Developing and implementing a treatment intervention for college students found responsible for sexual misconduct

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Abstract

Purpose – *The purpose of this paper is to summarize the development of a treatment program for students found responsible of sexual misconduct.*

Design/methodology/approach – *This project, supported by the SMART (Office of Sex Offender Sentencing, Monitoring, Apprehending, Registering and Tracking) of the Department of Justice, was requested by The White House toward the end of President Obama's last term and was intended to identify the confluence of factors related to sexual misconduct on college campuses, and to design a treatment program to address those factors.*

Findings – *This paper will discuss the unique factors of this population that ought to be considered to successfully develop an effective program, and the complexities of implementing treatment programs to this population, within a higher education system. This will include a discussion of barriers to implementation and challenges of employing treatment. This paper will present steps for implementing a treatment program and outline the core components of a treatment intervention for this population.*

Originality/value – *Implementing a treatment option for students found responsible of sexual misconduct that specifically targets the associated risk factors as part of a comprehensive approach to help improve campus safety.*

Keywords *Treatment intervention, Risk factors, Campus sexual misconduct, Program implementation, Students found responsible for sexual misconduct*

Paper type *Conceptual paper*

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Introduction

This paper documents the efforts by a multidisciplinary team consisting of researchers and practitioners from clinical psychology, forensic risk assessment, public health, student conduct, and jurisprudence to develop a treatment program that adheres to the science of risk and treatment factors, while providing maximum flexibility to serve a range of students and universities. We employ a multifaceted approach of four stages over the course of four years. The first stage was a review of the extant literature, primarily on college students and a separate literature on juvenile and adult sex offenders. The second stage gathered survey data from male and female students and from university administrators. The principle focus of the male survey was to identify risk factors associated with self-reported sexual misconduct as a first step in designing a treatment program targeting criminogenic needs. This survey was necessary in order to, comprehensively examine all of these risk factors together with the sexual experiences survey (Koss and Gidycz, 1985).

The survey of college women focused primarily on campus climate, perception of institutional and systemic obstructions and challenges to reporting incidents of sexual misconduct, and suggestions about mitigating risk of sexual assault on campuses. Data obtained from campus administrators consisted of a survey about campus policies, and discussion with university stakeholders about a wide range of challenges that they faced, as well as their thoughts about the need for a therapeutic intervention. Discussions with stakeholders eventually led to the addition of a

Received 2 June 2017
Revised 15 August 2017
Accepted 31 August 2017

The project reported here is supported by Grant No. SMART-2014-3915 awarded by the SMART Office of the Department of Justice. The conclusions and recommendations expressed in this paper are entirely those of the authors and do not reflect those of the SMART Office or the DOJ.

psychoeducation-only intervention. The third stage included developing a draft of the treatment program, followed by team facilitated in-person trainings with university administrators and treatment providers to present the treatment program, address questions, and demonstrate practice cases. Based on feedback, the team subsequently modified treatment materials to improve clarity, increase user-friendliness, and improve interrater reliability for the pilot stage. The fourth stage, to begin this fall, pilots this program at multiple colleges and universities across the country. It will include consultation about logistics and regular surveys to assess product usefulness. A final assessment will occur at the end of the pilot period (May, 2018).

Intervention products include two modular interventions with a risk-need-responsivity (RNR) framework – a cognitive behavioral treatment program and an active psychoeducational (AP) program. Each intervention contains resources, materials, and scripted, as well as student discussion videos about a range of topics related to campus sexual misconduct.

Statement of the problem, impact and population parameters

Campus sexual misconduct is a problem discussed as early as the 1950s (Kirkpatrick and Kanin, 1957). The impact of sexual assault for the complainant includes consequences that are often longstanding (Fisher *et al.*, 2000; Kerrick, 2014). Psychological consequences that occur when college women disclose sexual assault depend partly upon the social and institutional response (Orchowski and Gidycz, 2015). The consequences for the respondent can include expulsion, sanctions and suspension (DeMatteo *et al.*, 2015; Karjane *et al.*, 2002). The impact of sexual assault extends well beyond the parties directly involved (DeMatteo *et al.*, 2015).

We began by defining the treatment goals, population parameters, context, and potential barriers. The primary treatment goal is behavioral: to stop sexual misconduct and to encourage only consensual sexual activity. Secondary goals include increasing the protective factors and prosocial healthy relationships of the individual receiving treatment. Since the primary aim is behavioral, we drew from the extant literature in the following areas; risk and treatment literature on adults and juveniles who commit sexual offenses, and context specific literature on risk and associated factors of campus sexual misconduct.

The college student population

Arnett coined the term “emerging adulthood” to reflect the fact that those in the age range of roughly 18-23, capturing most college students, have not reached full developmental, cognitive and social maturity (Arnett, 2000). Normative hallmark features of adolescents and emerging adults include risk taking, emotional intensity and liability, poor problem solving skills, risk taking and impulsivity (Steinberg, 2008). College students’ emotions are experienced with greater intensity; social and interpersonal skills, attitudes, and beliefs are evolving, and remain heavily influenced by their peers. Their malleability and receptivity to change, however, provide a distinct advantage when it comes to behavioral change. They are at a stage in their lives where forming their identity is at the forefront (Arnett, 2000); interventions that explore the consequences of continuing adverse behavior can be highly beneficial. Abbey’s and McAuslan’s (2004) study demonstrates the importance of early interventions before behaviors become established.

The college population is increasingly diverse; thus, counselors must be trained and equipped to provide services to a wide range of different students (Kitzrow, 2003). A treatment program must take into account the unique social and sexual identities of this population and how those identities interact with risk and protective factors related to sexual misconduct. Generational considerations, including students’ ubiquitous connection to technology and multimedia, are reflected in our multimedia treatment tools.

The university

Each university is a discrete system with its own policies and procedures for sexual assault investigations, (e.g. investigators individuals or panels) who investigate and make determinations about responsibility, and subsequent sanctions and recommendations for students found

responsible (see Karjane *et al.*, 2002). Although there are compliance and regulations that guide universities, such as Title IX, Clery, Family Educational Rights and Privacy Act (FERPA), Health Insurance Portability and Accountability Act (HIPAA), and the dear colleague letter, institutions have some latitude in developing policies to maintain compliance within such guidelines, resulting in different ways of addressing, managing and resolving reports (Sabina *et al.*, 2017; Streng and Kamimura, 2015). Common sanctions include no-contact orders, educational interventions, suspension or expulsion (Karjane *et al.*, 2002; Reingold and Gostin, 2015). Student conduct professionals play a vital role in the process, and it is therefore important that treatment providers work with them in a coordinated effort to ensure continuity of care. A treatment intervention should not seek to change existing policies and procedures, and will need to be implemented into the existing framework.

Initial conversations with university stakeholders afforded us an opportunity to learn about their needs, concerns, and potential barriers. University stakeholders consistently expressed the need for treatment interventions applicable to the range of sexual misconduct behaviors that can be administered to all (e.g. gender fluid, heterosexual females, LGTBQ) students. Universities differed on their preference for treatment locations. Options include on-campus treatment at the counseling center, on-campus treatment at a psychology training clinic, off-campus treatment through an independent provider or off-campus treatment provided by a therapist affiliated with the university. Although some colleges preferred treatment to be delivered through their student counseling center, others preferred outside providers due to limited staff capacity, the stipulation that students receive treatment during the suspension period, concerns about victims and perpetrators receiving treatment at the same location (i.e. concerns about Title IX adherence, violating victim safety provisions), and upholding state regulations. Texas, for example, requires that adjudicated sexual offenders be treated by a provider who is certified (22 Tex. Admin. Code § 810.3). Administrators and treatment providers met together to discuss logistics, transitions, and continuity of care. In response to requests for a psychoeducational variant of our cognitive behavioral therapy (CBT) program, we created an option devoid of therapy for use with appropriate students (i.e. lower risk, core knowledge/information gaps, less severe offenses). For schools opting to use both programs, consistent with the RNR framework, training consisted of guidance for determining which program would be appropriate based on the student's risk and needs.

A third level client; the larger campus community

Mitigating campus sexual misconduct and enhancing campus safety requires a multimodal approach that does not reduce resources for victims of sexual misconduct. Victims (complainants), as well as the safety of the campus community in general, should be the central focus and the chief priority. A victim-centered approach should consist of two components: providing direct services to victims; indirect amends to victims and direct amends to the campus community through changes in policies and interventions that will mitigate sexual violence on campus. We argue that the same logic applied to primary prevention (i.e. prevention efforts must include men, as they are the ones most likely to engage in sexual misconduct; Rich *et al.*, 2010) should apply to intervention programs. The second component includes interventions specifically designed for students found responsible of campus sexual misconduct that will return to or remain part of the campus community. They include ensuring a just process that will enact change, but that also provide assistance for both complainants and respondents, and ultimately increase campus safety. From a public health perspective, expulsion, while it serves to protect the campus community from a particular individual, does nothing to protect other campus communities that the respondent might subsequently enroll at (e.g. Reingold and Gostin, 2015). Providing treatment services to the students found responsible potentially impacts not just that one student, but the campus community at large by promoting a campus climate that is responsive to sexual misconduct and sets a forthright policy that seeks to address a complex cultural and social problem. Research with adult sexual offenders reflects an uptick in recidivism when offenders are ostracized and segregated, often by law, to small pockets without access – or very limited access – to treatment services (Levenson and Cotter, 2005). Although it may be understandable that the community feels more secure thinking that there are no sex offenders "living on my block," isolating and segregating offenders, as well as imposing insurmountable barriers to reintegration, has the opposite effect – risk increases. The same is true

on college campuses. When we kick a student off campus with all of his problems intact, and now angrier than before due to being banished, we have effectively kicked down the road an even bigger problem.

Treatment and risk assessment

There has been an increase in the magnitude of psychological problems of college students, shifting from relatively benign developmental issues to more serious psychopathology (Yorgason *et al.*, 2008). The increase of students with a serious mental illness (Storrie *et al.*, 2010) has led to an increase in counseling services at college campuses (Kitzrow, 2003). Moreover, some research has shown that students who identify as LGTBQ report higher levels of mental health issues (Oswalt and Wyatt, 2011).

Risk and treatment literature on sexual offenders and models of interpersonal violence are based primarily on heterosexual populations. Although it cannot be assumed that these risk factors are identical or operate similarly in LGTBQ populations, the converse it true, and providers should consider how the unique identity and diversity of the student receiving treatment may impact treatment. For members of the LGTBQ community, additional treatment considerations may include discrimination and other negative experiences (Potter *et al.*, 2012). Members of the LGBTQ community are subject to higher rates of victimization than heterosexual students (de Heer and Jones, 2017). Clearly, more research is needed to identify and understand how specific risk and treatment factors related to sexual misconduct operate in LGBTQ populations.

Effective treatment starts with knowledge of the population, a review of treatment tools, and a thorough assessment of the individual receiving treatment. The cornerstone of the RNR model is the accurate and regular assessment of risk factors and criminogenic needs. Treatment dose and duration are tailored to the individual's level of risk (i.e. higher risk level, more treatment; lower risk, less treatment), and criminogenic needs; specific tools are matched to the individual's responsivity. RNR has been consistently found to be effective in reducing general recidivism and sexual recidivism (Andrews *et al.*, 1990; Hanson *et al.*, 2009). The modality is typically CBT (Hofmann *et al.*, 2012), including treatment for sex offenders (Lösel and Schmucker, 2005).

Meta-analyses found that sexual recidivism rates for treated sexual offenders were significantly lower than rates observed for comparison groups of untreated sexual offenders: "Programs that adhered to the RNR principles showed the largest reductions in sexual and general recidivism" (Hanson *et al.*, 2009, p. 865).

The extant literature on adult sex offenders has identified risk factors associated with sexual violence and sexual recidivism. The two major types of empirically based risk assessment scales, actuarial and structured professional judgement (SPJ), contribute to substantially improved accuracy when compared with unstructured (unguided or unaided) clinical judgement (Tully *et al.*, 2013). Actuarial scales intended for use with adult sex offenders (e.g. Static-99, Static 02, SORAG) are empirically derived and provide recidivism estimates based on a selected exposure period (e.g. one year, five years, 10 years). Actuarial scales tend to be composed of static risk factors (i.e. historic, unchangeable) vs SPJ tools (SVR-20) that include dynamic (changeable) risk factors. Evaluation of risk assessment scales intended for juvenile sex offenders are challenged by lower base rates for recidivism, resulting in more false positive errors, as well as the highly fluid developmental nature of adolescents. The J-SOAP II and the ERASOR are risk assessment scales designed for juveniles with adequate predictive validity (Parks and Bard, 2006). Risk factors associated with sexual offending behavior in both adults and juveniles include, broadly speaking, antisocial orientation, self-regulation problems, nonsexual criminal behavior, and sexual drive/sexual preoccupation/sexual "deviance" (in the case of child molesters) (Hanson and Morton-Bourgon, 2005).

Factors associated with campus sexual misconduct "converging factors"

A comprehensive model for sexual aggression among college students is Malamuth's Confluence Model that states that sexual aggression is the result of two synergistic pathways: hostile masculinity and impersonal sex (Malamuth *et al.*, 1991). Sexual misconduct can also be

framed as the convergence (or "confluence") of multiple risk factors, coupled with limited or minimal protective factors (Armstrong *et al.*, 2006). The "intersection" of this unique population of college students along with "context" (college campus environment) creates a "perfect storm" of "converging factors" that include: 1) The population of emerging adults who are at the height of sexual exploration and are drawn to socializing and peer activities. The culture promotes informal, casual dating (e.g. "hook-ups" Garcia *et al.*, 2012). Abbey (1991) noted that the vast majority of the rapes that occur on college campuses are committed by someone with whom the victim is acquainted and that most occurred on dates. 2) Ubiquitous opportunities for social engagement, such as campus events, social gatherings, parties, etc. 3) Ever present alcohol and occasionally drugs that facilitate disinhibition, a high rate of binge drinking (Wechsler *et al.*, 1999), as well as "rape drugs" (Rohypnol, GHB), Abbey (2002) noted that the association between alcohol and sexual assault among college students has been widely documented in the literature. Men's alcohol consumption is positively correlated with sexual assault and positively correlated with hostile masculinity attitudes (Parkhill and Abbey, 2008). Hayes and colleagues (2016) found a positive association between drinking behavior and rape myths. 4) Respondents are typically young men (in the age range of 18-21) that possess the same psychosocial, psychosexual, cognitive and neurocognitive immaturity of juveniles, with all of the predictable sequelae of risk taking, impulsivity, poor decision-making, increased proneness to breaking the law, and intense, often poorly managed emotions (Pharo *et al.*, 2011; Taber-Thomas and Perez-Edgar, 2015). 5) College students are highly influenced by their peers. Coercion-supporting peers and peer groups are more likely to espouse and condone rape-supportive attitudes, and sexual entitlement, and trivialize sexual assault. Canan *et al.* (2016) found that members of fraternities were more likely to endorse rape myths. Attitudes that condone violence and unhealthy sexual behaviors have been found to be highly associated with sexual violence (Tharp *et al.*, 2012). These attitudes are often characterized by hostile or negative masculinity (Franklin *et al.*, 2012; Malamuth *et al.*, 1996). This is particularly relevant in hierarchical peer groups such as athletic teams and fraternities where deference to individuals in higher positions of power in the social structure is expected. 6) Complainants are at college and away from home for the first time; they are likely to be naïve and assume safety with their peers. They too, are looking to have a good time. 7) There is a perceived sense of immunity on the part of complainants who understandably feel that a college campus is a safe, protected environment and poses no obvious warning signs of possible danger, as well as respondents who may believe they are protected from legal consequences.

Existing responses to the problem and effectiveness of prevention programs

Some universities have obtained information from students about their experiences, needs and concerns through focus groups and campus climate surveys (see Wood *et al.*, 2017 for a review), and are now providing information about 1) what constitutes sexual misconduct, 2) policies and procedures for reporting sexual misconduct, 3) services available for individuals who experience sexual misconduct (e.g. Sabina *et al.*, 2017).

Prevention programs are primarily educational, focus on strategies for avoiding or managing risky situations, and may include initiatives that raise awareness. Generally, these initiatives attempt to mitigate rape myth atttitudes (Palm Reed *et al.*, 2015). *One Act*, a prevention training program that taught intervention skills, reportedly produced significant improvements in date rape attitudes and behaviors, and increased bystander confidence and willingness to help (Alegria-Flores *et al.*, 2017). The *Men's Project* resulted in reductions in sexism, rape myth acceptance, and gender-biased language and increases in collective action willingness, and bystander efficacy (Stewart, 2014). *Enhanced Assess, Acknowledge, Act (EAAA)* is a sexual assault resistance education program designed for first year college women and has been effective in reducing rape, attempted rape, and other sexual violence. (Senn *et al.*, 2015). Prevention programs are most effective when they engage the participants, are administered multiple times, and have interactive activities (Anderson and Whiston, 2005; Potter *et al.*, 2016; Vladutiu *et al.*, 2011). A review of prevention programs found that they are most effective if they target single-gender audiences, although this finding varies (Vladutiu *et al.*, 2011). Many studies show that the positive effects fade over time (Breitenbecher, 2000). This is not the least surprising since they

target only one existing group of students; whatever the intervention is, it would have to be repeated for every new incoming class of students. It has also been shown that results can be enhanced when they are facilitated or involve fellow students taking an active role in the delivery of the program (e.g. the Green Dot program; Coker *et al.*, 2011).

Meta-analyses of college sexual assault education programs found "average" effects sizes for rape attitudes, rape knowledge, behavioral intent and incidence of sexual assault (Anderson and Whiston, 2005), and that bystander education programs increased bystander efficacy and intentions to help others at risk (Katz and Moore, 2013), but had smaller effect sizes for self-reported bystander helping behaviors and lower rape supportive attitudes.

Limitations of existing programs

The research on these programs demonstrates positive attitudinal changes, increased knowledge and awareness, and some changes in increased bystander effectiveness (Foubert *et al.*, 2010). There are some important limitations. Programs were found to be effective for women that do not have a prior history of sexual victimization (Hanson and Gidycz, 1993). Stephens and George (2009) found that a prevention program for men impacted rape myth acceptance, victim empathy, attraction to sexual aggression and behavioral intentions to rape – but only rape myth and victim empathy effects were sustained 5 weeks later. A crucial finding is that high risk men were generally unaffected by the intervention and low risk men produced the largest effects of the entire sample. This is consistent with our approach of an RNR framework that states that those with the greatest risk get the highest intervention dosage. The authors concluded that more research is needed to develop effective rape prevention programs, but we suggest that treatment interventions are appropriate for high risk individuals. Prevention and educational based programs are not likely to be effective with individuals with relevant risk and needs.

Few studies have examined the effectiveness of prevention and psychoeducation programs on decreasing the incidence of sexual assault (Breitenbecher and Scarce, 2001), and these have produced mixed results (Hanson and Gidycz, 1993). Specific significant changes in sexual misconduct behaviors, as well as significant increases in bystander behaviors, remain inconclusive or "an elusive outcome" (Casey and Lindhurst, 2009, p. 91). Changes in rape myths and rape-supportive attitudes do not appear to be related to actual changes in behaviors (Fisher *et al.*, 2008). Katz and Moore (2013) found similar results in their meta-analysis with no difference with respect to perpetration and they concluded that educational programs have a stronger impact on attitudes and behavioral intentions than actual behaviors.

If a student found responsible is not expelled, sanction options include reflection papers and other self-guided activities, with unknown effectiveness on recidivism. Treatment suggestions or mandates for students found responsible are for general treatment, as there is no existing treatment program that has been developed and piloted on students found responsible for sexual misconduct that specifically targets the risk relevant factors and treatment needs related to the sexual misconduct behavior. Throughout outreach efforts to enlist pilot sites, the authors have discovered a university that takes a clinically informed approach throughout the entire process, and contracted with clinicians in the area of sexual offending to develop an intervention program. To our knowledge this is the only treatment specific program designed to target sexual misconduct behaviors that exists, besides STARRSA.

Filling a gap: treatment as part of a comprehensive, multifaceted and continuous approach

Sexual misconduct is a complex behavior that is multifactorial (Armstrong *et al.*, 2006). Targeting this problem includes providing various prevention and intervention services for all parties impacted that sends a clear and consistent message about values that can facilitate cultural and behavioral change.

Interventions can help prevent the recipient from committing future acts of sexual misconduct and can therefore be viewed as a form of secondary prevention (i.e. preventing reoccurrence).

The higher education system as a leader in promoting education and growth is a prime institution to take the lead on implementing a system of care that is capable of addressing the needs of its multiple constituents.

Why treatment is necessary

Prevention and educational programs are necessary components of preventing sexual misconduct and increasing campus safety, but are insufficient by themselves. Our intervention includes two RNR program options, a CBT treatment option (which includes psychoeducation) and a psychoeducation option at the request of universities, both of which are administered individually. Psychoeducation is primarily effective for providing knowledge and facilitating skills, although it may affect attitudinal change. The STARRSA AP emphasizes discussion and engagement. The AP program is appropriate for students with a primary knowledge or skill deficit related to their misconduct, who are at lower risk, and have protective factors. The AP program is not appropriate for students with higher risk factors and needs, those who experience behavioral/emotional dysregulation, anger management/impulsivity problems, and/or personality pathology. Treatment provides the optimal conditions for managing more complex presentations, and is most effective for complex behaviors, particularly those that are long standing, entrenched, or whose origins may involve the complex interactions of variables. Treatment is more likely to facilitate lasting behavioral and attitudinal change (Hanson *et al.*, 2009; Lösel and Schmucker, 2005). Treatment can provide effective change for a range of students with comorbid conditions by providing tools that challenge distorted beliefs in safe environment. Given the nature and topic of the areas explored, many students receiving treatment will become upset and it is important that the complex feelings that are likely to arise (e.g. depression, anger, shame and guilt) are appropriately managed, while maintaining respect and rapport. Mental health professionals are the best trained to manage these situations.

Students are likely to be resistant because they are not entering treatment voluntarily. Incorporating motivational enhancement techniques can help address this barrier. Understanding the complex interaction of various factors as they operate specifically for the individual is best achieved through one-on-one treatment, where they can be identified, explored and analyzed. Many other types of intervention programs (e.g. psychoeducation) are administered in groups, and issues about confidentiality and embarrassment may limit the utility and effectiveness of these methods.

An overview of STARRSA (science based accountability and risk reduction for sexual assault) treatment program

STARRSA starts by assessing risk factors and needs related to sexual misconduct and tailors treatment accordingly. For example, if the student has a problem with alcohol use and alcohol is related to sexual misconduct, then exploring alcohol use will be a relevant treatment need. Responsivity is built into the program, focusing on optimizing the individual's response to treatment by recognizing ethnic, cultural and sexual identity/orientation needs, as well as targeting specific program resources. For example, some students are more readily engaged and responsive to experiential exercises; others more responsive to multimedia videos or Powerpoint presentations. Recognizing resistance, motivational enhancement techniques are built in to help facilitate engagement and to explore how treatment might be helpful for the particular individual. STARRSA is experimentally sited at a dozen universities around the country for the coming academic year and feedback in late Spring will permit final changes to the overall program and dissemination.

Significant challenges

Additional challenges include liability, confidentiality and sustainability. There is pressure to expel students due to liability concerns if a student who completed treatment subsequently reoffends. Blanket expulsion polices may prompt lawsuits from students who receive this disciplinary action. Some universities may feel uncomfortable with mandating treatment as opposed to other interventions (e.g. journaling, reflection papers). For universities that opt for treatment to be completed, a suspension period is preferred. A student who receives services in a home state that is different from where they attend college may encounter different legal mandatory reporting and practice obligations.

Regardless of whether an intervention is mandated, the university is likely to request information upon completion. The logistics of how information is shared should be guided through appropriate releases and should be established prior to the intervention during the informed consent process. We recommend that treatment providers maintain maximum confidentiality. Psychoeducation interventions are typically administered by student conduct facilitators, and students may have false perception that complete confidentiality exists. It is crucial that the limits of confidentiality are made abundantly clear during the initial session (i.e. through a signed agreement in psychoeducation).

Prior to starting treatment, the treatment provider and university should discuss what information will be shared between the two parties. Additionally, the treatment provider should establish with the university how requests for additional information will be handled after treatment has commenced. We provide guidance and an informed consent template, but reiterate that the provider and the university must have a clear agreement of the limits of confidentiality and that this is conveyed to the student during the consent process. Students receiving services must understand the standard limits of confidentiality (i.e. mandated reporter contexts when confidentiality is broken, harm to self or others) as well as additional limits as a result of this particular treatment context (i.e. what information might be reported to the university). Information should be limited to general treatment information, although statements about supportive or reintegration services may be included. The therapist must be clear about the reasons for the referral, the school's expectations about reporting progress and completion of therapy, and any other communications that might affect confidentiality. It is important to remember that universities have FERPA guidelines to follow just as treatment providers have HIPAA guidelines and specific mandated reporting requirements (e.g. imminent risk of harm to self or others) as stipulated by state statues. Any information that the treatment provider shares with the school must be considered in the context of what is minimally necessary to demonstrate participation in treatment, as well as what could be clinically contraindicated to therapeutic engagement or undermine effectiveness of treatment.

Despite these challenges, a successful, empirically based treatment program will incorporate relevant risk factors, remain flexible, and consider the needs of the student and university clients. Coordination between student conduct professionals and treatment providers is also necessary for successful program implementation.

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