CURRENT ISSUES IN PROVIDING CAMPUS- AND COMMUNITY-BASED ADVOCACY, MENTAL HEALTH, AND MEDICAL SERVICES TO COLLEGE SURVIVORS OF SEXUAL ASSAULT

By

McKenzie Javorka

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ABSTRACT

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Sexual assault occurs at a high rate among college students. Recent policy reforms at the federal, state, and local levels have aimed to improve university responses to sexual violence. These reforms include increased requirements for campus employees to report incidents of sexual assault, including some campus providers of victim services (i.e., advocacy, mental health, and medical services). Campus-based victim services may therefore be more affected by policy reforms than community-based victim services. The current study explored challenges and benefits of providing campus- and community-based victim services for college survivors through the lens of the current US policy context. Semi-structured qualitative interviews were conducted with national experts on responses to campus sexual assault. Participants characterized campus-based services as easily accessible to college survivors, but noted these services operate within a university context of competing interests that can lead to a lack of confidentiality for survivors. Participants saw community-based services as independent of university interests and having robust confidentiality protections, but difficult for college students to access. Strong coordination between campus- and community services was seen as an ideal model for addressing the limitations of each service context. Implications of these findings include the potential utility of coordinated campus sexual assault response models, the need to consider unintended negative consequences of university reporting policies, and areas for future research on help-seeking and service provision for college sexual assault survivors.

This thesis is dedicated to the memory of Tamar Hanna Kaplan, who planted the seeds of feminism in my mind and showed me what it means to live a big, brilliant, passionate life.

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INTRODUCTION

The sexual victimization of college women in the United States is alarmingly high, with several recent studies finding that 14 to 23% of undergraduate women have been sexually assaulted while in college (Cantor, Fisher, & Chibnall, 2015; Krebs, Lindquist, Warner, Fisher, & Martin, 2007; Krebs, Lindquist, & Barrick, 2011; Krebs et al., 2016). The trauma of sexual assault is associated with significant adverse mental and physical health consequences, as well as decreased academic performance (Banyard et al., 2017; Campbell, Dworkin, & Cabral, 2009; Carey, Norris, Durney, Shepardson, & Carey, 2018; Jordan, Combs, & Smith, 2014). Few college victims[1] of sexual assault seek help from formal support systems, such as the university, criminal justice, medical, or mental health systems (Wolitzky-Taylor et al., 2011). For those who do seek formal help after their assault, victim-focused services like advocacy, counseling, and medical care are more frequently utilized than criminal justice or campus disciplinary options (Wolitzky-Taylor et al., 2011).

Though researchers have examined college survivors' decisions to seek formal help, there is a lack of research on issues in *providing* victim services (Sabina & Ho, 2014). Recent policy reforms, including the implementation of university mandatory reporting policies, have substantially reshaped university responses to campus sexual assault. However, the potential effects of these policies on victim services have not yet been examined. Additionally, although universities now frequently provide on-campus sexual assault services (McCaskill, 2014), no studies exist comparing the relative advantages and disadvantages of campus-based and community-based services for college survivors. The current study aims to understand challenges

[1] The author recognizes that many people who experience sexual victimization do not self-identify as victims of sexual assault or rape, and that they may also prefer the term *survivor* rather than *victim*. The terms *victim* and *survivor* are used interchangeably in this document.

and benefits in providing campus- and community-based advocacy, mental health, and medical services to college survivors through the lens of the current US policy context.

LITERATURE REVIEW

Prevalence of Sexual Assault Among College Students

Studies have consistently found high prevalence rates of sexual assault among college women in the United States. Recent reviews of prevalence studies indicate that on average, approximately 20%, or one in five, women have experienced sexual assault while in college (Muehlenhard, Peterson, Humphreys, & Jozkowki, 2017; Fedina, Holmes, & Backes, 2018). However, prevalence estimates vary substantially, with one review finding rates of unwanted sexual contact among college women ranging from 2-34% (Fedina et al., 2018). Rates varied depending on how sexual victimization was defined and measured, as well as which types of victimization were included. For example, rates of *unwanted sexual contact* (i.e., unwanted kissing, fondling, or other sexual touching but not penetration) and *sexual coercion* (i.e., unwanted sexual contact or penetration completed through nonviolent means such as intimidation or pressure) were generally higher than rates of *forcible rape* (i.e., vaginal, anal, or oral penetration using physical force or threat of force) or *incapacitated rape* (i.e., vaginal, anal, or oral penetration while intoxicated or on drugs; Fedina et al., 2018).

In addition to the overall high rates of sexual assault among college women, certain groups of students are at even greater risk for sexual violence. In their review of four national college sexual assault prevalence studies, Muehlenhard et al. (2017) argue that the frequently cited "one in five women" prevalence statistic can disguise important differences in risk for sexual violence, "depending on campus, year in school, sexual orientation, gender identity, race, and disability status" (p. 19). Research on sexual violence risk for college women of color is mixed. In a study of historically Black colleges and universities (HBCUs), 14% of women had experienced sexual assault since entering college, compared with 19% using a similar

methodology and a primarily white sample (Krebs et al., 2007; Krebs et al., 2011). Similarly, white women have been shown to be at higher risk than women of other races or ethnicities of rape while intoxicated, which may be attributable to higher rates of heavy alcohol use among white college students (Mohler-Kuo, Dowdall, Koss, & Weschler, 2004). However, other research has found higher odds of past-year sexual assault for Black college students than for whites, as well as among students with intersecting minority identities (Coulter et al., 2017). In particular, Black transgender students were shown to have more than eight times the risk of being assaulted than white transgender students (Coulter et al., 2017). Research has also demonstrated similar or higher risk for assault among gay, lesbian, and bisexual students as among heterosexual female students (Coulter & Rankin, 2017). Taken together, the high average prevalence rates among college women broadly and increased risk for students with intersecting minority identities indicate both that sexual assault has a widespread impact on college students, and that some groups of students will be affected to an even greater extent.

Consequences of Sexual Assault for College Survivors

Sexual assault and rape have been firmly linked with numerous health and mental health sequelae. A high proportion of victims develop posttraumatic stress disorder and fear or anxiety, and are at greater risk for depression, substance abuse, and suicidal ideation and/or attempts (Campbell et al., 2009; Carey et al., 2018). In addition to mental health symptoms, victims often face other psychological consequences as a result of the assault such as shame and self-blame, which may be exacerbated by negative reactions from friends, family, or others to whom victims disclose the assault (Campbell et al., 2009). Sexual assault and rape have also been associated with a wide range of negative health outcomes, from acute injuries to long-term sexual dysfunction, gynecological problems, chronic pain, and gastrointestinal disorders (J. Campbell,

2002; Black, 2011; Paras et al., 2009). Among college women specifically, sexual assault has been associated with poor self-rated health (Zinzow et al., 2011) and increased health risk behaviors, such as heavy episodic drinking, drug use, and risky sexual behaviors (Gidycz, Orchowski, King, & Rich, 2008; Turchik & Hassija, 2014). Women who are sexually victimized in college also experience adverse academic consequences. Sexual assault has been prospectively associated with lower grade point averages in the semester following the assault (Jordan et al., 2014), and is correlated with lower academic efficacy and higher academic stress (Banyard et al., 2017).

To serve victims' psychological, physical, and academic needs, campuses and communities have created a host of *victim services*, defined for the purposes of this study as victim advocacy, mental health services, and medical care[2]. Advocacy involves assisting victims with accessing needed services and resources, as well as providing empathetic support. Mental health services may involve individual or group counseling provided either in traditional mental health settings or through rape crisis organizations. Medical services include acute post-assault treatment and medical forensic evidence collection, as well as long-term care to address chronic assault-related symptoms. The current study focuses on current challenges and benefits in providing campus- and community-based victim services for college students through the lens of the current US policy context.

[2] For this study, *victim services* are defined as services intended to provide a direct benefit or support to the victim. The criminal justice system and university disciplinary systems are excluded from this definition; while they may eventually provide a benefit to the victim, such as a sense of justice or removal of the perpetrator from the campus or community, these systems do not necessarily provide direct support to victims and are also intended to serve the broader interest of public safety.

Services for College Victims

Help-seeking. Despite the high prevalence rate of sexual assault, few college women who experience sexual victimization report the assault to formal sources (e.g., police, university administrators) or seek help from formal systems like the medical or legal systems (Sabina & Ho, 2014). In a national study of college women with a lifetime history of rape, 19% had received medical attention for the rape and 18% sought help from another victim services organization (Wolitzky-Taylor et al., 2011). Studies of past-year victimization among college women have revealed even lower rates of help-seeking, with one study finding that only 3% of victims of unwanted sexual contact and 6% of victims of unwanted sexual intercourse sought any services related to the assault (Walsh, Banyard, Moynihan, Ward, & Cohn, 2010). Although there is limited research on whether college victims seek services at different rates from on- and off-campus service providers, one study using a convenience sample of undergraduate women found that 22% of those who experienced a sexual assault used any on-campus resource, whereas only 6% used an off-campus resource (Nasta et al., 2005).

Most studies of services for college survivors focus on their decisions to seek help (i.e., service utilization). However, few studies have investigated characteristics of the services themselves that may impact their quality, accessibility, and acceptability for college survivors (i.e., service *provision*; Sabina & Ho, 2014). The current study focuses on current issues in *providing* victim services. This approach moves away from an emphasis on individual determinants of help-seeking, and instead prioritizes investigating how service practices are improved or constrained by structural factors and policy at different levels. An overview of the literature related to service provision for advocacy, mental health, and medical services for college victims is presented below.

Advocacy for college victims. When sexual assault victims do disclose that they have been assaulted and are contemplating seeking help, it is often helpful for them to have the assistance of a victim advocate. Advocates accompany and assist victims in navigating complex and often re-traumatizing response systems, such as medical and criminal justice systems (Townsend & Campbell, 2018). Advocates have traditionally been a confidential resource and are protected by confidentiality statutes in over half of US states, reflecting the belief that victim-advocate privilege is vital to both maintaining a trusting relationship and to ensuring victims feel they can seek services while retaining control over their private information (Cole, 2011). Depending on their institution and community, college victims may have access to either campus-based or community-based advocacy, both, or neither.

Campus-based advocacy includes services that are provided directly on campus, often by university employees and/or peer student volunteers (Bergen & Maier, 2011). Campus-based advocates may provide a range of services including trainings on sexual violence, prevention efforts, and direct advocacy and intervention (Payne, Ekhomu, & Carmody, 2009). Recent studies using nationally representative samples of universities found that campus-based advocacy was available on 43-55% of campuses, with advocacy being more frequently available at larger and public institutions (McCaskill, 2014; Richards, 2016). Community-based advocacy includes the provision of similar services to campus-based advocacy, but advocates are not directly employed by the university and instead work for a community-based organization, such as a rape crisis center, domestic and sexual violence shelter, or women's center (Payne et al., 2009). Whether on or off campus, advocacy organizations and rape crisis centers also frequently provide individual and/or group counseling, which is generally short-term and focused on mental

health sequelae of sexual victimization (Ullman, 2007; see the following section on mental health).

Few studies have examined challenges that campus-based advocates may face given their status as part of a university. In one qualitative study, campus-based advocates from four-year universities in one state identified a need for greater statewide coordination of sexual assault services and increased funding specifically for campus advocacy (Carmody, Ekhomu, & Payne, 2009). This study points to themes that merit further investigation, including a desire for increased coordination among campus and community-based advocacy organizations (Carmody et al., 2009). However, the study was conducted prior to recent significant policy changes (see section below on Recent Policy Reforms), and as such may not reflect current challenges in campus-based advocacy. In addition, this study relied on a regional sample, which likely does not reflect the full range of contexts, policies, and practices related to advocacy services. A national lens on issues in advocacy and victim services is warranted given that availability of such services has been found to vary widely across institutions (McCaskill, 2014; Richards, 2016).

Mental health services for college victims. To address the trauma of sexual assault and related mental health symptoms, college victims may seek counseling services from traditional community mental health centers or from college counseling centers. Additionally, on- or off-campus victim advocacy organizations and rape crisis centers frequently offer individual or group counseling. Evaluations of counseling provided by rape crisis centers have shown that counseling generally improves victims' well-being (Townsend & Campbell, 2018). However, research is limited on the effectiveness of mental health treatments and counseling specifically for college sexual assault survivors.

Outside of specialized sexual assault counseling, mental health services for college students are frequently available from on-campus counseling/mental health centers for low or no cost. However, the quality and availability of such services may vary, and concerns have been raised that campus providers may not be adequately trained in handling severe mental illness (Mowbray et al., 2006). A recent nationally representative study of institutions of higher education revealed that 35% of institutions did not report having any on-campus counseling, whether for sexual assault specifically or in general (Richards, 2016). Additionally, the extent to which campus-based mental health providers receive specialized training in supporting survivors of sexual assault remains unclear, despite survivors having unique needs for both acute post-assault intervention and longer term trauma-focused psychotherapy (White Kress, Trippany, & Nolan, 2003). Some institutions have created counseling programs or positions specifically for sexual assault survivors as part of on-campus sexual assault advocacy programs, yet little has been published about these services (Bergen & Maier, 2011).

As with campus-based advocacy, researchers have not examined challenges in providing campus-based sexual assault counseling. Although on-campus mental health services are usually free or low cost and may be more accessible to students than community mental health services, victims may not trust institutional resources or may worry about the confidentiality of campus-based services. Even in community mental health settings, concerns about confidentiality are frequently cited by victims as a barrier to disclosing a history of intimate partner violence to their providers (Rodriguez, Sheldon, Bauer, & Perez-Stable, 2001). Similar to other institutions like the military, universities (especially residential ones) may form a kind of "closed system," or an organization that comprises a distinct social system and has its own policies and procedures for resolving issues internally (Brenner, Darcy, & Kubiak, 2017). As part of a closed system, college

victims in particular may be concerned about disclosing an assault to campus mental health providers if they believe this information could be shared with others at the university. However, empirical research is lacking on the extent to which confidentiality concerns pose a barrier to disclosing sexual assault to campus providers and/or to seeking mental health services on campus.

Medical care for college victims. Victims of sexual assault have a variety of acute post-assault medical needs, including screening and treatment for sexually transmitted infections, pregnancy testing and emergency contraceptives, and treatment of bodily injuries (Campbell, 2008). Additionally, victims may choose to undergo a medical forensic exam in which forensic evidence of the assault is collected from the victim's body, often by a Sexual Assault Nurse Examiner (SANE) (also called a Sexual Assault Forensic Examiner, or SAFE) who has received specialized training to provide empathetic, victim-focused care while documenting evidence and addressing health concerns (Campbell, 2008). In addition to acute medical needs, the long-term health consequences of sexual violence are extensive and victims may seek general health care for assault-related symptoms (Macy, Ermentrout, & Johns, 2011).

The extent to which SANE services and other post-assault health services are available to college students has not been comprehensively investigated. In one national survey of 236 institutions, 15% reported having a SANE program, with fewer small institutions having a SANE program than medium or large institutions (McCaskill, 2014). In the same survey, the majority of institutions reported that their student health centers offer services to those who have reported sexual violence, and nearly all (90%) reported that such services were available in their community (McCaskill, 2014). However, the self-report nature of the survey and lack of precise definitions about what constitute "services" for sexual violence mean that these numbers should

be interpreted cautiously. Overall, very few studies have examined either the availability or quality of post-assault medical services specifically for college students.

One study examined the frequency with which students are screened for sexual assault or intimate partner violence (IPV) by campus health providers, finding that only 10.2% of a sample of college women from five different colleges were screened during their most recent college health center visit (Sutherland, Fantasia, Hutchinson, & Katz, 2017). However, women in this study who visited the health center for a gynecological or sexual health reason were almost four times as likely as other women to have been screened. This study indicates that screening for sexual assault may be particularly low among general campus health providers, and the authors argue that "without screening, unique opportunities for secondary prevention...and referral are being missed" (Sutherland et al., 2017, p. 17). As in advocacy and mental health services, privacy and confidentiality have been identified as key elements of best practices for screening for sexual assault in medical settings (Macy et al., 2011). However, research has not yet examined potential factors, such as being part of a "closed system" as described previously, that could limit the confidentiality of screening and services provided by campus physicians.

Recent Policy Reforms Related to Confidentiality of Services for College Survivors

Overview of campus reporting and confidentiality policies. Recent policy changes at the federal and state levels may have significant implications for advocacy, counseling, and medical services for college survivors. Student activism and public attention to university mishandling of sexual assaults have resulted in increased enforcement of existing statutes, as well as the creation of new policies aimed at improving prevention of and responses to campus sexual assault. Under the Obama administration, the US Department of Education's Office for Civil Rights (OCR) worked to improve enforcement of Title IX of the Education Amendment of

1972 (Title IX), which prohibits sex or gender discrimination in federally funded educational institutions. As part of this enforcement, the OCR issued regulatory guidance for schools in the form of a so-called "Dear Colleague Letter" (US Department of Education, OCR, 2011). The letter described the steps institutions must take when they have knowledge that sexual misconduct has occurred on campus or among its students. Further regulatory guidance was also provided in the form of a Frequently Asked Questions document (US Department of Education, OCR, 2014). At this time, the Department of Education under the Trump administration has rescinded these guidance documents and issued interim guidance, with the intent of reviewing current practices due to concerns about their equity to victims and accused students (US Department of Education, OCR, 2017).

Although the future of these guidance documents is uncertain, one key component of Title IX guidance that has direct implications for victim services is the requirement that certain school employees be designated "responsible employees." These employees are required to report any disclosures they receive of sexual misconduct, including involved parties' names, to a university official such as the Title IX Coordinator (US Department of Education, OCR, 2014). Universities have crafted varying reporting policies in order to comply with this federal guidance. Such university policies are commonly referred to as mandatory reporting policies; however, some scholars have argued that they should be called *compelled disclosure* policies to emphasize a) that they are distinct from actual mandatory reporting *laws* that require reporting to law enforcement (e.g., for suspected child abuse) and b) that they in essence create an involuntary disclosure of survivors' experiences to the university (Holland, Cortina, & Freyd, 2018). A recent study using a random stratified sample of four-year institutions of higher education found that over two-thirds of institutions designated all staff and faculty as responsible

employees (except those whom the OCR explicitly exempts, including licensed psychologists and counselors, health care providers, and clergy; Holland et al., 2018). The same study found less than 5% of institutions limited this designation to only certain supervisory, leadership, and/or administrative employees (e.g., Residence Assistants, Deans, high level administration). The fact that most institutions have implemented broad compelled disclosure policies raises concerns about the confidentiality of campus victim services, especially because federal guidance has left it to institutions to decide whether advocates are exempt from such policies (see section on potential impacts on victim services below).

In addition to compelled disclosure policies, recent amendments to the federal Jeanne Clery Disclosure of Campus Security Policy and Crime Statistics Act of 1990 (Clery Act) also impact the confidentiality of victims' disclosures. The Clery Act requires all institutions of higher education to publicly report crime statistics for their campuses (Clery Center, 2018). The Act also stipulates that, in addition to campus security/law enforcement, certain individuals on campus are designated "campus security authorities" and must report campus crimes of which they are aware (Clery Center, 2018). If a report indicates that public safety could be at risk, such as in the case of a potential serial perpetrator, the Clery Act requires that a notification be sent to all members of the university with information about the crime. Recent guidance on the Clery Act lists victim advocates as campus security authorities, meaning that they are required to report known instances of sexual assault to the institution (US Department of Education, OCR, 2016). Additionally, the recent guidance stipulates that the director of a campus health or counseling center is considered a campus security authority, and that physicians, non-licensed or peer counselors, and health educators could also be considered as such if their institution instructs students or employees to report crimes to these individuals (US Department of Education, OCR,

2016). Though generally only aggregate information is required for Clery Act reporting, the expansion of the definition of "campus security authority" to include advocates and other service providers means that college survivors cannot access victim services or disclose to certain providers without at least some information about the assault being reported to campus officials.

Separate from Title IX and Clery Act reporting requirements, aspects of the Family Educational Rights and Privacy Act of 1974 (FERPA) may impact the confidentiality of survivors' campus medical and mental health records. FERPA is a federal policy that protects the privacy of students' educational records and specifies the limited situations in which educational records can be released. Recent federal guidance on FERPA from the Department of Education's Office of the Chief Privacy Officer clarifies that university-based medical and mental health records are typically considered educational records rather than treatment records, except in some narrow circumstances (US Department of Education, Office of the Chief Privacy Officer, 2016). As educational records under FERPA, medical and mental health records may be accessed without student consent by school officials with a "legitimate educational interest" (US Department of Education, Office of the Chief Privacy Officer, 2016, p.4). For survivors, this provision means that confidential sexual assault-related medical and counseling records can be accessed by university attorneys if a survivor is involved in litigation with the university. However, federal guidance does specify that medical and mental health records should not be shared with attorneys unless the lawsuit pertains directly to the services themselves or payment of such services (US Department of Education, Office of the Chief Privacy Officer, 2016).

Potential impacts on victim services. As described above, compelled disclosure policies, Clery Act requirements, and FERPA have evolved in recent years in ways that may impact university-provided services for sexual assault survivors. Federal reporting policies are

presumably intended to ensure that victims receive support and institutions respond in a timely manner to potential campus safety threats. However, scholars and practitioners have expressed concerns about the lack of agency victims may experience as a result of university compelled disclosure policies (Holland et al., 2018). Feminist conceptualizations of sexual assault frame the experience as one in which agency and control are stripped from the victim, and as such, responses to sexual assault should include helping victims "regain control over their lives" (Martin, 2005, p. 104). When victims disclose an assault to others and those individuals tell more people about the assault without the victims' consent, it can exacerbate post-traumatic stress symptoms (Orchowski, Untied, & Gidycz, 2013; Ullman, Filipas, Townsend, & Starzynski, 2007). Compelled disclosure and other reporting policies may increase the likelihood that when a sexual assault victim discloses an assault to a campus provider, that provider must inform someone else at the institution, regardless of the victim's desires.

Because of the recency of compelled disclosure policies and expansion of Clery Act reporting, there has been little research on how these policies might affect service provision. One recent study conducted after the Obama-era policies were implemented found that campus-based advocates working in Northeastern universities had significant concerns about being designated responsible employees and the changed "dynamic" (p. 12) that occurs when they inform victims that they must report information to the university (Moylan, 2017). Advocates reported that they were seeing negative ramifications of such policies, with some victims choosing not to receive services after learning that their confidentiality could not be ensured (Moylan, 2017). This study provides initial evidence that compelled disclosure policies may complicate the role of campus-based advocates and make it difficult to guarantee confidentiality of victims' information, which

is important both for maintaining victims' sense of control and for continued help-seeking (Cole, 2011).

The recent inclusion of victim advocates as campus security authorities under the Clery Act may raise similar concerns to compelled disclosure policies regarding the sharing of victims' information and experiences without their consent, although Clery reports can usually consist of non-identifying information. Including physicians and non-licensed or peer counselors as possible campus security authorities is also troubling, since patient concerns about lack of privacy in medical contexts are a primary barrier to disclosing sexual victimization to providers (Robinson & Spilsbury, 2008). If campus security authorities do not clearly understand the limits of what must be reported to meet Clery requirements, victims' identifiable information could be included in the report. Additionally, if victims perceive that disclosing an assault to a provider could trigger a campus-wide notification, they may be less likely to seek medical and mental health services related to post-assault symptoms or to disclose a history of assault to their provider. It is therefore important to study the impact of recent Clery Act amendments on the confidentiality of campus advocacy, health, and counseling services and records for college survivors.

In addition to concerns about campus-based service providers' confidentiality protections at the federal level, recent policies enacted at the state and local levels have further complicated the legal status of providers. Multiple states have passed or considered mandatory reporting laws that require universities to notify law enforcement about reported sexual assaults in some cases, such as if a felony sex crime has been committed (Richards & Kafonek, 2016). While such laws do not directly change the reporting responsibilities of victim service providers, they conflict with provisions of the Clery Act that require institutions to inform victims of their right to notify

or *decline to notify* law enforcement. At the institutional level, some universities do require responsible employees themselves to report sexual assaults to both university administrators *and local law enforcement*, despite this not being encouraged by any OCR guidance (Holland et al., 2018). Victim service providers who are considered responsible employees on some campuses, such as advocates, may therefore have to choose between complying with their institutional reporting policy or federal law. Depending on local and state laws governing confidentiality of victim services (e.g., state laws requiring that victim advocates maintain clients' confidentiality), the intersections of institutional or state *reporting* policies with *confidentiality* policies may make it virtually impossible for campus-based advocates, counselors, or physicians to comply simultaneously with all policies. The effects of the current state of policy complexity on victims' experiences seeking services, as well as on providers' ability to navigate this complexity, merit further investigation.

CURRENT STUDY

Policy reforms at the national and state levels have raised concerns about the confidentiality of college victims' disclosures of assault to campus employees, yet research on compelled disclosure has not yet sought to understand the implications of these concerns for on-campus victim services. Additionally, while college survivors may have access to campus-based services, community-based services, or both, there is a lack of research on potential differences in these types of services, including their ability to meet the specific needs of college students. The current study addresses this gap by exploring current issues in service provision for college survivors. The purpose of this study was to explore experts' perceptions of the unique challenges and benefits of campus-based and community-based victim services for college survivors through the lens of the current US policy context through the following research questions:

1) What are key challenges and benefits in providing *campus-based* victim services to college survivors, given the current US policy context?
2) What are key challenges and benefits in providing *community-based* victim services to college survivors, given the current US policy context?

Data from in-depth qualitative interviews were selected as an appropriate methodology for a topic such as this that is complex, relatively unexplored, and undertheorized (Creswell, 2012). A broad, macro-level approach was appropriate for the exploratory nature of the research questions; this approach aimed to explore cross-cutting issues in how policies and reforms are playing out for victim services on campuses across the US, which is appropriate given recent large-scale federal policy initiatives. A national lens was also well suited because the availability and nature of each type of service varies considerably across communities and regions.

Based on this macro-level framework, the author determined that national experts who provide training and consultation to multiple campuses regarding sexual assault responses are in the best position to provide insights into current challenges in the provision of victim services. These experts would be able to share concerns that they hear from institutions with which they work, rather than focusing on the issues of one specific institution. It was also important to include experts from a variety of disciplinary backgrounds (e.g., nursing, law enforcement, university administration, legal, advocacy) who are likely to have interacted with advocates, counselors, and medical providers during their work.

Although other target populations for this study were considered, ultimately a sample of national, multidisciplinary experts was the most appropriate for answering the current research questions. Previous research in this area has primarily relied on practitioners working within one campus or community (e.g., Moylan, 2017), or has involved asking survivors themselves about their help-seeking experiences (e.g., Holland & Cortina, 2017). While research on the practices of any one institution or community may be helpful for gaining an in-depth understanding of specific processes, it does not capture larger trends and issues, and may overemphasize challenges that are specific to one location. Similarly, conducting interviews with survivors on any one campus does not allow for a national analysis of the impacts of recent policies, and it is logistically very difficult to interview survivors across multiple universities who have sought victim services. Therefore, the target population was determined to be national experts who frequently interact with survivors, service providers, and policymakers, and can therefore speak to how campus- and community-based services may differentially meet the specific needs of college survivors, as well as the impact of recent policies on victim services in the college context.

METHOD

Research Paradigm and Qualitative Approach

This project was guided by a pragmatic, applied research paradigm in which the research questions, rather than a specific paradigm, dictate the methodology and approach (Tashakkori & Teddlie, 2003). Given this pragmatic paradigm, the author used Miles, Huberman, and Saldaña's (2014) approach to qualitative research, which itself is pragmatic and useful for conducting rigorous analyses in applied contexts (see Data Analysis below). The current study involved secondary data analysis of qualitative data collected by the author and her advisor that was focused on current challenges in victim services, but also included data on campus Title IX activities (e.g., accommodations, investigations) and the interface between Title IX and criminal justice investigations. For the current study, only data pertinent to advocacy, mental health/counseling, and medical services (as well as policy related to these) were analyzed. As discussed above, this data was collected from national experts on campus sexual assault who had worked across multiple settings and institutions and therefore had a sense of national cross-cutting issues in responding to campus sexual assault. The sample, measures, and procedures of the original study are reviewed below.

Sample

To identify national experts on campus sexual assault, an initial sampling frame was derived by searching for presenters in national conference programs on sexual violence, campus sexual assault, and Title IX from the past three years (i.e., 2015-2017). Presenters were included in the sampling frame if the following criteria were met: 1) their presentation abstract was related to responses to campus sexual assault (including direct responses on an individual level as well as systemic responses); 2) their position title, organization name, or presentation indicated that

they were not exclusively a direct service provider or responder (i.e., they did some training and technical assistance); 3) they worked in multiple settings or with multiple institutions; and 4) they were listed as a primary speaker for a symposium, presentation, workshop, or keynote presentation. If it was unclear from the conference program whether these inclusion criteria were met, we searched online for additional information about the presenters and their organization to assess the scope of their work and verify that they had worked in multiple settings. Additionally, only one person from a given organization was included in the sampling frame; if an organization had multiple presenters, the presenter with the most senior and/or relevant position was included.

To ensure that our sampling frame had good breadth of disciplinary background and perspectives, we asked participants at the end of their interview to provide names of other national experts as potential participants. This type of snowball recruitment is common in qualitative research to ensure good reach and coverage into a network, particularly one that is geographically diffuse (Beitin, 2012; Patton, 2015). Additional experts identified in this way were purposively sampled after the initial sampling frame had been contacted to provide breadth where certain disciplinary backgrounds were not yet adequately represented, or to provide depth where they held particular expertise on an issue that had been touched on by previous participants (see Procedures below).

Participants were invited to participate in the study via email using contact information that was publically available online. Of the 24 potential participants who were contacted, 22 responded, at which point additional information about the study and a consent form were sent and a phone interview was scheduled. Of these 22, two recommended we speak with a different person within their organization who had more experience working with multiple universities.

Both of these people were then contacted and agreed to participate. The 22 final participants came from a variety of disciplinary backgrounds, including nursing, law enforcement, university administration, legal, and victim advocacy. Four participants identified their gender as male and 18 identified as female; participants' age ranged from 28 to 66 years old. 10 participants held a juris doctorate (JD), five held Master's Degrees, and the remaining seven had educational backgrounds ranging from Associate's Degrees to some graduate school.

Measures

For the interviews, a semi-structured qualitative guide was created covering several topics, including: 1) the nature of participants' work on campus sexual assault; 2) key challenges and issues in responding to campus sexual assault; 3) specific questions about each of the main response systems, including university procedures, criminal justice, medical, and advocacy; 4) coordination of these systems; and 5) key training issues for responders and universities (the full interview guide can be found in Appendix A). To ensure that all areas of campus sexual assault response were probed, the interview guide was developed based on the researchers' prior knowledge about system responses to sexual assault, specific elements of the OCR's 2011 "Dear Colleague Letter," and literature on coordinated campus sexual assault response models (Barry & Cell, 2009; US Department of Education, OCR, 2011).

Procedures

The procedures used in this study were reviewed and approved by the IRB at Michigan State University. Informed consent was obtained from all participants. All phone interviews were conducted by the author and her advisor during a four month period in the summer and early fall of 2017. After the original sample was recruited and interviewed, participant recruitment and interviewing continued using purposive snowball sampling until saturation was achieved, at

which point no new themes emerged from additional interviews and existing themes were repeated by other participants (Guest, Bunce, & Johnson, 2006; Patton, 2015; Sandelowski, 1995; Starks & Trinidad, 2007). To determine who to purposively sample and when saturation was reached, the interviewers reviewed completed interviews from the original sample, discussed emerging themes, and I conducted initial coding to look for saturation or gaps in content and themes. The interviewers then reached out to additional experts identified by the original sample to fill gaps in disciplinary breadth or to achieve more depth on a specific issue. After 22 interviews, clear patterns and themes had emerged in the data surrounding key issues and challenges in responding to campus sexual assault across multiple systems and under a complex set of policies. The length of interviews ranged from 33-63 minutes. All interviews were audio recorded with consent from participants, transcribed by a research assistant or through an online transcription service, and checked for accuracy. Transcripts were then loaded into Atlas.ti software version 8.0 for analysis. The interviewers also took notes throughout the interviews, which were used to check for accuracy of transcripts and to aid in preliminary analyses.

Researcher Characteristics

It is important in qualitative research to describe characteristics and perspectives of the researcher that may influence the research (O'Brien, Harris, Beckman, Reed, & Cook, 2014). The author of this study is a graduate student who volunteered as a campus-based victim advocate throughout the course of the research, which meant that she had firsthand experience with some of the benefits and challenges in providing advocacy for college students as part of an on-campus program. However, because of the national and macro-level approach of this study, many of the issues raised by participants were not ones that the author has experienced directly.

The author's experiences providing medical advocacy (i.e., accompanying victims during hospital-based SANE exams) also provided an underlying understanding of community-based post-assault medical care for victims. In comparison, the author has had relatively little experience or interaction with mental health and counseling services for college survivors. This lack of exposure may have influenced the study in terms of developing the interview guide, which did not include a specific question about mental health services (see Limitations section). The author had not had any prior interactions with the participants, with the exception of one participant whom she had met on one previous occasion.

During the course of this research, the author was also involved in her own university's response to the criminal investigation and prosecution of a physician who had committed hundreds of acts of sexual abuse while employed by the university. The author currently works as a graduate assistant for a group of faculty and practitioners appointed by the university president in response to this crisis to improve prevention, services, and institutional responses to sexual assault. Because much of the current study was planned and executed before the author began in this role, the research questions, methods, and analysis were not directly impacted by this work. Instead, the author frequently saw patterns and themes that had already emerged in this study play out at her own university. While these experiences underscored the salience of the current study for the author, they did not occur until after much of the analysis had been completed. Throughout data analysis, the author engaged in reflexive memoing to help understand her own assumptions and biases, which are described below.

Reflexivity

The author identified several of her own assumptions that were relevant to the current study. First, the author views sexual assault and other forms of intimate partner violence through

a critical feminist lens, in which societal power differentials between genders are an essential component of these forms of violence. This lens informs the author's understanding of sexual assault as an act of power and control over the victim, as well as her understanding of universities as patriarchal structures that have historically been oppressive to women and other marginalized groups. Second, based on her knowledge and experience as both a researcher of gender-based violence and as a victim advocate, the author believes that responses to sexual assault should emphasize the experiences and needs of the survivor, an approach that has been termed "survivor-centered." To limit potential bias due to her belief in a survivor-centered approach, the author wrote reflexive memos about this bias during analysis and took steps to ensure she was representing the views of her participants, rather than her own opinions or experiences. Third, in keeping with the pragmatic research paradigm of this study, the author believes that many different methodologies and approaches are useful for studying complex social phenomena such as campus sexual assault, and that the specific research questions at hand should dictate the study's methodological approach.

Data Analysis

For the current study, analyses focused specifically on any interview data related to victim services, including campus- and community-based advocacy, mental health, and medical services, as well as data related to implications of federal, state, local, or institutional policies. Interviews were analyzed using Miles et al.'s (2014) approach to qualitative data analysis, which does not adhere to one specific genre of qualitative analysis but instead takes a pragmatic and rigorous approach that is well-suited for the exploratory research questions in this study. This analysis strategy follows a three-phase process comprised of "data condensation," "data display," and "drawing and verifying conclusions" (Miles et al., 2014).

The first phase of *data condensation* involved focusing and organizing the data in preparation for more nuanced analysis in Phases Two and Three. Data condensation included two steps or cycles of coding: in the first cycle, preliminary codes were used, followed by a second cycle in which pattern codes were developed and applied. For this study, first cycle coding involved applying mostly *descriptive* codes across the data, which Miles et al. (2014) define as codes that "summarize . . . the basic topic of a passage" (p. 74). Some descriptive codes were *provisional*, or researcher-generated prior to beginning analysis. Provisional codes for this study included broad content categories, such as "advocacy," "mental health," "medical," and "policy." Other descriptive codes were emergent and created based on topics that appeared in the data, such as a more general "victim services" code that was used when participants did not specify a particular type of service. For the current study, the author referred to codes resulting from this first cycle of coding as "primary constructs" codes in order to distinguish them from later coding. Each passage that received a primary construct code was also coded as either describing "campus-based" or "community-based" services, unless this was not specified. An example of how interview passages were coded during the first cycle is presented in Table 1.

Table 1: First cycle coding examples

Primary construct codes: "advocacy," "campus-based" R: I think of campus advocates akin to an advocate that works in law enforcement or a prosecutors' office. They're really great and helpful if you're trying to navigate that one institution, but when you start asking them about the nuances of seeking out a civil protection order in [redacted] and what that looks like, they're not quite as good because that's not their system, that's not their institution.
Primary construct codes: "medical," "policy," "campus-based" In the campus setting, if the campus has made it that all campus employees are mandated to report to the Title IX officer, any known or suspected sexual assault, in the absence of a state statute requiring that, they're asking basically the nurse to give personally identifying healthcare information to a campus investigator or Title IX person where the potential is that that is a breach of what is called the Healthcare Information Portability and Accountability Act, or HIPAA, which is a federal obligation to protect the privacy of patients.

After the first coding cycle, data were analyzed for a second time using *pattern* codes, which Miles et al. (2014) define as "explanatory or inferential codes . . . that identify an emergent theme, configuration, or explanation" (p. 86). Pattern codes help pull together and condense the many codes generated in the first cycle into more meaningful and thematic units. These codes may be categorized as themes, explanations, social relationships, or theoretical constructs (Miles et al., 2014). For the current study, pattern coding involved re-reading all passages that had received a primary constructs code and developing pattern codes to capture emergent themes in the data. After approximately every fifth interview had been pattern coded, the author collapsed or consolidated pattern codes that had only been used once (unless the pattern code was expected to apply to interviews that had not yet been coded). This process ensured that pattern codes were reflective of themes across participants rather than only within one interview, and prevented the list of pattern codes from becoming too long to be interpretable. This second cycle of coding ultimately resulted in a list of fifteen pattern codes (see Table 2 for an example of second cycle coding) that were then grouped into six overarching themes.

Table 2: Second cycle coding example

Pattern code: "lack of knowledge about confidentiality/privacy issues"
R: There is a really disheartening lack of information and understanding that I think permeates all levels of those who provide services to survivors regarding survivors' privacy rights and how to protect them. For example... oh, I think we did a national webinar and one of the questions that I asked was to measure the advocates' understanding of whether a survivor disclosed to a responsible employee, whether that responsible employee could keep the survivor's information confidential in the context of campus sexual assault and like 84% of the people either got it wrong or said they didn't know.

After the pattern codes were applied and grouped into themes, the analysis moved into the second phase, *data display* (Miles et al., 2014). This phase involved organizing data into visual displays that helped to present the data in a systematic, easily interpretable format. Two types of matrices were used in the current analyses: descriptive construct matrices that show

variability in central constructs, and effects matrices that illustrate the outcomes of some factor (e.g., a specific policy) on variables of interest (e.g., different types of victim services; Miles et al, 2014). All data matrices developed in the current study can be found in Appendices B and C.

First, construct matrices were developed for each theme in order to compare and contrast patterns between campus- and community-based services, and across advocacy, mental health, and medical services (the full set of construct matrices can be found in Appendix B). These matrices involved tallying the number of quotations for each pattern code by service type (e.g., advocacy) and context (e.g., campus). The number of quotations was not used as a definitive, quantitative measure of each pattern and theme, but rather as a means of making visual comparisons and looking for contradictory evidence in the final analytic phase of *drawing and verifying conclusions* (Miles et al., 2014; see below).

Table 3: Example construct matrix: Variability in campus & community services

Theme: Confidentiality & privacy of services	**Campus**	**Community**	**Not specified**
Weak confidentiality or privacy protections	XXXXX +++++++ ## O	+	
Lack of clarity/knowledge about confidentiality policies	XXXXX ++++		
Strong confidentiality protections	X	+++	
Key: X = medical # = mental health/counseling + = advocacy O = victim services & supports (general)			

Table 3 shows an example construct matrix for the theme "confidentiality and privacy of services." The matrix displays the three pattern codes that comprise this theme: 1) weak confidentiality or privacy protections, 2) a lack of clarity or knowledge about confidentiality policies by providers, and 3) strong confidentiality protections. This matrix demonstrates that medical and advocacy services (as well as mental health services to a lesser extent) were frequently described by participants as having weak confidentiality protections in the campus

context, but not the community context, and that campus providers of these services were described as lacking clarity or knowledge about confidentiality policies. Table 3 also shows the utility of construct matrices for showing data that is contradictory to the overall theme, such as the one quotation (marked with a single "X" in the bottom left cell) that described campus-based medical services as having strong confidentiality protections. Once construct matrices were developed for all themes, two of the themes were found to have more conceptual overlap than others and were collapsed, yielding five final themes.

A second type of matrix was developed to better understand the theme of confidentiality and privacy of services through a policy lens. An effects matrix was created to show how various policies at different levels (i.e., federal or state/local) were described by participants as impacting the confidentiality of each type of service (see Appendix C). This effects matrix was necessary because of the complexity of the policy context related to confidentiality and reporting of campus sexual assaults. The matrix helped to delineate which policies were described in relation to each type of service, as well as to show areas where policies appeared to be contradictory. An effects matrix was not created for the other four themes because they did not directly relate to policies.

Finally, after all data were fully explored using data displays, analysis moved into the final phase of *drawing and verifying conclusions*. In this phase, patterns and themes that emerged through coding and data displays were interpreted, and meaning was drawn from the data (Miles et al., 2014). Multiple tactics for drawing conclusions were used, including noting patterns and themes as previously described, counting, and making comparisons/contrasts. Noting patterns and themes is a typical way to draw conclusions from qualitative data and occurred organically during the analysis process. Miles et al. (2014) caution that when looking for patterns, it is

important to both note additional evidence for the pattern and also to remain skeptical and open to the possibility of disconfirming evidence. For the current study, pattern codes and data displays from Phases 1 and 2 were reviewed to generate overarching themes and note any disconfirming evidence, which added context and nuance to the results. Counting is another common form of making meaning from data. Distinct from intentionally quantifying data (turning qualitative into quantitative data), Miles et al. (2014) describe counting as a process that often happens "in the background" of qualitative analysis when identifying a pattern and determining how consistently the pattern applies. More explicit counting may be useful for quickly viewing large amounts of data, verifying a hypothesis, or "keeping yourself analytically honest" (Miles et al., 2014, p. 284) by counting to make sure a theme accurately describes the data. Counting was used in the current study to generate the data matrices and to compare and contrast the frequency of pattern codes across the constructs of interest. The tactic of comparing and contrasting data is itself another means of drawing and verifying conclusions (Miles et al., 2014). In the current study, comparisons were used to draw conclusions about the different challenges and strengths across types of victim services (e.g., advocacy vs. mental health vs. medical), as well as between on-campus and off-campus services.

Trustworthiness

Lincoln and Guba (1985) described four criteria that must be met in order to demonstrate the trustworthiness of a qualitative study: *credibility, transferability, dependability,* and *confirmability*. *Credibility* involves demonstrating that the data have been accurately represented, and that readers can have confidence in the study's findings. In this study, the credibility of analyses were established by: 1) checking for the representativeness of the participants and events described in the data; 2) peer debriefing with the Committee Chair, Dr. Campbell, and

other colleagues as appropriate; and 3) looking for negative evidence, or disconfirmation of proposed conclusions (Lincoln & Guba, 1985; Miles et al., 2014). To evaluate *transferability* of conclusions, or how well findings might apply in different contexts, this study includes "thick description" (p. 316) of data, which provides readers with rich detail about the participants, study context (including geographical and time/historical context, which is particularly important given this study's focus on current policies), and focal constructs (Lincoln & Guba, 1985). *Dependability* of the analysis refers to the extent to which analyses are conducted systematically and consistently, and were addressed in this study by defining codes in a codebook, as well as keeping an audit trail of coding procedures and analytic memos about the coding process. The study's dependability was also enhanced by following Miles et al.'s (2014) rigorous analytic framework, as described previously. Finally, *confirmability*, or the extent to which conclusions are free from researcher bias and represent participants' perspectives faithfully, was addressed by writing reflexive memos about the author's thoughts, emotions, and possible biases throughout the analytic process. The strategies outlined here helped to ensure the rigor of the research and its potential utility for researchers, practitioners, and policy makers.

RESULTS

This study explored experts' perceptions of the unique challenges and benefits of campus-based and community-based victim services for college survivors through the lens of the current US policy context. While the research questions for this study were focused on challenges and benefits of campus- and community-based services independent from one another, a more comparative framing emerged from the analysis in which participants often spoke of these two service contexts in comparison or contrast with one another (i.e., campus-based services *versus* community-based services). Results are therefore presented for each service context in relation to the other to reflect participants' framing.

Participants raised concerns about the ability of campus-based services to meet survivor needs given the constraints of operating as part of a university with multiple competing interests and complicated policy obligations. Despite these limitations, a strong benefit of on-campus services was their accessibility for college students. In comparison, community-based services hold distinct advantages in terms of protecting the confidentiality of survivors and avoiding institutional conflicts of interest, yet off-campus services were described as hard to access for college students and less responsive to their unique educational and social needs. Coordination of campus- and community-based victim services emerged as an ideal model through which to fill the gaps in both of these contexts, and to provide holistic, survivor-focused services.

Campus-Based Services

Competing interests and confidentiality concerns. Participants explained that providers of on-campus victim services face an overarching challenge of operating within a university context in which there are multiple competing interests, which can negatively affect providers' ability to prioritize survivors' needs. Participants described how universities must

balance the needs and rights of student survivors with the need to protect the broader campus safety, as well as universities' own liability and reputational interests:

> *So what I see campuses struggling with . . . is that they have three . . . very distinct interests that they have to manage. The first interest is the person who is victimized who is a student, so they have to care about that person, that person's education, their needs, their safety. The second thing that they have to care about just as much is if the assailant is a student, they care about that person, they care about their education, they care about their safety, they care about their future. . . The third thing that they have to care about is the whole student body, their safety, their security, their education, their future. . . I talk to people about this a lot, about that struggle to balance those constituencies which are and should be equally important to the school. So that poses a problem in terms of victim services, because victim services is traditionally solely focused on the needs of the person who was victimized.* (Participant 6)

In this context of competing interests, victim service providers based within an institution may be perceived as acting on behalf of the institution rather than serving the best interests of the survivor.

Participants described the particularly difficult position of campus-based advocates as both university employees/volunteers and as advocates whose function is to support fully the victim:

> *[W]hat comes to mind is an Audrey Lorde quote, "The master's tools will never dismantle the master's house." . . . [There are] situations where the advocates, who are survivor-centered, really find themselves at odds with their employer who has an interest in either protecting the perpetrator or covering up what happened or otherwise undermining the survivor and the survivor's experience . . .* (Participant 11)

The potentially conflicting functions of these roles may result in campus advocates being required or pressured by the university to share confidential information about the survivor (see discussion of confidentiality of services below). Participants also noted that campus-based mental health and medical providers might be perceived as working on behalf of university interests rather than the survivor/client. Regardless of whether or not providers actually prioritize

university interests over survivors, this perception of conflicting interests may lead college survivors to avoid seeking help on campus.

The interaction of competing university interests with the current US policy context produced significant concerns about campus-based providers' ability to maintain survivors' confidentiality and privacy. This theme cut across advocacy, mental health, and medical services, but played out differently depending on the specific policies that affect each service type. For campus advocacy services, participants explained how existing federal, state, and/or local mandatory reporting policies explicitly limit survivors' confidentiality. Such policies address universities' interests in protecting campus safety, but may conflict with survivors' desire to maintain confidentiality by requiring campus-based advocates to report either aggregate crime statistics (i.e., Clery Act reporting) or identifying information (i.e., "responsible employee" provision of Title IX guidance; state or local mandatory reporting laws) to university administrators and law enforcement. One participant explained the benefits and drawbacks of requiring campus advocates to report crime statistics under the Clery Act:

> *So there's a pro there, and there's a con there. There's a pro that we actually could be counting more offenses. In my opinion, that's a pro, because then we give people access to resources and process. The con is that some victims truly want a confidential place where they can just talk about what happened, and they don't want even the reporting of a statistic to come forward.* (Participant 14)

Title IX-related reporting policies may also conflict with state or local privilege laws that protect the confidentiality of advocacy services, which participants explained can create confusion for universities and campus advocates about which policies supersede others:

> *I'm a responsible employee… [b]ut what if there is also a local privilege law that says that I'm not allowed to re-disclose anything that is communicated to me in my role as a sexual assault victim-advocate? …[H]ow do I balance my role on campus making me a responsible employee, and then my local jurisdiction telling me I'm not allowed to re-disclose because it's actually a privileged communication?* (Participant 7)

In comparison with campus advocates who have reporting requirements under federal law, campus-based mental health providers are explicitly exempt from such requirements under the Clery Act and Title IX guidance. However, participants explained how the confidentiality of campus mental health records may be compromised if they are considered by the university to be academic records, which are accessible by university attorneys in some circumstances under FERPA. Participants provided notable examples of how university attorneys have been able to access survivors' mental health records from campus counseling centers as part of their academic records:

> *We have seen a few universities taking the position that if there's later a dispute between the university and the student, like a Title IX lawsuit, the university will then go to its employees who hold records and say, ". . . We want to see the records of sexual assault advocacy counseling, mental health counseling. And we can look at them because you work for us." And FERPA says that a school can show their lawyers anything.* (Participant 6)

Participants felt that this kind of breach of confidentiality was particularly concerning because mental health records are protected by most state privilege laws. One participant described the harm and betrayal associated with universities using survivors' extremely sensitive information in this way to protect their own interests: "*Students feel like, 'Oh my gosh, we just lost this critical resource because anything that we say to a therapist is now going to become information that the school thinks it's entitled to view without the victim/patient's permission*'" (Participant 11).

For campus medical services, confidentiality concerns centered around the lack of clarity and guidance on how federal educational (i.e., Title IX, FERPA) and healthcare (i.e., Health Information Portability & Accountability Act (HIPAA)) policies impact campus health services. As with mental health records, a major concern of participants was that universities may consider campus health clinic records to be academic records under FERPA, which would allow

university attorneys to access survivors' health records. A related concern was that under FERPA, a survivor's assault-related health record could potentially be transmitted along with her academic record if she transfers to a different university:

> *That could be a problem because . . . if the student decides . . . they want to transfer to another university, . . . their academic record will go with them from one university to another. The other university has access to that record. And [the campus health clinic] record could potentially be included during that transfer.* (Participant 4)

Participants also identified a gap in which campus medical services that are provided by a university at no cost are not covered by the privacy protections of HIPAA, and would then be considered academic records under FERPA instead. Overall, participants described a state of confusion and varying policy interpretations among providers and universities, with individual states and universities determining how to handle survivors' health records in relation to HIPAA, FERPA, and other policies. As one participant stated, "*I think there's pretty much an absence of guidance. There's some information that has come out on HIPAA and FERPA, and the responsibilities for universities but those have been done on an individual state or university level*" (Participant 4). Given the context of universities having varying interests to consider, this lack of clarity may allow universities to interpret policies in a way that prioritizes campus safety, their own legal interests, or their reputation over survivors' confidentiality and privacy.

Availability and cultural responsiveness of services. In addition to affecting the confidentiality of services, participants described how university interests and values may result in some types of victim services simply being unavailable on campus. Participants explained that because of the numerous financial demands universities must balance, they typically cannot or choose not to fund on-campus post-assault medical care and SANE services. Aside from financial constraints, university characteristics such as religious affiliation may influence the availability of campus victim services if universities prohibit the provision of pregnancy

prophylaxis and other important post-assault medical needs. One participant elucidated this conflict between universities' religious values and their ability to support victims: *"[R]eligious institutions . . . may not offer certain services because it goes against their principles, and that is their right, . . . but how do you best serve your students if you're not giving them the full spectrum of care?"* (Participant 20).

Participants expressed the concern that even when services are available on campus, they are often not culturally responsive for survivors from marginalized populations, such as women of color and LGBTQ survivors. This theme was discussed as a broad issue in campus victim services, with participants noting the general lack of diversity among providers and a failure to consider the needs of marginalized groups first when providing services or creating supports:

> *I would wager to say that we're not spending enough time and energy trying to understand the specific needs of students who may be students of color, who may be marginalized students in different ways. I think we're starting to chip away at kind of the four year traditional residential student, but I don't think that addresses students of color, students with disabilities, students who have other things going on in their lives, whether it's immigration status or all of that.* (Participant 20)

A lack of racial and ethnic diversity was also noted specifically among campus-based advocates, who participants noted tend to be predominantly white women:

> *I think advocacy offices sometimes have trouble having a multitude of people that work there or volunteer . . . that look like all their constituents. There's a lot of homogeneity in those offices and often they're aware of it but they just don't know what to do about it or how to change it.* (Participant 19)

Several participants raised concerns about a lack of culturally responsive medical care on campus, pointing especially to stigma for sexual or gender minority survivors in accessing post-assault medical care. One participant explained that campus health providers may not receive adequate training on working with diverse populations:

> *[E]specially when you think about folks that don't identify as cis, heterosexual women and what healthcare looks like for them, and if they're disclosing that they're male*

> *survivors or transgender individuals, how they're treated by health center folks . . . If they don't feel safe at their health center with their providers, then they're going to be missing out on really necessary healthcare.* (Participant 5)

Overall, participants perceived campus services for college survivors to be inadequately tailored to address the needs of survivors with marginalized identities, for whom traditional services *"[don't] always feel like help for very legitimate reasons*" (Participant 19). It is worth noting that while much of participants' discussion on this point focused on campus-based services, several participants spoke more broadly about the need to improve cultural responsiveness of services across both campus and community victim services.

Accessibility of campus services. Although campus-based services' ability to meet the needs of survivors may be limited due to competing university interests, inadequate confidentiality protections, and culturally unresponsive services, participants stated that a major benefit of campus-based services is their accessibility to college students. Participants noted the advantages of having advocates available on campus for students' awareness of and ability to access campus-based advocacy. One participant explained, "*I think in terms of students being able to access it, in terms of making sure that advocates are involved in orientation or in training, having them be an on-campus resource is really important*" (Participant 18). Similarly, participants described the potential benefits of implementing campus-based SANE programs, including ease of accessibility and students' existing familiarity with campus health clinics. One participant noted the possible value of campus-based medical interventions for sexual assault:

> *[W]e think there's enormous potential . . . in doing health center-based interventions and working with students, because there's not a big stigma around going to the campus health center. Most students do, multiple times over their campus careers for all sorts of reasons. So we think . . . there's a great opportunity there.* (Participant 2)

Thus, while participants raised significant concerns about the limitations of campus-based services given the university context, they also pointed out that providing services on campus removes substantial logistical barriers for college survivors in terms of accessing care.

Community-Based Services

Independence and confidentiality protections. Community-based services were described as having several strengths in comparison with campus-based services, most notably their independence from university interests and corresponding ability to offer robust confidentiality protections for survivors' information in most cases. In contrast with campus-based advocacy, participants viewed community-based advocates as likely to be independent from outside interests, especially those of a university. This independence, one participant noted, may be important for victims to feel that their needs are being put first:

> *[B]ecause if I get assaulted on campus by someone on campus, and then go to a campus named organization for help, I just don't believe that they're going to have solely my interest at heart, whereas if I go to somebody who is [a] private, community-based nonprofit . . . there is just a much better likelihood that they are solely focused on me and not beholden to the university.* (Participant 6)

Whereas participants viewed on-campus advocates as "system-based," similar to advocates affiliated with a prosecutor's office, participants saw community-based advocates as autonomous and able to focus completely on survivors' needs. One participant asserted that community-based advocates are vital in comparison with system-based advocates because "*those are the folks that have no agenda, no dog in the fight, no conflict of interest, they have one job and that is to support the victim*" (Participant 1). Participants did not specifically mention the independence of community-based mental health and medical services, but did describe the confidential nature of such services (see below).

Because of their independence from university interests and policies, participants noted that community-based services offer stronger confidentiality protections for survivors. Concerning advocacy, participants stated that the majority of community-based advocates are protected by strong state or local privilege laws, meaning that advocates could be held liable for releasing clients' information. One participant explained that privilege laws are more likely to exist for community-based than campus-based advocates:

> *In probably about half of the states that offer privilege for community-based non-profits, the law is written in such a way that the university victim services advocates would not have privilege . . . [T]here's a substantially better chance that you have state law protections for your information if you go to a community-based [advocacy organization] rather than the university.* (Participant 6)

Community-based advocates therefore have much stronger legal protections for survivors' information, and do not face the same pressures to release information to universities. Another participant highlighted the benefits of legal privilege, as opposed to university confidentiality policies, for survivors:

> *We believe as community-based advocates that there is no replacement for a safe space for survivors to process their experience so they can make an informed decision about the best way for them to proceed in their recovery. The only way someone is able to truly do this is if we create a confidential space that is guarded, not only by confidentiality policies, but by actual law that has created legal privilege.* (Participant 7)

With respect to off-campus medical and mental health providers, although they may have to report certain types of injuries or abuse to local law enforcement, participants described community-based medical and mental health records as entirely independent from universities and not accessible as part of a university lawsuit or proceeding unless a provider specifically releases them with permission from the survivor. Overall, participants described community-based services as much more likely to ensure the confidentiality of survivors' information than

campus-based services, due to the conflicting policies and interests that universities must navigate in providing such services.

Participants did note that an exception to this independence arises when universities contract with community organizations to provide advocacy services to students. In this case, because community advocates are being paid by the university, they may become susceptible to similar pressures as campus advocates. Participants stated that this plays out especially in terms of confidentiality in that if advocates are paid by or affiliated with a university, the university may require them to report either aggregate Clery statistics or survivors' identifying information as responsible employees. One participant explained the rationale of universities who are requiring such reporting: *"[S]ome of the schools are using their money . . . to contract with community-based non-profits . . . then they're saying, 'Even though you're privileged under state law . . . you now must report to us what you learn from any of our students. Because you've contracted with us*"" (Participant 6). Therefore, the independence of community-based advocacy and other victim services appears to be primarily a function of whether they are financially independent from universities.

Limitations on accessibility. Despite the advantages of being independent and having strong confidentiality protections, participants explained that community-based services (especially medical services) may not meet the needs of college survivors with regards to the accessibility and perceived appropriateness of such services. Participants indicated that the availability of SANE programs and other post-assault medical care in the community varies by geography (i.e., urban vs. rural) and community resources. One participant explained how particular medical services that may be relevant for college survivors are frequently unavailable:

> *Unfortunately, I've seen another troubling pattern where a lot of survivors will go in and they don't want a rape kit, but they want date rape drug testing because they're pretty*

> *sure that they were drugged and . . . [the] hospital there . . . doesn't even offer it. So, you go in and you want just this one piece of information to help you decide whether to get a giant, invasive multi-hour examination and you won't get it.* (Participant 15)

Outside of a basic lack of services, participants also discussed the substantial difficulties college students may have in accessing off-campus medical care. Participants pointed to multiple barriers such as a lack of affordable and safe transportation, the need to navigate complex cities or travel long distances to reach a hospital with SANE services, and college students' lack of familiarity with off-campus medical resources. One participant described the difficulty students in rural communities can have in obtaining a forensic exam while in acute post-assault crisis:

> *Access is a huge issue. Literally, just access. I mean, if you're talking about a student in a rural college community, you might be talking about driving 45 minutes or getting a taxi 45 minutes to get to a place where they can get a forensic exam. And that's really troubling to me.* (Participant 20)

Additionally, participants explained that universities often lack formal agreements with community health organizations and other elements of logistical coordination needed to ensure college survivors can consistently access free community-based medical services:

> *[P]robably the greatest challenge is how are health providers within campuses and institutions that are providing services coordinating and communicating with the local jurisdiction's response, that's already equipped to ensure any survivor of sexual violence has this accessible process free of charge?* (Participant 7)

Therefore, while off-campus medical care is often the only available option for college survivors, many are unable to access medical services in the community.

While participants did not describe substantial difficulties with accessing community-based advocacy organizations, they had concerns about whether such services are responsive to the unique needs of college survivors. Participants felt that community-based advocates may not be adequately trained about the university context, where college survivors (and their perpetrators) often live, study, and socialize in the same setting. For example, community-based

advocates may not fully understand the Title IX investigation process or academic and residential accommodations that may be available to survivors:

> *[T]he advocates are doing protective orders, but they have no idea how to get quality no contact orders that are preemptively set up to be effective. They don't know how to ask for a no trespass order, they don't know how to ask for an interim suspension. They know nothing about the rights of survivors on campus, but they do know about restraining orders. I think there's a giant learning gap.* (Participant 15)

In contrast, participants noted that campus-based advocates are often peer volunteers who have in-depth knowledge of the university context and are trained to help survivors navigate on-campus resources. One participant was also concerned that community-based advocacy may not use the same language to describe services and experiences of sexual violence that students are accustomed to in the university context, saying, *"[W]hen off-campus services are called 'rape treatment' . . . a lot of students feel like it's not right for them. . . . [M]any folks who experience sexual violence on college campuses don't think of what happened to them in that way*" (Participant 18). This point illustrated a broader concern among participants about whether the nature of campus sexual assault requires specialized services for college students that community advocacy organizations are not well suited to provide.

Participants also raised concerns about the extent to which college survivors perceive off-campus medical care, particularly medical forensic exams (MFEs), as necessary or appropriate after experiencing an assault. Participants stated that because campus perpetrators' tactics more often involve drugs or alcohol than overt physical violence, many college survivors may not immediately label their experiences as sexual assault in a way that would prompt them to seek a MFE. One participant explained how the nature of assault among college students may not fit the "typical" narrative of violent rape, and therefore survivors may not realize medical care would be appropriate:

> *[I]t's not uncommon for a victim to maybe not recognize the experience as sexual assault right away, not think of it that way, be confused, have some questions, confusion, whatever's going on. . . . And so maybe because they don't necessarily see it as your typical rape off the TV screen, that they don't think of going to the hospital.* (Participant 3)

Additionally, participants explained that universities have not focused on raising awareness about the existence or importance of off-campus post-assault medical services, and campus health providers do not consistently explain the role of off-campus services such as SANE exams to survivors who seek acute care on campus. One participant described a surprising lack of messaging from institutions and governmental agencies on the importance of post-assault medical care for students:

> *[T]here isn't any information . . . getting out there for the students on access, like exam access, like what's the importance of getting a medical forensic exam? I haven't seen any national effort or . . . anything that I would say would be a state exemplar.* (Participant 4)

Participants agreed that post-assault medical care *is* appropriate and important for college survivors, both to document forensic evidence if desired and to address non-forensic needs such as testing for sexually transmitted infections and pregnancy prophylaxis. One participant described the care that a trained SANE can provide above and beyond typical campus health providers:

> *Campuses obviously have healthcare, you definitely want folks to get that healthcare, but . . . the trained, educated, and experienced SANE examiner brings a lot more to the table. Their interview obtains great information, they document it well, they recognize the impact of the trauma of the sexual assault, can provide support during those times, and I don't know that campus medical has that same insight and training and would be doing the same things that a SANE would do.* (Participant 1)

Despite the significant benefits to college survivors of seeking care from a SANE program, participants' perceptions were that off-campus healthcare has not been given the same priority as other aspects of coordinated responses for college victims.

Coordination of Services

On their own, neither campus- nor community-based services appear to meet fully the needs of college survivors. Participants explained that the ability of campus-based services to prioritize survivors' needs is challenged by constraints related to universities' need to balance multiple interests, resulting in potentially harmful encroachments on survivors' confidentiality; additionally, post-assault medical services are rarely available on campus, and campus victim services may not be culturally responsive. While participants viewed community-based services as free from university interests and having strong confidentiality protections, these services may be difficult for students to access and may not be perceived as necessary or appropriate for the needs of college students. To address the gaps and limitations of on- and off-campus services, participants discussed strong campus-community coordination as a means to efficiently leverage existing resources and provide holistic support for survivors.

Participants described coordination between on- and off-campus services as a means to pool limited resources for victim services. Under-resourced colleges (e.g., those with limited funding or staffing) can contract with community-based organizations to provide advocacy services for college victims without needing to hire full-time, on-call staff, as one participant explained: "*I actually think if you have a community-based resource that can serve a bunch of different places, that that probably makes more sense and is cost effective*" (Participant 22). The challenging logistics of staffing an on-campus 24-hour SANE program and other acute post-assault medical services make it infeasible for many universities to provide such services; instead, participants noted the advantages of coordinating with community health providers who already provide around-the-clock services. One participant explained why coordinating with

community organizations for medical forensic exams may be more feasible than implementing campus-based SANE programs:

> *It would be great if every institution could offer this, but that's just probably not realistic for any number of reasons, mostly having to do with resourcing and capacity, and all that kind of stuff. I think community-based organizations are a great option and they do amazing work.* (Participant 2)

Though not specific to one type of service, participants also noted that communities may have existing supports for survivors with marginalized identities such as "*the LGBT group in your city*" (Participant 21), whereas currently most on-campus identity-affiliated resources are not confidential and confiding in those resources could result in a report to university administrators. Although the logistics of coordinating with community organizations can be challenging for universities and confidentiality policies must be carefully crafted to protect survivors' information, participants indicated that closely coordinating with community-based services is often the best option for universities that cannot offer a full range of culturally responsive victim services and supports themselves.

In addition to being resource-efficient, participants emphasized that coordination of services ensures the most consistent, holistic, and survivor-focused support. In terms of advocacy, creating ties between campus and community advocates allows for warm referrals to community organizations if college survivors are concerned about going to a campus-affiliated resource or losing their confidentiality due to campus reporting policies. Survivors also have a wide variety of needs and may need to navigate both on- and off-campus systems (e.g., academic accommodations, Title IX investigations, criminal investigations), in which case it is essential to have help from advocates who have in-depth knowledge about all of these various systems, as one participant emphasized:

> *I think that if we all agree that a survivor of sexual violence has a complexity of needs, and the campus process is just one of many of them, they could also be navigating getting a restraining order, they could be navigating potentially family issues . . . and having a plethora of mental health needs and emotional needs. . . . I mean there's so many little things that we cannot realistically expect a campus advocate is so experienced with that they are the best pulse of that person's experience. . . . [S]urvivors are going to need information about systems outside of that institution.* (Participant 7)

Participants saw having strong relationships between campus- and community-based advocates (where both are available) as a way to meet survivors' extra-institutional needs and ensure access to the independence of community-based services.

As previously described, consistent coordination of medical services with other on- and off-campus services is lacking. Participants explained that improving campus-community coordination through formalized protocols and relationships will help ensure that college victims can access timely post-assault medical care, and that the university is properly billed for those services. Several participants stated that formal memoranda of understanding (MOUs) are essential for this:

> *What we've seen a good amount of is institutions have a relationship with . . . a hospital or some form of medical center, . . . but they may not have formalized that relationship with an MOU. Those are the kind of things, I think, make the system stronger. If everybody's clear on who's doing what, and where the bill is going to go, and how the student is . . . not going to have the bill show up at their parents' for their forensic exam. I think all of that is more clear when you have a formalized relationship in place with an MOU.* (Participant 20)

Participants highlighted how MOUs and other formal means of coordination can ensure that victims can access independent, confidential community medical services if desired, either instead of or in addition to campus health services. Overall, participants highlighted the importance of strong, coordinated victim services for prioritizing college survivors' well-being and addressing the limitations of both campus and community services in terms of availability, accessibility, responsiveness, independence, and confidentiality.

DISCUSSION

Summary of Key Findings

The current study aimed to understand national experts' perspectives on key issues in providing victim services (i.e., advocacy, mental health, and medical services) for college survivors of sexual assault. More specifically, this study explored experts' perceptions of the unique challenges and benefits of campus-based and community-based services for college survivors. The study examined these issues through the lens of the current US policy context, which has changed substantially over the past several years (and continues to change) in response to activism and social movements.

The results of the current study regarding victim advocacy show that experts believe campus-based advocates face significant challenges in ensuring confidentiality of services due to universities' concerns about legal compliance. Previous research has found that campus-based advocates themselves are concerned about their confidentiality status in the context of universities' focus on compliance (Moylan, 2017). Findings from the current study also mirror the results of a recently published study of victim advocates in which key findings centered on the conflicts of interests and values involved in working within the university system, as well as concerns among advocates regarding compelled disclosure/mandatory reporting policies (Brubaker, 2018). The current study therefore contributes to a small but growing literature on the difficulties of providing confidential, independent advocacy within the university system. This study also somewhat supports earlier qualitative research on campus-based advocacy that revealed the need for stronger coordination of advocacy services (Carmody et al., 2009). However, whereas advocates previously called for coordination *between campuses* within one state to improve consistency of services, experts in the current study emphasized the need for

greater *campus-community* coordination in order to fill service gaps and ensure victims can access independent, confidential community advocacy when desired. This difference may be related to the dramatic policy shifts that have occurred since Carmody et al's (2009) study, resulting in a different set of challenges for campus advocates. Increased enforcement of Title IX at the federal level has placed intense pressure on universities to know about sexual assaults occurring on campus. Universities have accomplished this with broader reporting policies that limit the confidentiality of on-campus advocacy services, which may necessitate greater coordination with independent community-based advocacy.

Although the results of the current study were not as extensive in regards to mental health services as the other types of victim services, experts described how competing university interests and confidentiality can be significant concerns for campus-based mental health providers. Even though mental health providers are specifically granted confidentiality protections under federal policy and guidance, experts highlighted the ease with which university administrators have been able to overcome those protections in the name of university interests, at a significant cost to survivors. Specifically, university attorneys can use FERPA to access survivors' university counseling records to assist in their legal defense when faced with litigation. Such findings help to demonstrate why survivors' concerns about confidentiality are a major barrier to disclosing intimate partner violence to mental health providers (Rodriguez et al., 2001). These breaches in confidentiality are a form of *institutional betrayal*, or violation of an individual's trust by an institution (Smith & Freyd, 2014), which has been shown to exacerbate the effects of trauma for survivors of sexual violence (Smith & Freyd, 2013). Experts in this study were concerned both about the immediate effects of this kind of institutional betrayal on

the survivor whose records have been accessed, as well as how this may impact other survivors' trust in campus counseling services.

Results of the current study also add to the very limited existing research on post-assault medical care specifically for college survivors. With regard to privacy and confidentiality, experts explained that little guidance currently exists on how HIPAA, FERPA, and Title IX should be applied in the campus health context, leading campus health providers to struggle with privacy-related questions. Experts also generally echoed the findings of previous research that most universities do not currently provide SANE services on campus (e.g., McCaskill, 2014). More generally, experts were concerned that campus and community health providers are often not included in broader campus response efforts for sexual assault, and that campus providers may not know to whom in the community to refer students for acute post-assault care. Some prior research has found that campus health providers (especially providers who do not specialize in women's health) only infrequently screen for sexual assault, and the authors of that study propose that improved screening practices have the potential to better connect college survivors to post-assault services (Sutherland et al., 2017). The current study supports this suggestion, finding that experts see campus health centers as an underutilized resource for both providing post-assault care and referring students to community providers for additional services. Experts in this study noted that students often feel comfortable going to campus health centers, but face multiple logistical barriers to seeking off-campus medical care. Better screening and referral practices by campus health providers could improve the likelihood of college survivors being able to access community-based SANE services and other important medical care, such as pregnancy prophylaxis, that may not be available on campus.

Across all three service types studied (advocacy, mental health, and medical), the cultural responsiveness of victim services was a consistent concern. Previous research has shown that marginalized survivors face additional "culture-specific" barriers to seeking services in general, such as historical mistreatment by formal systems (Brubaker & Mancini, 2017, p. 289). Experts expressed strong concerns that marginalized students who do decide to seek help may not be well served by campus-based services, yet also face significant barriers to seeking help off-campus. Scholars have begun to examine service gaps for marginalized college survivors, relating this to the historical exclusion of minority voices in the violence against women movement (e.g., Brubaker, 2018). The current study underlines the importance of continuing to bring a social justice lens to research, policy, and practice on service provision for college survivors.

Limitations

The current study had several limitations. First, this study did not specifically include a question in the interview guide about mental health services. Instead, experts spontaneously discussed mental health services when responding to broader questions about challenges in supporting college survivors or in providing advocacy and medical care. The author acknowledges that including a specific question about mental health services would have likely generated richer information about such services for college survivors. Additionally, the current study's sample size of 22 people is not unusual for qualitative research (Sandelowski, 1995), but it is somewhat small for capturing a national picture of service provision for college survivors. However, the participants have a significant depth of experience and expertise in this area and come from organizations that have provided technical assistance to dozens of institutions across the US. The expertise of the sample meant that saturation was reached, in which no new themes

emerged from additional interviews, with 22 participants. It is also important to note that both the sampling frame and the interview guide for this study were framed to explore issues in providing services for college survivors, and that this may have constrained the data to be more focused on campus-based services than community-based services. In other words, although interview questions asked about *services for college survivors* generally, participants did tend to provide more details about campus-based services to the extent that these may have seemed more salient for college survivors than community-based services. However, the interviewers frequently used follow-up probes asking specifically about community-based services to elicit more information. Therefore, to the extent that participants may have described campus-based services in more depth than community-based services, this was more reflective of the former's salience for college survivors than of inherent bias toward these services in the sample or interview guide. Lastly, the current study uses data from national experts who work with service providers, but does not include the perspectives of college survivors themselves. National experts in this sample were able to give insight into overarching issues in providing campus and community victim services in the current policy context. However, the current study did not examine how survivors appraise their experiences with on- and off-campus services. Future research should attempt to fill this gap to understand key issues in victim services from the perspective of college sexual assault survivors themselves.

Implications for Practice, Policy, & Research

Results of the current study have direct implications for practice, especially for universities and campus-based providers. Findings illustrate the importance of informing students about community-based service options that are independent from the university, as well as the need to provide mechanisms through which students can access these services for free

or at low costs. Universities should consider drawing on existing models of service coordination, such as sexual assault response teams (SARTs), that aim to create more consistent responses to sexual assault by bringing together stakeholders from various response systems like the advocacy, medical, and criminal justice systems (Greeson & Campbell, 2013; Greeson, Campbell, Bybee, & Kennedy, 2016). Community SART models have been adapted for campus settings by creating campus-specific SARTs that bring together university stakeholders, or by including campus providers in joint campus-community SARTs (Barry & Cell, 2009). Campus-community SARTs may promote training for community providers on the unique needs of college survivors. Additionally, campus-specific SARTs provide a venue for working through the complex web of university reporting and confidentiality policies to create response protocols that ensure survivors can access confidential resources. University administrators and other key stakeholders should also prioritize inclusion of both campus and community medical providers in coordination efforts, given this study's finding that there is a need for better coordination of post-assault medical services. Finally, coordination efforts should emphasize meeting the needs of marginalized survivors by assessing the cultural responsiveness of existing services, increasing population-specific training and tailored services, and identifying existing campus or community resources that better address the needs of survivors who do not trust or feel comfortable accessing more traditional system-based services.

The results of this study can also inform public policy debates regarding university responses to sexual assault, particularly how compelled disclosure/mandatory reporting policies may have unintended negative consequences (Brubaker & Mancini, 2017; Holland et al., 2018; Moylan, 2017). The potential for harm is especially great if advocates and other victim services providers are not explicitly exempt from such policies, or if they hold multiple conflicting roles

that could require them to release survivors' information without survivors knowing that this will happen. In addition to potentially being experienced as a betrayal by survivors, reporting sexual assaults to university administrators limits survivors' control over what happens after an assault. Regaining agency and control is an important part of healing for survivors (e.g., Martin, 2005), and when others respond by taking away control, it can exacerbate survivors' posttraumatic stress (Orchowski et al., 2013; Ullman & Peter-Hagene, 2014). Compelled disclosure policies may therefore result in a decrease in well-being for survivors. However, universities do have discretion in who they name as "responsible employees" that must report incidents of sexual assault, and the now-rescinded 2014 guidance from the Office for Civil Rights encouraged universities to exempt advocates from reporting responsibilities (US Department of Education, OCR, 2014). The current study underscores the need for campus-based advocacy to be considered confidential, and for such programs to strengthen confidentiality protections as much as possible in the university context.

In addition to the specific findings on Title IX-related compelled disclosure policies, the current study revealed a complex and often conflicting policy context surrounding reporting and confidentiality of victim services. In their review of state legislation regarding campus sexual assault, Richards and Kafonek (2016) noted that numerous proposed mandatory reporting bills (requiring reporting not just to the university, but to law enforcement) would conflict with federal policy requiring survivors to be able to make that choice themselves. Similarly, many of the experts in this study noted situations in which victim services providers would not be able to comply simultaneously with institutional, state, and federal reporting or confidentiality policies. Service providers may be uncertain about how to comply with conflicting policies, which impairs their ability to communicate clearly with survivors about their confidentiality status and

what information may potentially be released to others at the university. Federal and state legislators proposing additional or stricter mandatory reporting policies should consider whether and how such policies would achieve their assumed goals of increasing safety for students and accountability for perpetrators, or whether they would merely add to the existing regulatory complexity.

The current study points to several areas for future research on service provision for college survivors. First, while provider-focused studies have been instrumental to building the burgeoning literature on campus-based advocacy, research is lacking on how survivors perceive and experience on-campus advocacy. Future research should therefore explore the extent to which concerns about confidentiality and university conflicts of interest influence survivors' help-seeking from and satisfaction with advocacy services. Second, findings from the current study support the call from Holland et al. (2018) that evaluation of compelled disclosure policies is sorely needed, especially regarding possible unintended consequences for survivors and campus employees. Future research should investigate whether these policies may increase the likelihood of survivors experiencing institutional betrayal and decrease survivors' well-being. Third, while a robust literature exists on community and hospital-based medical care for survivors (e.g., Campbell et al., 2006), there is little evidence regarding current campus health center practices in response to sexual assault. The current study is a first step in understanding challenges in providing medical care for college survivors, showing that medical concerns have largely been left out of the conversation around responding to campus sexual assault. Participants noted that many universities do not have comprehensive post-assault health care services such as SANE programs, but for those that do, research and evaluation could help to understand barriers and facilitators of successful programs.

In conclusion, this study demonstrates how recent policy reforms have created challenges for campus-based providers of victim services in terms of confidentiality, while community-based services remain difficult for college survivors to access. Current issues in services for college survivors therefore center on how to improve coordination of services to ensure college survivors can easily access confidential, comprehensive, and culturally responsive services. Increased activism and national attention to campus sexual assault have resulted in improved resources for college survivors, but collaboration between campuses and surrounding communities is also integral to meeting survivors' needs.

APPENDICES

Appendix A: Qualitative Interview Protocol

Participant ID Number _____ Interviewer ID Number _____

Date Interview Conducted _____ Length of Interview _____

INTRODUCTION AND OVERVIEW

As we talked about before, this interview will take approximately 1 hour to complete. I am doing these interviews to gain a better understanding of the key issues and challenges you see in current national responses to campus sexual violence. I really appreciate your willingness to talk with me today and share your expertise regarding this topic. The information you provide will be extremely helpful.

I would like to audio record this interview for my own use in coding the interview later on—it is going to be hard for me to get everything down on paper, so the recording can help me fill in anything I might have missed. Everything we discuss today is confidential—your name will not be connected to anything you say. Your name is not on this interview or the audio recording.

As we are going through the interview, if you need to take a break or stop, just let me know. If there are any questions that you do not want to answer, just say so, and I will move on to the next section. You do not have to answer all of the questions in this interview. Before we get started I need to go through the procedures to obtain your consent to be interviewed (go through procedures to obtain informed consent).

Do you have any questions before we start?

Section 1: Background Information

1. Please briefly describe the nature of work you have done in relation to addressing sexual violence among college students.

Probe: What is the title of your current position?

Section 2: Key Questions

Introduction: I am going to ask you some questions about how universities, law enforcement, advocates, and sexual assault nurse examiners are addressing sexual violence among college students. If you are unsure about what a question means or do not feel that you can provide an answer, it is okay to skip the question.

2. What are some of the main issues you see in improving university responses to college student victims or survivors of sexual violence?

Probe: What are some barriers that universities face in addressing these issues?

Probe: What, if any, are some areas that have not been addressed by current federal policy and enforcement efforts?

3. (TITLE IX) *Many university employees, such as faculty, teaching assistants, and residence assistants, are now considered "responsible employees," meaning they are mandated to report possible incidents of sexual harassment or violence to university administrators.*

What are some challenges universities face in implementing mandatory reporting policies?

Probe: How does mandatory reporting impact coordination and data-sharing between administrators and other responders, such as law enforcement?

4. (TITLE IX) *The Dear Colleague Letter outlines specific requirements for university (e.g., Title IX) investigations of sexual misconduct, such as using a "preponderance of the evidence" standard of proof and ensuring due process rights for the accused.*

What are some of the main issues being raised by implementing these kinds of requirements?

Probe: What, if any, are some unanticipated consequences of universities using the "preponderance of the evidence" standard?

Probe: What are some key issues related to ensuring the due process rights of college students who have been accused of perpetrating sexual violence?

Probe: How do universities and law enforcement work together to ensure due process rights for accused students?

5. (LAW ENFORCEMENT) What are some key challenges that law enforcement face in responding to sexual violence among college students?

Probe: How do law enforcement and university investigators coordinate their investigations of the same assault?

Probe: What, if any, differences exist between how campus-based and community-based police work with universities to respond to sexual violence?

6. (MEDICAL) What roles do Sexual Assault Nurse Examiners, or SANEs, currently play in responding to sexual violence among college students?

Probe: What unique challenges, if any, do college victims face in accessing medical forensic exams and other health services?

Probe: What differences exist between campus-based and community-based health services in terms of services for college victims?
Probe: How, if at all, are community-based SANEs involved in campus efforts to coordinate responses to victims?

7. (MEDICAL) What are key issues related to SANE participation in university (e.g., Title IX) investigations?
Probe: What issues, if any, arise when SANEs are asked to provide factual information about a specific patient they have examined?
Probe: What issues, if any, arise when SANEs are asked to provide expert opinion during an investigation?

8. (ADVOCACY) What are key issues related to victim advocates' participation in university investigations?
Probe: What, if any, challenges do college victims face in accessing advocacy services?
Probe: What differences exist in services for college victims between campus-based and community-based advocacy programs?
Probe: How do community-based and campus-based advocacy programs coordinate their services for college student victims?

9. How are university administrators, law enforcement, medical personnel, and victim advocates coordinating their responses to student victims of sexual violence?
Probe: What are some key challenges you see to coordinating responses across these disciplines?
Probe: What kinds of barriers, if any, do community-based service providers and universities face in working together?
Probe: How, if at all, has coordination between service providers improved responses to victims?

10. What are key issues you see in providing training to those involved with university responses to sexual assault, including administrators, law enforcement, victim advocates, and SANEs?
Probe: How would you characterize the quality and quantity of training for each of these groups?
Probe: What do you think are pressing needs in terms of training service providers?

Section 3: Demographics
12. What is your age?
13. What is your gender?
14. What is your level of education?

CLOSING
Thank you so much for taking the time to speak with us today about this important topic.
We would like to make sure we are speaking with key national experts on these issues. With that in mind, is there anyone else you would recommend we speak with? If we contact any of the people you mention, we will *not* identify you as another participant and will only tell them that another national expert on campus sexual assault recommended we speak with them.

Appendix B: Construct Matrices

Table 4: Construct Matrices:
Variability in campus vs. community services (tallied by quotation)

Key: X = medical # = mental health/counseling
+ = advocacy O = victim services & supports (general)

Theme 1: Availability & Accessibility	**Campus**	**Community**	**Not specified**
Some types of services unavailable	XXXXXXX +	XX ++	
Difficult to access		XXXXX	
Easy to access	XXX ++		
Theme 2: Appropriateness/Responsiveness	**Campus**	**Community**	**Not specified**
Less responsive to needs of college survivors		+++	XXX
Responsive to needs of college survivors	X +	X	
Lack of culturally responsive services & supports for marginalized groups	XX ++ OOOO		XX
Theme 3: Competing Interests/Independence	**Campus**	**Community**	**Not specified**
Competing interests/lack of independence	XX ++++ # OO	+	X
Independent from other interests		+++	
Theme 4: Confidentiality & Privacy	**Campus**	**Community**	**Not specified**
Weak confidentiality or privacy protections	XXXXX +++++++ ## O	+	
Lack of clarity/knowledge about confidentiality policies	XXXXX ++++		
Strong confidentiality protections	X	+++	
Theme 5: Coordination	**Intra-Campus**	**Campus-Community**	
Weak coordination & communication of available resources	XXXX ++	XXXXXXXXX	
Coordination can be problematic/challenging		X ++	
Coordination leverages existing resources		XXX ++++	
Coordination provides holistic, consistent support	OO	XXXX +++ # O	

Appendix C: Effects Matrix

Table 5: Effects Matrix: Impacts of policies on confidentiality of services			
Policy	**Service Type** Advocacy	Medical	Mental Health
Federal			
Title IX: responsible employee	- Campus advocates may or may not be considered responsible employees depending on university - If responsible employee, must report identifying info about survivor and perpetrator to university	- (Despite federal guidance) some campuses may include campus health providers as responsible employees - SANEs unsure of obligation to participate in or release records for Title IX investigations and/or hearings - Possible policy conflicts if provider is funded by VOCA	
Clery Act	- Campus advocates, those affiliated w/university who volunteer outside of university, and advocates paid/contracted by university considered "campus security authorities," must report non-identifying aggregate data to university with possibility of timely warning being issued		- Licensed counselors are not considered campus security authorities
HIPAA		- Individual states and universities are determining how to handle student survivors' health records w/r/t HIPAA and FERPA - If campus providers/SANEs considered responsible employees or mandated reporters, this possibly violates HIPAA privacy protections - If campus provides free medical services to survivors (no insurance billed), services not covered by HIPAA (covered by FERPA instead)	

Table 5 (cont'd)			
FERPA		- Some campuses consider campus health clinic records to be academic records, in which case FERPA applies - If considered academic record, can be accessed by university & transferred if survivor changes universities - Confusion about whether campus SANEs can release police report/records to survivor	- Universities have used FERPA to allow their lawyers access to survivors' campus-provided counseling records
State/Local			
State mandatory reporting to law enforcement	- If paid by university, advocates considered mandatory reporter of child abuse & abuse of adult w/disability under state law		
State or local privilege policies	- In most states, information shared w/community advocates is protected by legal privilege - Privilege laws in many states were not written to cover campus advocates - Possibility of policy conflict/legal liability if confidentiality is protected by local privilege law but advocates considered responsible employees by university		- Some universities have disregarded state privilege laws and pulled survivors' campus-provided counseling records
University student conduct policies		- If survivors seeks on-campus medical care, may prompt a university investigation if student has violated restrictive student conduct policies (e.g., drug or alcohol use, engaging in premarital sex)	

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