been abused. They have this fear that if they disclose that they have been abused, people are going to think that they go on and be an abuser.'* (Interviewee 2)

3. Reward and Challenges

3.1 Reward - seeing the progress

Most services reported that the most rewarding aspect of working with male survivors of CSA was seeing individuals making progress.

- *'The rewards were absolutely huge. I think that's why we do what we do basically. I mean when you actually see somebody who's progressed so well.'* (Interviewee 2)
- *'So when you have successfully completed a piece of work, with someone who's been struggling with sexual abuse, a male (who) has been struggling with sexual abuse, perhaps has told no one through shame and guilt. And you complete that piece of work, and they are managing their emotional state. They are managing to move on with their lives, have healthy relationships. They are sleeping. Their moods are up. The rewards are enormous, absolutely enormous.'* (Interviewee 7)

3.2 Challenge- vicarious traumatisation

Most services interviewed recognised that intensive work with trauma victims may result in vicarious traumatisation, which can be stressful for counsellors and psychotherapists.

- *'Vicarious trauma is well known in the profession, where workers aren't resourced themselves, who do get involved in a hopeless situation, find themselves worn out by the work.'* (Interviewee 1)
- *'I think, listening to abuse and trauma can affect you, and does affect a lot of people. Some of those effects can be difficult to manage. So for example staff members have presented to me with, showing symptoms of the clients, so having nightmares, having intrusive thoughts, not of their own trauma, but their client's trauma, because they've heard stories in*

detail, and histories in detail. They can also (report) more general changes, such as the way they see the world, the way they see males.' (Interviewee 7)

3.3 Challenge- Building a trusting relationship with male survivors

Some services also reported that it could be difficult to build a trusting therapeutic relationship and encourage male survivors to open up, and talk about how they feel.

- *'With men sometimes it can take up to you know, say we are offering 12 sessions. It could take till like session 8 before they would even talk about what's happened in childhood.'* (Interviewee 2)
- *'It's the way men are socialised; it can be a bit harder for them to you know, do the sort of feeling, emotional side of things. ... 'So I think maybe that, just sort of being aware of that, is perhaps more challenging at times. It means maybe takes a bit longer.'* (Interviewee 3)

4. Supervision

While recognising that those working with trauma may face challenges like vicarious traumatisation and difficulty in building trust to work therapeutically, all services stressed the importance and benefits of regular, skilled and supportive supervision.

- *Staff need a place that's structured, that's safe, where they can explore, supportively explore what's going on for them.'* (Interviewee 1)
- *'This is a really crucial thing for all staff that work in the survivors (service). ... It needs to be regular, it needs to be skilled.'* (Interviewee 4)
- *'I think you have to have experience (as a supervisor) in this particular client group. We have an external supervisor for the whole team. And I do case management with the team.'* (Interviewee 6)

5. Advantages and Disadvantages of specialist CSA and Gender Specific Services

Services were asked to identify the possible advantages and drawbacks of having specialist CSA service and a gender specific clinic. The responses were similar across all interviewees.

5.1 Advantage- developing expertise

Some services felt that having a specialist CSA or gender specific service would encourage services to develop expertise in working with psychological trauma or men who have experienced abuse.

- *'A professional, who's heard someone's story maybe before, won't easily be shocked, or what ever it is they are getting.'* (Interviewee 1)
- *'There are so many issues with survivors, where you can make things worse instead of better, and I think you need years and years of experience to be able to cope with that.'* (Interviewee 2)
- *'As for any specialist service, (the) main argument in favour of it is you can develop you expertise.'* (Interviewee 5)

5.2 Advantage- sending a clear message

A few services explicitly stated that they promote their service specifically to CSA survivors.

- *'Our rationale for getting funding at the time (was) to try to put a message out there that we have this specialist service.'* (Interviewee 3)
- *'They often have experienced three, four, five, six complex trauma experiences, and the impact on these individuals are much more significant in terms of mental health difficulties, much more significant in terms of functioning difficulties. And it is my strong belief that they require longer term, more specialist interventions.'* (Interviewee 7)

Another service also raised the issue of waiting list, reporting that a gender specific clinic could provide a waiting list just for men, which is shorter than generic service waiting list, and men could perhaps be seen earlier.

- *'And what was different is the fact that they have their own waiting list. If they go on to a generic service, the waiting list will be longer. Because there are many more women accessing services than men.'* (Interviewee 6)

5.3 Drawback - increasing stigma

A few services were concerned about the possible risk of increasing stigma by responding to CSA with specialist services; the provision of gender specific clinics was seen as possibly increasing the stigma even more.

- *'By making it special in some way, you are perhaps adding to the stigma. When we are having a drug problem service, for example, actually going to the building where the drug problems are dealt with, can become stigmatising. Even when you try for that not to be the case, or the same would be true for the sexual enquired infection clinics. By creating the specialist clinic, it's very clear when that person attends that building or*

that clinic, why they are there. And potentially, that can become a barrier to accessing the service.' (Interviewee 5)

- *'One of the barriers to accessing help in males is stigma, often. And my fear is, when we start having specialist, gender specific services, we start increasing the stigma. I know that's not the intention. The intention is to decrease the stigma, but by being, having the specialist service, by definition, makes it different, how we are treating people.'* (Interviewee 7)

5.4 Drawback - too much focus on trauma

There was concern -re the impact of CSA work on the mental health of staff who did not have a mixed case load of sexual abuse and generic work.

'One is for the staff working in the specialist service. I think to have an undiluted case load of sexual abuse, may not be all together healthy for the clinician offering that service.' (Interviewee 5)

Another service felt that too great a focus on a person's trauma history may miss the importance of a person's whole life experience.

- *'In psychotherapy and counselling there can be a danger of too much focus on the past, too little emphasis on the future. It is, how to help the individual to actually also get in touch with that they have survived, and they have strengths, while not doing away with the suffering and tremendous trauma they have experienced.'* (Interviewee 1)

5.5 Client preference

A few services had worked with service users who considered a mixed service to be beneficial to them and preferred this to a gender-specific service.

- *'But I find once men come into service where they are with women, they actually do really, really well in it. Maybe we think that's (a gender specific service) what men need. But maybe men, when they are actually coming into the service, find, no, that's not. They actually, actually find it really positive when you can get men and women working together.'* (Interviewee 2)
- *'Last year we did a questionnaire, covering a lot of different areas. One of the things we asked people was, did they think we should have specific times for men; specific times for women, as well as mixed. And just over half of the respondents said no, (they) didn't want (a) different time. Just under half said they did. ... I think one of the respondents actually said, that they would have said yes, but actually now that they've come in to use a mixed service, it's not a problem for them, its fine. So having the experience of using a mixed service, has meant now they say no, it's not needed.'* (Interviewee 3)

6. Training Needs

6.1 Trauma awareness

When asked about staff training needs, most services agreed that all services should be trauma informed and in order to this staff need specialist CSA training.

- *'So we are trying to get a trauma informed perspective integrated into their very basic training. We are trying to develop, which is (in) the early stage, trauma informed services, so all services start to look at whether their services provide (a) service which is openly accessible to trauma survivors, that they don't (do) anything that would be a barrier to trauma survivors.'* (Interviewee 4)
- *'Now if he doesn't have officers who are psychologically attuned to the potential that the person they are working with has possible (CSA) history, you wouldn't understand why he would engage in certain behaviour or his language would be in certain way, or he would become aggressive, or why he would become sad. So it is important that we have this awareness across this spectrum. So that it directly influences our practice.'* (Interviewee 8)

6.2 Male sexuality & identity

Most services state that work with male survivors raises some issues which are not apparent in services for female survivors, including issues around male sexuality. Training on male sexuality and identity issues are therefore required.

- *'I've had a number of male clients, confused or wondering, if they are gay because they were abused, or does it mean anything, are they attracted to men? Are they not attracted to men? And lots, lots of confusion in there.'* (Interviewee 1)
- *'They are confused about sexuality, sexual boundaries. They had their identity stolen. So they are coming in the counselling room with all of that. And if we don't take that on board, we don't know how to work with that. So we absolutely have to train people how to work with male survivors, if we are going to do a good job.'* (Interviewee 6)
- *'I think adult male survivors of sexual abuse, males and females are not a homogenous group. They have different needs and different demands.'* (Interviewee 7)

6.3 Need for evidence to support clinical work with male survivors

A few interviewees also felt the need to gather more research evidence to guide their practice, and currently such evidence is not sufficient.

- *'I know women who have been abused could well have a history of drink and substance misuse as well, but is it more so for men than it is for women. And seeing the whole issue around aggression, and how aggression is being expressed. Is that more so for men or not? Now those are important questions to ask. ... But I think at the moment, we know little about that.'* (Interviewee 1)
- *'But I still don't think there is actual hard fact and evidence there to back it up. And that's what we really need. So I'd like to see more research into what really is working and proper trials, clinical trials to see what is working.'* (Interviewee 3)

Implications

Generally speaking, respondent NHS services take a significantly lower percentage of Local Authority, Voluntary Sector and Self-referrals than Voluntary Organisations. The latter may reflect the requirements of funders. This may have implications for service accessibility, particularly since issues around stigma and CSA as well as mental health remain.

Based on the number of FTE's, relevant NHS staffing is 25% higher than the staffing of Voluntary Organisations, but waiting lists for counselling are 236% higher. One reason for this could be the high levels of referrals within the NHS, however this could benefit from further investigation. No information was collected on the average numbers of counselling sessions provided per client, so this difference cannot be linked to variations in policy or practice.

The negative impact which CSA might have on staff was highlighted – training, effective supervision and support and maintaining a balanced caseload are all factors which can minimise this.

Specialist training was broadly considered valuable and whilst it was available to most specialist staff, there was a dearth of specialist training for generic services, in both the NHS and in the Voluntary Sector. This is particularly important to develop trauma-informed services. Training content for specialist services should be different from generic services.

Whilst nearly all relevant NHS staff are accredited, this contrasted with 26% of Voluntary Organisation staff being accredited. However this audit did not investigate accreditation criteria or membership of a variety of accreditation bodies or the effect of the accreditation on the quality of service offered and no conclusions can be drawn from this.

Overall, there was a huge geographical disparity in service provision across Scotland which needs to be addressed. There was no information about levels of unmet need and there were questions about the relationship between prevalence and demand. It was acknowledged that initial referral to counselling and psychotherapy may be for a different presenting issue.

In terms of specialist vs. generic counselling services, the benefits of both were highlighted and they should be complementary – Male survivors require both.

Recommendations

1. Recommendation: services should review their referral policies to ensure that they are widely accessible to male survivors e.g. they may not wish to discuss this with their GP and may not have any social work contact which would limit

access to NHS services; or a Voluntary Sector service may not take an NHS or Social Work referral when this may be the client's preference.

2. Recommendation: further research to look at the impact of policy on practice may be helpful. For example, offering open-ended counselling / psychotherapy and its impact; offering limited number of sessions etc. It may also be important to investigate the effectiveness of different therapeutic modalities for the mental health problems of male survivors.
3. Recommendation: training for generic and specialist services should be available. Training should cover the specific issues that may be particularly relevant for male survivors such as male sexuality and identity.
4. Recommendation: the adoption of relevant quality standards e.g. appropriate registration of counsellors and psychotherapists with relevant bodies such as BPS, BACP, UKCP and COSCA as a means of external regulation of service standards.
5. Recommendation: the audit did not consider quality standards, accreditation criteria of staff or membership of accreditation organisations. The sector might benefit from core standards for all services to ensure a consistent approach to monitoring quality.
6. Recommendation: a minimum standard for resourcing generic and specialist provision should be set across all NHS board areas, regardless of the nature of the provider. However, the cost-effectiveness of both service models should be explored by future research.
7. Recommendation: this audit addressed prevalence rates hypothetically; however prevalence does not necessarily indicate demand. A further audit to correlate prevalence and actual demand would be helpful.

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Appendix 1 Project Information Sheet



Mapping project of current counselling and psychotherapy services for male survivors of childhood sexual abuse

Background and context

Following research* into the care and support needs of male survivors of childhood sexual abuse (CSA) in Scotland, SurvivorScotland which is part of the Scottish Government identified the need to map current counselling and psychotherapy services for male CSA survivors in Scotland. The mapping will identify both geographical and service specific gaps and where there are gaps undertake suggestions with a view of meeting these gaps.

Mapping - overview

This mapping will comprise the following elements:

1. Scoping of current statutory and voluntary sector services in Scotland which are explicitly for male survivors of CSA; these may be in either single sex or mixed settings
2. Review of current specialist counselling services for male survivors in Scotland
3. Scope training and awareness needs relating to male CSA issues amongst staff working in the voluntary and statutory sectors delivering services explicitly for male survivors.
4. Identification of gaps in service delivery and training

Scope of mapping

The mapping will cover the following statutory and voluntary sector services

- Psychological therapy services with 14 NHS Boards (Heads of Services or Representative)
- Approximately 73 Voluntary sector counselling providers (Directors of Services or Representative)
- Specific Local Authority counselling services (Directors of Services or Representative)
- Counselling and psychotherapy within the Scottish Prison Service (Heads of Services or Representative)

Approaches

All organisations which agree to participate will be invited to a brief telephone interview, lasting no more than 10 minutes. Telephone Interview Questionnaires will be provided before the actual interview. Following the initial review of the information collected, some of the interviewed organisations will be invited to participate in a brief in-depth interview for further information on service and perceived staff training needs.

The information and data collected in both telephone interviews and in-depth interviews will then be analysed and organised to meet the project aims.

Dissemination

A final project report will be produced, presenting the reviewed counselling/ psychotherapy service availability to male survivor of CSA, the geographical and service gaps, and the staff awareness and training needs in Scotland. The report will also evaluate the information collected and make recommendations for future service planning.

The final project report will be presented to the Scottish Government to inform future service development.

Time scales

The mapping study is expected to be concluded by October 2010.

Project team

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* Care and Support Needs of Men Who Survived Childhood Sexual Abuse – Sarah Nelson, CRFR 2009



Appendix 2 Endorsement SurvivorScotland

Supporting Male Survivors of Childhood Sexual Abuse

Background

A qualitative research project with adult male survivors of childhood sexual abuse in Scotland was reported in February 2009 (Sarah Nelson). The aim of the research was to improve male survivors' wellbeing, through establishing their perspectives on their major care, support needs to inform and improve services across all sectors.

Findings from the SurvivorScotland Communication Strategy Regional Workshops confirmed similar findings and concerns on lack of parity of services for male survivors and a general lack of awareness on prevalence of abuse of young boys.

The SurvivorScotland National Reference Group set up a sub group to consider ways of implementing key recommendations from the above research and findings.

There is broad agreement that funding for services for male survivors should be in addition to, and not competing with, those for female survivors. However, an increase in therapeutic and support services is urgently needed for male survivors in both voluntary and statutory sectors across Scotland.

- Male survivors are reluctant to seek help particularly in statutory services due to fear they might be wrongly considered as abusers.
- Male survivors have issues on their identity and sexuality as a result of the abuse.
- Those who do seek help from survivor agencies who accept men report positively on their experiences.

Future development

There is a requirement to scope what current services there are for male survivors across Scotland in both statutory and voluntary sectors. Where there are services these should be examined for capacity and potential expansion. Where there are gaps, the cost of provision should be undertaken with a view to implementing a service.

To this end the Scottish Government has funded Health in Mind to carry out the Scoping Exercise and in addition a Pilot Telehelp Counselling and Support service in the Lothians.

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Appendix 3 Telephone Interview Questionnaires

Scoping project into the current range of counselling and psychotherapy services for adult male survivors of childhood sexual abuse and relevant staff training needs

Interviewee Information

Sector: _____

Organisation: _____

Service: _____

Name of the Interviewee: _____

Position of the Interviewee: _____

Interview Date: _____

Initial Screen Question:

Do you currently offer specialist counselling/ psychotherapy services for adult male survivors of childhood sexual abuse (CSA)?

Yes ____ No ____

If yes, turn to questionnaire 1; if no, turn to questionnaire 2.

Telephone Interview Questionnaire 1

(For those answered “yes” in screening question)

Q1. How many full time equivalent psychotherapists/ counsellors are currently offering sessions in your specialised service?

Q2. How many of the above in the specialised service are accredited by a professional body? _____

Q3. How long is the anticipated waiting list at the moment? _____

Q4. Who are the referral agencies?

NHS

Voluntary Sector

Local Authority

Self-referral

Q5. Are you aware of any special training on mental health issues of adult male CSA survivors that your staff has attended?

Yes _____ No _____

Q6. How many of your staff in the specialised service has attended?

Q7. In your opinion, what are the staff training needs for the service provided to adult male survivors of CSA?

Q8. Would you consider doing an in-depth interview on the counselling and psychotherapy service available for adult male survivors of CSA?

Yes _____ No _____

Q9. Can we audiotape the in-depth interview for better recall and analysis?

Yes _____ No _____

Q10. Open-end comments

Telephone Interview Questionnaire 2

(for those who answered “no” in screening)

Q1. Do you currently offer counselling/ psychotherapy services to adult male survivors of CSA?

Yes _____ No _____

If “no”, go to **Q9**

Q2. How many full time equivalent counsellors/ psychotherapists are currently offering sessions? _____

Q3. Among them, how many are accredited by a professional body?

Q4. How many of your counsellors/ psychotherapists can offer service to adult male survivor of CSA? _____

Q5. How long is the anticipated waiting list at the moment? _____

Q6. Who are the referral agencies?

NHS

Voluntary Sector

Local Authorities

Self-referral

Q7. Are you aware of any specialised training on mental health issues of adult male CSA survivors that your staff has attended?

Yes _____ No _____

If “no”, go to **Q9**

Q8. How many of your staff attended? _____

Q9. In your opinion, what are the staff training needs for the service provided to adult male survivor of CSA?

Q10. Would you consider doing an in-depth interview on the counselling and psychotherapy service available for adult male survivors of CSA?

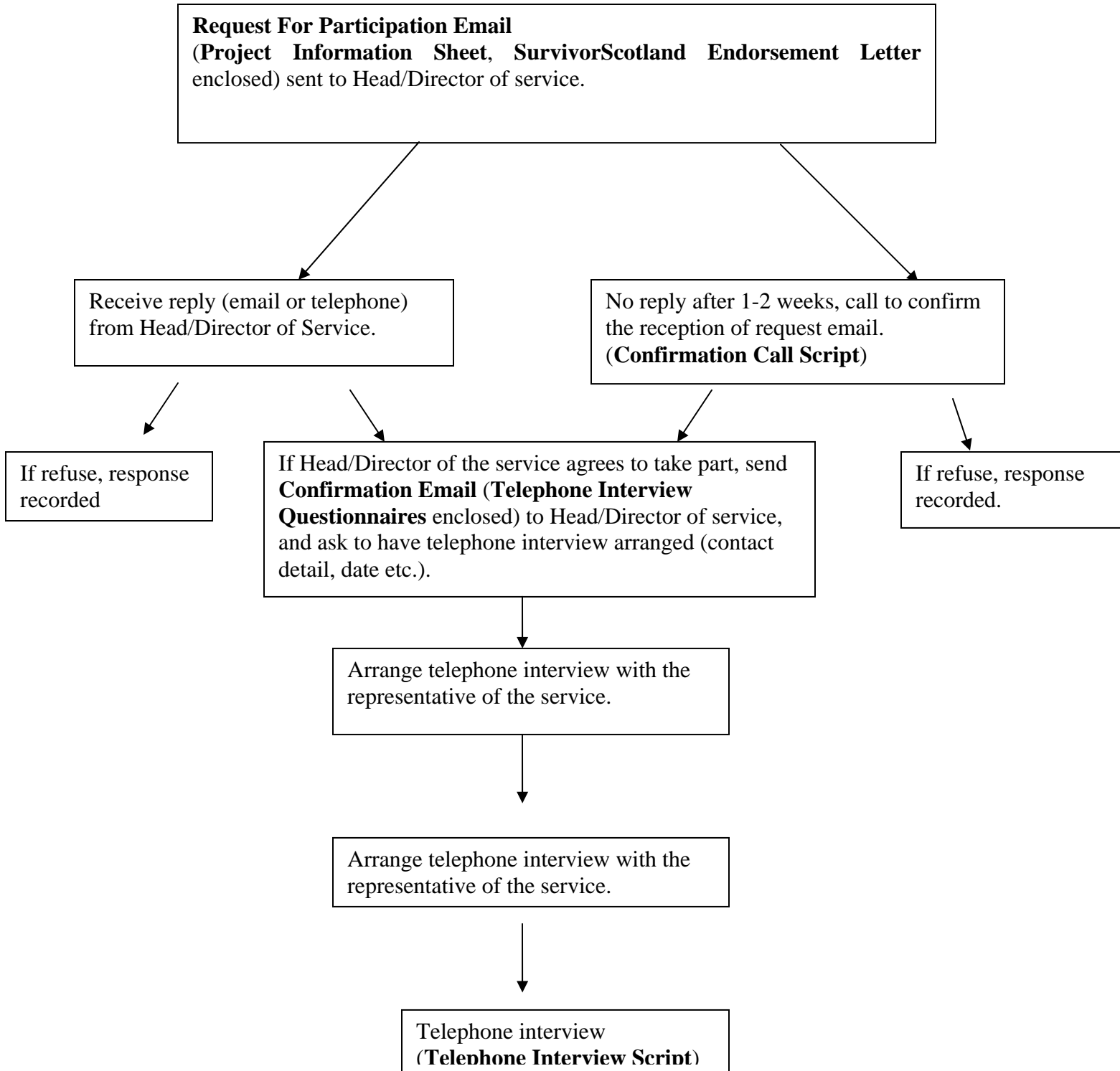
Yes _____ No _____

Q11. Can we audiotape the in-depth interview for better recall and analysis?

Yes _____ No _____

Q12. Open-end comments

Appendix 4 Participant Contact Procedure



Appendix 5 In-depth Interview Participant Information Sheet



In-depth Interview Participant Information Sheet

Mapping project of current counselling and psychotherapy services for male survivors of childhood sexual abuse

Dear participant,

Following the telephone interview of the above Mapping Project and your permission in relation to the second stage of the Project, Health in Mind would like to invite you to take part in an in-depth interview.

The in-depth interview will be carried out face-to-face, at a time and place agreed between the participant and Fan Zhang, the Project Assistant. The interview should take approximately 30 minutes. The questions for the interview and a consent form will be provided to the participant via email before the interview, with this Participant Information Sheet.

On the day of the interview, two copies of the consent form will be signed by the participant and the Project Assistant. One copy will be kept by either party for future reference. **The interview will be audiotaped with your consent for better recall and analysis only.** The content of the interview will then be transcribed into word processing software for qualitative analysis.

The raw data (audio tapes) from the in-depth interviews will be kept securely in Health in Mind Head Office. The only parties with access to audio tapes are the Project Leader and the Project Consultant, who will also have access to the transcript of the interviews and data analysis results. The paper copy of telephone interviews and audiotapes will be destroyed once the data analysis is finished and the final report has been written up.

The result of the in-depth interviews will contribute to the final project report, along with the data collected from the telephone interviews. The final project report will present the reviewed counselling/ psychotherapy service availability to male survivor of CSA, the geographical and service gaps, and the staff awareness and training needs in Scotland.

The report will also evaluate the information collected and outline resource requirement to provide core services to address identified gaps. The final project report will be presented to the Scottish Government to inform future service development.

Finally, participation in this project is entirely voluntary and you are free to withdraw your input from the project at any stage, without having to provide reasons. Please contact Fan Zhang, the Project Assistant at the address below if you wish to withdraw from this project.

If you have any concern or question in relation to this project, please do not hesitate to contact the Project Leader or Project Assistant for more information at the address below:

Project team

Project Leader:

Theo Dijkman – Depute Chief Executive Health in Mind
Health in Mind, 40 Shandwick Place, Edinburgh, EH2 4RT
Tel 0131 225 8508
Email: theo@health-in-mind.org.uk

Project Consultant: Thanos Karatzias – Research Consultant Napier University

Project Assistant:

Fan Zhang
Health in Mind, 40 Shandwick Place, Edinburgh, EH2 4RT
Tel 0131 225 8508
Email: fan@health-in-mind.org.uk

Thank you for much for your participation in both the telephone interview and the in-depth interview.

Kind regards,

Fan Zhang

Project Assistant,
Health in Mind

Appendix 6 Consent Form

Mapping Project of Current Counselling and Psychotherapy Services for Male Survivors of Childhood Sexual Abuse

Please tick (✓)
appropriate box

Have you read and understood the Participant Information Sheet? Yes No

Have you been given an opportunity to ask questions and further discuss this project? Yes No

Have you received satisfactory answers to all your questions? Yes No

Have you now received enough information about this project? Yes No

Do you understand that participation is entirely voluntary?
Do you understand that you are free to withdraw from this project:

At any time? Yes No

Without having to give reason for withdrawing? Yes No

Do you agree to have the interview audiotaped for better recall and analysis purposes? Yes No

Do you agree to take part in this project? Yes No

Name of participant **Date** **Signature**

Name of person taking **Date** **Signature**
the consent

Thank you for agreeing to take part in this audit

Appendix 7 In-depth Interview Questions

1. What is the current demand for psychotherapy / counselling for male CSA survivors?
2. Do you have enough resources to meet the demand?
3. What are the clinical skills that staff needs to have in order to meet this demand?
4. What do you think are the theoretical models that make a difference (e.g. person-centred, CBT etc.) to the mental health needs of male CSA survivors?
5. How does your staff find working with CSA male survivors? What do you think are the challenges / rewards?
6. What do you think are the needs for supervision of staff?
7. Do you think that male CSA survivors' needs are better accommodated in specialist or generic adult mental health services? What do you think are the benefits / drawbacks of either setting?
8. What are your views on gender specific clinics for male survivors? What are the benefits / drawbacks of this approach?
9. What are the staff's needs for training on mental health issues of CSA survivors?

Appendix 8 List of contacted organisations and services

Voluntary Sector organisations

Aberdeen Counselling and Information service (ACIS)
Breathing Space
Central Scotland Rape Crisis & Sexual Abuse Centre
The Centre of Therapy (Glasgow)
Changes East Lothian Community Health Project
Charis Foundation Fife
Couple Counselling Lothian
Crisis Counselling
Crossreach Counselling
Cruse Bereavement Care Scotland
Drugs Action Aberdeen
Drug Counselling at Crew
Edinburgh Counselling Ministries
Encompass Counselling and Support
Falkirk & District Association for Mental Health Counselling Services
Gay Men's Health
Gingerbread Counselling Service
Glasgow Council on Alcohol
Greater Easterhouse Alcohol Awareness Project
The Haven Kilmacolm
Health All Round
Health in Mind
Insight Counselling Dundee
Kingdom Abuse Survivors Project
Lider8 (Lanarkshire Ltd.)
Lighthouse Christian Counselling Trust
MASA
Moving On Ayrshire
National Association for People Abused in Childhood
North East Edinburgh Counselling Service
North Edinburgh Drug Advice Centre
Open Secret
Orkney Alcohol Counselling & Advisory Service
Perth Association for Mental Health
PF Counselling
Pilton Counselling Service
Rape & Abuse Line
Rape Counselling & Resource Centre Kilmarnock
Safe Space
Scottish Institute of Human Relations

Scottish Marriage Care
Simpson House Counselling Service
Stirling District Association for Mental Health
SurvivorsUK
Taking Steps Counselling Service
Talbot Association Limited
Tara Rokpa Edinburgh
The Edinburgh Counselling Centre
The Garnethill Centre
The Junction
VOCAL
Waverley Care Community Services
Wellspring Scotland
Wester Hailes Health Agency
Your Call
Argyll & Bute Rape Crisis
SHIR Psychotherapy Service

NHS Boards & Services

NHS Ayrshire & Arran
NHS Borders
NHS Dumfries & Galloway
NHS Fife
NHS Forth Valley
NHS Grampian
NHS Greater Glasgow & Clyde

- Compass
- Sexual Assault and Sexual Abuse Team (North)
- Sexual Assault and Sexual Abuse Team (West)
- Thrive
- Trauma and Homelessness Team

NHS Highlands
NHS Lanarkshire
NHS Lothian
NHS Orkney
NHS Shetland
NHS Tayside
NHS Western Isles

Scottish Prison Services

Local Authorities

Argyll & Bute Council
Clackmannanshire Council
Dumfries & Galloway Council
Dundee City Council
East Ayrshire
East Dunbartonshire
East Lothian Council
East Renfrewshire
Edinburgh City Council
Falkirk Council
Fife Council
Glasgow City Council
Highland Council
Inverclyde Council
Midlothian Council
Moray Council
North Ayrshire Council
North Lanarkshire Council
Orkney Islands Council
Perth & Kinross Council
Refrewshire Council
Scottish Borders Council
Shetland Islands Council
South Ayrshire Council
South Lanarkshire Council
Stirling Council
West Dunbartonshire Council
West Lothian Council
Western Isles Council