



Core Services & Characteristics of Rape Crisis Centers:

A Review of State Service Standards

Second Edition





By Kris Bein



**Resource Sharing Project
Rural Sexual Assault Services**

[http://www.resourcesharingproject.org/
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**Resource Sharing Project at the Iowa
Coalition Against Sexual Assault**

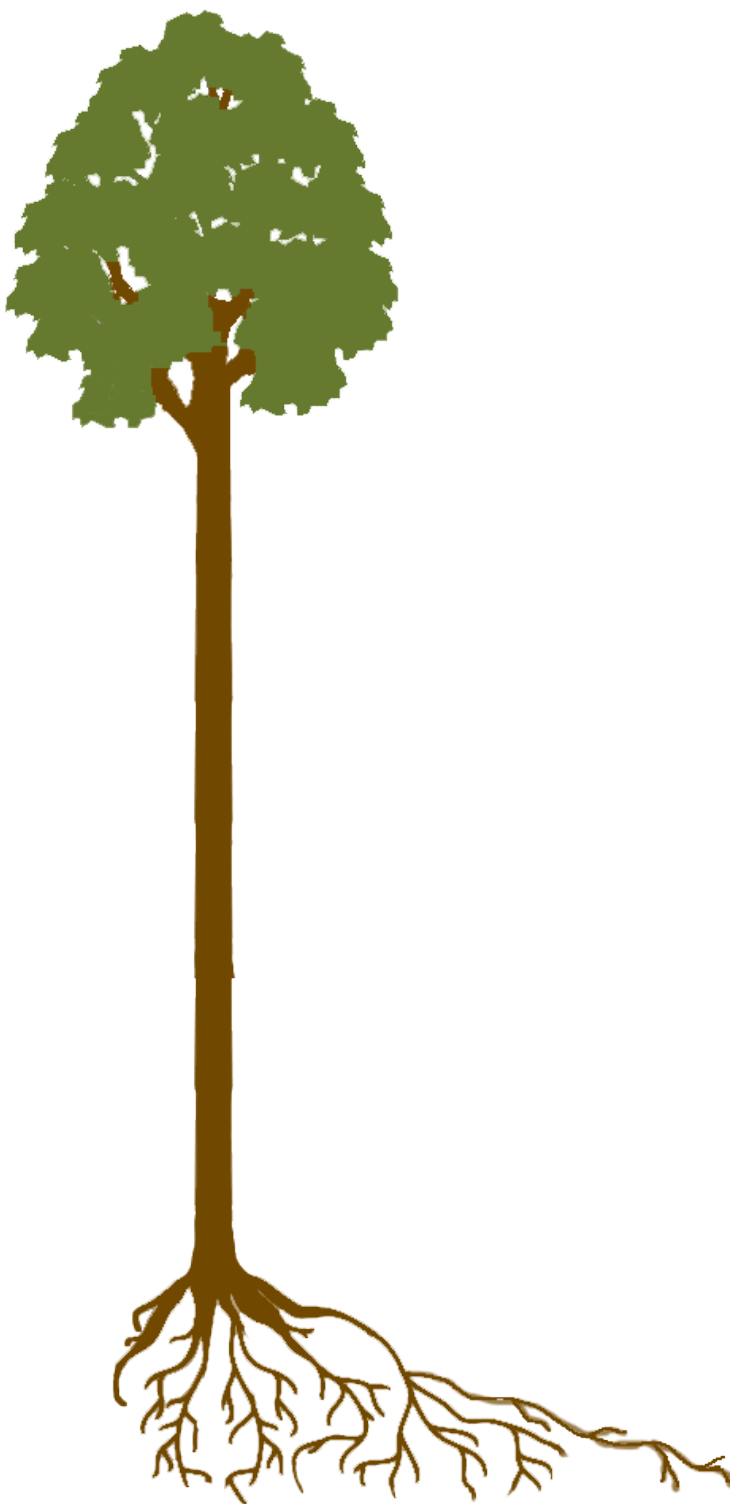
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Introduction

What is a rape crisis center? What makes rape crisis work different from other social work? Must rape crisis centers provide certain services to be a rape crisis center?

People have been organizing to serve victims of sexual violence for forty years. In at least 1,300 places across the country, communities have established rape crisis centers. Because these rape crisis centers 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 rape crisis centers and state coalitions remain strong, independent voices today, supported by the work of national sexual assault organizations. Although these 1,300 rape crisis centers and 56 state coalitions have evolved in unique circumstances, there are commonalities across the field of sexual assault services.

This document examines several states' sexual assault service standards to uncover similarities

and differences in sexual assault service provision across the country. State service standards help local rape crisis centers determine what services must be provided at a minimum: the core services. This analysis of state service standards details what services and methods are widely seen as core services of rape crisis centers, and what services may be considered supplemental to those core services or recommended practices. These core and recommended practices look slightly different in each state, but are strikingly consistent across this sample.

Rape crisis centers are community-based not-for-profit agencies whose major purpose is providing advocacy and support services to sexual violence survivors. They may be co-located with a domestic violence shelter or other social service agency; these dual/multi-service agencies often come together or merge their sexual violence and domestic violence services. RCCs may provide more services than the core, depending on resources and capacity. Whatever the context or capacity of an RCC, the fo-

cus 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.

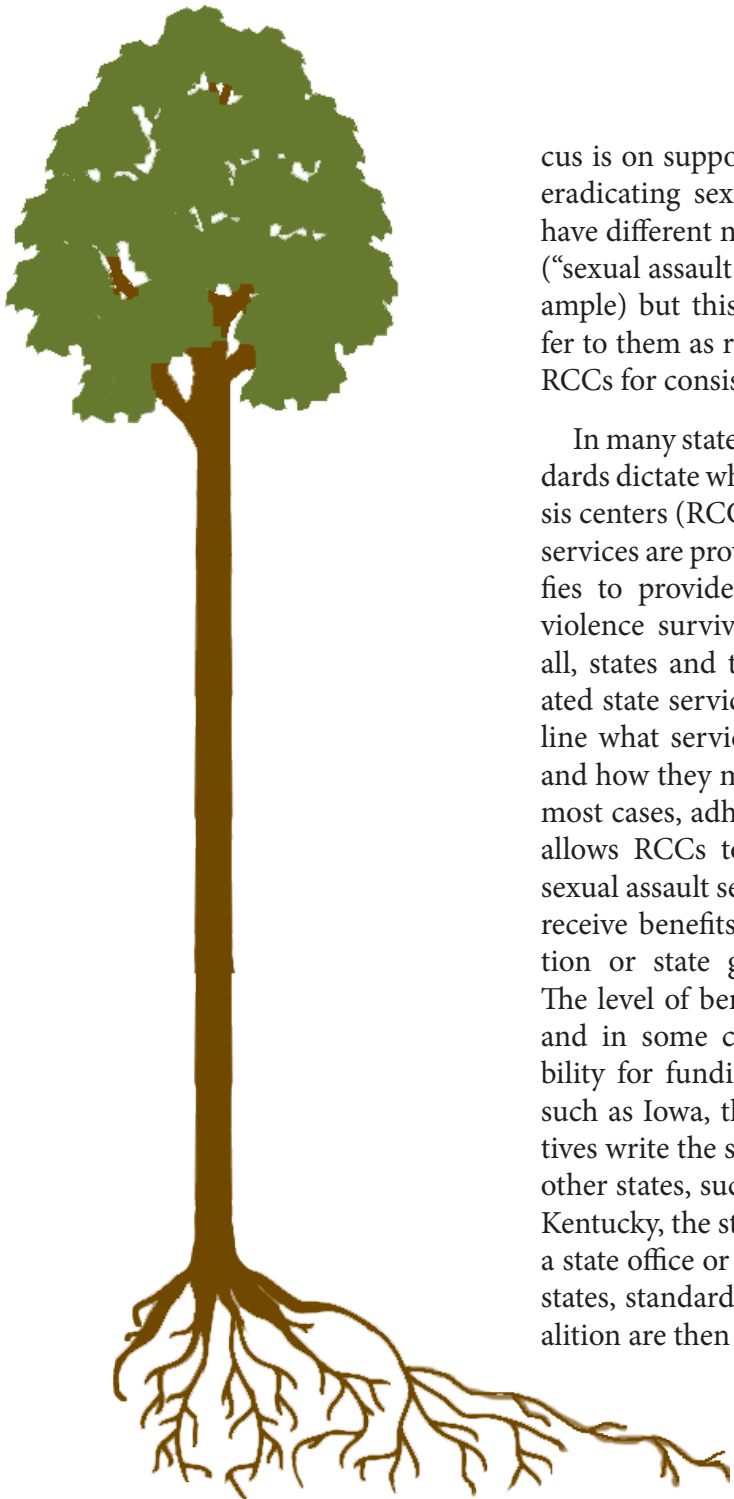
In many states, state service standards dictate what services rape crisis centers (RCCs) provide, the way services are provided, or who qualifies to provide services to sexual violence survivors. Many, but not all, states and territories have created state service standards to outline what services must be offered and how they must be provided. In most cases, adherence to standards allows RCCs to be recognized as sexual assault service providers 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. In many states, such as Iowa, the RCC representatives write the service standards. In other states, such as California and Kentucky, the standards come from a state office or legislation. In some states, standards written by the coalition are then adopted by funding

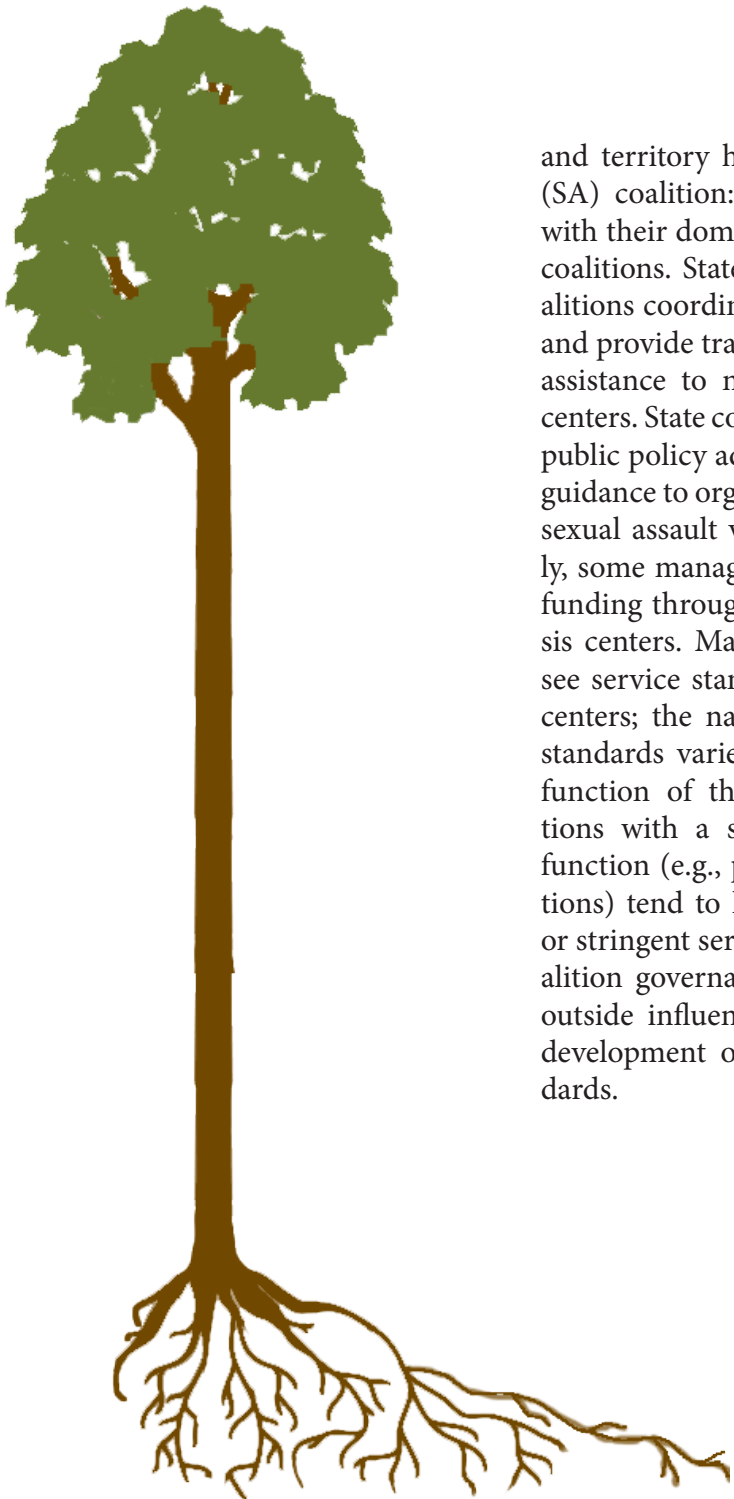
entities. The relationship between coalitions, RCCs, state regulations, and other funder requirements play a strong role in the development of each state’s services and service standards.

Core services are the essential services that make RCCs unique service providers. Without these services, the agency would not be a complete RCC. There is concurrence throughout the field on many indispensable features and services provided by RCCs, and those emerge in these pages. Services such as advocacy and crisis intervention emerge as necessary, or core, services. Supplemental services are also important, but their presence or absence does not change the agency’s fundamental identity as a sexual assault services provider. A center that provides all the core and supplemental services could be considered a comprehensive rape crisis center. In many states, the coalition or state administrative office provide guidance on how to provide supplemental services, but do not require the provision of such services.

For the purposes of this document, services are considered core when the standards explicitly require rape crisis centers to provide that service. Services are considered supplemental when the standards explicitly make provision of that service optional or when there is no clear mandate. Most states in this sample—whether through coalition requirements, state funding eligibility, or state law—explicitly require the provision of certain services to sexual violence survivors. What is required or optional varies by state, but some clear themes in service emerge in this review. In a few cases, the state standards serve as a best practice guide, but do not place any requirements on their RCCs. Rather, these standards tell RCCs how to provide a service, if the RCC chooses to provide that service. In these cases, we consider all of the services to be supplemental in that state.

Sexual assault coalitions are membership associations for local services providers, and often advocates for improvements in laws, services, and resources for survivors of sexual violence and their service providers. Each state





and territory has a sexual assault (SA) coalition: some are merged with their domestic violence (DV) 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 regulatory function (e.g., pass-through coalitions) tend to have more detailed or stringent service standards. Coalition governance structures and outside influences also shape the development of the service standards.

Method

There is much documentation and dialogue in the field about the function and nature of RCCs. RCCs use many different sources and perspectives to arrive at their services and self-identity, with the state standards providing only one perspective. State service standards are the best record of official statewide definition of sexual assault services. This report investigates state service standards to discover the field's definitions of the core services and characteristics of RCCs. This is not a scientific study, but a compilation of information from the field. It is a view into the service standards of 20 states, as they were in 2012.

For this report, the National Sexual Assault Coalition Resource Sharing Project sent a request for service standards to all 56 state and territorial sexual assault coalitions. Over the course of a six-month collection period, twenty-three states responded; no territory responded. Of the twenty-three responses, two reported that they did not have service standards in their state, and twenty >> >> provided service standards. One reported that their standards

are going through a major revision and are not available at this time.

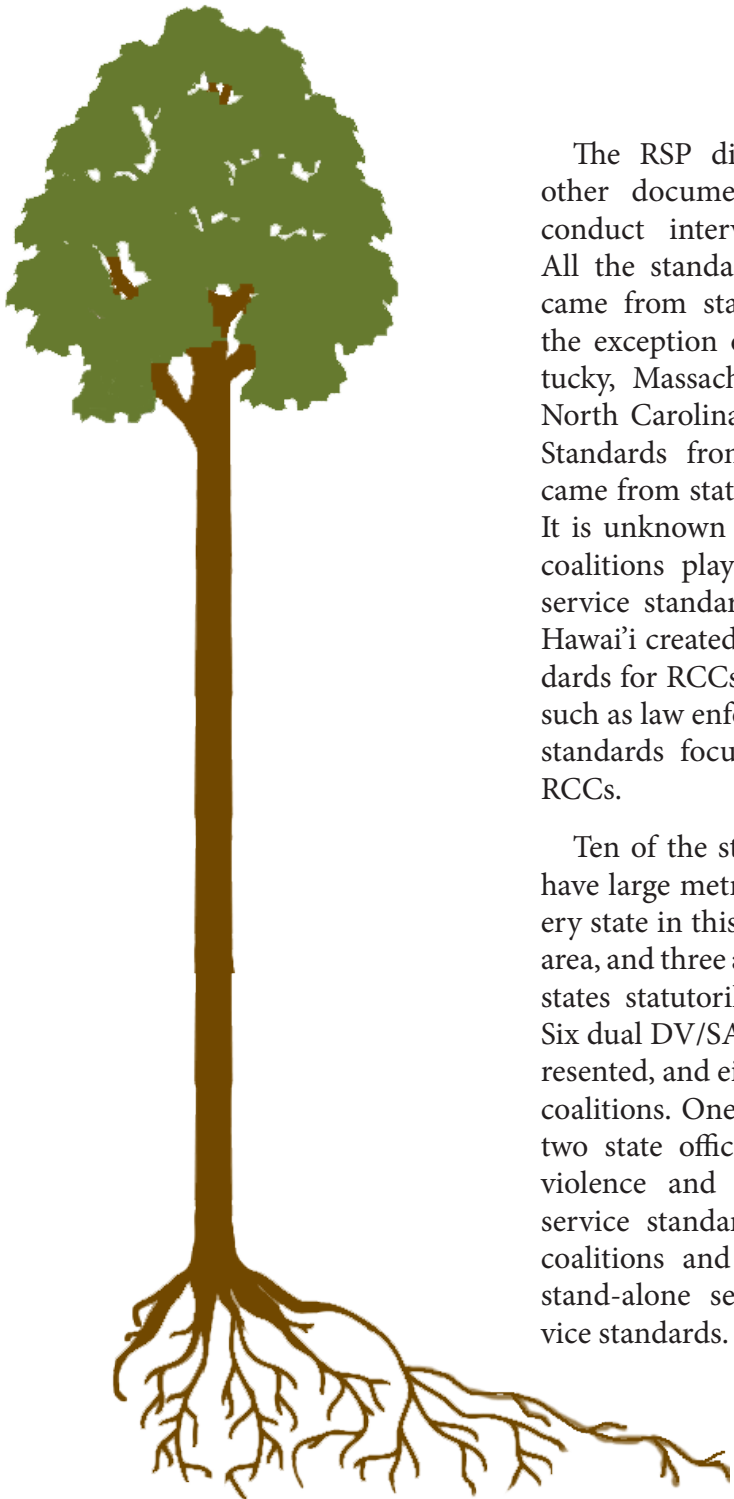
RSP staff read and analyzed services standards from:

- California
- Connecticut
- Florida
- Hawai'i
- Iowa
- Illinois
- Kentucky
- Massachusetts
- Michigan
- Missouri
- Nebraska
- New Hampshire
- New York
- North Carolina
- Oregon
- Pennsylvania
- Tennessee
- Vermont
- Washington
- West Virginia

The RSP did not collect any other documents, and did not conduct interviews or surveys. All the standards in this sample came from state coalitions, with the exception of California, Kentucky, Massachusetts, New York, North Carolina, and Washington. Standards from those six states came from state regulation or law. It is unknown what role the state coalitions played in shaping the service standards in those states. Hawai'i created best practice standards for RCCs and other systems such as law enforcement. All other standards focused exclusively on RCCs.

Ten of the states in this sample have large metropolitan areas. Every state in this sample has a rural area, and three are designated rural states statutorily through VAWA. Six dual DV/SA coalitions are represented, and eight stand-alone SA coalitions. One dual coalition and two state offices combine sexual violence and domestic violence service standards; all other dual coalitions and state offices have stand-alone sexual violence service standards.

This paper will explore the themes, commonalities, and divergences in this sample's service standards to help us understand how the field thinks about core and supplemental services. In this review and analysis, all references to states or service standards refer only to the service standards examined in this review. Many states use different terms for similar services. Where the tasks and activities of different terms are clearly similar, as is the case of institutional advocacy and systems advocacy, they are combined for analysis. In some cases, this is difficult to determine. These issues, and more, are discussed in the analysis of themes. The chart at the back summarizes the core and supplemental services defined by this sample of service standards.



Snapshot of RCC Services

Crisis Intervention

“A timely response...to an individual presenting a crisis related to sexual violence.” (Florida Council Against Sexual Violence)

- Active listening, empathy
- Teach or reinforce coping skills
- Reduce current trauma symptoms
- Provide information

Support Groups

“[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” (West Virginia Foundation for Rape Information and Services).

- Groups exchange information, share techniques for problem solving, and explore feelings
- May be run by advocates or counselors
- May be curriculum-based; open or closed; short-term or ongoing

Advocacy

“Supporting and assisting a victim/survivor to define needs, explore options, and ensure rights are respected within any systems.” (New Hampshire Coalition Against Domestic and Sexual Violence)

- Medical
- Legal
- Accompaniment
- General

Counseling & Therapy

“Supporting the victim’s recovery process through listening, encouraging, validating, reflecting, giving resources, and providing a safe counseling environment.” (Illinois Coalition Against Sexual Assault)

- Education/explanation
- Exploring options
- Trigger plans
- Planned interventions and goals
- Use of specific modalities and techniques

Institutional Advocacy/ Systems Change

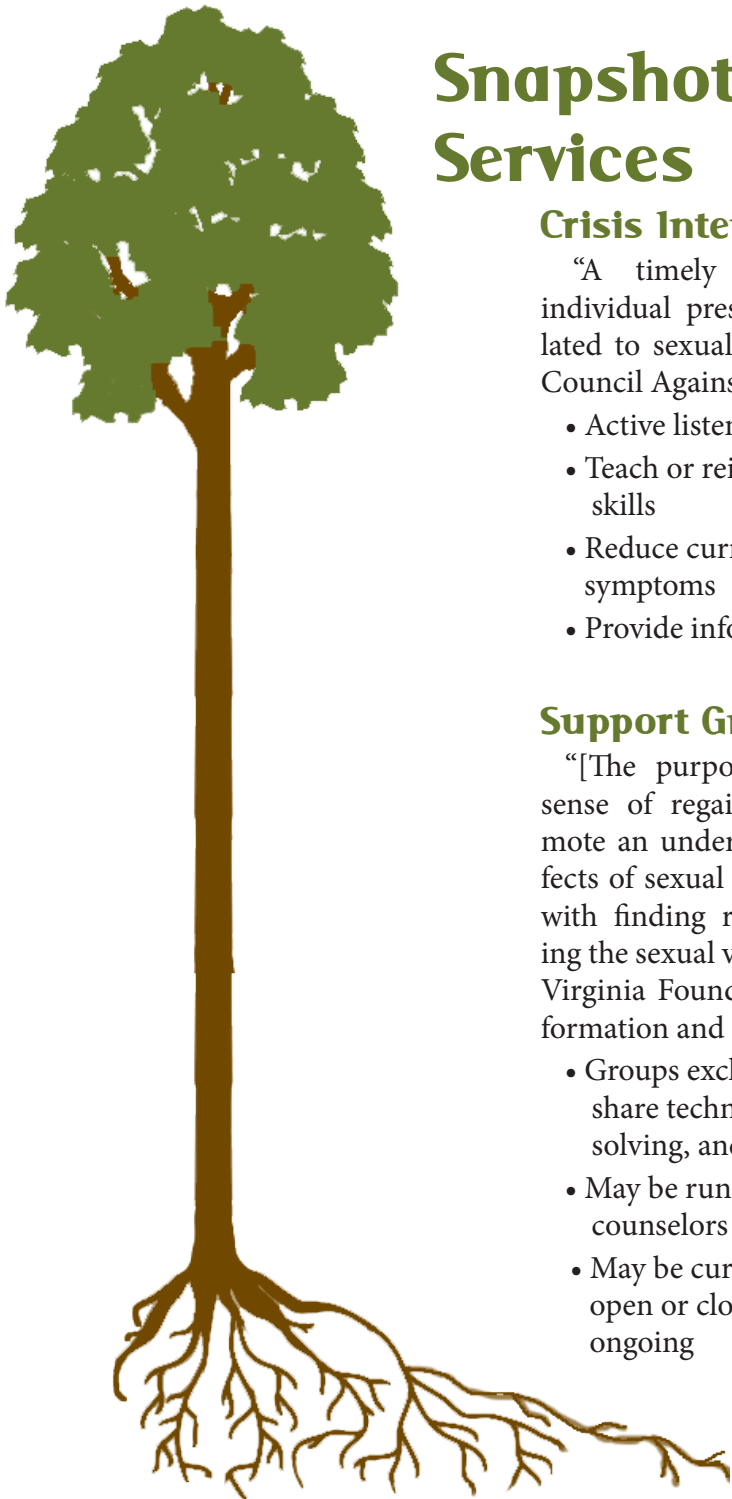
“The agency advocates for social change by addressing community conditions which adversely affect sexual violence victims/survivors and with other organizations working toward the elimination of sexual violence.” (Washington Coalition of Sexual Assault Programs)

- Advocating for groups of survivors, not specific survivors
- Professional training
- Community task forces (SARTs, etc)

Prevention & Awareness

“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.” (Connecticut Sexual Assault Crisis Services, Inc.)

- Community awareness events
- Prevention Education programs



Information & Referral

“A source for information and referral for victims, significant others, and the community on sexual assault...[with] an updated resource system for staff and volunteers” (Tennessee Coalition to End Domestic and Sexual Violence)

- Referrals to other community service providers that can support survivors
- Information to the public on sexual assault and sexual assault services

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 a strong 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 model of intervention holds that clients are inherently whole, strong people who are not at fault, but who might benefit from support after sexual violence.

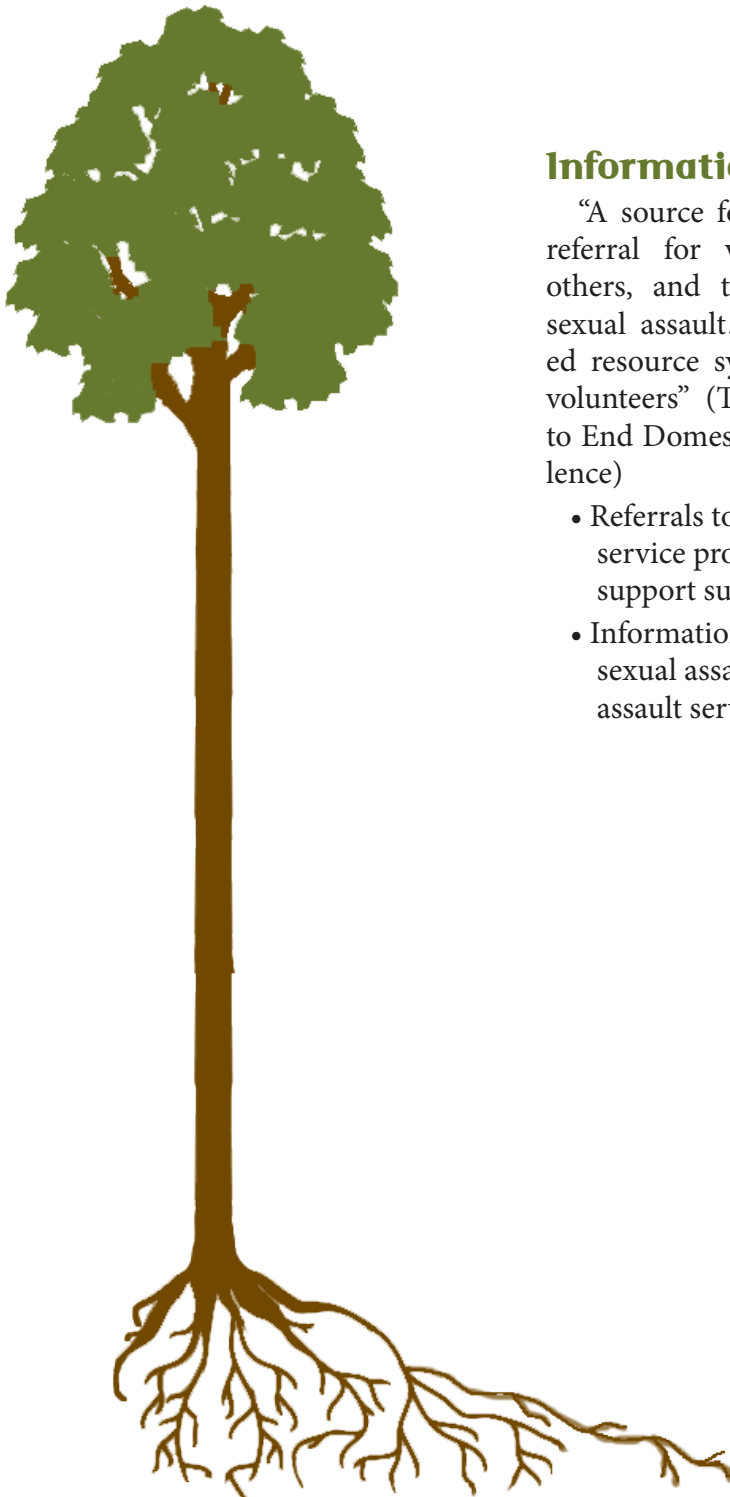
There is variation of social justice models used in the standards for RCCs, but very few of the standards omitted a theoretical framework for understanding sexual violence. The service standards examined all have sections on philosophy, approach, guiding principles, or ethics that used terms like “empowerment,” “victim-centered,” “without blame,” or “trauma-informed.” Some go further in defining a framework for under-

standing 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 Nebraska Domestic Violence Sexual Assault Coalition begins their standards with this instruction:

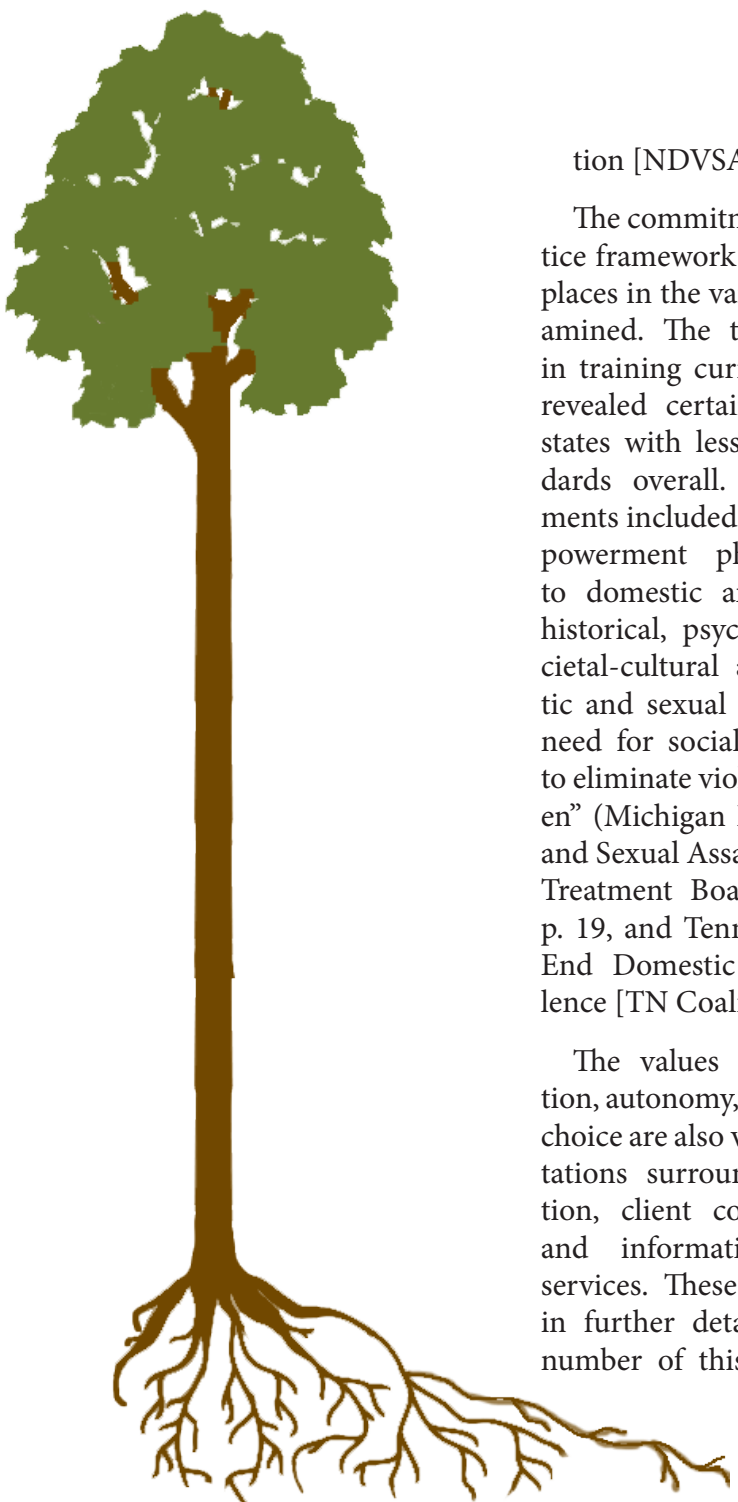
“It is important for programs to use an empowerment model for service provision that actively supports each individual’s right to self-determination. We seek to empower those we serve with accurate information” (Nebraska Domestic Violence Sexual Assault Coali-



tion [NDVSAC], p. 1).

The commitment to a social justice framework shows up in many places in the various standards examined. The topic requirements in training curricula most clearly revealed certain values, even in states with less value-laden standards overall. Training requirements included such items as “empowerment philosophy specific to domestic and sexual assault; historical, psychological, and societal-cultural aspects of domestic and sexual violence” and “the need for social change necessary to eliminate violence against women” (Michigan Domestic Violence and Sexual Assault Prevention and Treatment Board [MDVSAPT], p. 19, and Tennessee Coalition to End Domestic and Sexual Violence [TN Coalition], p. 13).

The values of self-determination, autonomy, and fully informed choice are also visible in the expectations surrounding documentation, client consent, grievances, and information and referral services. These will be discussed in further detail below. A good number of this sample expressly



discussed the gendered nature of violence, typically using terms like “violence against women” in philosophy and service. One state in this sample requires first responders to be female; a few more express a preference for females but did not have mandates.

Nobody exists outside the context of their culture or life experiences. Every day, we each have different experiences and struggles with various forms of oppression: racism, classism, homophobia,

able-ism, and the like. These experiences of oppression shape our worldview, and the world’s view of us. They also shape our access to resources and systems. Sexual violence happens in this context of real people’s lives. Most of the standards address anti-oppression work to some degree in their guiding principles, ethical codes, or other sections. More specific direction on anti-oppression work and cultural competence is discussed below.

Snapshot of Common Philosophies

- **A Social Justice Approach:**
 - **Victim-centered**
 - **Anti-oppression**
 - **Empowerment**
- **Specifically trained workers**
- **Free**
- **Maintain Community Presence**
- **Support survivors’ choices and ability to control life**
- **Provide services to ALL survivors**
- **24-hour access**
- **Confidential Services**

Survivors

Service to sexual violence survivors is one of the primary functions of RCCs. To know whom to serve and whom not to serve, a definition of sexual violence survivor or RCC client is required. First, let us discuss the word “client.” This sample was about evenly split on use of the term “client.” Many in the field feel that “client” belongs to the traditional medical model or the business world. Others find it a linguistically simple way to describe the survivors of violence and significant others to whom we provide professional services. Others prefer “service recipients.” No standards in this sample have adopted the currently preferred term in mental health services, “consumers.” Here, we will use “client” and “survivor” interchangeably, however “client” is used more often as it encompasses significant others and survivors.

The majority of this 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), or “sexual assault victims” (California Governor’s Office of Emergency Services [OES], p. 1).

Massachusetts directs programs to serve:

Adult and adolescent survivors of any form of sexual assault including sexual harassment, sexual threats and intimidation, rape, attempted rape, incest, sexual assault by intimate partners, child sexual abuse, sexual exploitation, sexual trafficking, starling, and other forms of unwelcome or coerced sexualized activity (Sexual Assault Prevention and Survivor Services, Massachusetts Department of Public Health [SAPSS], p. 6).

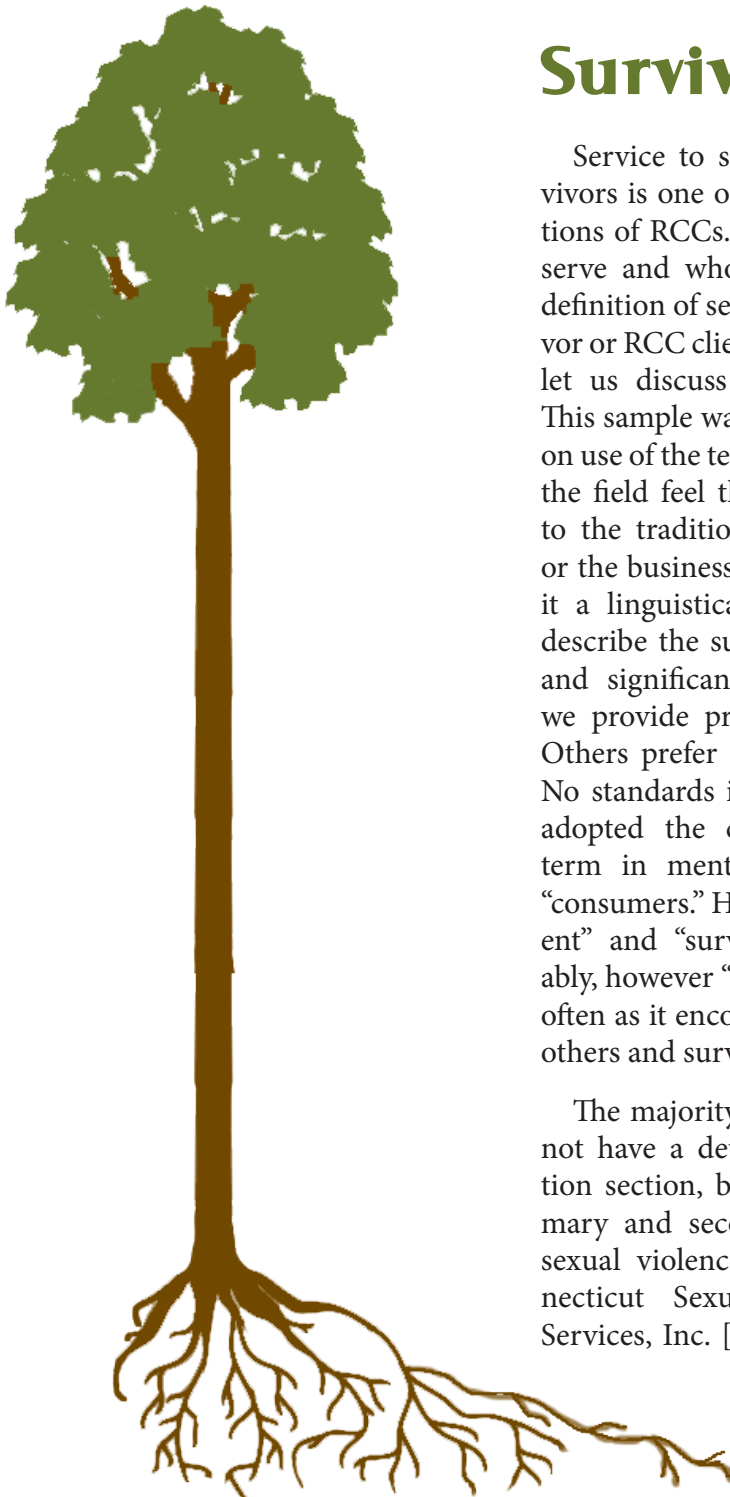
The Pennsylvania Coalition Against Rape requires:

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. 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)

Finally, the Illinois Coalition Against Sexual Assault determines:

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 (Illinois Coalition Against Sexual Assault [ICASA], p. 5-3).

None of the standards ask for evidence or corroboration of sexual assault; some assert that staff and volunteers must treat all clients as credible. No state put limitations on services related to timing or type of sexual assault. That is, survivors do not need to seek services within a certain window of time after the assault to be eligible for services. Some states are more explicit in this than others are. Though every state is clear about serving adults who have been sexually assaulted, there are differences in whether services are offered to other clients: children and adolescents, significant others/secondary victims, and survivors who perpetrate violence.

Children

There is a wide variation 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. Tennessee, for example, mandates programs to have

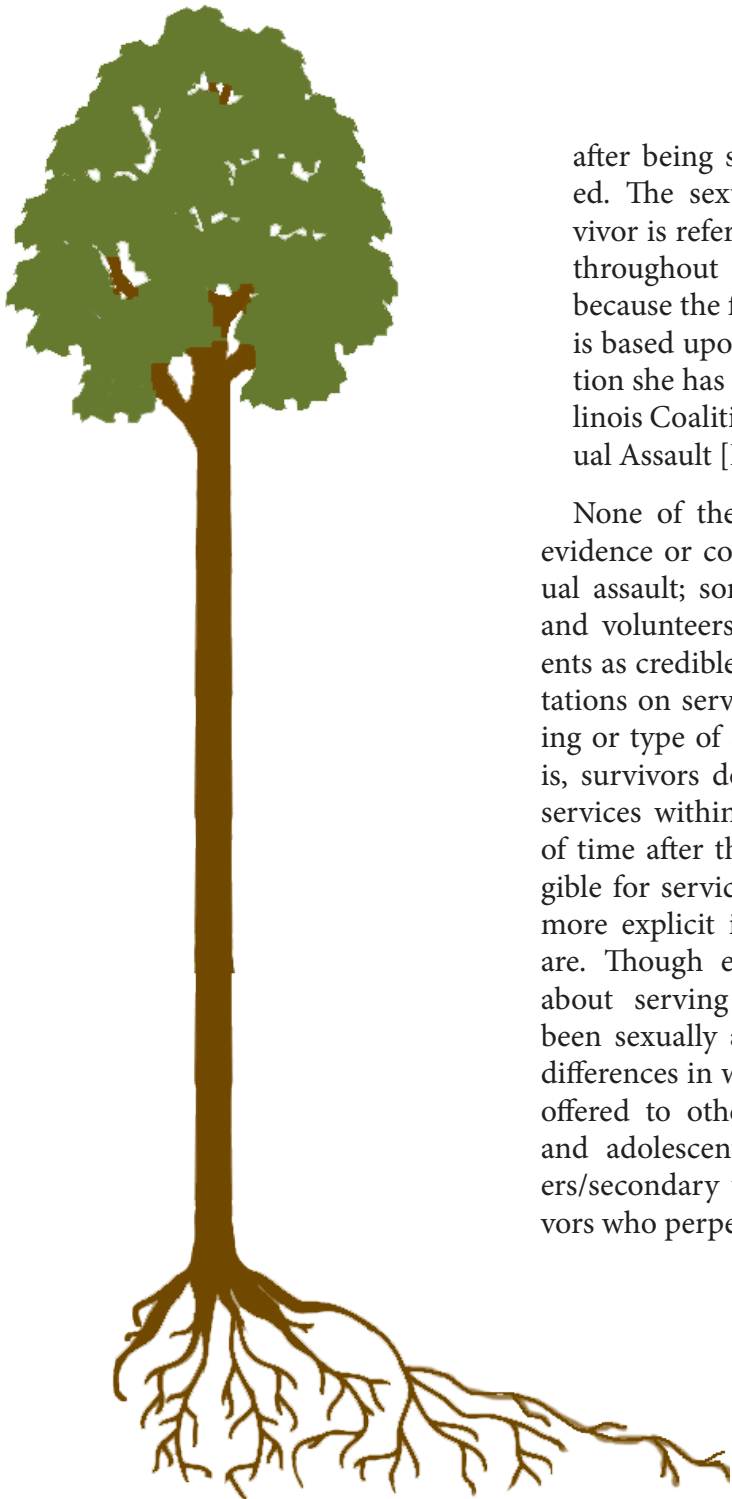
“staff or volunteers trained to meet the needs of minors; written policies regarding the rights and responsibilities of minors receiving services;...appropriate furniture and equipment that would help put a minor at ease; [and] provision of an age-appropriate orientation for minor clients” (TN Coalition, p. 3).

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.

Significant Others/ Secondary Victims

“Significant others also feel the impact of sexual assault... 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” (ICASA, p. 5-3).

“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” (PCAR, p. 13).

There is variation regarding the amount of discussion on services for 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. Some allow for or encourage full services to significant others, especially those of child victims.

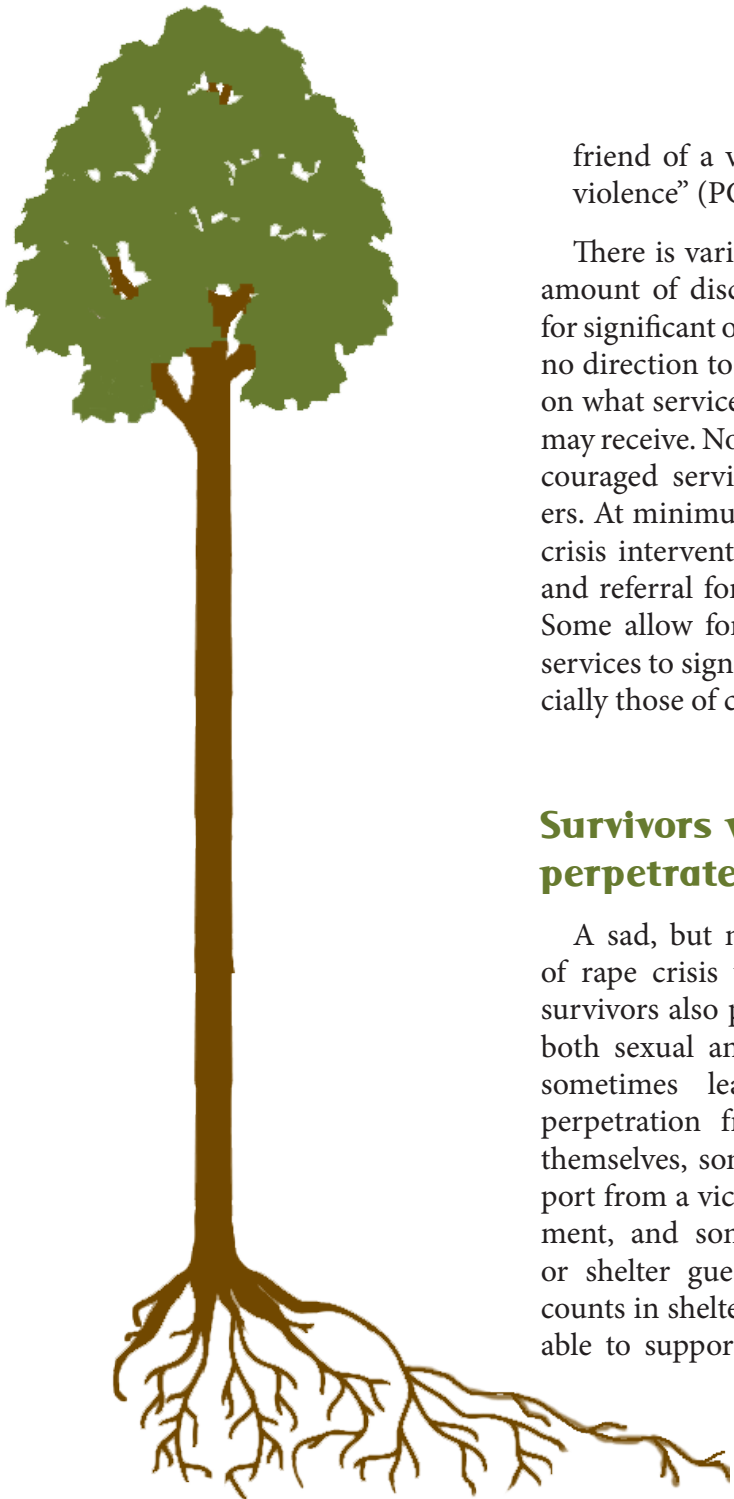
Survivors who perpetrate violence

A sad, but not unusual, reality of rape crisis work is that some survivors also perpetrate violence, both sexual and domestic. RCCs sometimes learn of survivors’ perpetration from the survivors themselves, sometimes from a report from a victim or law enforcement, and sometimes from staff or shelter guests’ eyewitness accounts in shelter. RCCs want to be able to support all survivors, but

we must also protect other clients at the agency. Additionally, RCCs generally do not provide offender services and are not qualified to provide sex offender counseling. A few of the standards offer guidance to RCCs on this issue, generally directing programs to provide brief emotional support and a referral to other services:

“survivors or their friends or family members who have been sexually abusive shall be offered only brief referral to appropriate accountability and treatment services and may not receive survivor services” (SAPSS, p. 6).

Most of the standards did not address perpetration by survivors.



RCC Services to Individuals

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:

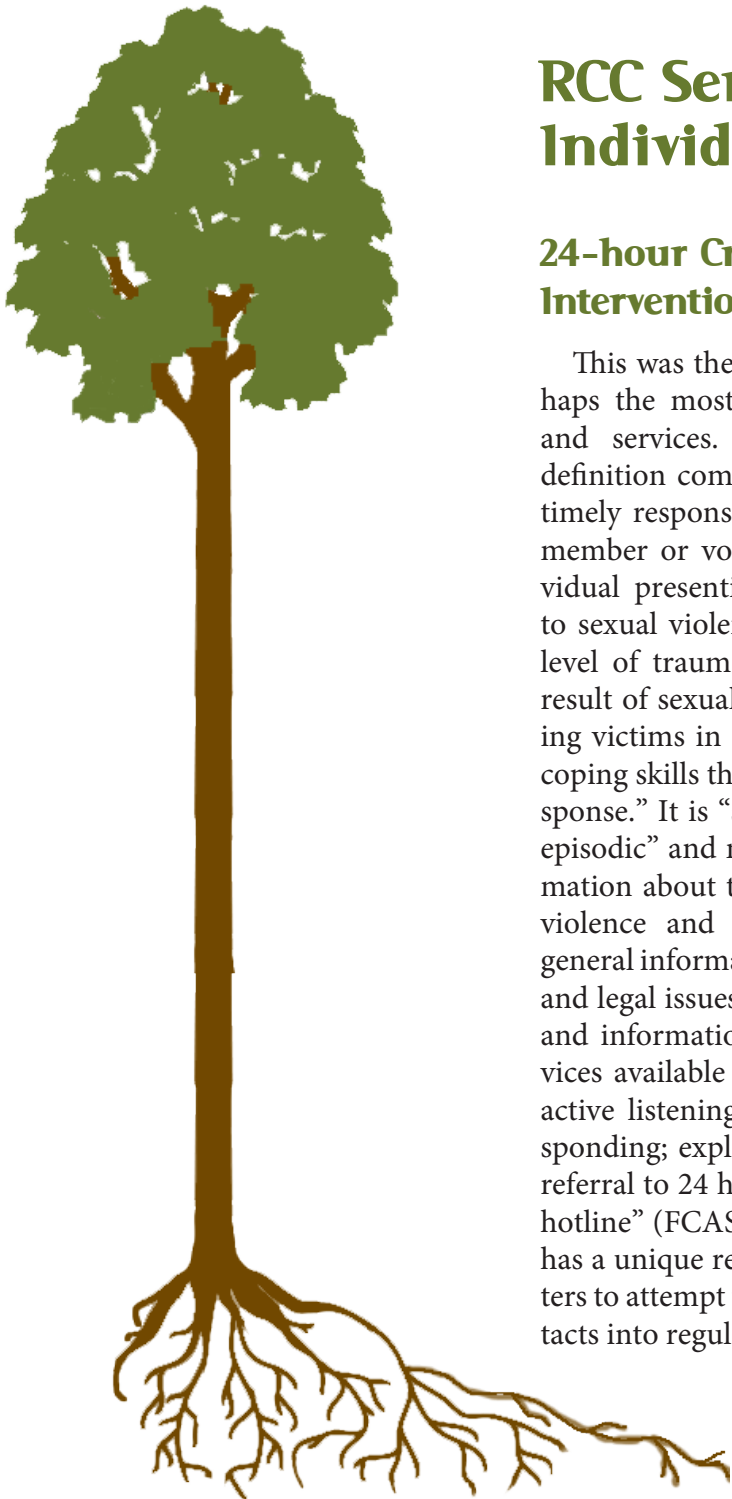
Centers must attempt to re-contact all clients/survivors within three working days after first contact/crisis intervention services if indicated by the needs of the client...A minimum of 45 % of clients/survivors receiving first contact/crisis intervention services must receive follow-up services (OES, p. 2).

All states in this sample consider a 24-hour telephone hotline a core service. Even states with minimal regulations on other issues have detailed hotline requirements. 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. A few standards allow for testing of hotlines, but this is rare. Hawai'i shapes hotline standards to meet special geographic considerations: “Every island should have a 24-hour sexual assault hotline that is a local number...callers can be certain that their call is be-

ing answered by someone on their island and is not being routed to the mainland” (Hawai'i Coalition Against Sexual Assault [HCASA], p. 13). Provision of in-person crisis intervention is detailed in only a few of the standards, and often conflated with other services, such as counseling, medical advocacy, or general crisis intervention.

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). 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). The level of detail on advocacy tasks among the standards varies considerably. Some standards discuss advocacy only in the context of emergency response, while others allow for a wider range of advocacy tasks.



There is generally more detail and focus on medical advocacy than legal advocacy across this sample.

Medical Advocacy

Washington 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

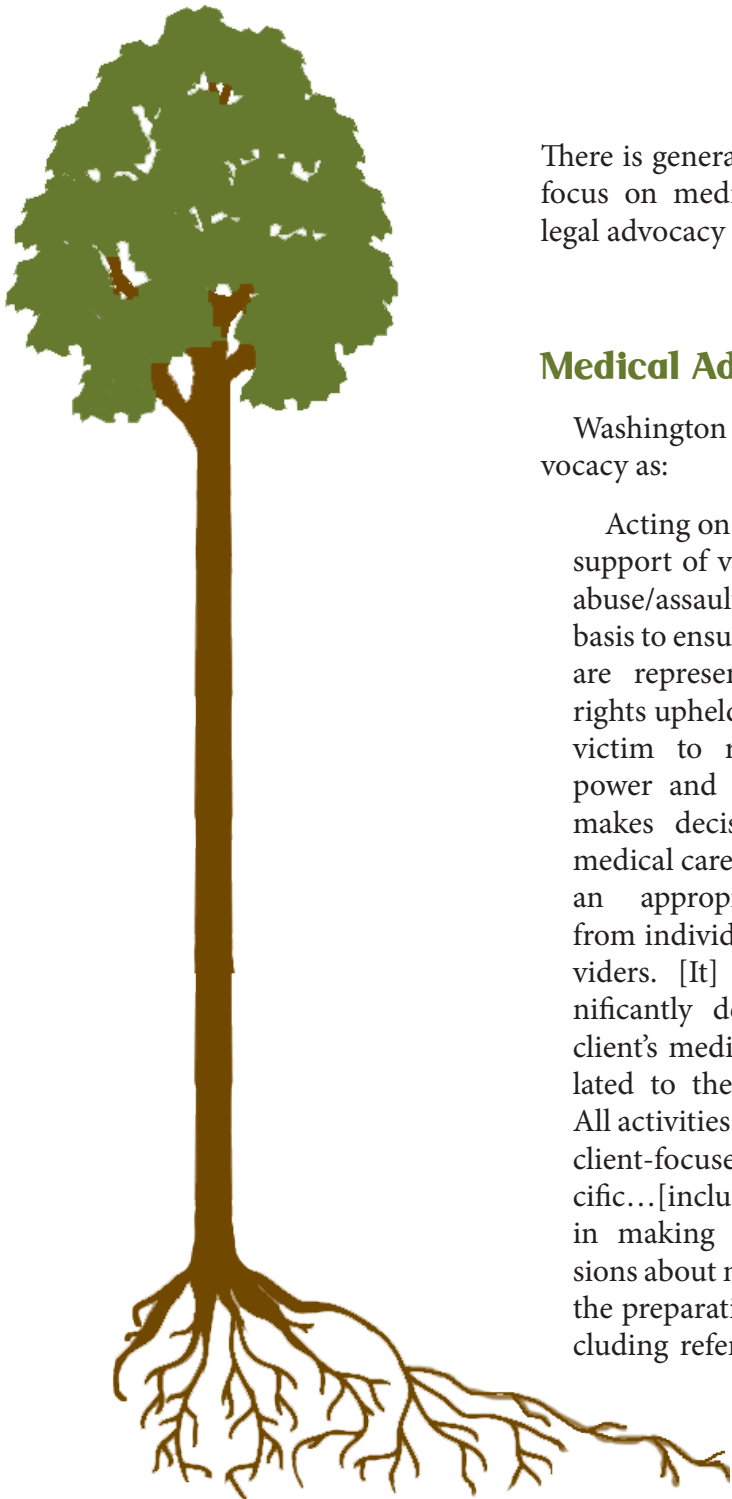
forensic exam; information about medical care/concerns, including assistance with needed follow-up; support at medical exams and appointments, and; information and/or assistance with Crime Victim Compensation applications (Washington Office of Crime Victim Advocacy [OCVA], p. 4).

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 per-

sonnel 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).

Several states particularly direct programs to provide information and resources on post-coital contraception and HIV testing and prophylaxis. 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 medical advocacy. The intention of the states that use the term accompaniment is to provide in-person emotional support or 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 be-



tween 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

Legal advocacy focuses largely on law enforcement and criminal justice proceedings, though most states allow for information and referral on civil matters. Expectations run from providing legal referrals to substantial involvement in supporting survivors through legal proceedings. 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 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).

The level of detail on legal advocacy varies considerably, though some level of legal advocacy is generally considered a core service.

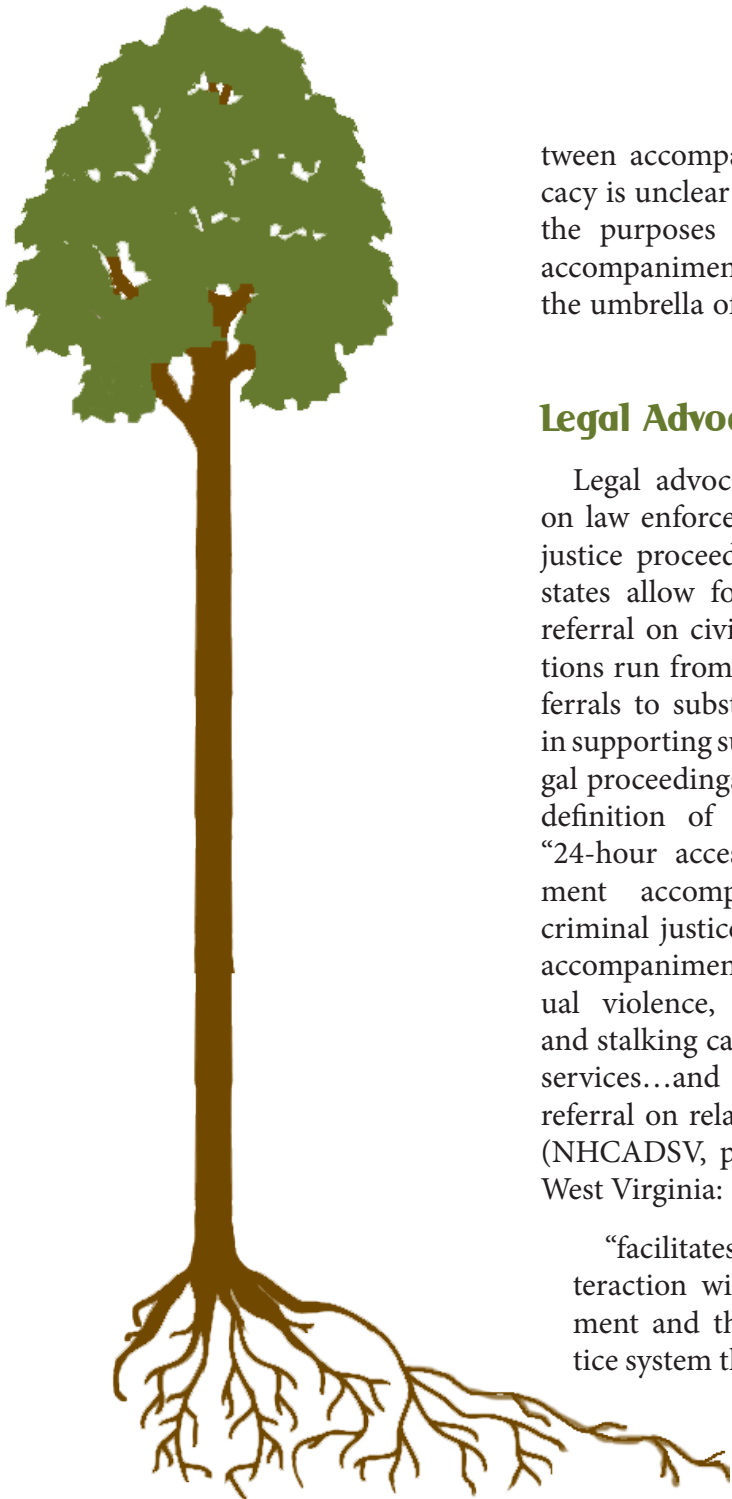
General Advocacy/ Other Advocacy/ Case Management

The majority of the states in this sample focus only on medical and legal advocacy, but a few attend to other advocacy issues or case management. This is a murky point because the tasks covered under general advocacy in one state may

be considered information and referral in another state, or counseling or medical/legal advocacy in yet another. 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).

Hawai'i directs programs to have a caseworker, who will "actively coordinate a variety of services on their client's behalf and serve as a central point of contact for the survivor when she needs assistance or has questions" (HCASA, p. 24).



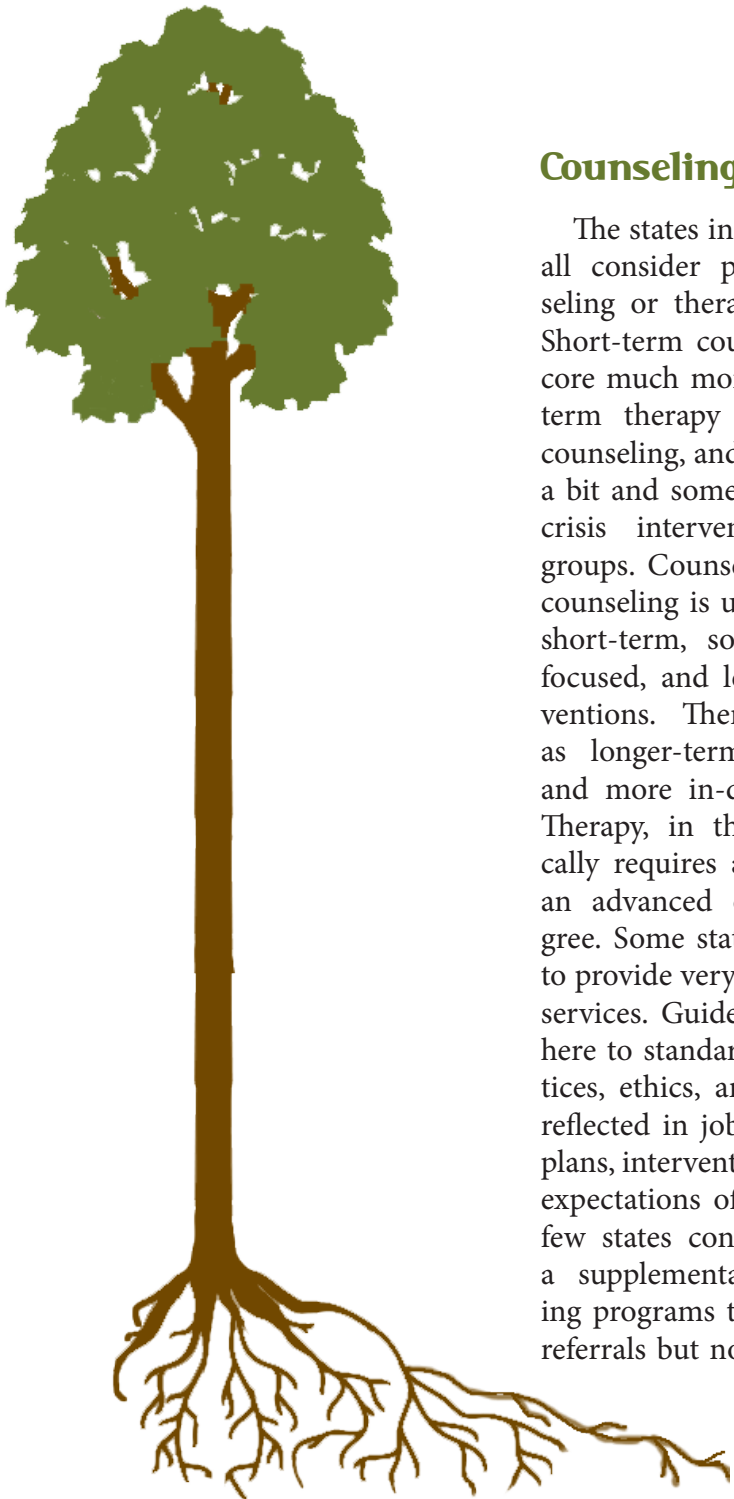
Counseling and Therapy

The states in this sample do not all consider provision of counseling or therapy a core service. Short-term counseling is deemed core much more often than long-term therapy is. Definitions of counseling, and therapy vary quite a bit and sometimes overlap with crisis intervention or support groups. Counseling or supportive counseling is usually described as short-term, solution- or action-focused, and less intensive interventions. Therapy is described as longer-term, more intensive and more in-depth intervention. Therapy, in the standards, typically requires a practitioner with an advanced or specialized degree. Some states allow advocates to provide very limited counseling services. 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 a supplemental 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 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).



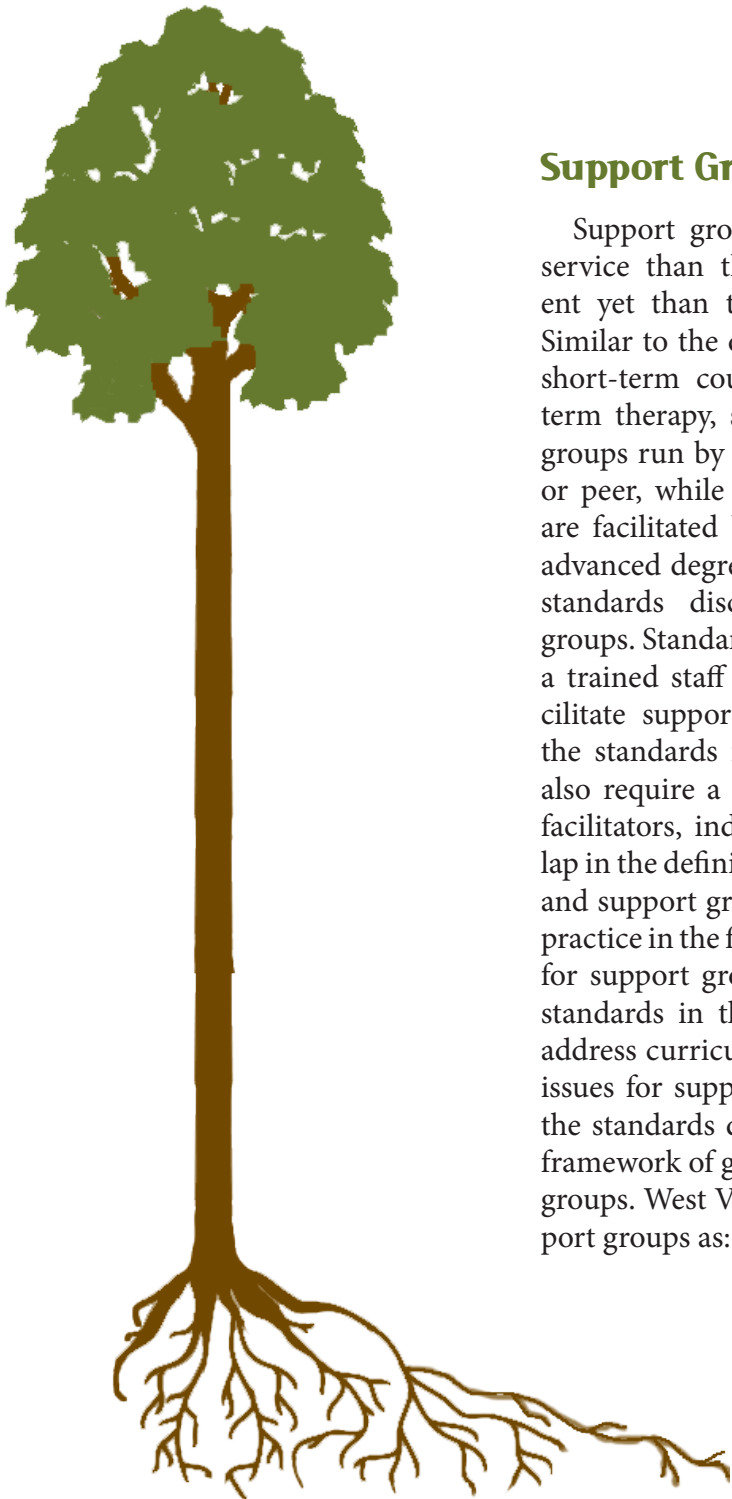
Support Groups

Support groups are a different service than therapy, and different yet than therapeutic groups. Similar to the differences between short-term counseling and long-term therapy, support groups are groups run by a trained facilitator or peer, while therapeutic groups are facilitated by counselors with advanced degrees. Very few of the standards discussed therapeutic groups. Standards typically require a trained staff or volunteer to facilitate support groups. Some of the standards for support groups also require a Master's degree for facilitators, indicating some overlap in the definitions of therapeutic and support groups. It is common practice in the field to use curricula for support groups. However, the standards in this sample did not address curricula or other content issues for support groups. Rather, the standards dealt with the basic framework of groups and access to groups. West Virginia defines support groups as:

Individuals meeting in a safe, supportive, non-judgmental environment on a regular, scheduled basis to exchange information, share techniques for problem solving, and 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). As with counseling and therapy, there is no consensus among this sample on whether provision of support groups is a core service. Some standards, like New York, mandate programs to provide individual or group counsel-

ing, but do not require both (New York Public Health Law, section 206(15), p. 2). Therapeutic groups are considered supplemental service by most of the standards, if they are considered at all.



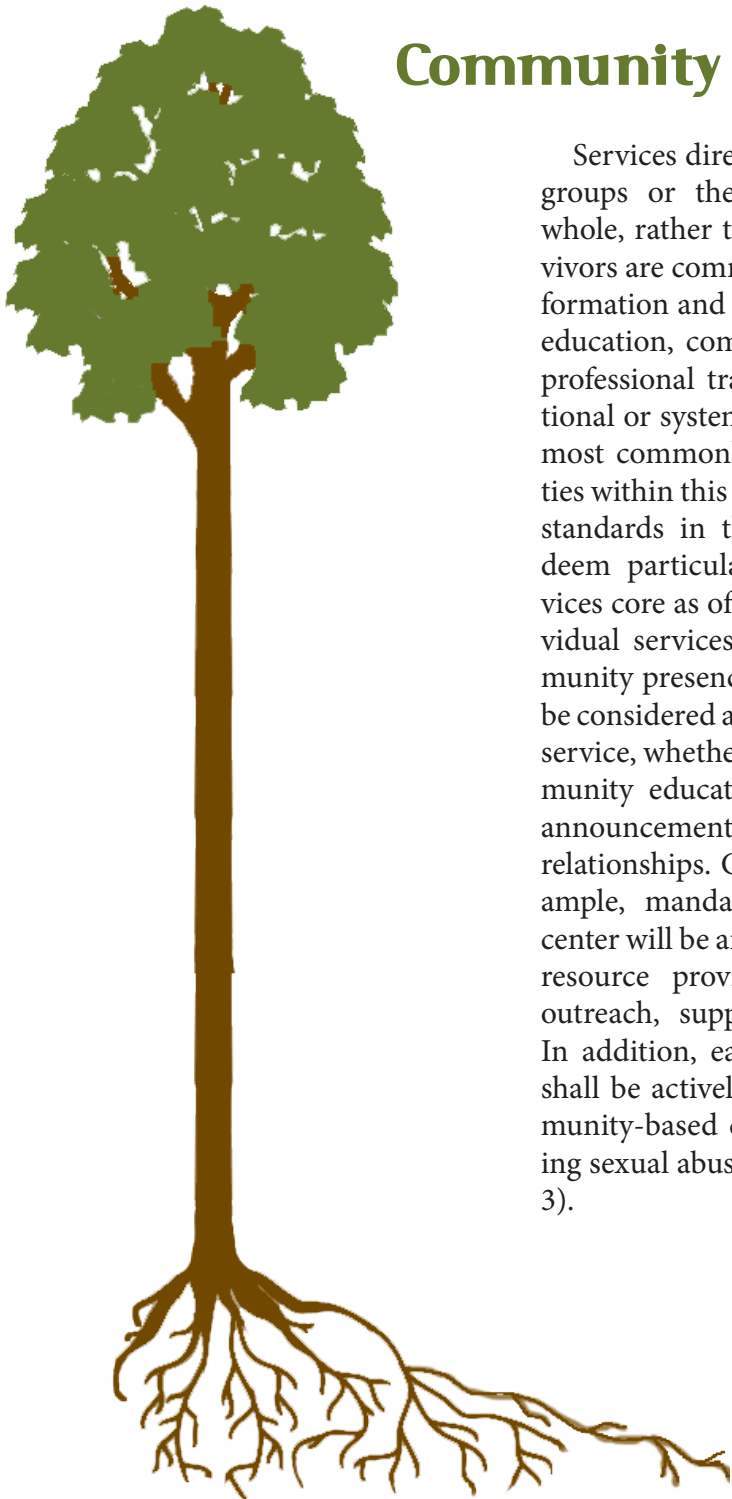
Community Services

Services directed at institutions, groups or the community as a whole, rather than individual survivors are community services. Information and referral, prevention education, community awareness, professional training, and institutional or systems advocacy are the most commonly described activities within this broad category. The standards in this sample do not deem particular 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).

These community services are not defined uniformly across the states. The divisions between these categories are generally unclear; there is little agreement on any distinct definitions of the tasks or categories within community services. The standards use terms like systems change, institutional advocacy, professional training, community awareness, prevention education, and social service advocacy to describe the various services for institutions and communities sometimes using different terms to describe the same activity. Outreach, social change, and activism are some other terms used under this umbrella. Further confusion arises from the fact that a few 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. However, within

all of these various definitions and vocabularies, there are common themes.

For many states, the link between community work and survivor services is clear: programs cannot effectively serve survivors unless survivors know the RCC exists and is welcoming. When survivors seek help after sexual violence, they typically do not come to RCCs first. Rather, they seek medical care, spiritual guidance, material resources, or the support of friend, if they seek help at all. If service providers, community leaders, spiritual leaders, and general community members know about sexual violence and the RCC, they can be a bridge for the survivor to the RCC. Thus, RCC community work vitalizes and strengthens our survivor services. California makes this link explicit: “at a minimum, centers must serve the same number of sexual assault victims as there are cases of forcible rape reported to law enforcement agencies in the center’s service area” (OES, p. 2).



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. As mentioned previously, the line between information and referral services and general advocacy is often blurry. In some states, where fulltime advocates or counselors may not be the norm, referrals to community advocacy services or counseling services are in 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). Tennessee RCCs, as the "source for information and referral for victims, significant others, and the community on sexual assault," are required

to have "an updated resource system for staff and volunteers...Staff and volunteers are trained to use the resource system" (TN Coalition, p. 5). Iowa expects the "extent of program involvement in education/outreach will be such that the program is viewed as a vital member of the community. The development of education/outreach methods should be guided by and reflect the diversity and character of the community. For example, written and broadcast service information might be made available for non-English speaking populations to match the diversity of the community" (IowaCASA, p. 27).

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

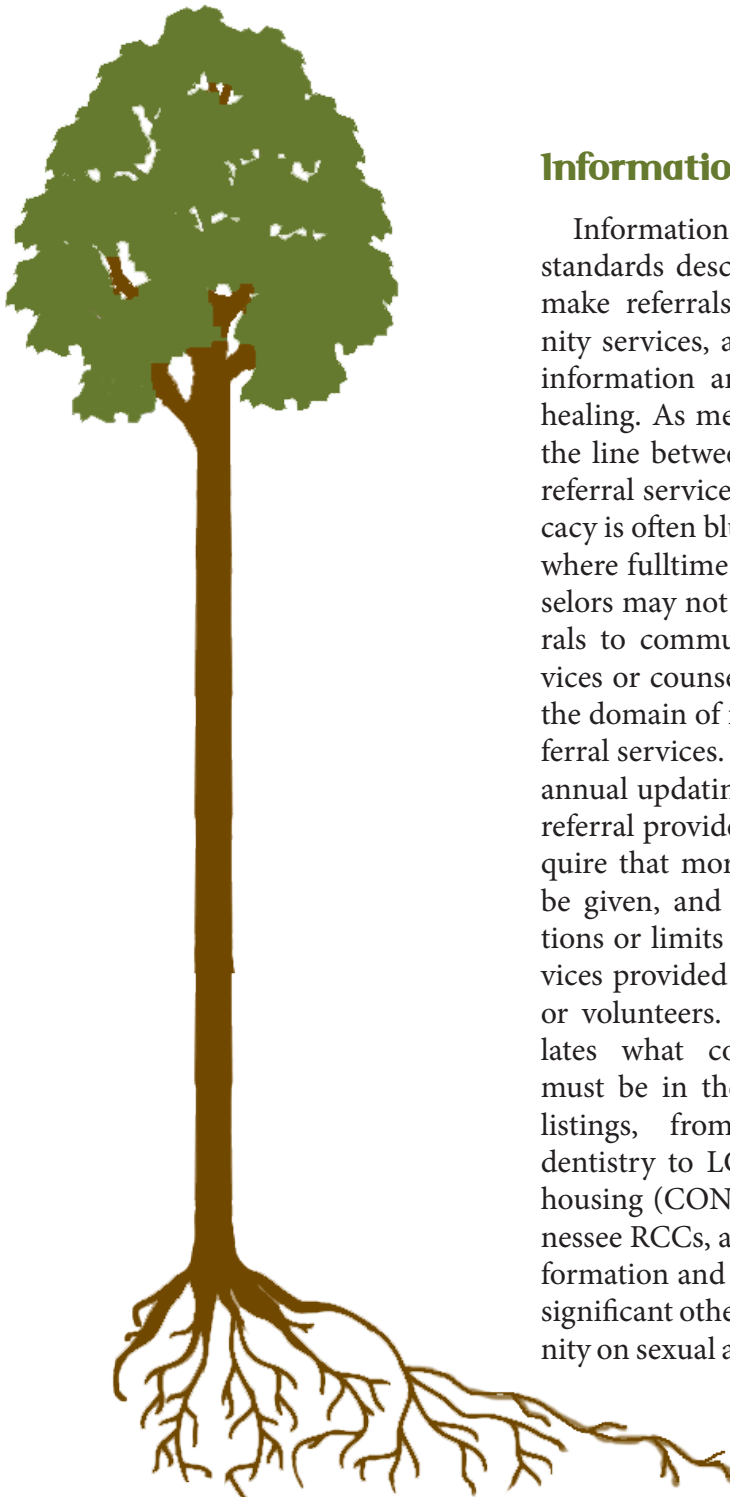
under prevention education. New Hampshire requires:

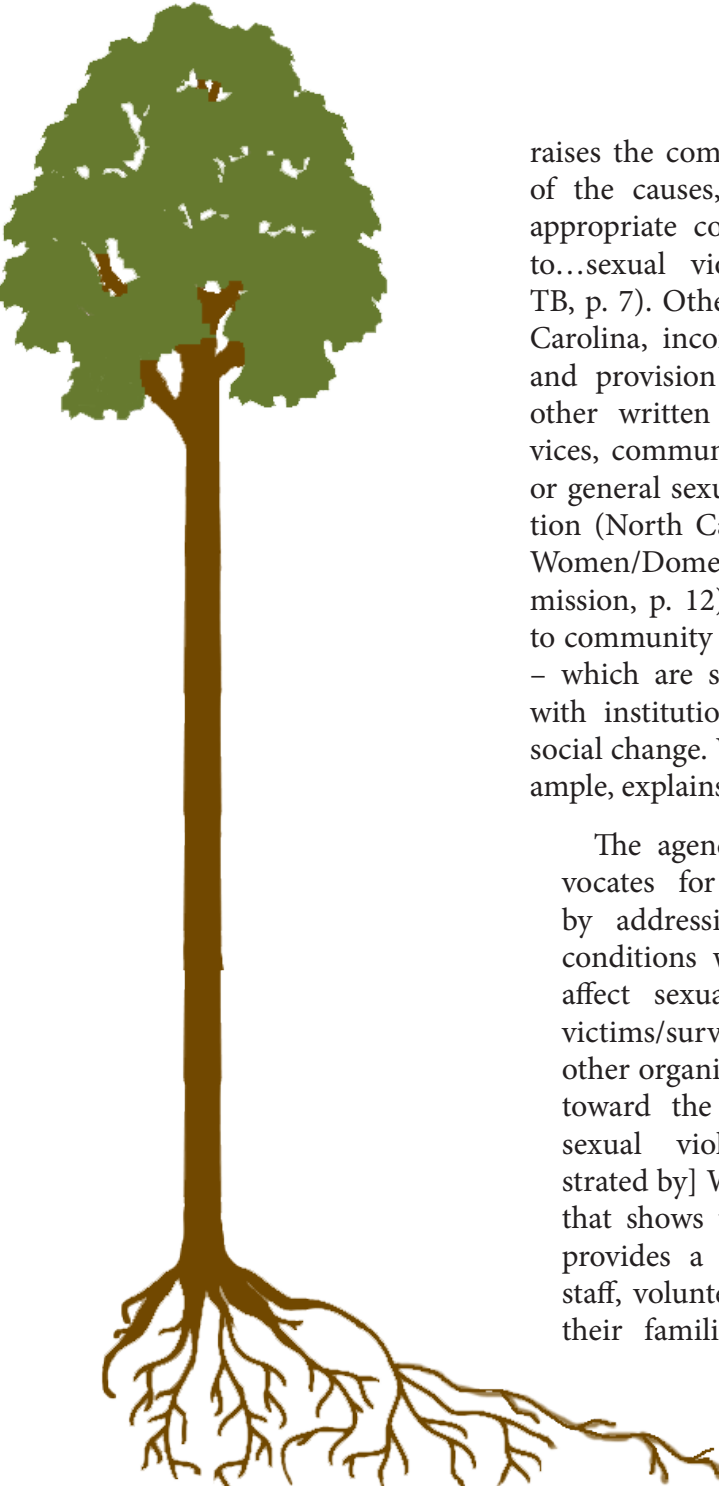
Member programs shall develop and maintain relationships with schools and youth organizations to promote awareness of sexual violence, domestic violence, and stalking within their catchment area. Member program utilizes, at a minimum, research or science based programs and curricula and whenever possible,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

Massachusetts, in one of the broadest approaches to prevention education, directs programs to include "community leadership, education, mobilization, and organizing to promote healthy sexuality and relationships, and prevent sexual assault across the lifespan" (SAPSS, p. 1).

Community Awareness

Michigan, like many states, requires community education "that





raises the community's awareness of the causes, implications, and appropriate community response to...sexual violence (MDVSAP-TB, p. 7). Other states, like North Carolina, incorporate 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, p. 12). Some states refer to community awareness activities – which are somewhat conflated with institutional advocacy – as social change. Washington, for example, explains,

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).

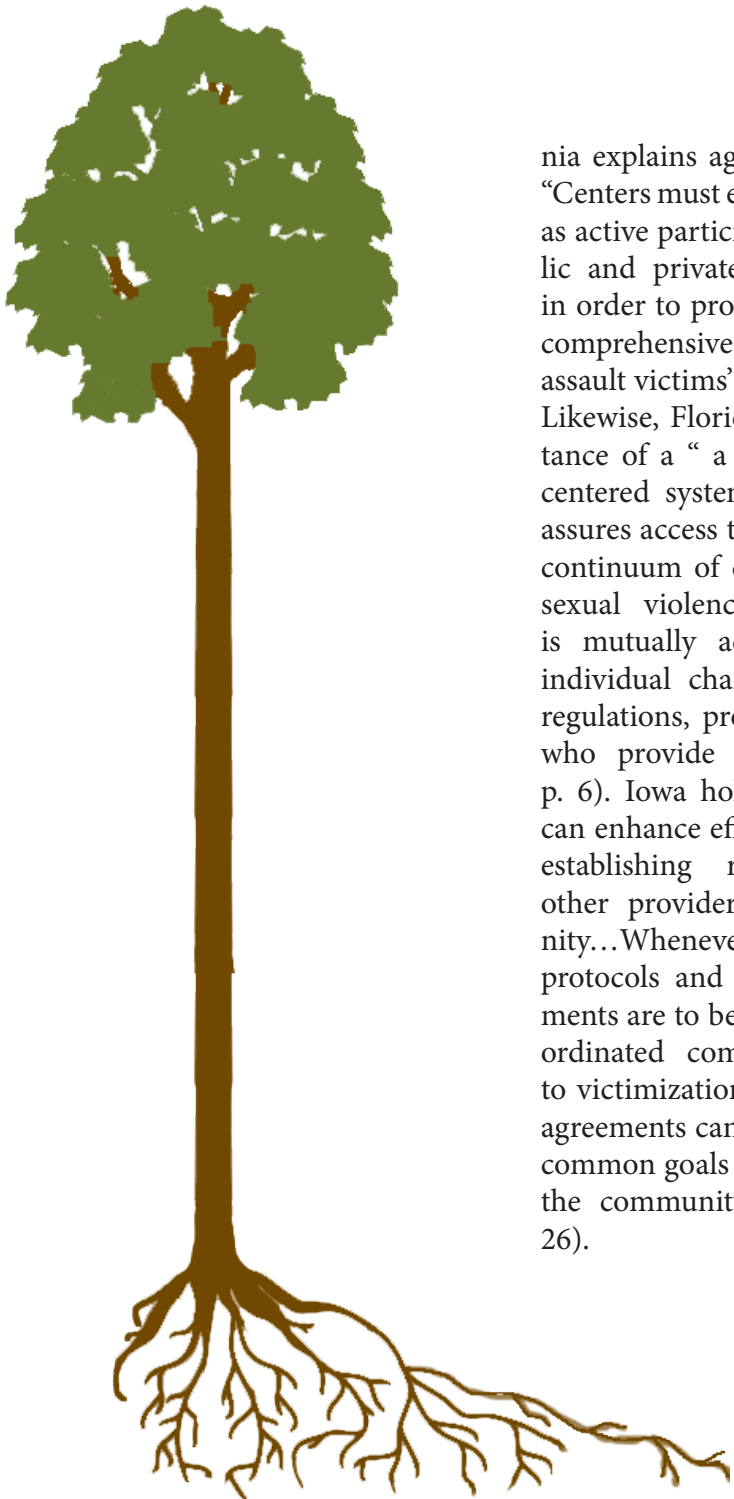
Professional Training

Of the states that address professional training, most list it as a task under prevention education/community awareness or institutional advocacy. However, 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. West Virginia directs programs to provide “education, evaluation of skills, and the building of skills to prepare allied

professionals to provide victim-centered services and to intervene on the behalf of the victim within their own institution” (FRIS, p. 11). 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 survivors 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 this sample, however, leaves the specific activities and targeted institutions to the individual center's discretion. Califor-



nia 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). Iowa holds that “programs can enhance effectiveness through establishing relationships with other providers in the community...Whenever possible, written protocols and interagency agreements are to be established for coordinated community responses to victimization, such cooperative agreements can be used to further common goals across programs in the community” (IowaCASA, p. 26).

RCC Organization & Operation

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 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.

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” (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 Network's mission and principles" (Network, p. 6).

Initial Training

The amount of training employees and volunteers must receive before interacting with clients varies across states, from twenty to forty hours. There is also great variation in the window for completion of training. Some states require a portion of training before any contact with survivors and the remainder of training to be completed within a longer period, while others require the entire training to be completed before any contact with survivors. A few states had slight variations in training requirements based on the services provided (e.g., different topics are required to work on the hotline than provide advocacy). A few others required minimal training for administrative staff or staff that would have little to no contact with survivors.

Continuing Education

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

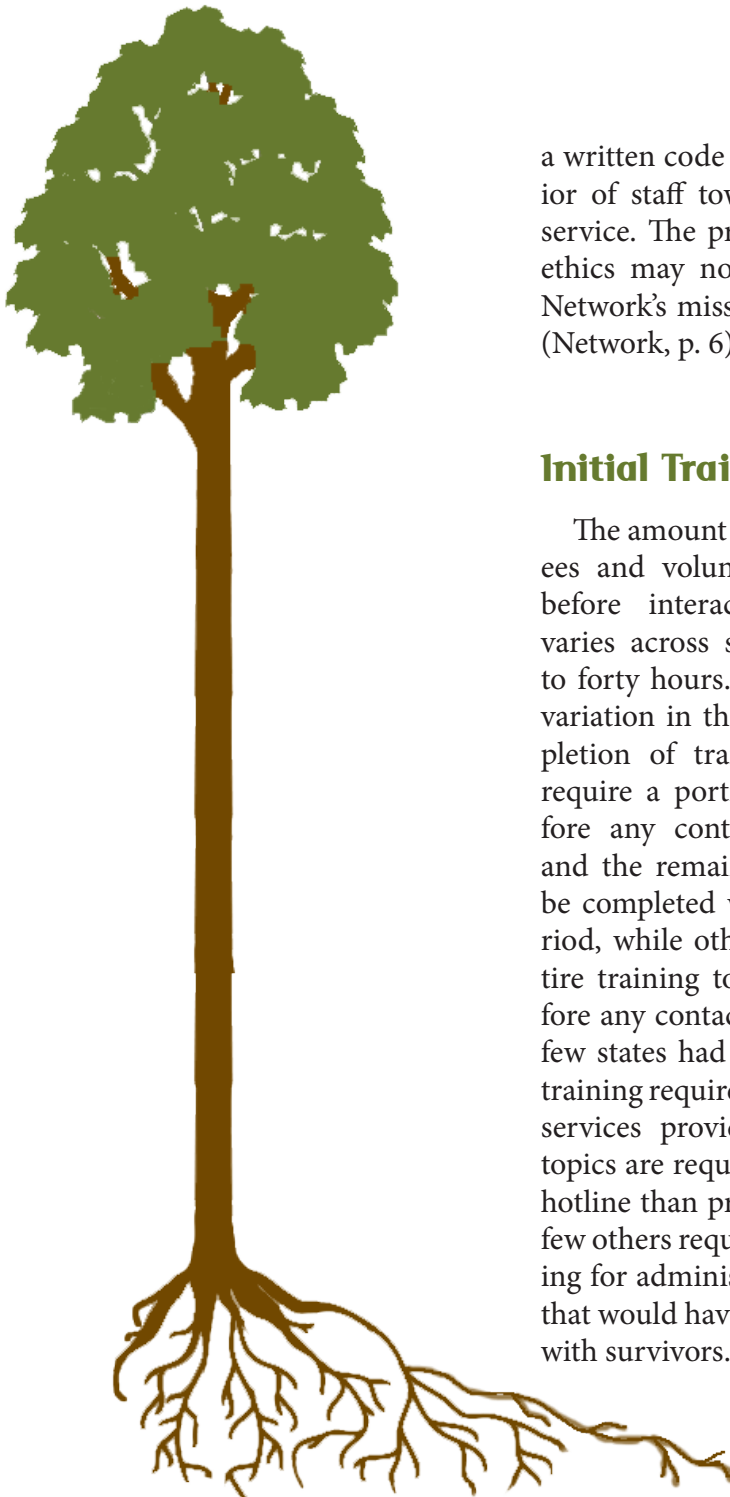
Supervision, Record Review, Counseling Plans and Service Documentation

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. Many states in this sample directed programs to create case plans with survivors. 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 (e.g., child therapists get different or more intensive supervision than adult therapists do). Accountability, 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 of the 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 for more detail).

Educational requirements for employees

The majority of this sample had no standards on educational degree requirements for employees. This seems to be in keeping with the grassroots, social justice orientation of the field, in that many rape crisis centers were founded on a peer-helping model that eschewed clinical degrees. Those that did have requirements typically only covered degree requirements for therapists and counselors.

Response times and usage of answering services or outside services

Many, though not all, have guidelines on response time for

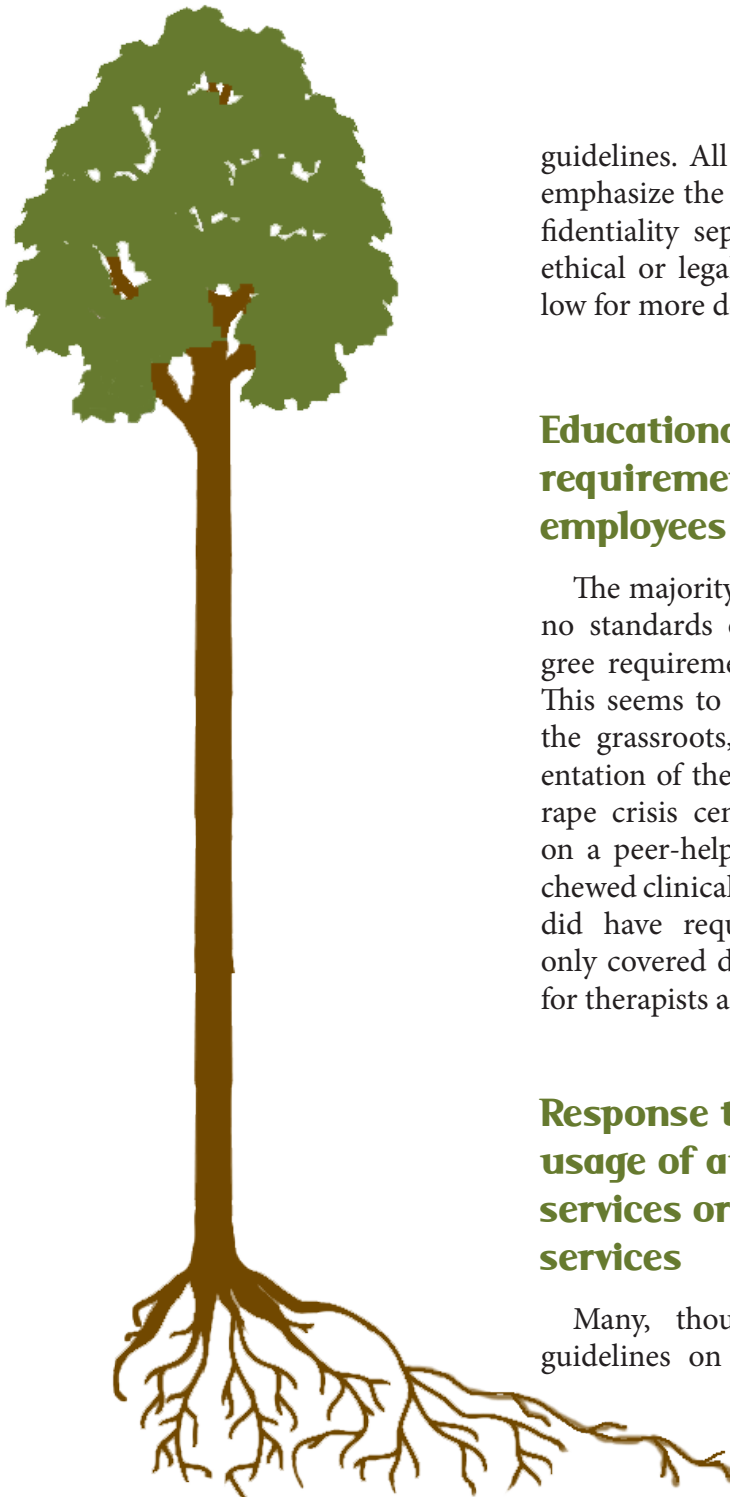
telephone and in-person crisis intervention; Iowa, for example, specifies response should be “within 15-30 minutes for urban and as soon as possible for rural” (Iowa-CASA, p. 30). Most states required that a live person answer the crisis telephone, although there was wide variation in the allowable methods for receiving and responding to calls. Most states that allowed the use of answering services have clear guidelines on parameters of use.

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 many RCCs are dual/multi-service agencies, 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).

However, most standards do not discuss staffing patterns for sexual assault services in dual/multi-service agencies.



Confidentiality

Policies may or may not clearly reference state code, but confidentiality is explicitly discussed in all policies reviewed. About half this 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 review of standards). Many emphasize confidentiality as a guiding principle.

Agency Identity

Several states instruct RCCs to promote themselves as the community sexual assault crisis agency (through networking agreements, public service announcements, and the like) 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). For example, West Virginia’s standards require programs to:

Publicize available service

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).

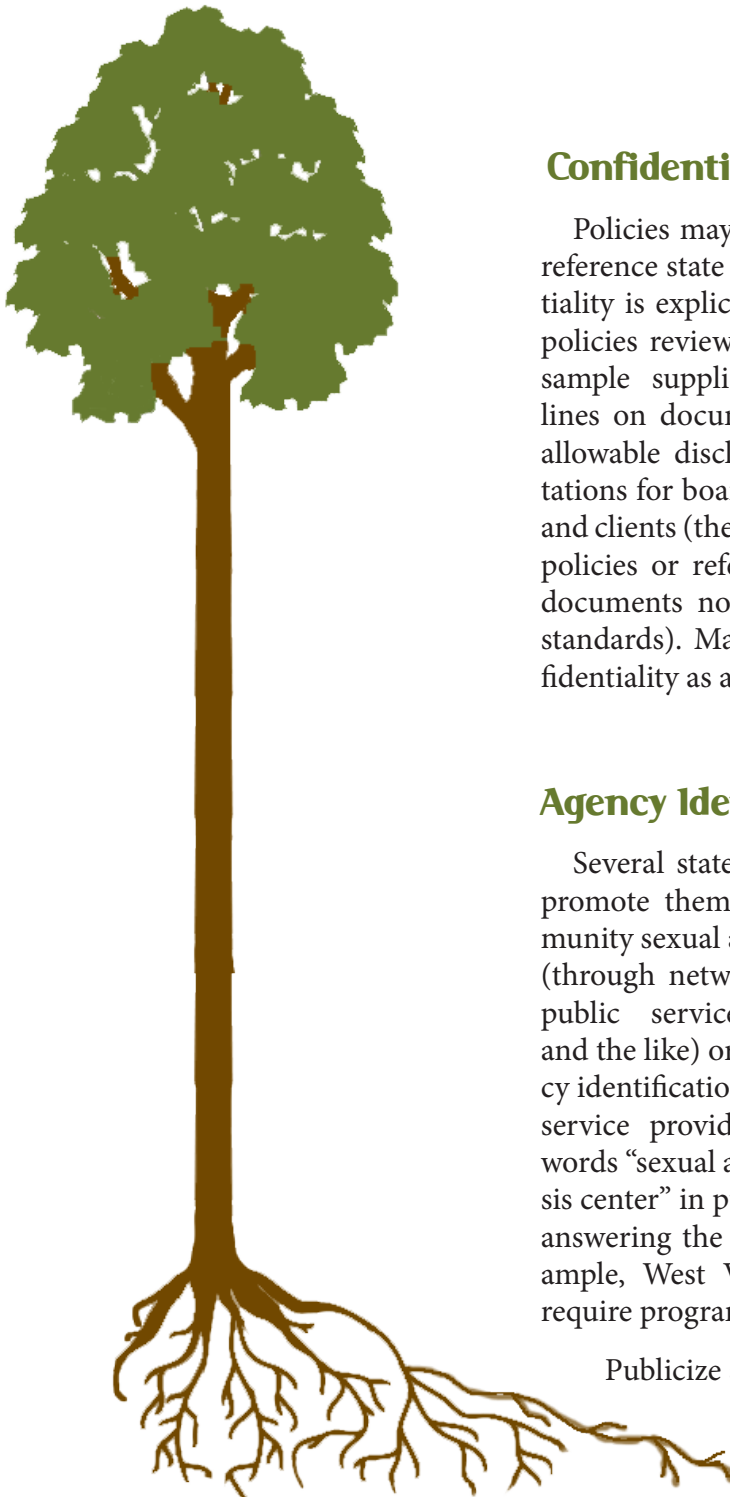
Cost

Most in this 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 this 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 most 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. A handful of states have additional statements on religious non-affiliation of RCCs. Washington allows for specific services and activities beyond core services that are directed at marginalized communities. Hawai’i encourages programs to “be in tune with local culture” as many Native Hawaiians are more

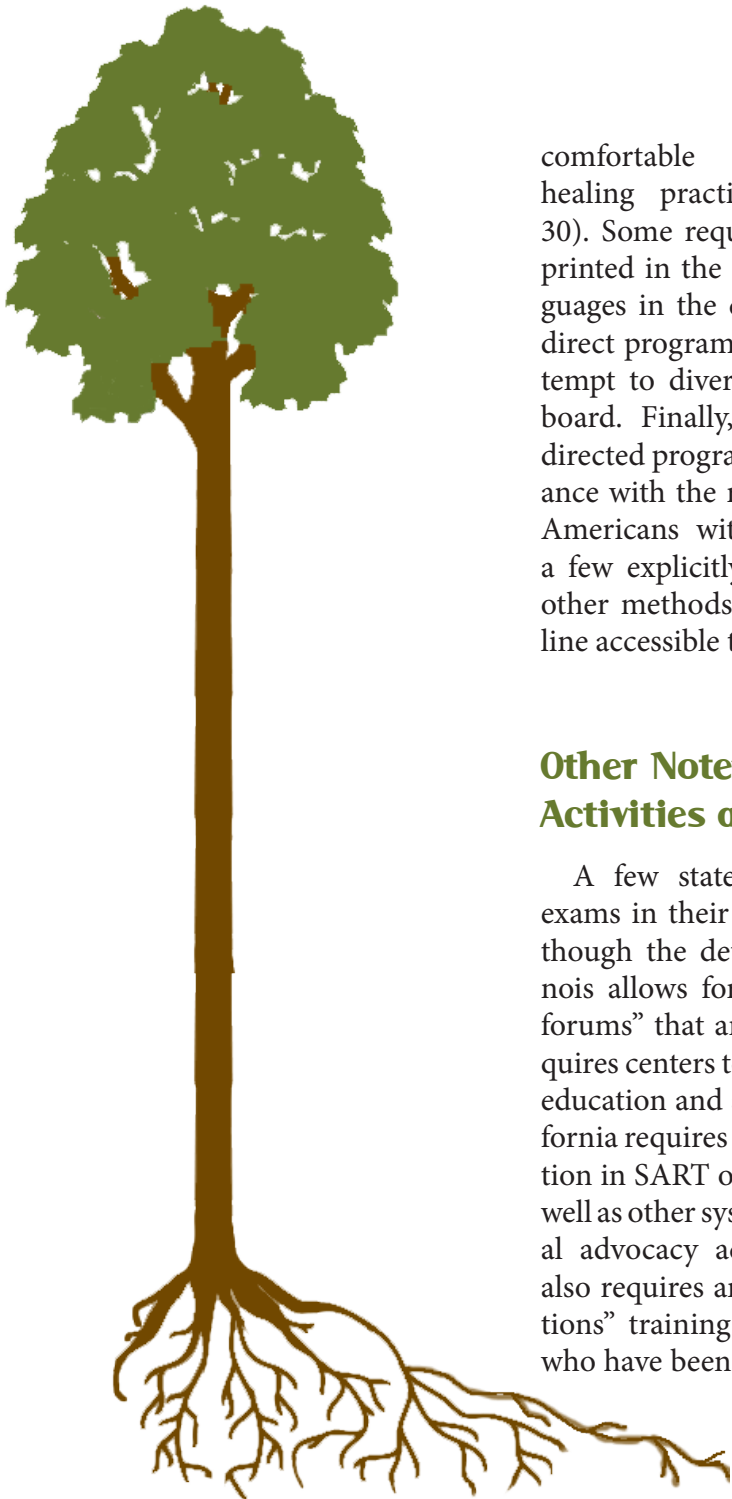


comfortable with “traditional healing practices” (HCASA, p. 30). Some require publications to be printed in the most common languages in the community. Others direct programs to diversify or attempt to diversify their staff and board. Finally, all the standards directed programs to be in compliance with the requirements of the Americans with Disabilities Act; a few explicitly required TTY or other methods to make the crisis line accessible to deaf survivors.

Other Noteworthy Activities and Features

A few states include medical exams in their 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 expe-

rienced discrimination for all staff and volunteers. 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. Several states also have detailed ethical codes for RCC workers. North Carolina’s programs must reserve one seat on the board of directors for a sexual assault survivor, though the survivor is not mandated to disclose their history to the entire board.



Recommendations for Future Practice

Service standards reflect current thought and best practices in the field, and as such, they are living documents that grow and change. As coalitions and member programs enhance or develop their service standards, there are a few recommendations that may bolster the response to sexual violence survivors.

Expand vision to long-term and complex service.

The aftermath of sexual violence is neither neat nor simple. Many survivors experience difficulties years after the sexual violence. Additionally, many survivors do not tell right away. They may not have crisis needs, as currently identified by the field, but do need support and advocacy. Those who set standards can aid survivors with complex needs by setting expectations for long-term, complex advocacy and counseling. It may also be useful to consider advocacy expecta-

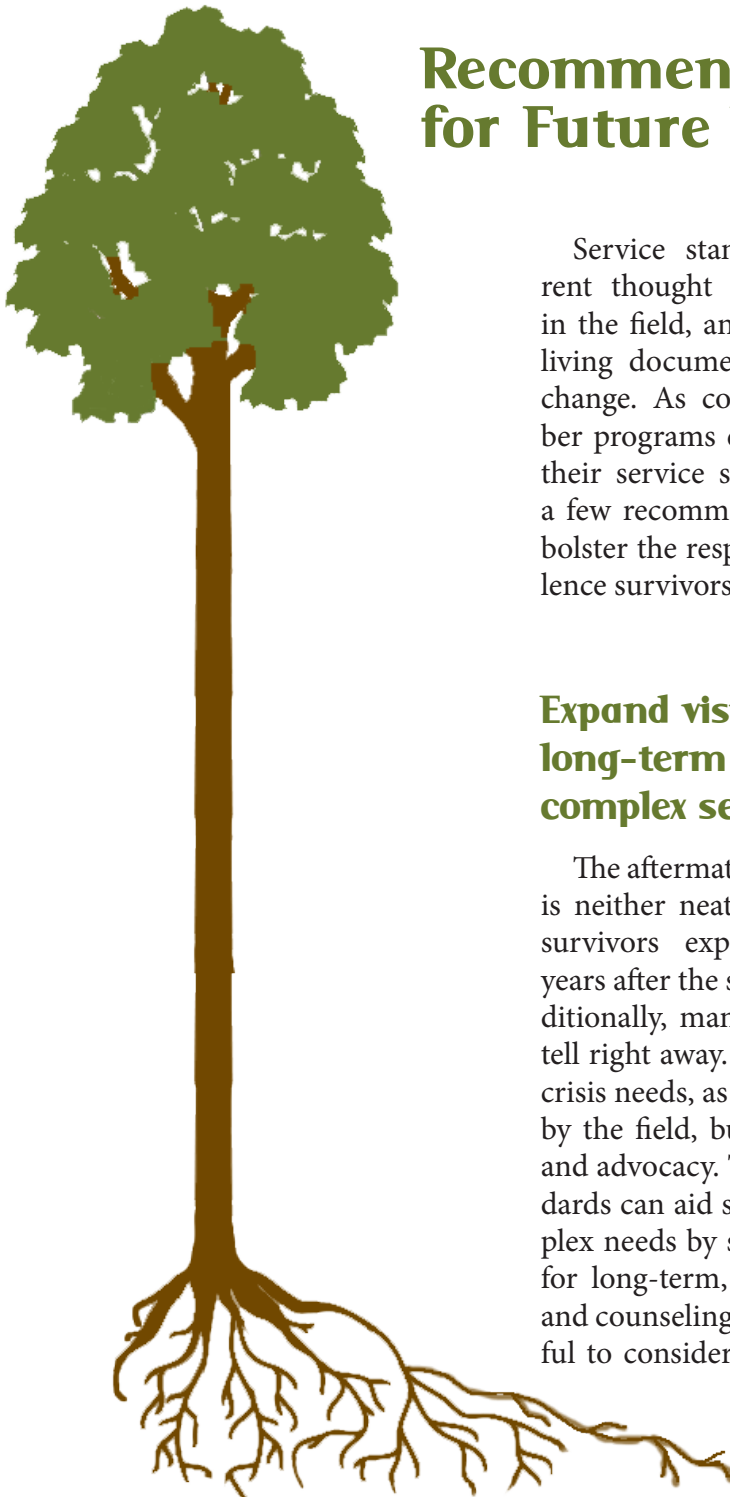
tions for special populations, such as incarcerated victims or survivors who struggle with chemical dependency.

Alternative healing modalities, such as yoga, Somatic Experiencing, art therapy, are becoming more popular as we learn more about their efficacy for survivors. Standard setters can support the emotional, spiritual, physical, and relational needs of survivors by encouraging programs to provide a range of creative interventions. They can also set guidelines for the competent and compassionate provision of various interventions and supports to help programs make good decisions about utilizing alternative healing.

Give special attention to rural realities.

Every state and territory has at least one rural community, and many have large rural areas. Rural communities have lower populations spread over a large geographic region. In most parts of the country and territories, ru-

ral communities are poorer than their urban counterparts are. They tend to lack essential resources like comprehensive medical care, social services, or public transportation. For these reasons and more, rural RCCs do not operate like urban programs. A few of the standards in this sample have specific provisions for rural RCCs, but these are rare. Rural RCCs would benefit from special consideration of their challenges and strengths in service standards. For example, rural advocates tend not to spend much time in offices, as rural survivors find it difficult to travel to wherever the advocate is. Service standards could set parameters for ethics and safety when an advocate is working out of borrowed space in other community programs or the survivor's home. Moreover, managing confidentiality and dual relationships is a particular challenge of rural communities, where everyone knows everyone. Guidance from the standards on managing dual relationships and protecting confidentiality in rural settings would be a great support to rural advocates.



Consider systems change work.

Systems change or institutional advocacy is present in some but not all of the service standards. One of the aspects that sets RCCs apart from other social services is our determination to fundamentally change society. We want a society free of violence, and that means a society with changed institutions. Providing advocacy for survivors only, while helpful in the moment, is likely to be frustrating for advocates and ultimately ineffective for survivors. It is recommended that those who set standards provide guidelines for systems change work.

Make a plan for survivors who also perpetrate violence.

Sending these clients to sex offender treatment immediately may seem like the simplest or best solution, but it does not meet the needs of the client as a whole person. There are several questions to con-

sider in constructing guidelines for these clients.

•*What is the nature of the offense?*

Was a domestic violence victim forced to sexually abuse her children? Was a developmentally delayed adult acting out what was done to him? Was an adult survivor of child sexual abuse forced to abuse a sibling in childhood? Was an adult survivor acting with planned, malicious intent as an adult? These very different survivors require very different responses.

•*How can we keep our center safe?*

If the RCC does provide some survivor services to these clients, the program may want to set up guidelines to protect other clients.

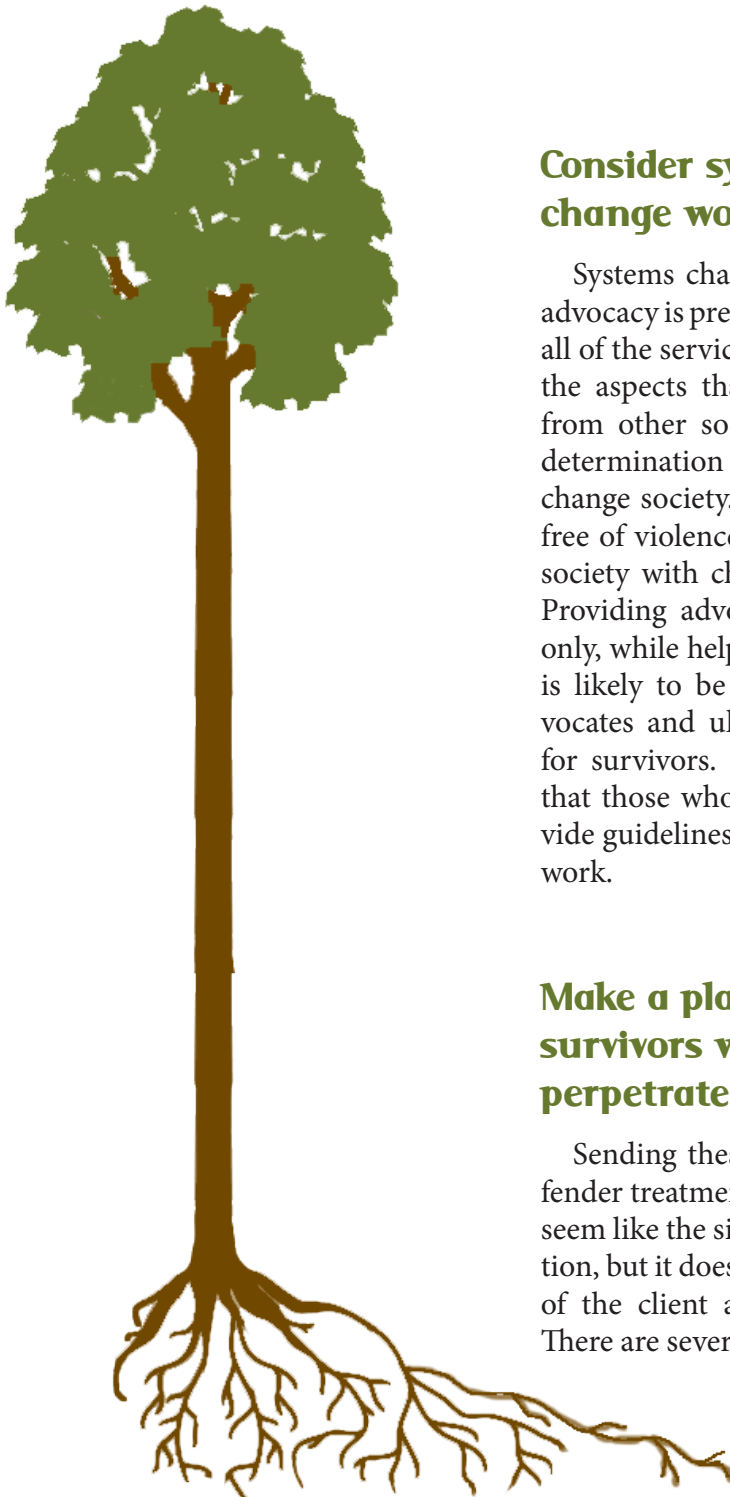
•*What are we qualified and capable of doing?*

The mission RCCs is, primarily, supporting survivors and ending violence. RCCs may feel able to help the survivor with healing from sexual violence while they refer the survivor to sex offender counsel-

ing. It is not recommended that RCCs work with someone who is facing criminal charges related to sexual violence, as it creates legal and ethical challenges for the program.

•*How can we act ethically and with compassion?*

When we must refer a survivor to sex offender treatment, it is important to consider how that transition is made. Clients may disclose current or past violence to their counselor/advocate because they trust the RCC and are looking for help. If possible, it is helpful to slowly transition the client, so they do not feel abandoned. Programs should not serve both the client who perpetrated and any victims of that client, and should follow any state reporting laws for child abuse.



Make allowances for culturally specific rape crisis work.

Service standards, largely, are authored by mainstream organizations for the benefit of mainstream organizations. Culturally specific organizations and tribal governments or organizations often find that service standards do not fit their culture's way of providing or interacting with RCCs. Hotlines, for example, are not used by all cultures, so requiring a hotline would be a poor fit for that organization and community. As tribes are separate nations and have their own unique issues and approaches, state service standards may not neatly apply to tribal work. Those who set standards are encouraged to find ways to support rape crisis work in tribes.

Synopsis of Core Services

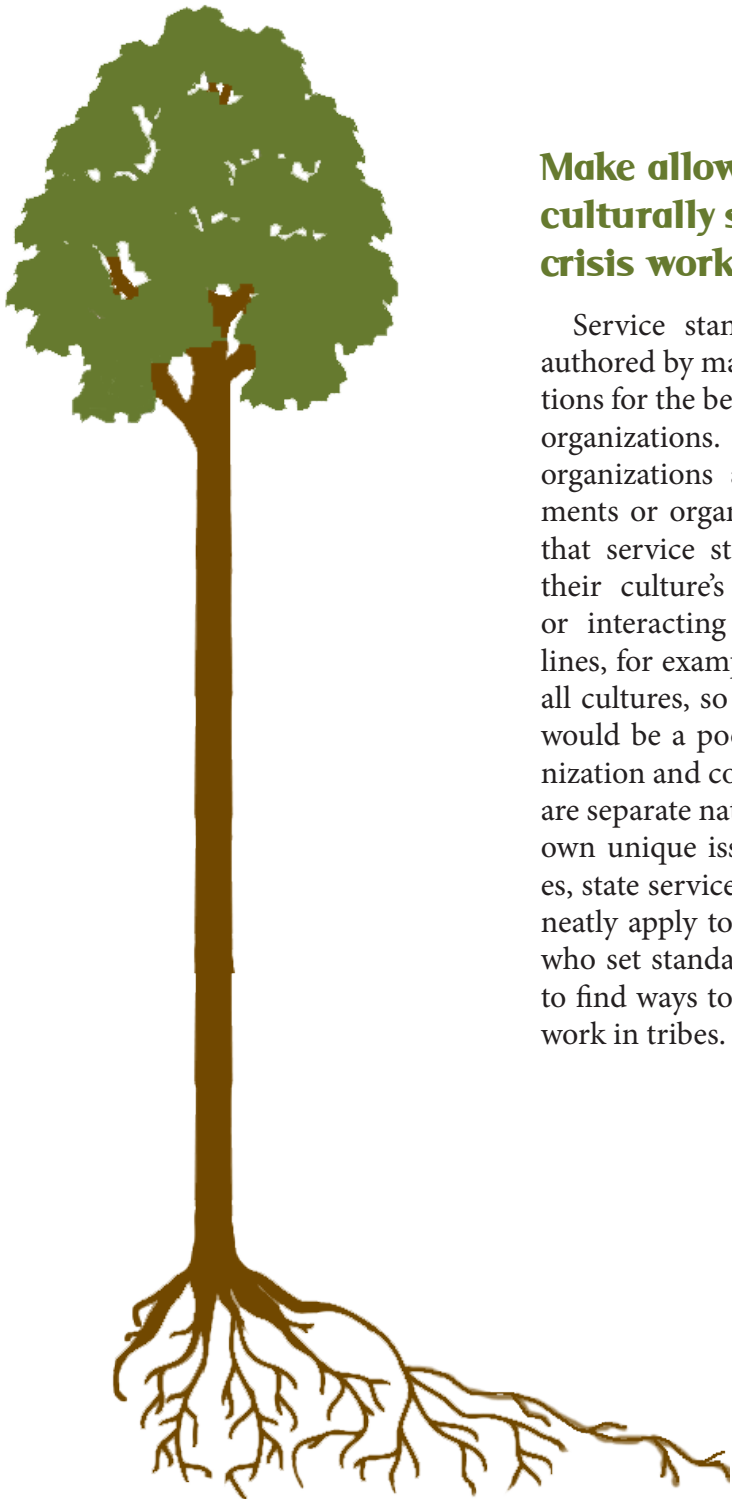
The chart on the next page illustrates the services that are core or recommended in state service standards.

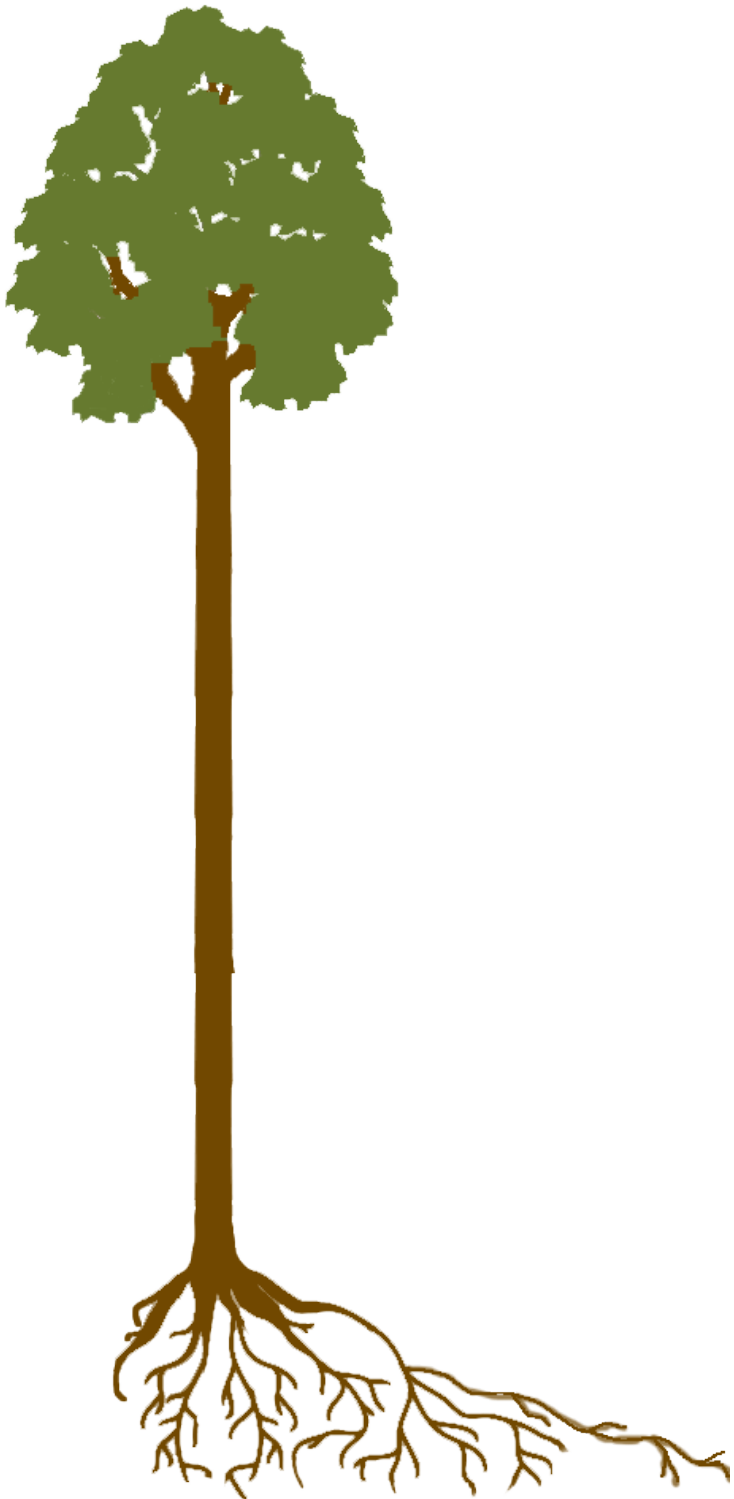
Services considered core in each state are marked in blue. Services that are recommended or supplemental are marked in orange. The box is left empty in cases where the service is not addressed by the state.

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 these cases, the service is considered recommended or supplemental. Other states, like Missouri, have guidelines for provision of various services, but do not explicitly require the provision of any of those services. The standards in these states are directives for how to provide each service, if provided.

Initial Training and Continuing Education hours were left blank if the standard did not refer to specific hours or left it unclear. See

above discussion of services for more information on definitions of services in this chart. In many states, the distinctions between types of service (prevention and community awareness for example) are unclear or nonexistent. In these cases, the boxes in the chart have been merged.





Legend:

Core	
Recommended	

	Initial Training hours	Continuing Education hrs	Systems Advocacy	Professional Training	Community Awareness	Prevention	Support Groups	Counseling/Therapy	Legal Advocacy	Medical Advocacy	General Advocacy	Information & Referral	Crisis Intervention
CA	40	12											
CT	30	4											
FL	30	6											
HI													
IA	20 ¹	12											
IL	40	6-12											
KY	40	8											
MA	35	6											
MI													
MO	40												
NC	20												
NE													
NH	30	6											
NY	40												
OR	30												
PA	40	6											
TN	40	8											
VT	20												
WA	30	12											
WV	40	8											

¹ 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.

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