National Sexual Assault Coalition
reshāp Resource Sharing Project

Working together to end sexual violence

Core Services and Characteristics of Rape Crisis Centers:

A Review of State Service Standards

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What is the National Sexual Assault Coalition Resource Sharing Project?

The RSP was created to help state sexual assault coalitions across the country access the resources they need in order to develop and thrive. The project is designed to provide technical assistance, support, and to facilitate peer-driven resources for all statewide sexual assault coalitions. The RSP recognizes the needs of all coalitions, especially those designated as new or emerging, regarding issues of organizational growth, professional development, and policy development.

Who is the RSP?

The RSP is led by the Iowa Coalition Against Sexual Assault (IowaCASA), assisted by the North Carolina Coalition Against Sexual Assault (NCCASA) and the Washington Coalition of Sexual Assault Programs (WCSAP).

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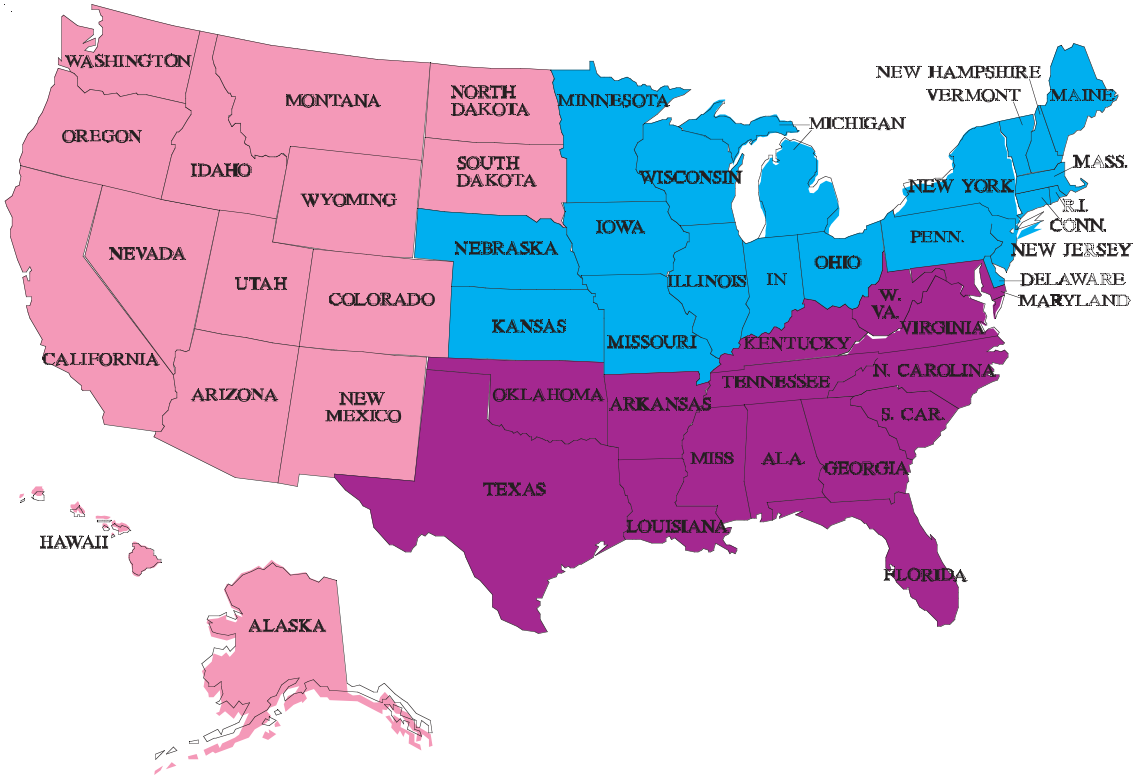

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By Kris Bein

The anti-sexual assault field is a grassroots movement. People have been organizing to serve victims of sexual violence for close to forty years. In at least 1,300 places across the country, community members have established rape crisis centers (RCCs). Because these RCCs were created locally, they have each evolved differently, fitting into the milieu of community needs and existing systems. State coalitions, in most places, sprang up as these local centers banded together to pursue statewide and even national action. Local RCCs and state coalitions remain strong, independent voices today, supported by the work of national sexual assault organizations. The field's nationwide organizations support this individualized growth and do not attempt to make the work uniform.

To discuss trends, changes and growth in the field of rape crisis work, it is vital to have dialogue defining the field. This document is part of the conversation about defining sexual assault services. Rape crisis centers and state coalitions have evolved in unique circumstances, but there are commonalities across the field, and there is consensus on some important facets of providing sexual assault services. This document examines several states' sexual assault service standards to uncover similarities and differences in service provision across the country. State service standards help local rape crisis centers determine what services must be provided at a minimum, its core services. From this analysis of state standards, we can begin to see a national picture of which services make up the core services of a rape crisis center. This core looks slightly different in each state, but there are striking consistencies in core services across this sample.

Terminology

Rape crisis centers are agencies whose major purpose is providing victim advocacy and support services to sexual violence survivors. They may be attached to a domestic violence shelter or other social service agency, and they may provide more services than the core, but their focus is on supporting survivors and eradicating sexual violence. RCCs have different names or descriptors ("sexual assault services" as one example) but this document will refer to them as rape crisis centers or RCCs for consistency. Services based in law enforcement, courts or hospitals are not included as RCCs as their goals and methods differ considerably from the work considered in this report.

In many states, *state service standards* dictate what services rape crisis centers (RCCs) in that state provide, the way services are provided, and/or who qualifies to provide service to sexual violence survivors. Many, but not all, states and territories have created state service standards to outline what services must be offered and how they must be provided. In most cases, adherence to standards allow RCCs be recognized as a sexual assault service provider and receive benefits through the coalition or state government offices. The level of benefit varies by state, and in some cases includes eligibility for funding.

At the state level, *sexual assault coalitions* often serve as membership associations for local services providers, and also often advocate for improvements in laws, services, and resources for survivors of sexual violence and their service providers. Each state and territory has a sexual assault coalition (some are combined with their domestic violence coalitions).State sexual assault coalitions coordinate statewide work and provide training and technical assistance to member rape crisis centers. State coalitions function as public policy advisors and provide guidance to organizations assisting sexual assault victims; additionally, some manage contracts or pass funding through to local rape crisis centers. Many coalitions oversee service standards for member centers; the nature of the service standards varies according to the function of the coalition. Coalitions with a stronger governance or regulatory function tend to have more detailed or stringent service standards. Coalition governance structures and outside influences shape the development of the service standards. Representatives of member centers govern some coalitions, while others have community boards with member center advisory committees or specific seats for member centers. In many states, such as Iowa, the RCC representatives wrote the service standards. In other states, such as California, the standards come from a state office. In some cases, standards written by the coalition are then adopted by funding entities. The relationship between coalition and member centers, state regulations, and other funder requirements play a strong role in the development of each state's services and service standards.

Core services are the essential services, the services that define an RCC as an RCC. Without these services, the agency would not be a complete RCC. There is consensus throughout the field on many indispensable features and services provided by RCCs, and those emerge in these definitions. Services such as advocacy and crisis intervention emerge as necessary, or core, services. Many other services are also important, but their presence or absence does not change the agency's fundamental identity as a sexual assault services provider. These additions to the core services are considered *enhanced services.* This analysis of state service standards details what services and methods are widely seen as core to the rape crisis center, and what services may be considered enhanced to those core areas.

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Method

The only documents under consideration in this report are state service standards. There is other documentation and dialogue in the field about the definition and nature of RCCs but this is not included here. RCCs may use many different sources and perspectives to arrive at their core services and self-identity, with the state standards providing only one perspective. This report is an attempt to synthesize the core services and characteristics of RCCs as defined by state sexual assault coalitions. For this report, the National Sexual Assault Coalition Resource Sharing Project collected and analyzed services standards from fifteen states: California, Connecticut, Florida, Iowa, Idaho, Illinois, Kentucky, Missouri, New Hampshire, North Carolina, Oregon, Pennsylvania, Vermont, Washington, and West Virginia. All the standards in the sample came from state coalitions, with the exception of California, North Carolina, Washington, and Kentucky. Standards from those four states came from state regulation or law. It is unknown what role the state coalitions played in shaping the service standards in those states.

This document recognizes services to be core when the standards explicitly require the provision of that service or attribute. Services are considered enhanced when the standards explicitly make provision of that service optional or when there is no clear mandate. States may disagree on whether a service is core or enhanced. The purpose of this document is to illustrate what services the field views as core or enhanced, and where the field concurs on core services. On any given service in this document, if all the state service standards mandate provision of service it is found that there is consensus on that service being a core service. If a clear majority, but not all, of the standards mandates a service, the service is identified as a common theme or it is generally considered core. Where there is no clear majority or agreement, it is found that there is no consensus among the sample.

Many states use different terms for similar services. Where the tasks and activities of different terms are clearly similar, as in the case of institutional advocacy and systems advocacy, they are combined for analysis. In some cases, this is difficult to determine. These issues are discussed in the service analysis and noted in the core service chart.

This report is an attempt to synthesize the core services and characteristics of RCCs as defined by state sexual assault coalitions.

Rape Crisis Center Service Philosophy

For all the standards examined in this sample, the understanding of or approach to sexual violence is grounded in social justice. The language about social justice is sometimes subtle, sometimes overt, but it is an underlying theme to the RCC approach to sexual assault. Many traditional mental health treatments and social work practices are based in the medical model of diagnosing problems and treating symptoms. The social justice-based models of intervention that grew out of the anti-violence movement hold that clients are inherently well people, but it helps to get some support after a devastating event such as violence. There is wide variation of social justice models used in the standards for rape crisis centers (RCCs), but few standards omitted a theoretical framework for understanding sexual violence. The service standards examined have sections on philosophy, approach, guiding principles or ethics that used terms like "empowerment," "victim-centered," "without blame," or "trauma-informed." Some go further in defining a framework for understanding sexual violence, trauma, and working with survivors in specific standards on advocacy and intervention practices. Missouri begins their service standards with guiding principles, including, "Violence against women is rooted in the institutional imbalances of power between men and women, in sex-role stereotyping, in gender based values and in misogyny" (Missouri Coalition Against Domestic And Sexual Violence [MCADSV], p. ii). The topic requirements in training curricula most clearly revealed certain values, even in states with less value-laden overall standards. The values of self-determination, autonomy, and fully informed choice are visible in the expectations surrounding documentation, client consent, grievances, and information and referral services. One state in the sample requires first responders to be female; a few more expressed a preference for females but did not have mandates.

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Service to sexual violence survivors is one of the primary functions of RCCs, so a definition of sexual violence survivor is required to know whom to serve and whom not to serve. The majority of the sample did not have a detailed client definition section, but referred to "primary and secondary victims" of sexual violence or assault (Connecticut Sexual Assault Crisis Services, Inc. [CONNSACS], p. 2; Florida Council Against Sexual Violence [FCASV], p. 1) ,"sexual assault victims" (California Governor's Office of Emergency Services [OES], p. 1), or simply, "clients" (Idaho Coalition Against Sexual And Domestic Violence [ICASDV] p. 1). No state asks for evidence or corroboration of sexual assault, and some assert that staff and volunteers must treat all clients as credible. Here are two examples of detailed client definitions:

> A contractor shall identify an individual as a client if the individual is a victim of sexual violence, requests services from the center, and if the center opens a case file that contains a PW-652 form, a service plan, and case notes. A significant other shall be defined as an individual of any age, other than the victim, who has been affected by sexual violence, who requests service from the center and receives such service. A significant other includes a parent, guardian, spouse, partner, sibling, child, and/or close personal friend of a victim of sexual violence. The contractor shall provide crisis services to the community served. Crisis not only includes the victimization incident, but also recent memory, disclosure, triggering event, or any legal proceeding or involvement. (Pennsylvania Coalition Against Rape [PCAR], p. 13)

and

> "Client" – In the case of counseling, a person generally becomes a client when the center has gathered enough information to assign a client identification number or the person seeks additional services from the program subsequent to crisis intervention services. In the case of advocacy, a person generally becomes a client when the center provides telephone or in-person advocacy services related to medical care or reporting to law enforcement. "Victim" – Any person of any age who seeks assistance after being sexually assaulted. The sexual assault survivor is referred to as victim throughout these standards because the focus of services is based upon the victimization she has experienced. "Significant others" – Significant others also feel the impact of sexual assault and these standards also apply to services provided to significant others. A significant other is any person of any age who seeks assistance in dealing with their own crisis/feelings as a result of the sexual assault of a loved one... (Illinois Coalition Against Sexual Assault [ICASA], p. 5-3)

No state put limitations on service related to timing or type of sexual assault. That is, survivors do not need to seek services within a certain window to be eligible. Some states are more explicit in this than others. Though every state is clear about serving adults who have been sexually assaulted, there are differences in service to other clients, e.g. children and significant others/secondary victims.

Children. There is a wide deviation in the expectations and standards of service provision to children. Some standards do not broach the subject at all, some require programs to serve adults and children, and some require programs to serve teenagers, but not children less than thirteen years of age. Some states serve teenagers thirteen and over with the same services given to adults, but RCCs must meet additional requirements in training, facilities, and services to serve children under thirteen. Some states encourage relationships with Child Advocacy Centers or other community service providers, while others do not. Some child-related state service standards are heavily influenced by state regulation or law or funder requirements concerning any social services to children. There is no clear consensus on service to children.

Significant others/secondary victims. There is variation regarding the amount of discussion on services to significant others, ranging from no direction to detailed regulation on what services significant others may receive. No state barred or discouraged serving significant others. At minimum, most encourage crisis intervention or information and referral for significant others and some allow for or encourage full services to significant others, especially those of child victims. Thus it can be determined that service to significant others is a generally agreed upon as a core RCC service.

24-hour Crisis Intervention

This was the category with perhaps the most varied definitions and services. A good working definition comes from Florida: "a timely response by a trained staff member or volunteer to an individual presenting a crisis related to sexual violence…to reduce the level of trauma experienced as a result of sexual violence by assisting victims in strengthening their coping skills through empathic response." It is "short-term; may be episodic" and may include "information about the effects of sexual violence and possible reactions; general information about medical and legal issues; offering advocacy and information about other services available in the community; active listening and empathic responding; exploring options; and, referral to 24 hour sexual violence hotline" (FCASV, p. 3). California has a unique requirement for centers to attempt to turn hotline contacts into regular clients:

Centers must offer to contact all clients within 3 working days after providing crisis intervention services and shall do so when appropriate and/or according to the needs of the client…A minimum of 45 % of clients receiving crisis intervention services must receive follow-up counseling services. An attempt to provide this service for each client is required (OES, p. 2).

Advocacy is "supporting and assisting a victim/survivor to define needs, explore options, and ensure rights are respected."

Telephone. All states in the sample consider a 24-hour hotline a core service. States have many clear requirements on availability, the maximum allowable time lapse between initial contact and connection with the agency if using an answering service, plans for hotline failure, training, and other facets. Even states with austere regulations on other issues have detailed hotline requirements.

In-person. Provision of in-person crisis intervention is detailed in only a few places, and often conflated with other services, such as counseling or medical advocacy. A distinction of in-person crisis intervention as a separate service may be superfluous.

Medical Advocacy

Broadly speaking, advocacy is "supporting and assisting a victim/survivor to define needs, explore options, and ensure rights are respected within any systems with which the victim/survivor interacts" (NHCADSV, p. 48). The level of detail here varies considerably. Some standards discuss advocacy only in the context of emergency care, while other states allowed for a wider range of advocacy tasks. Washington, for example, defines medical advocacy as:

> Acting on behalf of and in support of victims of sexual abuse/assault on a 24-hour basis to ensure their interests are represented and their rights upheld… To assist the victim to regain personal power and control as s/he makes decisions regarding medical care and to promote an appropriate response from individual service providers. [It] may vary significantly depending upon client's medical needs as related to the sexual assault. All activities and services are client-focused and case specific…[including] assistance in making informed decisions about medical care and the preparations needed, including referral for possible forensic exam; information about medical care/concerns, including assistance with needed follow-up; support at medical exams and appointments, and; information and/or assistance with Crime Victim Compensation applications (Washington Office of Crime Victim Advocacy [OCVA], p. 4).

Illinois explains:

> The advocate provides in-person support and information to sexual assault victims at medical facilities. With victim permission, the advocate stays with the victim throughout the exam and evidence collection process and provides follow-up services and referrals. The priority of the advocate is with the victim, not the medical facility…Individual medical advocacy services include telephone and in-person contacts with sexual assault/abuse victims and their non-offending significant others and contact with emergency room or other medical personnel regarding medical issues as related to the sexual assault/abuse. Services include provision of information and resources regarding the victim's rights and options regarding follow-up services. Medical advocacy also includes corresponding with the victim or medical personnel regarding specific concerns about the victim's case (ICASA, p. 5-15).

Accompaniment. Many states differentiate accompaniment from advocacy, consider it a task within the umbrella of advocacy, or require programs to provide only accompaniment (but not ongoing advocacy). The intention of the states that use the term accompaniment seems to be the activity of providing emotional in-person support/supportive presence to survivors during medical exams, police interviews, and other legal processes (though most often in medical exams). However, in all cases, the line between accompaniment and advocacy is unclear or not defined. For the purposes of this document, accompaniment is a task under the umbrella of advocacy services.

Legal Advocacy

Again, advocacy is "supporting and assisting a victim/survivor to define needs, explore options, and ensure rights are respected within any systems with which the victim/survivor interacts" (NHCADSV, p. 48). The level of detail here varies considerably, though some level of legal advocacy is generally considered a core service. Expectations run from providing legal referrals to substantial involvement in supporting survivors through legal proceedings. There is generally more detail and focus on medical advocacy than legal advocacy across the sample. Legal advocacy focuses largely on law enforcement and criminal justice proceedings, though most states allow for information and referral on civil matters. New Hampshire's definition of advocacy includes "24-hour access to law enforcement accompaniment…ongoing criminal justice system support…accompaniment for criminal sexual violence, domestic violence and stalking cases, referral to legal services…and information and referral on related civil processes" (NHCADSV, p. 27). Advocacy (and accompaniment) in West Virginia:

> facilitates the client's interaction with law enforcement and the criminal justice system through support, information, referrals, and requested accompaniments to any investigations, interviews, court hearings, and other proceeding related to the sexual victimization [to] assist the individual in receiving dignified, victim-centered treatment within the law enforcement and criminal justice system as it relates to sexual victimization (West Virginia Foundation for Rape Information and Services [FRIS], p. 6).

General Advocacy/ Other Advocacy/Case Management

The majority of the states in the sample focus only on medical and legal advocacy, but a few attend to other advocacy issues. This is a murky point because the issues covered under general advocacy in one state may be considered information and referral in another state or medical/legal advocacy in yet another, and most are not detailed. Iowa, in one of the few detailed examples of general advocacy, calls for:

> a written plan for providing ongoing advocacy to assist sexual assault victims in meeting their additional needs in accessing services not provided by the program, including but not limited to legal services; housing (transitional, temporary, permanent); financial assistance; mental health services; alcohol and other drug treatment and recovery programs; immigration assistance; healthcare; employment; and parenting assistance (Iowa Coalition Against Sexual Assault [IowaCASA], p. 31).

Pennsylvania simply defines all advocacy as "[facilitating] the client's negotiation of the different systems encountered as a result of being impacted by sexual violence" (PCAR, p. 14). There is a further directive to provide accompaniment, but this directive does not confine services in any way.

Counseling/Therapy

The states in this sample do not all consider provision of counseling or therapy a core service. Crisis intervention and short-term counseling are deemed core much more often than therapy is. Definitions of crisis intervention, counseling, and therapy vary quite a bit. Crisis intervention is usually separated from counseling, therapy and support groups in the standards, and is therefore separated here (see above for discussion of crisis intervention). Counseling or supportive counseling is usually described as short term, solution or action-focused and less intensive interventions and therapy is described as longer-term, more intensive and more in-depth intervention. Guidelines generally adhere to standard counseling practices, ethics, and theories; this is reflected in job descriptions, case plans, intervention modalities, and expectations of duration. Quite a few states considered counseling an enhanced service, requiring programs to have community referrals but not a staff counselor. Many more states consider short-term counseling core but therapy an enhanced or optional service. Some, like California, mandate access to longer-term counseling: "Centers must make long-term counseling services available. This means to provide the service or to make

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arrangements through other agencies or individuals" (OES, p. 3). A few have detailed guidelines for referring to therapists. Some states have superseding laws or regulations concerning licensure or education for all counselors; these are reflected in the respective sexual assault service standards. Illinois describes the difference between counseling and therapy:

> Sexual Assault Counseling is victim-centered counseling with the goal of supporting the victim's recovery process through listening, encouraging, validating, reflecting, giving resources, and providing a safe counseling environment. Sexual Assault Counseling is seen as working with the victim on current issues, normalizing and validating her reactions to the trauma and facilitating a return to pre-trauma functioning…Sexual Assault Therapy encompasses Sexual Assault Counseling and entails more in-depth, process-oriented work for adults or more experiential work for children. Sexual Assault Therapy is most often aimed at helping the victim identify longer-term life patterns and coping mechanisms, or established survival skills. Sexual Assault Therapy may work on more process-oriented internal changes. The goal of Sexual Assault Therapy is for the victim to be able to utilize the insight gained to promote healthy internal and external changes. Sexual Assault Therapy is typically (but not always) longer-term work (ICASA, p. 5-24—5-25).

Support Groups

Support groups are a different service than therapy, and different yet than therapeutic groups. Standards typically require a trained staff or volunteer to facilitate support groups. The few standards on therapeutic groups in this sample required Master's level counseling degrees for facilitators. Some of the standards on support groups also require a Master's degree for facilitators, indicating some overlap in the definitions of therapeutic and support groups. West Virginia defines support groups thusly:

> Individuals meeting in a safe, supportive, non-judgmental environment on a regular, scheduled basis to exchange information, share techniques for problem solving, and to explore feelings resulting from sexual violence. [The purpose is to] foster a sense of regaining control, promote an understanding of the effects of sexual violence, and assist with finding resolution concerning the sexual victimization (FRIS, p. 9).

Vermont directs centers to "offer support groups…whenever the program determines that support groups are an appropriate peer support strategy in their service area and there are a sufficient number of service users to form a group" (Vermont Network Against Domestic and Sexual Violence [Network], p. 10). Therapeutic groups are certainly an enhanced service. Like counseling and therapy, there is no consensus among the sample on whether offering support groups is a core service.

Information and Referral

Information and referral service standards describe how providers make referrals to other community services, and provide general information and resources about healing. The line between information and referral services and general advocacy is often blurry. In some states, where fulltime advocates and/or counselors may not be the norm, referral to community advocacy services or counseling services are held within the domain of information and referral services. A few states require annual updating of a resource and referral provider manual. Most require that more than one referral be given, and some had prohibitions or limits on referring to services provided by board members or volunteers. Connecticut stipulates what community services must be in the agency's resource listings, from counseling and dentistry to LGBTQ services and housing (CONNSACS, p.2).

Support groups "foster a sense of regaining control, promote an understanding of the effects of sexual violence, and assist with finding resolution concerning the sexual victimization."

Services directed at institutions, groups or the community as a whole, rather than individual survivors are grouped here as community services. Within community services, prevention education, community awareness, professional training, and institutional or systems advocacy are the most commonly described activities. The standards in the sample do not deem community services core as often as they do individual services. However, a community presence of some type can be considered an agreed-upon core service, whether it is through community education, public service announcements, or institutional relationships. Connecticut, for example, mandates "each member center will be an active community resource providing information, outreach, support, and training. In addition, each member center shall be actively involved in community-based committees regarding sexual abuse…" (CONNSACS, p. 3). Because these community services are not defined uniformly across the states, it is difficult to determine whether they are considered core across the sample. The divisions between these categories are generally unclear; there is little agreement on any distinct definitions of the tasks or categories within community services. Standards use terms like systems change, institutional advocacy, professional training, community awareness, prevention education, and social service advocacy to describe the services to institutions and communities. Outreach, social change, and activism are some other terms used under this umbrella. Further confusion arises from the fact that some states call individual criminal justice or medical advocacy with clients "systems advocacy." Prevention education is becoming a well-defined activity in the field, but there is still much overlap with community awareness or other terms in the state service standards. Notably, professional education and institutional advocacy do not necessarily go hand-in-hand; some states required one but not the other. Within all of these various definitions, there are common themes in service.

Prevention Education

There is great variation among the states on prevention education requirements. Within its prevention education standard, Pennsylvania differentiates presentations from training; presentations "inform the public" while trainings "develop skills" (PCAR, p. 15). Some states, such as Pennsylvania and Iowa, include systems change or social change advocacy as a task under prevention education. New Hampshire requires:

> Member programs shall develop and maintain relationships with schools and youth organizations to promote awareness of sexual violence, domestic violence, and stalking within their catchment area. Member program utilizes, at a minimum research or science based programs and curricula and whenever possible, evidence-based curricula and materials (New Hampshire Coalition Against Domestic and Sexual Violence [NHCADSV], p. 44).

Community Awareness

Idaho, like many states, requires community education to cover "The availability of agency services/resources related to sexual violence and victims' rights [and] the incidence, severity and dynamics of sexual violence, which may include local statistics" (ICASDV, p. 5). Other states, like North Carolina, mandate publication and provision of brochures and other written materials on services, community resources, and/or general sexual assault information (North Carolina Council for Women/Domestic Violence Commission [NC Council]). Some states refer to community awareness activities (which are somewhat conflated with institutional advocacy) as "social change," as in Washington:

> The agency/program advocates for social change by addressing community conditions which adversely affect sexual abuse/assault victims/survivors and with other organizations working toward the elimination of sexual violence…[demonstrated by] Written evidence that shows that the agency provides a mechanism for staff, volunteers, clients and their families to advocate for social change around sexual abuse/assault issues, both within the agency and in the community at large…Evidence that the agency participates (through membership or other evidence of involvement) in statewide and national groups to improve service for individual clients, identify gaps in service, advocate for needed change, and share training and other resources (OCVA, p. 11).

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Professional Training

Of the states that address professional training, most list it as a task under prevention education/community awareness or institutional advocacy, but a few pull it out as a separate task. Professional training in these states is normally directed at law enforcement, prosecutors, medical personnel, social service personnel, and other institutional allies. Illinois provides a typical definition of professional training: "the center provides in-depth education, skills building and evaluation of skills to prepare other professionals to effectively intervene on behalf of victims of sexual violence within their institutions" (ICASA, p. 5-31). Some states specifically identify medical and criminal justice personnel as targets of professional training, but most leave the audience for RCCs to determine.

Institutional Advocacy/Systems Advocacy/Relationships with Institutions

Advocating for change in the system responses to all (or large clusters of) sexual violence survivors, not individual cases, is an important component of anti-violence work. The mandated activities for institutional relationships generally include networking agreements and attempts to participate in Sexual Assault Response Teams, Multi-Disciplinary Teams, or community task forces of some sort. Most of the sample, however, leave the specific activities and targeted institutions to the individual center's discretion. California explains agency coordination: "Centers must establish themselves as active participants in local public and private service networks in order to provide for timely and comprehensive responses to sexual assault victims' needs" (OES, p. 5). Likewise, Florida cites the importance of a " a permanent, client-centered system which offers, or assures access to, a comprehensive continuum of core and enhanced sexual violence services, which is mutually accountable despite individual changes over time in regulations, procedures or people who provide services" (FCASV, p. 6). Illinois states that the work is "on behalf of all sexual assault victims to secure sensitive, effective policies and procedures for handling sexual assault cases. The needs and rights of victims rather than institutions are the priority of institutional advocacy" (IL, p. 5-29).

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The services provided to sexual violence survivors compose the quintessential defining features of rape crisis centers. However, the methods and structuring of service provision merit discussion here as well. These features provide additional insight and perspective into the work of RCCs.

Accountability. Accountability is not a core service, or a specific service or action, but is an essential feature of RCCs for a few important reasons. First, some federal, state, and local funders, licensing bodies, and other regulatory bodies require and/or reward good business practices and sound client service techniques. Demonstrating accountability and responsibility builds trust and respect in the eyes of community members and funders. Second, rape crisis work is a client-centered, survivor-driven field. One facet of client-centered service is transparent, responsible service, as seen in the provision of information on grievance procedures and client rights to all clients, or high training standards. In its "Principles of Service Standards and Guidelines," Missouri proclaims that "sexual violence programs are accountable to the survivors requesting or receiving services" (MCADSV, p.ii). Third, as a grassroots movement, advanced degrees or extensive traditional clinical experience are not often required of workers. Thus, state service standards are not based on an assumption of other, overriding conduct codes (although many direct workers to obey codes from applicable state and regulatory bodies) or training such as social work degrees and licensing. This has led to the genesis of sexual assault-specific training standards and conduct codes that hold workers and agencies accountable. A variety of tasks, products, and procedures evince RCC accountability, as illustrated in this sample of states. The level of accountability or evaluation for all the services varies considerably from state to state. New Hampshire's standards, for example, require that "the crisis line will be tested once per quarter and tests will be reported in the monitoring visit/report" (New Hampshire Coalition Against Domestic and Sexual Violence [NHCADSV], p. 25). Vermont requires, "programs will establish written principles or a written code of ethics for behavior of staff towards persons they service. The principles or code of ethics may not conflict with the [Vermont] Network's mission and principles" (Network, p. 6).

Initial Training. The amount of training workers (both employees and volunteers) must receive before interacting with clients varies widely across states, from fifteen to forty hours. There is also great variation in the window for completion of training. Some states require a portion of training before any direct-service contact with the remainder of training to be completed within a longer period, while others require the entire training to be completed before any direct-service contact. A few states had slight variations in training requirements based on the services provided (i.e. different topics are required to work on the hotline than provide advocacy, etc).

Continuing Education. These regulations also vary widely, though some amount is required in nearly all the standards. The enforcement mechanisms are largely unclear.

Supervision, Record Review, Counseling Plans, And Service Documentation. Much of this is consistent with generally accepted counseling practice. The collected standards vary widely in the amount of detail and structure provided. However, the emphasis on client-driven counseling plans is somewhat of an RCC specialty and is an important departure from classic mental health modalities. For counseling supervision and review, some states use a loose formula: everyone gets at least one hour of supervision per month, but this increases based on the amount of contact the worker has with SA survivors. Other states base supervision requirements on job title (e.g. counselors and therapists) or types of clients served (child therapists get different or more intensive supervision than adult therapists do).

Agency policies, procedures, by-laws are up-to-date and in force; agency uses good business practices. This is noted in most, though not all standards. Some have detailed guidelines, while the majority has simple directives.

Adherence to applicable state and federal laws, such as confidentiality, licensure, and mandated reporting. This is noted in most, though not all standards. The degree of detail varies widely, from a directive to follow applicable state law to detailed interpretation and guidance on application. A handful of standards include ethical codes or ethical guidelines; the standards more commonly direct programs to have their own written ethical guidelines. All the state standards emphasize the importance of confidentiality separately from other ethical or legal concerns (see below). The majority of the sample had no standards on educational degree requirements for employees. Those that did have requirements typically only covered degree requirements for therapists and counselors.

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Response times and usage of answering services or outside services. Many, though not all, have guidelines on response time for telephone and in-person crisis intervention; Iowa, for example, specifies response should be "within 15-30 minutes for urban and as soon as possible for rural" (IowaCASA, p. 30). Most states required a live person answer the crisis telephone, although there was wide variation in the allowable methods for receiving and responding to calls. A few states require TTY access explicitly.

Coverage for sexual assault clients in dual agencies. Many states cover the qualifications for providing service to sexual assault survivors in their training requirements or personnel requirements, but do not address the issues of service parity in dual domestic violence/sexual assault agencies. A few states, in recognition that almost all center staff is dual, mandate coverage specifically for sexual violence survivors. Iowa requires:

> A minimum of at least the equivalent of one full-time Certified Sexual Abuse Counselor must be employed by the Center. Only Certified Sexual Abuse Counselors will provide individual and group counseling to victims and training to staff and volunteers. Sexual Assault Crisis Centers are strongly encouraged to have two out of every five employees certified as Sexual Abuse Counselors. Any Sexual Assault Victim Counselor that is providing 25% or more time to sexual assault victims, regardless of years of experience or licensure, is required to be a Certified Sexual Abuse Counselor (IowaCASA, p. 47).

Idaho has several levels of services, but requires "all basic programs must have at least one staff person who meets the criteria for a 'Sexual Assault Crisis Advocate/Victim Advocate'" (ICASDV, p. 2)

Confidentiality. Policies may or may not clearly reference state code, but confidentiality is explicitly discussed in all policies reviewed. About half the sample supplies detailed guidelines on documentation, releases, allowable disclosures, and expectations for board, staff, volunteers, and clients (the other half had brief policies or referred the reader to documents not in this sample) Some emphasize confidentiality as a guiding principle.

Agency Identity. Several states mandate local agencies to promote themselves as the community sexual assault crisis agency (through networking agreements, PSA's, etc.) or require clear agency identification as a sexual assault service provider (e.g. using the words "sexual assault" or "rape crisis center" in publications or when answering the crisis line). This was not common enough to be considered an agreed-upon feature, but it is noteworthy. For example, West Virginia's standards require programs to:

> Publicize available services on a regular basis. Written documentation must be kept detailing communications. Incorporate a marketing mix such as press, radio, internet, and television in public relations campaign. Take the lead role in being the primary resource in the community for providing information about sexual violence. Network with a wide range of organizations/groups including business, religious, civic, educational, community, and other professional groups (FRIS, p. 14).

Cost. Many in the sample required all or some of the services to be provided free of charge. Only a few provided no guidance on this issue. The most common free services were crisis intervention, accompaniment, and advocacy; the most likely to be subject to a fee was counseling/therapy. In many cases, a number of free sessions (of any service) had to be provided before the center could assess a fee. The only cost allowed regarding the hotline in any of the sample was a toll for the call. However, many states require toll free hotline services, including toll free TTY access.

Cultural Competence, Anti-Oppression, and Non-Discrimination. Standards diverge in extent, placement, and language, but all specifically include some remarks on non-discrimination and diversity. The minimal message was simply a non-discrimination policy; the most comprehensive standards require specific training and/or require the profile of the board/staff to be representative of the local community. West Virginia and Pennsylvania have additional statements on religious non-affiliation. A handful of states also have HIV/AIDS-specific standards on non-discrimination and medically accurate information.

Other Noteworthy Activities and Features. Florida includes medical exams in its enhanced services, though the details are scant. Illinois allows for annual "advocacy forums" that are optional, and requires centers to provide an annual education and activism plan. California requires quarterly participation in SART or MDT meetings as well as other systems or institutional advocacy activities. California also requires annual "human relations" training on serving people who have been oppressed or experienced discrimination for all staff and volunteers. Washington allows for specific services and activities beyond core services that are directed at marginalized communities. A handful of states consider access to emergency or temporary housing a core service. Iowa includes multicultural outreach (which includes help with VAWA self-petitions and U-Visas), and transportation. Iowa also has a detailed ethical code for RCC workers. North Carolina's programs must reserve one seat on the board of directors for a sexual assault survivor (though disclosure of survivor status to the entire board and beyond is not mandated).

Synopsis of Core Services

This chart illustrates the services named core or required in the state service standards. Services considered core in each state are marked with an "X." In some cases, it is difficult to determine the level of requirement for a service, because the service definition is unclear (professional training, for example) or there is not clearly directive language. In those circumstances, the box is marked with a "+."The box is left empty in cases where services are clearly considered enhanced or are not addressed by the state.

Continuing Education hours were left blank if the standard did not refer to continuing education or left it unclear. Some services are excluded from this list because they are considered core in only a few states. Therapy, for example, is not considered core often enough to be included here but counseling is. (See discussion above for the distinction between counseling and therapy.)Crisis intervention includes 24-hour telephone hotline and other crisis services; see above discussion for more information on this category.

	CA	CT	FL	IA	ID	IL	KY	MO[1]	NC	NH	OR[1]	PA	VT	WA	WV
Initial training hours	40	30	30	20[2]	40	40	40	40	20	30	30	40	20	30	15[3]
Continuing ed. hours	12	4	6	12	20	6-12	8			6		6		12	8
Crisis intervention	X	X	X	X	X	X	X		X	X	+	X	X	X	X
Info & referral	X	X	X	X	X	X	X		X	X	+	X	X	X	X
General Advocacy	X	X	X	X	X	X	X		X	X	+	X	X	X	X
Medical Advocacy	X	X	X	X	X	X	X		X	X	+	X	X	X	X
Legal Advocacy	X	X	X	X	X	X	X		X	X	+	X	X	X	X
Counseling	X	X		X		X	X		X			X			X
Support Groups	X	X		X		X			X	X		X	X		X
Prevention [4]	X	+				X	X			X		X		X	X
Community Awareness [4]	X	X	X	X	X	X			X	X		X		X	X
Prof. training	+	+				X	X		X						X
Systems Advocacy	X	+	X	+		X				X		X		X	X

1 Missouri's Service Standards and Guidelines for Sexual Violence Programs has guidelines for crisis intervention/ 24-hour hotline, information & referral, general advocacy, medical advocacy, legal advocacy, professional therapy, and support groups, but does not explicitly require the provision of any of those services. The standards are directives for how to provide each service, if provided. Oregon's Self-Assessment Tool is similar, though the tool proclaims, "sexual assault (SA) services should provide emergency crisis intervention, advocacy and information services to adult and adolescent survivors of rape and sexual abuse" (OCADSV, p. 28).

2 Workers in Iowa are cross-trained with DV initially, and only eight of these twenty hours must be sexual assault-specific. Workers must obtain an additional 48 hours of sexual assault training within their first year of work.

3 Training standards currently under revision; initial training hours will be raised to 40.

4 The difference between these two was unclear or unaddressed in many states; the author used best judgment or combined the categories.

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