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## Final Research Report

**Project Title:** *Campus Sexual Assault Responses (CSAR): Informing Trauma-Informed Policies, Protocols, and Training*

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## INTRODUCTION

Sexual assault on college and university campuses is a pervasive issue leading to short- and long-term consequences for students. An estimated 20-33% of women report experiencing sexual violence since entering college (Conley & Griffith, 2016; Koss et al., 2022; Krebs et al., 2009; Mellins et al., 2017). Sexual violence can lead to decreases in personal well-being, academic success, and relationship building (Schroeder et al., 2023) and result in higher levels of self-injury, suicidal ideation, and co-occurring depression, anxiety, and post-traumatic stress for years after an incident occurs (Carey et al., 2018; Khadr et al., 2018; Parr, 2020; Rothman et al., 2021).

The Campus Sexual Assault Response (CSAR) study was a mixed-methods study designed to identify effective models of campus sexual assault prevention and response and understand the components of such models that make them successful. We also aimed to understand the extent to which campuses are implementing trauma-informed approaches into their sexual assault prevention and response efforts.

The study set out to address four research objectives:

- (OBJ. 1) In collaboration with IACLEA, NCHA, and our expert Advisory Panel, design survey instruments to capture answers to the most pressing questions about best practices for trauma-informed campus responses to CSA. Supporting the instrument design will be a literature review and environmental scan of guidelines and 'best practice recommendations' for our research questions about aligning current and best practices. Qualitative interviews with CPSA and CHWC staff from two selected campuses will also be collected to inform the study instrumentation.
- (OBJ. 2) Collect and analyze nationally representative survey data from 1,000 campuses, reaching out to the CPSA and CHWC on each campus, designed to be representative of public and private, two-year and four-year, urban and rural institutions across the U.S. We will generate the first national assessment of the

state of trauma-informed responses to CSA on residential and commuter campuses, identifying the most common practices and what patterns of policies, protocols, training, and interventions align with best practice recommendations.

(OBJ. 3) Investigate and identify the strongest CSA response models (in terms of individual skillsets, intrapersonal, institutional, and community factors, and public policy that aligns with best practices) under real-world conditions on five campuses. These case study campuses will be selected based on national survey results and in consultation with IACLEA, ACHA, and our Advisory Panel.

(OBJ. 4) Disseminate survey and case study results to key audiences through a multifaceted dissemination plan reaching CPSA, CHWC, and campus leadership; Title IX officers; advocacy organizations; policymakers; CSA and higher education researchers; and CSA preventionists and service professionals.

## Methods

### Phase 1 – Survey

#### **Survey sample**

The national representative sample was drawn from the 2018 U.S. Department of Education’s Integrated Postsecondary Education Data System (IPEDS). The sampling accounted for multiple school characteristics, including two vs. four-year institutions, public vs. private, and the student body size (fewer than 1,000; 1,000-4,999; 5,000-9,999; 10,000-19,999; and greater than 20,000).

#### **Survey instrument development**

The CSAR instrument was created as the sum of three modules, developed in collaboration with project partners IACLEA and ACHA, and an expert panel of campus sexual misconduct practitioners. To get feedback on the instrument language and recruitment materials, we pre-tested each instrument module via interviews with campus administrators (with representation

from health, public safety, and administration) from institutions not selected to participate in the study.

### **Survey Measures**

The three related but independently fielded modules of the CSAR survey consisted of Module 1 for Campus Safety and Security staff, Module 2 for Campus Health and Wellness staff, and Module 3 for Administrative staff (e.g., Title IX or Executive team on campus).

Descriptive Information – Both safety and health respondents were asked questions regarding the types of services offered by staff members, the number of employees, and how students could access available services (e.g., by visiting a physical location on campus, through referrals with local providers, etc.).

Staff Training and Skillsets – The surveys also included questions regarding prevention training for students, faculty, and staff and any training that safety and health staff must complete. Further, both safety and health respondents were asked to indicate how well-trained and equipped staff members were to respond to sexual misconduct and trauma in survivors.

Collaboration – Both safety and health respondents were also asked about their participation in collaborative teams, described as campus and regional Sexual Assault Response Teams (SART) and taskforces. Respondents were also asked how frequently they collaborated with partners on and off campus and what activities they collaborated on.

Operational Procedures – Both safety and health respondents were asked to detail what clinical and safety/security services and protocols were available to students, whether policies were consistent with IACLEA and ACHA guidelines, and the state of access to sexual assault forensic exams (SAFEs) and SAFE kits.

Contextual Information – Safety and health respondents were asked questions regarding barriers and facilitators to implementing trauma-informed responses to sexual misconduct, including how COVID-19 impacted services.

Administrative Questions – Campus administrators were asked (Module 3) questions about types of campus housing and available campus services (including questions on training and available resources to respond to sexual misconduct). Administrators were also asked to provide details on the campus’s sexual misconduct policy, including definitions, source documents, and specific information included in the policy. Given the timing of survey fieldwork, administrators were asked about COVID-19, its impacts on sexual misconduct response, and budgetary implications.

### **Survey Data collection**

The CSAR survey modules were launched in October 2020 (the launch was held back for a period of time in acknowledgment of the COVID-19-related challenges that school staff would personally and professionally be facing at the outset of the academic year). Each selected institution of higher education (IHE) was emailed a link to a screener and asked to provide contact information for the best staff person to complete each module. While the initial link to complete the survey was sent to the recommended point of contact, instructions included encouraging respondents to seek input from colleagues better suited to answer a given question. The instrument was programmed to allow initial recipients the ability to forward survey links to others.

The research team employed a variety of recruitment efforts to encourage participation. Study partners IACLEA and ACHA posted announcements of the CSAR survey to their listservs and in their newsletters, and reminder postcards were mailed to points of contact, contacts identified via the website or a phone call, or more broadly to the “Head of Campus Security” and “Head of Student Wellness.” Generic “CSAR Study” recruitment emails and reminders were also supplemented by personalized contact from NORC field staff (each of whom had experience working in higher education) and the Principal Investigator, offering to answer questions and encouraging engagement with the study. Toward the end of data collection, respondents were offered a \$50 gift card to encourage participation from hard-to-reach schools.

In reflecting on the relatively lower response rate to Module 3 (fielded to school administrators), the research team shortened the Module 3 questionnaire and ceased direct recruitment efforts. This decision reduced the burden on campuses and allowed for the consolidation of NORC's recruitment efforts. To increase the probability of collecting key information for all campuses, the research team identified six key questions from Module 3 and added them to Modules 1 and 2.

Data collection closed in June 2021. Of the 1,500 campuses initially selected, 879 completed health and wellness survey responses were received, and 936 completed safety and security survey responses were received. Additionally, 293 schools completed the full-length Module 3, and 637 completed the shortened module.

## **Phase 2 – Campus Case Studies and Key Informant Interviews**

**Interview Sample.** As a sample frame, we created a list of campuses that had completed both modules of the CSAR survey. The list was stratified by campus type (e.g., public/private, minority-serving institutions), size, and degree program (i.e., 2-year, 4-year). We also captured demographic characteristics (e.g., percentage of male vs. female population, majority/minority white) and geographic region of the U.S. With input from our partners ACHA and IACLEA, we invited a small sample of campuses to participate in virtual site visits. Subsequently, we worked directly with campus leaders to identify participants from each selected campus who could share diverse perspectives about CSAR activities, with the requirement that each participating IHE include at least one representative from the health/wellness and safety teams for interviews.

We conducted virtual site visits with a sample of seven campuses representing diverse institutional, demographic, and geographic characteristics. Some participating IHEs operated from a single campus, while others had multiple locations across a metro area or region. IHEs also differed by the percentage of students living on or off campus, which added to the diversity of experiences working with residence life services, campus or local police, and addressing off-

campus harassment and assault cases. We conducted 43 key informant interviews, with 5-7 participants per participating IHE.

Interview participants represented various campus services, including health and wellness officials, counselors, campus security, Title IX and Compliance officers, victim advocates, and other student services such as residence life. Participants' roles also varied by who was a confidential student resource versus mandatory reporters, who are required by law to share information about violence and assault with the campus Title IX office. Table 1 shows site and participant characteristics.

**Table 1: Qualitative Site and Participant Characteristics**

Site	School Characteristics			Number of Participants by Role					Total
	Campus Size	Campus Type	Degree Program	Health & Wellness	Safety & Security	Title IX / Compliance	Advocacy	Student Services	
1	Small	Private	4-year	3	1	2	0	0	6
2	Large	Private	4-year	1	1	0	1	2	5
3	Large	Public	2-year	1	2	1	0	1	5
4	Small	Public	2-year	2	1	1	1	2	7
5	Small	Public	4-year	2	1	4	0	0	7
6	Large	Public	4-year	2	1	2	2	0	7
7	Small	Public, MSI	4-year	2	1	2	0	1	6
<b>Total</b>				<b>13</b>	<b>8</b>	<b>12</b>	<b>4</b>	<b>6</b>	<b>43</b>

**Interview guide development.** We created three interview guides based on role (i.e., health, safety, administration), which covered the same broad topics as the CSAR survey instrument enhanced by specific probes based on interviewee type (e.g., health, safety). Interview guides captured themes related to prevention activities, collaboration and communication during incidence response, and typical day-to-day interactions. Interview guides also inquired about participants' views about trauma-informed care principles and how these approaches are implemented at their institution. However, these questions were intentionally

asked at the end of the interview so the team could assess the extent to which such principles were described organically earlier in the interviews before being asked explicitly.

**Qualitative data collection.** We began recruiting campuses in January 2023 and conducted interviews from January to May 2023. Interviews, conducted virtually using Zoom, lasted between 30 and 60 minutes. A trained facilitator led each interview, and a research associate took notes about key themes using the interview guide. We asked all participants for permission to record interview audio for transcription purposes; all but one participant consented to the recording, and for this person, the team took high-level notes about discussion points. We used a transcription service to transcribe audio recordings, and a research associate reviewed each transcript for accuracy and de-identification.

## Data Analysis

### **Survey Data**

Analyses were conducted in Mplus, Stata, R, and SPSS, which allowed for the use of sampling weights and handling of missing data. Post-stratification weights were applied to ensure national representativeness. Weights were calculated to reflect the probability of selection and adjusted for survey non-response. To facilitate analyses by answering different research questions and drawing on the different module responses, each module had a separate weight, with an additional weight for schools that completed both Modules 1 and 2, as well as a weight for schools that completed Modules 1, 2, and 3 (short form). Descriptive analyses consisted of cross-tabulations, comparisons of means, and correlation matrices. Latent class analyses were estimated to address selected research questions.

### **Interview Data**

We coded de-identified transcripts using MaxQDA 2022 (release 22.2.1), a qualitative data analysis software. The team used deductive and inductive codes to create a codebook based on sections of the interview guide and topics that emerged organically through interviews. The

codebook captured information related to collaboration, incidence response, trauma-informed care, and other facilitators and barriers to sexual assault prevention and response. The team coded data in two rounds: first, members of the team independently coded all transcripts using broad thematic codes (e.g., collaboration, trauma-informed care); second, team members independently queried coded data related to only one theme and applied more specific codes (e.g., SAMHSA principles). This approach expedited the coding of a very large dataset and allowed researchers to quickly identify patterns across different participant and campus types. During the first analysis phase, our team agreed that sentiments about collaboration, communication, and trauma-informed care were fairly consistent across all sites, and we hypothesized that analyzing data at the participant/role level rather than the site level would produce more relevant and interesting findings. Thus, in our second phase of analysis, rather than producing site-specific case studies, we opted to analyze data at the role level (e.g., health and wellness, safety and security, administration) to identify key themes related to collaboration, communication, and trauma-informed care. After coding, the team met as a whole to discuss and agree upon emergent themes.

## Findings

### **Prevention Education, Training, and Coordinated Response Teams**

Descriptive analyses highlighted the consistency of responses to Module 1 and Module 2, bolstering confidence in the data and indicating good awareness of shared prevention and response protocols from safety and security staff and health and wellness staff. About 9 out of 10 IHEs provide sexual misconduct prevention education for students, staff, and faculty; however, participation in SARTs or Task Forces addressing campus sexual assault was less common, reported by about half of the IHE sample. In a latent class analysis of campus health and wellness and safety and security team survey responses, researchers identified a 3-class model of IHE policies and protocols (E. A. Mumford et al., Under Review). Over half of IHEs

(63%) fit a profile of “Comprehensive” policies and were likely to have sexual misconduct prevention education for students, staff training, and coordinated sexual misconduct response teams across all indicators. An additional third of IHEs (34%), the second profile, reported high levels of prevention education and training policies but were less likely to be involved in SARTs or Taskforces. Finally, three percent of IHEs reported that their sexual misconduct prevention efforts were limited to participation in SART/Taskforces and were not likely to have training requirements for faculty and staff, as well as a low probability of offering student education programs around sexual misconduct (the third profile). IHE size and the characteristics of public or private funding distinguished which profile the IHE was likely to fit into, with large public schools more likely to fall in the Comprehensive profile.

### **Collaboration**

Using both survey and qualitative data, our team explored rates of collaboration by school characteristics and identified barriers and facilitators to collaboration (O’Leary et al., Under Review). Almost half of campuses do not have any participation in a SART or task force (48.4% of safety and security staff and 43.3% of health and wellness staff). Of those that do participate in some sort of group, most participation occurs as part of a campus-specific group rather than a regional group (28.9% of safety and security staff and 30.6% of health and wellness staff). Looking at rates of collaboration, campus safety and security and health and wellness staff had high rates of collaboration with each other (81.6% of safety and security respondents said they “always” or “regularly” collaborate with their health and wellness counterparts and 85.1% of health and wellness respondents said the same about their safety and security counterparts) and with other campus student services (86.1% of safety and security respondents and 89.4% of health and wellness respondents). Collaboration with local partners predominantly occurred within the sector. Finally, the most frequently reported collaborative activities were referrals, followed by shared education materials, joint training, and joint programming. Across the board, smaller and private IHEs reported less frequent collaborative activities.

Drawing on qualitative interview discussions of barriers and facilitators to collaboration, setting clear goals, objectives, roles, and responsibilities was key to improving sexual misconduct response. Interpersonal relationships were also reported as being important to collaboration in sexual misconduct response. Interviewees recommended building trust through regular communication and interaction, being present, active, and responsive during regular meetings and check-ins, and communicating regularly outside of incident response to build rapport with fellow campus staff, faculty, and students.

### **Trauma-Informed Approaches (TIA)**

In the nationally representative survey, safety and security and health and wellness, participants were asked about their staff's specific skillsets that they can employ when responding to students who have experienced trauma related to sexual misconduct. Across staff types, health and wellness respondents had higher levels of confidence in their staff's trauma-informed skillsets compared to safety and security respondents. Safety respondents were less confident in the skillsets of contract security officers (25% disagreed or strongly disagreed that contract security officers had skillsets to implement strategies to support students over time as they recover from trauma). Of the health and wellness staff, respondents had the highest confidence in the trauma-informed skillsets of victim support staff (agreed or strongly agreed ranged from 95-99% on all skillset questions)(MacLean et al., Under Review).

Participants across sites were supportive of TIA training and integration of TIA principles into campus sexual assault prevention and response activities. Few participants shared hesitation or negative feelings about trauma-informed approaches, either personally or on behalf of others. Participants were aware of the widespread nature of trauma within their campus communities. They described how ignoring the impacts of trauma could lead to critical consequences for students, such as decreased

#### **SAMHSA Principles of Trauma-Informed Care**

1. Safety
2. Trustworthiness and Transparency
3. Peer Support
4. Collaboration and Mutuality
5. Empowerment, Voice, and Choice
6. Cultural, Historical, and Gender Issues

*Centers for Disease Control and Prevention (2022)*

engagement in academics, poor mental health outcomes, and potentially discontinuing their education.

Without prompting, the most common principle of trauma-informed care described by interview participants was empowerment, voice, and choice (Centers for Disease Control and Prevention, 2022). Participants agreed that empowering students to make informed choices about which steps to pursue throughout the incident response process is critical. Staff should be clear about the differences between confidential staff and mandatory reporters, as well as the potential outcomes of sharing incident details with one or the other. Staff should provide students with clear, consistent information about available support resources and steps in the incidence response process—including their unique benefits and consequences—to facilitate decision-making. Campus staff should also coordinate information collection, where possible, and avoid asking students to re-share their story multiple times.

Common barriers to implementing TIAs included federal policy constraints, conflicts between departmental goals and priorities, coordination challenges, and insufficient resources. Maintaining compliance with Title IX and the Clery Act dictates the steps staff must take during incident response and the information they must share publicly on campus, and these regulations conflict with campus professionals' efforts to promote empowerment through choice. Similarly, campus teams or departments may clash when their reporting priorities differ, especially when mandatory reporters seek information from confidential resources as part of the investigation process. Poor communication and coordination between campus staff often require a student to repeat their story multiple times, potentially causing additional trauma to the student. Finally, there are inadequate training resources available to staff on providing appropriate, competent care to students with cultural, gender, or socioeconomic differences and needs.

## **Campus Administration, Policies, and Procedures**

The CSAR survey also included a module that asked campus administrators to report on the policies, procedures, and resources relating to campus sexual assault prevention and response on their respective campuses (Module 3). As noted above, this module had a lower response rate, with 290 schools responding. We have constructed and utilized post-stratification weights to ensure these estimates are nationally representative. Of the campus administrators who responded, 98.9% reported that their campus has a sexual misconduct policy (SMP) in place, and 93% reported having a Standard Operating Procedure (SOP) for responding to sexual misconduct. Over 88% of respondents indicated that their campus SMP incorporates language from the 2020 Final Rule on Title IX, the Clery Act, and the Violence Against Women Act (VAWA). Further, nearly all respondents (99%) indicated that their campus employs a Title IX Coordinator, yet only 82.8% of campuses have an on-site Title IX office. Administrators reported that about 84% of campuses provide training on sexual misconduct and sexual harassment prevention to all students, and over 86% provide this training to all faculty and staff. Bystander training is somewhat less common, with 75% providing this training to all students (13% to some students) and 63% providing it to all faculty and staff (21% to some). This module also contains detailed data on campus resources available to respond to sexual misconduct reports; the terms included and defined in campus SMPs; protocols relating to standards of evidence, hearings, and sanctions; and the effect of the COVID-19 pandemic on campus operations and sexual misconduct prevention and response.

## **Discussion/Implications**

This study aimed to identify effective models of campus sexual assault prevention and response and understand the components of such models that make them successful. We also used quantitative and qualitative data to understand the extent to which campuses are

implementing trauma-informed approaches into their prevention and response efforts. The key takeaways from the Campus Sexual Assault Response study are as follows.

First, representatives of distinct sectors on campus – namely the safety and security sector and the health and wellness sector – were largely in agreement about key measures included in their respective survey modules (e.g., the availability of education programs for students, faculty, and staff, the frequency of collaboration between each other and on coordinated response teams such as SARTs and task forces). As described by McMahon et. al (2021), progress in preventing and improving trauma-informed responses to campus sexual assault requires a “whole school approach.” Concurrence of important policies and protocols from key players on campus is a strong first step to successful collaboration to achieve the relevant goals of each program. From these largely concurrent responses, we learned that about 90% of IHEs provide sexual misconduct prevention education for students, staff, and faculty, another positive with implications for the remaining 10% of schools. We also learned that participation in SARTs or task forces addressing campus sexual assault was less common, reported by about half of the IHE sample. Given subsequent qualitative results regarding the importance of collaboration, the CSAR data highlight an important need for coordinated teams.

Second, more than 80% of those surveyed said they have some collaboration with on and off-campus partners in the implementation of programs created to address sexual misconduct, collaborating through activities including referrals, shared educational materials, and joint training. However, collaborating effectively to prevent and respond to campus sexual misconduct remains a challenge. According to O’Leary and Vij (2012), some of the most important factors that affect collaboration include the purpose and mission of the partnership, who is participating, the motivation of the participants, how the partnership is structured, differences in power, accountability, communication, and trust. Given the galvanizing problem of sexual misconduct in IHE communities, attending to these factors through the establishment or refinement of collaborative teams is an important step. Successful collaboration is vital to a

seamless experience for survivors of sexual misconduct, ensuring that their needs are met and that they feel supported by the IHE, as well as important to the whole school approach to sexual misconduct prevention. IHEs should consider training for sexual misconduct prevention and response teams in collaborative skills, including conflict resolution, negotiation, collaborative problem-solving, and facilitation.

Third, this study found that IHE staff across sectors support incorporating trauma-informed approaches into campus prevention and response activities. Campus staff can improve the care they provide to students by sharing clear, consistent information about support resources, engaging students in decision-making, building student feedback into physical safety planning, and fostering a culture of trust and transparency (American College Health Association, 2020). More evidence and literature are needed to promote the development and implementation of TIAs in diverse campus settings. While trauma-informed principles may sometimes be at odds with federally mandated roles and responsibilities, staff should continue to empower students to make informed choices and be transparent about investigative processes' benefits and potential consequences.

**Research Implications.** The mixed methods approach to the CSAR study provides insights for subsequent research design. First, our approach to fielding an instrument with multiple modules for different campus sectors was successful. Future researchers can replicate it to triangulate information sources from different sectors of IHEs. While we did have to conserve resources by shifting recruitment efforts away from the “administrative” survey recipients, the extraordinary pressures felt by schools during the COVID-19 pandemic were indeed a contributing factor, and we did successfully collect responses from nearly two-thirds of the campuses that responded to the safety and security module and the health and wellness module. An alternative research approach to gathering administrative information in future research designs could be conducting an environmental scan of publicly available (web-based) information, followed by direct calls to fill in gaps through personal outreach. Second, topics

explored in more depth during the key informant interviews suggest updates to the CSAR survey instrumentation should subsequent research draw on this resource. For example, the survey did not inquire about the responsibilities of mandatory reporters compared to confidential resources, a distinction between staff types that appeared prominently in the qualitative findings. Third, there may be opportunities to review campus climate survey instruments (ARC3 Team, 2016; Cantor et al., 2019) in light of the CSAR Study results, in an extension of efforts to integrate perspectives from across the whole school.

**Limitations.** The quantitative survey data are subject to several limitations. First, the CSAR survey data collection period co-occurred with the COVID-19 pandemic and associated administrative challenges, which may have limited participation among smaller institutions (<1,000 students). While the study aimed to recruit a diverse sample of institutions (based on demographic and geographic characteristics), it is not representative of all institutions of higher education across the U.S. Thus, results cannot be widely generalized. Private trade schools were excluded because of the common absence of health services and Title IX staff. Second, the range of staff who provided input to the module responses is unknown. Additionally, there is evidence of high turnover in campus staff attending to sexual misconduct prevention and response (Backman et al., 2020), such that some respondents may have been less informed about campus protocols than other respondents. Third, the provision of educational activities on sexual misconduct may not match policy about these trainings in terms of content or regularity. Fourth, the CSAR instrument did not assess the integration of diversity and inclusion principles in staffing health and wellness and safety and security teams, and thus, the preparedness of IHE teams in these sectors to meet the needs of diverse student bodies is unknown. Fifth, qualitative data may be impacted by possible self-selection bias in those campuses that opted to participate and potential bias regarding which staff were selected (or volunteered) to participate in the interviews. Limitations that apply to the survey protocols may also apply to the qualitative interviews.

**Dissemination.** The research team has reported on study findings through multiple venues, including an NIJ-coordinated webinar (E. Mumford, 2022), a presentation at the 2023 NIJ conference (Watson, 2023), and a webinar hosted by IACLEA and jointly coordinated by the three partner organizations (E. Mumford et al., 2023). As a product of this research, three manuscripts have been prepared for peer review (MacLean et al., Under Review; E. A. Mumford et al., Under Review; O’Leary et al., Under Review). One describes policy implications, one describes components of successful collaboration on prevention and response teams, and the other describes attitudes and practices related to implementing trauma-informed approaches. A checklist entitled “Action Items to Improve Campus Sexual Assault Prevention and Response,” drawing on the CSAR research and the collective expertise of ACHA, IACLEA, and NORC staff, is available on the CSAR project page (NORC, n.d.) and through ACHA. Results will also be presented at the March 2024 NASPA conference in Seattle.

### APPENDIX A. WEIGHTED SAMPLE DESCRIPTION

	Module 1 (N=936)	Module 2 (N=879)	Module 3 (Short) (N=637)	Module 3 (Long) (N=293)
Size				
Fewer than 1,000 students	34.3%	33.7%	34.3%	27.5%
1,000 – 4,999 students	37.6%	37.8%	38.5%	43.2%
5,000-9,999 students	13.0%	13.2%	12.6%	14.0%
10,000-19,999 students	9.2%	9.3%	8.9%	8.8%
20,000+ students	5.9%	6.0%	5.7%	6.5%
Public/Private funding				
Public	44.0%	44.1%	51.7%	50.0%
Private	56.0%	55.9%	48.3%	50.0%
2-Year/4-Year				
2- year	34.0%	34.8%	32.0%	34.5%
4 -year	66.0%	65.2%	68.0%	65.5%
HBCU	2.8%	2.8%	2.5%	1.1%
Tribal Institution	1.8%	1.6%	1.4%	2.6%

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