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Mandatory Reporting and Adolescent Sexual Assault

Caroline Bailey[1], Jessica Shaw[1], and Abril Harris[2]

Abstract

Adolescents experience alarmingly high rates of sexual violence, higher than any other age-group. This is concerning as sexual violence can have detrimental effects on teens' personal and relational well-being, causing long-term consequences for the survivor. Still, adolescents are hesitant to report the assault or seek out services and resources. When an adolescent survivor does seek out services, they may interact with a provider who is a mandatory reporter. This scoping review sought to synthesize the current U.S.-based research on the role, challenges, and impact of mandatory reporting (MR) in the context of adolescent sexual assault. Database searches using key words related to MR, sexual assault, and adolescence identified 29 peer-reviewed articles. However, none of these articles reported on empirical investigations of the phenomenon of interest and instead consisted of case studies, commentaries, and position papers. The scoping review was expanded to provide a lay of the land of what we know about the intersection of adolescent sexual assault and MR. Results of the review indicate that though implemented broadly, MR policies vary between individuals, organizations, and states and have historically been challenging to implement due to this variation, conflicts with other laws, tension between these policies and providers' values, and other factors. Based on the available literature, the impact of MR in the context of adolescent sexual assault is unknown. There is a critical need for research and evaluation on the implementation and impact of MR policies, especially in the context of adolescents and sexual violence.

Keywords

adolescent victims, sexual assault, reporting/disclosure, support seeking

Operating within the gender binary, one in three females and one in six males are sexually assaulted during their lifetime, with most victimizations occurring during childhood or adolescence (Finkelhor et al., 2014; Tomlinson et al., 2018). Adolescents, specifically between the ages of 16 and 19, are four times more likely to be sexually assaulted as compared to any other age-group and continue to experience the highest rates of sexual victimization of all age groups (Campbell et al., 2013; Crawford-Jakubiak et al., 2017; Giroux et al., 2018; Martsolf et al., 2010; Trotman et al., 2016). Although uncommon, adolescent sexual assault survivors may seek out services from a range of service providers following the assault. If they do, many officials and service providers with whom they come into contact will be mandated by their state to complete a report of suspected child abuse to a child protection agency (Mathews & Bross, 2008, 2015). This mandatory report is intended to help ensure the adolescent's safety while also connecting them to services. The additional agencies and providers that the adolescent encounters as a result of the mandatory report may differ from the adolescents' initial expectations or wishes when initially seeking postassault care. Because adolescents are in a phase of rapid human development, both the sexual assault and their experiences with postassault providers can be formative events—impacting them not only in the short term but also having long-term effects on how they see the world and their place in it (American Psychological Association [APA], 2002; Black, 2017; De Bellis & Zisk, 2014; Eisman et al., 2018; MacMillan, 2001). This includes their experiences with being the subject of a mandatory report.

While there exists some literature on the experiences and outcomes of adolescent sexual assault survivors seeking postassault care, this literature largely does not consider or discuss the role, related challenges, and significance of mandatory reporting (MR) in adolescent sexual assault survivors' postassault help-seeking experiences and encounters. We determined this through a scoping review. Scoping reviews are most often conducted to provide a preliminary investigation of the potential size and scope of the available literature on a given topic—in this case, the role, challenges, and impact of MR in the context of adolescent sexual assault (see Booth et al., 2016, for

[1] Department of Psychology, University of Illinois at Chicago, IL, USA
[2] School of Social Work, Boston College, Chestnut Hill, MA, USA

Corresponding Author:
Jessica Shaw, Department of Psychology, University of Illinois at Chicago, 1007 W. Harrison Street, 1050D BSB, Chicago, IL 60607, USA.
Email: jlshaw2@uic.edu

a discussion of scoping reviews). As a first step in our scoping review, we searched PsycINFO, PubMed, Scopus, and Web of Science for peer-reviewed articles published through 2020 using the search words, "sexual assault" or "rape," in combination with (i.e., and) "adolescent," or "teenager," in combination with (i.e., and) "mandatory report," or "mandated report." This resulted in a total of 62 articles across all four databases. After removing duplicates across databases, and limiting the sample to only include U.S.-based work, the search yielded 29 articles. Nearly half of these articles ($n = 16$) were not empirical articles but instead were case studies, commentaries, and position or opinion papers. The remaining 13 articles were empirical papers but did not examine MR in the context of adolescent sexual assault. In determining there were no empirical articles on MR in the context of adolescent sexual assault, it became clear that research is needed in this content area. To inform future research that can address this gap in the literature, we expanded our search to provide a lay of the land (in line with a scoping review; see Booth et al., 2016) of what we know about the intersection of adolescent sexual assault and MR. Through nonexhaustive search strategies, we supplemented our initial search with additional and nonempirical articles on system responses to sexual assault; mandated reporting as a system response; MR purposes, models, and laws; challenges and barriers in MR; and MR policy impacts.

Based on our scoping review, this article provides a detailed discussion of the history, evolution, and variations in MR; the challenges and barriers for providers in fulfilling MR laws in the context of adolescent sexual assault; and what we know about the impact of MR. We focus on 12- to 17-year-old adolescents, specifically, as survivors as young as 12-years-old are able to access postassault services independently in many states throughout the country, and because MR statutes for suspected child abuse often apply until the age of 18 (Kenny et al., 2018; Mathews & Bross, 2015). To set the stage for this discussion and emphasize the importance of focusing on this particular age-group, we first briefly present the rates of adolescent sexual assault and postassault help-seeking within this group.

A Note on Terminology and the Existing Literature

In reporting on the prevalence of sexual violence, it is critical to be clear and intentional with terminology used. Throughout this article, we use the terms, "adolescent," and "teen" interchangeably. We use the term, "rape," to refer to nonconsensual attempted or actual penetrative acts (see Office of Violence Against Women, 2012). The term, "sexual assault," is a broader term that includes all nonconsensual sexual contact, up to and including rape. Throughout this article, we may also use the terms, "sexual violence," "sexual trauma," and "sexual victimization," as all-encompassing terms that recognize the sexual, violent, victimizing, and traumatic nature of these experiences (see Rape, Abuse, & Incest National Network, n.d.). It is also important to note that due to the limited literature on 12- to 17-year-old adolescent survivors' postassault experiences, we supplement parts of this article with literature on the experiences of survivors from younger and older age groups; we make clear when this is done. Finally, it is worth noting that much of the prior research discussed here often only reports on "male" and "female" participants. Individuals' gender identities extend beyond this limited gender binary (Ehrensaft, 2017). This is particularly relevant for the topic at hand as gender-expansive individuals often experience heightened rates of sexual violence because of their gender identity (Baams, 2018). Still, we are limited in our ability to report on such patterns due to the limited extent that they were explored and reported in prior work.

Rates of Adolescent Sexual Assault and Postassault Disclosure

Among those affected by sexual violence, adolescents continue to experience the highest rates of sexual assault among all age groups, with several studies indicating that adolescents are two to four times more likely to be sexually assaulted as compared to adults (Crawford-Jakubiak et al., 2017; Danielson & Holmes, 2004; Giroux et al., 2018; Hall & Gloyer, 1985; Martsolf et al., 2010; Planty et al., 2013; Snyder & Sickmund, 2006; Trotman et al., 2016). One nationally representative survey among high school students, aged 15- to 19-years old, examined rates of penetrative rape and found that 10.3% of female high school students and 3.1% of male high school students with a total of 6.7% of all high school students reported experiencing rape in their lifetime (Centers for Disease Control and Prevention [CDC], 2015). Because it is possible that these assaults happened prior to respondents' teenage years, the CDC survey also asked respondents to report on recent sexual assaults, with 10.6% of respondents experiencing a sexual assault sometime within the prior year (CDC, 2015). In examining a pooled sample of three very similarly designed national telephone surveys of 15- to 17-year-olds, Finkelhor and colleagues (2014) found higher rates of sexual assault in late adolescence, in particular; whereas 16.9% of 15-year-old females in a nationally representative sample report sexual assault at some time in their lives, this rate jumps to 26.6% for 17-year-old female respondents, suggesting a large portion of these assaults happen during the teenage years. Indeed, one in three women who report being raped at some point in their lifetime experienced their first rape between the ages of 12- and 17-years-old (Black et al., 2011; Breiding, 2014; Smith et al., 2017). Those assaulted as teens, then, are more likely to be assaulted again. In comparison to nonvictims, adolescent sexual assault survivors are two to 11 times more likely to be assaulted as adults (Black et al., 2011; Humphrey & White, 2000; Messman-Moore & Long, 2003; Snyder, 2000; Tjaden & Thoennes, 2006). It is important to note that while teens may be assaulted by an adult, extant research asserts that, unlike children, teens are most often assaulted by someone they know outside of their home—typically a peer acquaintance, like a classmate or intimate partner (Crawford-Jakubiak et al., 2017;

Finkelhor et al., 2014; Giroux et al., 2018; Kaufman, 2008; Muram et al., 1995; Peipert & Domagalski, 1994).

Adolescents are in a phase of rapid human development. Both the sexual assault and their experiences with postassault providers can be formative events—impacting them both in the short-term and how they see the world and their place in it in the long-term (APA, 2002; Black, 2017; De Bellis & Zisk, 2014; Eisman et al., 2018; MacMillan, 2001). Positive experiences in seeking or attaining postassault care can mitigate the negative impact of assault, while negative experiences can exacerbate the effect of the trauma. The number of survivors who disclose their assault to informal supports or seek help from formal services is low in comparison to the rates in which sexual assault occurs. This is especially true for adolescent survivors, who are a group with the lowest disclosure rates. In a nationally representative study among 12- to 17-year-old adolescents, 32% of those who indicated they experienced sexual violence had never disclosed their assault, 40% waited a month after the assault to disclose, and 29% disclosed even later (Broman-Fulks et al., 2007).

In disclosing a sexual assault, survivors are more likely to disclose to informal supports prior to, or rather than, formal supports (Ahrens et al., 2010; Casey & Nurius, 2006; Hanson et al., 2003; Starzynski et al., 2005). Informal supports may include romantic partners, friends, or family, whereas formal supports include medical providers, counseling services, clergy, police, or other entities to whom the survivor discloses because of their professional role (see Starzynski et al., 2005). Formal supports can provide mental health or advocacy services to support survivors' healing and recovery, medical care for the survivor following the assault, critical evidence collection to inform a criminal investigation, and a means to hold the offender accountable for their actions through the criminal legal system (see Campbell et al., 2013; Greeson et al., 2014; Whittier-Newton & Vandeven, 2010). Regardless, adolescent survivors are more likely than their adult counterparts to disclose to informal supports, with prior research finding that 81% of teen survivors first disclose to a mother or a friend (Campbell et al., 2015; Hanson et al., 2003). Teens' initial disclosures to informal supports increase the likelihood that they will be connected to a formal support, even if that was not their initial intention (Campbell et al., 2015). One study using data from the National Survey of Adolescents found that, of the 3,161 adolescents who responded, 17% of teens who disclosed to a friend and 55% of teens who disclosed to their mother were connected to formal postassault services (Broman-Fulks et al., 2007; Campbell et al., 2015). Recent qualitative interviews with adolescent survivors of sexual violence support these findings, with all teen participants first disclosing to a friend, followed by an adult being notified, and the adult linking the survivor to formal support services (Campbell et al., 2015).

Survivors who choose not to disclose an assault choose to do so for a variety of reasons including a lack of understanding about what happened to them, shame and stigma, fear of interfacing with officials, or a distrust toward officials (Campbell et al., 2013; Hall & Gloyer, 1985; Martsolf et al., 2010). Adolescent survivors' reasons for not seeking formal help services are similar; however, their decisions are also impacted by their developmental stage and restricted agency due to their age (Alderman, 2017). The literature thus far highlights that adolescent survivors primarily do not disclose or seek help due to lack of knowledge or awareness of how to understand their experience or of available services, concerns around confidentiality and the purpose of postassault services, shame and stigma, or fear of further repercussions if others were to find out (e.g., consequences from adults if they are made aware of certain aspects of the assault like drug or alcohol use; Alderman, 2017; Campbell et al., 2013; Hall & Gloyer, 1985; Schapiro & Meija, 2018). These reasons are important to note as they may be important concerns held by the teen survivor when seeking out support and can directly influence their experiences with and involvement in postassault services. If an adolescent survivor does end up interacting with formal support services, they may come into contact with a provider who is a mandatory reporter. To better understand the impact of MR on adolescent survivors, the rest of this article reviews what is known about the history, practice, and impact of MR on teen sexual assault survivors.

History of and Variation in MR Policy in the United States

MR is a mechanism instituted by law that requires certain professionals to report suspected child maltreatment to child protection authorities and has been a model used for decades to protect those who may be experiencing abuse or neglect, to connect individuals and families to needed services, and to prevent future abuse and neglect (Kenny et al., 2018; Mathews & Bross, 2008, 2015; Raz, 2017). MR policies have rapidly expanded, though, over the last several years to now include those most affected by abuse and neglect. This includes anyone under the age of 18, the elderly, those with disabilities, and situations in which individuals are in positions of power and authority over others, as this can create an environment for abuse to occur (Kenny et al., 2018; Mathews & Bross, 2015; Raz, 2017). Therefore, adolescents who experience rape or sexual assault, regardless of the perpetrator or context, may be subject to MR when seeking out services and resources. Here, we briefly describe the history and evolution of MR policies in the United States and the high degree of variation in how MR policies are implemented. In so doing, we pay particular attention to what this history, evolution, and variation means for adolescent sexual assault. It is important to note that throughout this section, the term "child" or "children" (i.e., anyone under the age 18) will be used regularly, as most literature and research on MR uses this term. Whenever possible and appropriate, we use the term, "teen" or "adolescent" to refer more specifically to the application of MR for 12- to 17-year-old individuals.

The History and Evolution of MR Laws

Before the implementation of MR laws in the United States in the 1960s, there were policies in place that required medical professionals to report select known incidents of violence (i.e., gunshot victims). However, agencies seeking to address issues around child welfare and abuse (e.g., child protection services, nonprofit agencies) acted separately and independently from medical professionals, creating a gap between direct service providers who often interact with those who have been abused and neglected, and the agencies seeking to help those individuals and families (Mathews & Bross, 2015; Myers, 2008; Palusci & Vandevort, 2014; Watson & Levine, 1989). As research on the impacts of child abuse and neglect brought increasing awareness to the topic and caught the attention of federal agencies, the Children's Bureau of the U.S. Department of Health and Human Services hosted a meeting in 1962 of researchers and policymakers to discuss child maltreatment (Mathews & Bross, 2015; Myers, 2008; Palusci & Vandevort, 2014; Watson & Levine, 1989). This convening resulted in a set of state guidelines on how to implement MR laws and placed the oversight of implementing child protection programs in the hands of the federal government. This resulted in the rapid expansion and institution of MR policies across the United States as the federal government provided incentives to states that adopted MR laws, including funding for training, multidisciplinary centers to address abuse, and additional research projects to demonstrate policy and program effectiveness (Myers, 2008; Palusci & Vandevort, 2014). Idaho and California were among the first states to adopt MR laws in 1963 (Mathews & Bross, 2015; Palusci & Vandevort, 2014). By 1967, all other states except Hawaii had adopted an MR law, and Hawaii followed suit a few years later.

MR models continued to grow in 1974 when Congress implemented the Child Abuse Prevention and Treatment Act (CAPTA). This legislation provided further financial assistance to states to improve agencies' capacity and effectiveness of investigating reported abuse as well as requiring additional professionals outside of just medical professionals (e.g., officers, teachers, counselors) to report suspected abuse, expanding reportable abuse to other abuses besides physical abuse, and removing qualifying words such as "serious" or "significant" for determining whether a suspected abuse is reportable (Kenny et al., 2018; Mathews & Bross, 2015; Myers, 2008; Palusci & Vandevort, 2014). With these changes, CAPTA brought more uniformity to MR laws across the country as federal funding was conditional on state's implementation of statutes requiring certain professionals to report child abuse (Kenny et al., 2018; Mathews & Bross, 2015; Palusci & Vandevort, 2014).

After 1974, several major events occurred in which limitations and gaps in MR were identified, inspiring further expansion of these protection models around who is a reporter and what situations require a report (Palusci & Vandevort, 2014; Raz, 2017). For example, in 2002, the Boston Globe Spotlight team revealed the ongoing abuse of hundreds of young and teenaged boys by clergy that had been covered up by the Catholic Church for decades (Brown & Gallagher, 2013; Rezendes, 2002). This event not only sparked a rise in national awareness around abuse perpetrated by religious leaders but also increased pressure on states for identifying, stopping, and preventing abuse in this context. In response to the scandal, several states expanded MR laws requiring clergy to be mandatory reporters (Brown & Gallagher, 2014). MR models were further expanded surrounding the events involving Jerry Sandusky. In 2011, Jerry Sandusky, a football coach at Pennsylvania State University, was charged and convicted of sexually abusing 10 young people he met through coaching and his charitable work with youth (Brown & Gallagher, 2014; Chappell, 2012). This event indicated that more was needed in the protection of minors outside of the home, influencing numerous states to amend their statues to protect populations other than children, and to require additional professionals to report suspected abuse, including additional higher education and high school professionals such as coaches, volunteers, additional staff, and administrators (Palusci & Vandevort, 2014). States who made these amendments also added more requirements for the training and education of mandatory reporters, harsher penalties for those who do not report, protections of employees who report abuse against employers, and increased coordination of investigations (Mathews & Bross, 2015; Palusci & Vandevort, 2014). Today, MR policies include the reporting of suspected or confirmed physical abuse, sexual abuse, psychological and emotional abuse, medical abuse, and neglect; an expansive list of professionals required to report abuse and the specific populations protected; and the identification and reporting of abuse committed by someone who is in a position of power or authority over others in addition to the reporting of abuse by caregivers (Mathews & Bross, 2015; Raz, 2017). With growing research and awareness, states continue to amend their MR laws to fit the needs of those particularly affected by abuse and neglect (Kenny et al., 2018; Mathews & Bross, 2015).

As is evident by its history and evolution, MR policies were developed in response to research on child abuse but have extensively grown to include other groups, like adolescents who experience sexual violence. However, as these policies have expanded, little has been done in terms of research or education on how MR policies should apply or may impact those who are not children. This includes how MR should apply and may impact teens who have experienced sexual assault, as the characteristics of adolescent sexual assault are different than child sexual assault or abuse (e.g., the relationship between the teen and the perpetrator), as are teens' unique needs. These circumstances have also contributed to the incredible variation in MR policies and their implementation across states, disciplines, individuals, and contexts (Kenny et al., 2018; Mathews & Bross, 2015).

Variation in MR Laws

Due to the nature and structure of federal and state governments, states have ultimate control over MR laws. The

variation in MR policies most often includes variation in who is a mandatory reporter, the parameters under which a report is filed (e.g., who and what rises to the level of a mandated report), and how and to whom the report is made (American Academy of Family Physicians, 2004; Mathews & Bross, 2015; Raz, 2017). Because individual agencies and providers are responsible for actually implementing state policies, additional variations in their application emerge. This variation directly impacts teen survivors of sexual violence as they are a group in which the mandatory report may be applied or may not, depending on the context, jurisdiction, and provider.

Variation in who is a mandatory reporter. A primary variation regarding MR laws is in *who* is and is not required by law to report abuse and neglect. This is because when states began to implement MR legislation, they could opt into two different models: universal reporting or nonuniversal reporting (Mathews & Bross, 2015; Palusci & Vandevort, 2014). Universal MR laws require *all adults* to report suspected abuse to child protection agencies, whereas nonuniversal reporting laws require *only certain professionals* to report (Mathews & Bross, 2015; Palusci & Vandevort, 2014). Although the intended benefits of a universal reporting model are to increase the reporting of substantiated cases by requiring all adults to report, research has found that there are minimal differences in average reporting rates between universal and nonuniversal reporting states (Mathews & Bross, 2015). Currently, 18 states operate under universal MR laws, with the remaining states choosing to expand their MR requirements to include nurses (34 states), teachers (24 states), and police officers (nine states; American Academy of Family Physicians, 2009; Brown & Gallagher, 2014; Mathews & Bross, 2015; Raz, 2017). The differences in MR models can create confusion and misunderstanding on *who* is required by law to report abuse between states, especially since individuals working within the same profession may have experience working in different jurisdictions. This variation can be very concerning to teens, as they may interact with a variety of providers after a rape or sexual assault, some of whom may file a mandatory report, and some of whom may not. Teens have more autonomy than children and often have the ability to seek and consent to care independently and confidentially from their parents; their decision to seek care may be impacted by knowing who is and who is not a mandatory reporter (Alderman, 2017; Crawford-Jakubiak et al., 2017; Schapiro & Meija, 2018; Teare & English, 2002; Tsai et al., 2017). While the same teenager may not seek care multiple times across state lines, thus encountering this variation first-hand, the variation nonetheless makes it less likely that teens will be fully informed on who is a mandatory reporter and who is not, limiting their ability to make informed choices related to seeking care. Resulting confusion and inconsistency can deter adolescents from interacting with providers and receiving needed care as they fear the involvement of not only their parents or caregivers but also other providers, like police and child protection agencies (Schapiro & Meija, 2018).

Variation in the situations that warrant a report. In addition to the differences in *who* is a mandatory reporter, there are differences in *what* circumstances require a mandatory report. As information and research continues to illuminate what abuse looks like, and to whom, how, and when it occurs, states have reformed their MR laws in response. For instance, some states changed their policies to require a mandatory report for sexual abuse only; other states deemed physical, emotional, and sexual abuse as reportable offenses; and some states have chosen to expand reportable incidents to all forms of abuse and neglect, including exposure to family violence (Brown & Gallagher, 2014; Kenny et al., 2018; Mathews & Bross, 2015).

Beyond the specific type of abuse, there is also variation in the implementation of MR policies when determining whether all sexual violence experienced by a teen is indeed abuse that requires a mandatory report. Unlike children who are often assaulted by a parent or adult within the home, adolescent survivors experience sexual violence at the hands of a range of perpetrators—from strangers to intimate partners and from peers to adults (Giroux et al., 2018). Most often, adolescent sexual assault occurs outside of the home and is committed by a nonfamilial known person, like a classmate, intimate partner, or other peer acquaintance (Crawford-Jakubiak et al., 2017; Finkelhor et al., 2014; Giroux et al., 2018; Kaufman, 2008; Muram et al., 1995; Peipert & Domagalski, 1994). Most MR laws require a mandatory report of abuse when the abuse is committed by a caregiver or someone in a position of power or authority. If the adolescent survivor was harmed by a perpetrator who is *not* a caregiver or in a position of authority (e.g., a friend or intimate partner), providers may be less certain if the mandatory report applies or of its utility in helping teens (Mathews & Bross, 2015; Raz, 2017; Sharkey et al., 2017; Tsai et al., 2017). For example, some agencies have policies that consider all sexual assaults of minors to be a form of child abuse, regardless of the nature of the relationship between the victim and the perpetrator (Child Welfare Gateway Information, 2016; Riviello & Rozzi, 2018). Other agencies allow for provider discretion in filing a mandatory report based on the survivors' relationship to the perpetrator and after assessing and prioritizing cases in terms of immediate danger and the need to intervene (Alderman, 2017; Child Welfare Gateway Information, 2016; Crawford-Jakubiak, et al., 2017; Riviello & Rozzi, 2018). Regardless, whether sexual assault of a minor is considered to always be a form of child abuse, or if its classification as child abuse depends on the context and nature of the assault, adds to the variation, and confusion, as to when it should be implemented.

In considering if MR applies in a particular instance of adolescent sexual assault, providers may consider if the teen is at risk of potential further harm and attempt to use this as the deciding factor in filing a report or not. However, state law varies here, too, in terms of when a case of *potential or future* abuse or neglect rises to the level of a mandatory report (Mathews & Bross, 2015; Mathews & Kenny, 2008). Some states specify that mandatory reporters should report if there is "reasonable cause to suspect" abuse or neglect or if there is a

"risk of imminent harm," while other states assert that a mandatory report is required only for abuse or neglect that has already occurred (Mathews & Kenny, 2008). For example, Arizona states that mandatory reporters should only report if they believe that the individual "has been a victim of" abuse or neglect, clearly outlining for providers that they should only report past or current abuse rather than potential future abuse (Mathews & Kenny, 2008). State MR laws may not provide adequate guidance for individual agencies and providers to know when MR applies. Even when they do, individual agencies and providers may vary in how they interpret and implement them.

Variation on what is reported is also further impacted by consent to sex laws and policies, as these intersect, and may even conflict, with MR policies (Tsai et al., 2017). For instance, adolescents who are engaging in consensual sex with a partner may qualify for the mandatory report while seeking gynecological care due to the age difference between the teen and their partner (i.e., statutory rape). However, it can be difficult to determine whether and how this applies, causing greater confusion for providers in fulfilling their MR duties (English & Ford, 2004; Teare & English, 2002; Tsai et al., 2017). This is further exacerbated by the variation in consent laws between states and little education, training, and guidance as to when MR policies usurp consent laws (Teare & English, 2002).

Finally, in addition to variation in state laws and agencies' implementation of those laws as to which incidents of adolescent sexual assault meet the requirements for a mandatory report, individual providers' own values, biases, and prior experiences in reporting abuse and harm likely impact if they decide to report or not (Kuruppa et al., 2020). For example, in one study, 58 physicians who were mandatory reporters were presented with 10 vignettes that highlighted cases of abuse and neglect that the physician might encounter (Morris et al., 1985). Of the 10 vignettes, not one was identified by any of 58 physicians as a case in which they would report the abuse. Their decision not to report was influenced by many factors, including their attitudes toward physical discipline, their familiarity with the family, the level of parental concern, and the child's behavior. While this particular study was not focused on cases of adolescent sexual assault, it can be expected that similar factors might influence a provider's decision in this context. For example, providers may be hesitant to unnecessarily complete a report, as the provider may be concerned that the report may deter the teen from seeking critical postassault care in the future. Other values, biases, and assumptions specific to young people, their behavior, and other aspects of their identities may also play a significant role when deciding whether to complete a mandatory report or not. For example, prior research has found that Black adolescent girls are hypersexualized and perceived to be older and less innocent than their White counterparts (Epstein et al., 2017). Such assumptions and biases may impact how a provider perceives a survivor and whether they choose to file a mandatory report or not.

Variation in to whom the report is made. As states adopted MR policies, reports of abuse and neglect to child protection agencies naturally increased, ultimately placing greater strain on these agencies to follow-up and identify the most severe cases that require intervention (Mathews & Bross, 2015). Because of the burden experienced by government child protection agencies, some states have employed a *differential response* approach: connecting reported cases of abuse or neglect to the most appropriate resources and agencies, which may or may not be state child protection agencies (Mathews & Bross, 2015). More specifically, a differential response seeks to divert less serious cases of abuse and neglect to welfare resources and agencies, easing the burden of child protection agencies by leaving only the most severe cases of abuse for follow-up (Mathews & Bross, 2015). For example, in cases of neglect where children are not getting their needs met (e.g., dirty clothes, lack of food) as a result of experiencing poverty, a differential response would be more beneficial when there is no indication of maltreatment at the hands of the caregiver (Mathews & Bross, 2015). An additional benefit of this approach is that the family would get connected to important resources without having to get involved with child protection services (Mathews & Bross, 2015). A differential response for cases that do not need the formal response of child protection agencies has been increasingly adopted by states; however, states that utilize the differential response still lack uniformity in how and when this alternative approach is implemented (Mathews & Bross, 2015).

Although the differential response has not been implemented or explored in the context of adolescent sexual assault, the idea of having other providers and agencies embedded in a coordinated response is often seen in community responses to sexual assault. For example, members of the legal, medical, health, and advocacy systems in some jurisdictions have created sexual assault response teams to foster collaboration and build positive relationships between providers, as well as improve the experiences of survivors (Greeson & Campbell, 2013). Although these many different agencies work with one another collaboratively, survivors get to choose which specific providers and services they engage. This may not be the case when it comes to MR for adolescent sexual assault. Some MR processes may also include notification of additional agencies, regardless of if the survivor wants such notification to be made or not. For example, some communities have policies to notify police and prosecution with jurisdiction over the location where the assault occurred as part of the MR process (e.g., Massachusetts; see Massachusetts SANE Adolescent Taskforce, forthcoming). As a result, the adolescent survivor may come into contact with a range of providers that they did not originally choose to engage. This may allow them to be connected to services they would not otherwise receive. However, this may also result in the adolescent feeling overwhelmed or out of control, as these additional agencies are informed of the incident and brought into the adolescent's life whether the adolescent wanted that to happen or not.

Challenges to MR in the Context of Adolescent Sexual Assault

Although MR policies and laws apply to adolescents and may be impactful in preventing future abuse or harm, there is a dearth of literature on how these policies apply in the context of adolescent sexual assault. The considerable variation in MR policies, and how and when they are implemented, means that mandatory reporters may encounter many challenges in deciding whether to file a mandatory report. Additionally, because MR was initially designed and implemented to intervene on current abuse and prevent future abuse of children, there remains little information and knowledge on how MR can help teens, specifically, and especially after they have experienced rape or sexual assault. The intersection of this confusion and lack of information creates hesitance and confusion for providers on the appropriateness and utility of MR as it relates to its implementation among adolescent survivors of sexual violence. Here, we describe specific challenges that may arise in implementing MR in the context of adolescent sexual assault.

Provider Education, Discretion, and Bias

The confusion around when to and when not to report the sexual assault of an adolescent largely results from limited education and a lack of proper training on the application of MR policies (Mathews et al., 2016; Palusci & Vandervort, 2014). Words often associated with MR legislation include "reasonable suspicion" and "confirmed abuse or neglect," but little training or education has been provided in a systematic way on what these words mean, how they translate into identifying cases that qualify for a mandatory report, and how to filter out cases that do *not* qualify for a mandatory report (Besharov, 2005; Mathews & Bross, 2008). This lack of training and education means that providers are often left to use their own discretion in deciding to file a mandatory report or not (Mathews & Bross, 2008, 2015; Smith, 2010; Whittier-Newton & Vandeven, 2010). In the absence of clear guidance, training, and education, providers may avoid MR altogether or rely primarily on their biases to dictate when a report is needed (Kuruppa et al., 2020). It is also important to note that even in the context of guidance, training, and education, providers may still use biases in deciding when they implement MR, with both contexts facilitating opportunities for racist and other discriminatory practices. This trend of racist and discriminatory practices in MR is evident in the available research, which has found that, MR is disproportionately implemented among low-income and Black and Brown families and communities (i.e., overreporting; Besharov, 2005; Detlaff & Boyd, 2020; Kuruppu et al., 2020; Raz, 2017; Webster et al., 2005). The overreporting of young people from low-income and Black and Brown communities causes increased harm to individuals and families in these communities as they are saddled with the financial and emotional burden of navigating the processes and requirements of child protection agencies after a mandatory report has been filed (Detlaff & Boyd, 2020; Kuruppu et al., 2020; Raz, 2017).

There is also increasing evidence of the role of age in providers' discrimination and bias toward survivors. More specifically, because adolescence is a time of exploration and discovery, teens may be engaging in developmentally appropriate or expected activities at the time of assault (e.g., staying out late, drug or alcohol use). However, the circumstances surrounding sexual violence among teens are often used by officials to blame or place the survivor at fault for the assault occurring, as survivors receive messages that if they were not doing or wearing certain things, they would not have been harmed (Greeson et al., 2014, 2016). Teens are also seen as a group incapable of making certain decisions without parental consent and involvement due to their developing brain, which is directly reflected in aspects of society as adolescents face many legal restrictions in different areas of their lives, including medical care, voting, and driving (Ford & English, 2004; Schapiro & Meija, 2018). Many biases and assumptions also live at the intersection of different aspects of teen's identities. The tendency to hypersexualize Black girls and perceive them as less innocent and older than their White counterparts may have significant impacts on how providers view Black girls and how they respond to them when they seek care (Epstein et al., 2017). These many institutional and cultural biases and assumptions may impact a provider's decision to file a mandatory report or not, particularly in the absence of clear guidance, training, and education of how it should be implemented.

Confidentiality Concerns and Value Incongruence

Survivors of all ages often delay seeking services after an assault; but, when survivors do choose to access services, they often want to do so confidentially (Alderman, 2017; American Academy of Family Physicians, 2009; Campbell et al., 2013; Hall & Gloyer, 1985; Schapiro & Meija, 2018; Walker, 2017). Depending on how providers implement MR, this may be less feasible or impossible for adolescent survivors. Confidentiality laws are designed to outline different circumstances in which individuals under the age of 18 have the right to confidentiality in accessing certain services, specifically regarding a minor's right to receive care without parents or caregivers being notified (Alderman, 2017). When adolescent survivors seek confidential care and a mandatory report is completed, the mandatory report may conflict with confidentiality laws and commitments (Watson & Levine, 1989; Whittier-Newton & Vandeven, 2010). An example of this is when a therapist encounters a reportable incident as part of a client's disclosure of recent trauma. In this scenario, the therapist faces the decision to break the client's confidentiality by reporting the incident, as directed by agency guidelines and MR policies, or maintain the client's confidentiality by choosing not to file a mandatory report, in line with confidentiality commitments (American Academy of Family Physicians, 2009; Kenny et al., 2018; Sharkey et al, 2017; Tsai et al., 2017; Watson & Levine, 1989).

This is often a difficult decision for providers to make as research indicates that survivors, and more so adolescent survivors, already have concerns around confidentiality in the context of seeking care. In a study conducted among adolescents, 59% of participants (of the 556 total participants) reported that they would discontinue services at a family planning clinic if their parents were made aware of them seeking out reproductive care (American Academy of Family Physicians, 2009; Reddy et al., 2002). Furthermore, one of the only studies that asks adolescents about postassault services found that a majority (95%) of the approximate 500 participants stated that they would seek services after experiencing a sexual assault from a treatment facility if confidentiality was guaranteed (Hall & Gloyer, 1985). The number of participants who would seek services dramatically decreased if parents or caregivers were notified of the teen's help-seeking, with only 50% of female respondents stating that they would still seek out treatment if their parents or caregivers were made aware (Hall & Gloyer, 1985).

This is particularly relevant in the context of MR, as parents and caregivers are routinely notified in the MR process. Although there is limited research on the experiences of adolescent survivors with MR, it is clear that because adolescents desire confidentiality when seeking out various services and resources, MR policies and their implementation can harm teens' relationships with providers (Crawford-Jakubiak et al., 2017; Hall & Gloyer, 1985; Schapiro & Meija, 2018; Tsai et al., 2018; Walker, 2017; Watson & Levine, 1989; Whittier-Newton & Vandeven, 2010). This is concerning not only because teen survivors' have already experienced a significant loss of power and control but also because if a teen experiences the mandatory report as a result of disclosing a rape or sexual assault, they can feel even more betrayed and out of control. These feelings can then cause distrust toward providers, deterring the teen survivor from interacting with other providers and receiving needed health and mental health care (American Academy of Family Physicians, 2009; Schapiro & Meija, 2018; Walker, 2017; Watson & Levine, 1989). This is part of why the Violence Against Women Act (VAWA) requires states that receive VAWA funding to offer forensic medical exams for rape and sexual assault without reporting to or involving law enforcement (Riviello & Rozzi, 2018). MR, particularly that includes notifying police and prosecution, may run counter to the spirit of VAWA which seeks to retain and promote survivors' rights when interacting with postassault systems and service providers. Ultimately, concerns related to confidentiality may not only deter teens from seeking out needed postassault services and resources but can also deter providers from implementing MR policies.

Beyond confidentiality concerns, MR policies can also be incongruent with professionals' broader values and guiding principles (American Academy of Family Physicians, 2009; Herendeen et al., 2014; Tsai et al., 2018; Walker, 2017; Whittier-Newton & Vandeven, 2010). For example, the medical profession's motto of "do no harm" can directly conflict with MR policies if filing a report places the vulnerable person in a further unsafe situation (e.g., if the perpetrator lives in the home or has access to the survivor and can retaliate; American Academy of Family Physicians, 2009; Sharkey et al., 2017; Walker, 2017; Watson & Levine, 1989). Social workers are also mandatory reporters and are guided by a code of ethics, as outlined by the National Association of Social Workers (NASW). Some of the NASW ethical standards include "Commitment to Clients" and "Privacy and Confidentiality," with most NASW ethical codes and standards emphasizing the safety and well-being of clients and their families; these values and ethics can be challenged when MR is not in the best interest of the individual or family (American Academy of Family Physicians, 2009; Goodman et al., 2019; Herendeen et al., 2014; Kuruppu et al., 2020; Lippy et al., 2019; NASW, n.d.; Teare & English, 2002; Tsai et al., 2018; Walker, 2017; Watson & Levine, 1989; Whittier-Newton & Vandeven, 2010). Much like navigating the conflict between choosing to report and maintaining confidentiality, providers may find themselves in an ethical quagmire, having to choose which principles and policies to abide by when interacting with teen survivors. Lack of understanding and confusion around reporting as a result of ambiguous and inconsistent guidance, paired with limited training and education, further deters professionals who may already have ethical qualms from abiding by MR laws (Sharkey et al., 2017; Smith, 2010; Teare & English, 2002; Tsai et al., 2018; Watson & Levine, 1989).

Contentious Interagency Relationships

In addition to confidentiality concerns and providers' values conflicts, providers may be hesitant to file a mandatory report as a result of contentious relationships with government child protection agencies or skepticism on case investigation and follow-up if a report is made (Kuruppu et al., 2020; Mathews & Bross, 2008, 2015). Some view government child protection agency workers as complicit actors within an overarching system that engages in punitive investigations rather than connecting families to needed services and protecting those who have experienced abuse and neglect (Mathews & Bross, 2008). Government child protection agencies are perceived and documented to offer inadequate responses in which no follow-up is provided, while also intervening to a significant extent when it is not warranted.

Some negative views of child protection agencies result from there being little to no follow-up after a mandatory report is made (Kuruppu et al., 2020; Mathews & Bross, 2008, 2015; Webster et al., 2005; Whittier-Newton & Vandeven, 2010). While adolescents are included as a group that qualifies for MR, the specific dynamics of the case may make it very likely that the case is "screened out," meaning no response or services are provided. Funneling cases into an overburdened system when such cases are likely to be screened out anyway places additional strain on state child protection systems as they continue to be overworked with limited resources (Mathews & Bross, 2008; Webster et al., 2005). This may deter

professionals from filing a mandatory report (Kuruppu et al., 2020; Mathews & Bross, 2008, 2015; Raz, 2017).

On the other hand, recent research documents how child protection agencies' responses are much more significant for select families and communities. Black and Brown communities are among those who have been historically and systematically harmed by child protection agencies and the overall child welfare system. Several studies have identified how child protection policies target Black and Brown children and families, disproportionately putting them through disruptive and painful processes associated with MR, and forcing separation of children from their parents at disproportionately higher rates (Child Welfare Gateway Information, 2016; Detlaff & Boyd, 2020; KIDS Count, 2020; Kuruppu et al., 2020). Providers who are familiar with this history and these practices may question whether filing a mandatory report has potential to do much more harm than good for the adolescent survivor.

Finally, in jurisdictions that include additional responders in the MR process, providers may also hesitate to complete a mandatory report out of concern for potential negative interactions between the adolescent survivor and these additional agencies. Prior research has documented how survivors, including adolescents, are often met with disbelief, victim-blaming, and otherwise cold responses from providers (Greeson et al., 2014, 2016). Such unsupportive reactions can exacerbate the negative impacts of the assault (e.g., see Ahrens et al., 2009). Thus, some providers may weigh the potential for help with the potential for harm from these overburdened, discriminatory systems and agencies before deciding to complete a mandatory report as well as teens may weigh the harm that can occur when interacting with providers when deciding to seek out follow-up care for a rape or sexual assault.

The Impact of MR

There is very little research on MR models generally and even less on MR's effectiveness and impact (Mathews & Bross, 2008, 2015; Mathews et al., 2016; Palusci & Vandervort, 2014; Palusci et al., 2016). What the research does tell us so far about MR policies is that their implementation increased the number of reports made to child protection agencies and that they corresponded to a decrease in child deaths (Besharov, 2005; Mathews & Bross, 2008, 2015; Mathews et al., 2016; Palusci & Vandervort, 2014; Palusci et al., 2016). In a series of studies, Palusci and Vandervort (2014) and Palusci et al. (2016) examined the relationship between MR laws and reporting rates in two states following changes that were made to the states' MR policies in 2010 (i.e., the laws were expanded to include clergy as mandatory reporters). As more individuals were deemed to be mandatory reporters, more cases were reported (Palusci & Vandevort, 2014; Palusci et al., 2016). In a separate study, conducted a decade earlier, and using data from the Department of Health and Human Services, Besharov (2005) examined the relationships between MR policies, reporting rates, rates of confirmed cases, and rates of child deaths for cases of child abuse and neglect in the United States from 1976 to 1999. Besharov found that as a result of increased reporting, subsequent investigations, and connection to services in relation to MR policies, child deaths decreased from 3,000 to 5,000 deaths annually to 1,100 deaths (Besharov, 2005; see also Mathews & Bross, 2015).

However, there is also a growing body of research asserting that although there appears to be an increase in reporting rates, there has not been an increase in substantiated cases of abuse and neglect with the implementation or expansion of MR policies. For example, in the auditing of one state's child protection service agency, officials found that although there were increased reports of abuse and neglect, many reports did not receive any follow-up or were ultimately unsubstantiated (DePasquale, 2016; Raz, 2017). Another early study on predictors of legal involvement in child maltreatment cases also found that although there has been a significant rise in the reporting of maltreatment as government agencies have implemented MR policies, only a small number of substantiated cases went forward with criminal prosecution (Mathews & Kenny, 2008; Tjaden & Thoennes, 1992). Instead, it appears that the influx of cases is due in part to racist MR practices, as research on MR reveals that increases in rates of reporting are not uniform across the population. Rather, rates of reporting have disproportionately increased among low-income communities and communities of color (Lippy et al., 2019; Raz, 2017). As a result of racial bias and discrimination, Black and Indigenous children are overrepresented in the child welfare system when compared to White children (Child Welfare Gateway Information, 2016). For example, while Black children make up 14% of children in the general population, they comprise 23% of children in the welfare system (Detlaff & Boyd, 2020; KIDS Count, 2020). As the child welfare system and MR expanded, the same racist beliefs and biases that resulted in the overrepresentation of children of color in the child welfare system initially resulted in the disproportionate increase in reported cases for this population (Child Welfare Gateway Information, 2016; Detlaff & Boyd, 2020; KIDS Count, 2020). In other words, expanded MR policies allowed providers more opportunities to file mandatory reports at a disproportionate rate for children of color.

In turning to the impact of MR in the context of adolescent sexual assault, specifically, there is simply no research available. We do not yet know whether or how MR in the context of adolescent sexual assault is successful in serving the main purposes of the MR laws: to stop ongoing and prevent future adolescent sexual assault, to mitigate the long-term impacts of adolescent sexual assault, and to create a culture of protecting against adolescent sexual assault. We also do not know how variations in who reports, what gets reported, and to whom affect survivors' experiences and case outcomes. This gap in the literature is glaring, particularly when we consider that adolescents are sexually assaulted at a rate higher than any other age group and may often be subject to a mandatory report as a result.

Table 1. Critical Findings and Implications for Practice, Policy, and Research.

Critical Findings	Implications for Practice, Policy, and Research
• Adolescents continue to experience sexual violence at alarmingly high and disproportionate rates but exhibit the lowest rates of reporting or seeking out services and resources • Mandatory reporting policies are one of the many legal approaches used in response to rising rates of abuse and neglect among different populations, specifically among those 18 and under • Although mandatory reporting policies have been adopted widely, research indicates that mandatory reporters experience many challenges to implementing these policies, particularly in the context of sexual assault, and especially because of variation in who must report, what must be reported, to whom, and consequences for failing to report • Mandatory reporting is particularly challenging among adolescents given their unique needs and interactions. There is also increased risk of mandatory reporting causing further harm to the adolescent and deterring them from seeking future resources and services • Mandatory reporting policies do not necessarily increase rates of substantiated cases, and minors from low-income communities and communities of color are overrepresented in child protective services • The effectiveness of mandatory reporting policies in protecting certain populations is unclear, with very little research on the impact of mandatory reporting on individuals and families subject to it, and no current research on mandatory reporting among adolescent survivors of sexual violence	• Organizations and professionals who are mandatory reporters need to be conscientious of the unintended consequences of mandatory reporting, especially as it relates to causing further harm and eliciting fear among individuals in accessing needed services • Further research on the experiences of those involved in the mandatory reporting process is needed, particularly on individuals who are the subjects of such reports. This will help us to understand the impact of these policies on the individuals they are meant to protect • Future research should assess mandatory reporting models and other protection models as they relate to addressing abuse and neglect and protecting certain populations, particularly sexual assault survivors • Future research should examine the challenges experienced by providers in fulfilling the mandatory reporting obligation to identify ways to ameliorate these issues • Research and evaluation should be used to inform explicit guidelines and policies related to mandatory reporting among adolescent survivors of sexual assault

Discussion

In light of this review of the literature, it is clear that adolescents continue to experience the highest rates of sexual violence while they also remain largely disconnected from the services they need (Ahrens et al., 2010; Broman-Fulks et al., 2007; Casey & Nurius, 2006; Crawford-Jakubiak et al., 2017; Danielson & Holmes, 2004; Giroux et al., 2018; Hall & Gloyer, 1985; Hanson et al., 2003; Martsolf et al., 2010; Planty et al., 2013; Snyder & Sickmund, 2006; Trotman et al., 2016). MR, as outlined above, is one of many legal approaches and models used to bring awareness to the harm experienced by adolescents, as well as to prevent future harm from occurring. MR has been adopted by communities across the country (Mathews & Bross, 2015; Palusci & Vandevort, 2014). Yet, there remains tremendous variation in who is required to report, what situations warrant a report, to whom the report is made, and the consequences individuals face for failing to report. This variation not only impedes providers' abilities to fulfill MR obligations but can deter those in need of services and resources from seeking care for fear of the mandatory report. This is particularly true for adolescent survivors of sexual violence who are attempting to practice more agency over their lives (see Finkelhor & Wolak, 2003).

The research available on the impact of MR since its implementation asserts that while MR policies have resulted in increased rates of reporting, they have not necessarily increased the rates of substantiated cases of abuse (DePasquale, 2016; Palusci & Vandevort, 2014; Palusci et al., 2016; Raz, 2017). In fact, emerging research indicates that the increased rates of reporting disproportionately impact low-income communities and communities of color, placing greater burden and harm on these families and communities (Detlaff & Boyd, 2020). Based on the research on the experiences of survivors with system personnel (Greeson et al., 2014, 2016), there is also a possibility that adolescent sexual assault survivors may experience further harm as a result of MR, which can have long-term consequences to the survivor's relationships with providers and to the survivor's well-being. Finally, it is clear that there is still a lot that we do not know—more research is needed that focuses on the impact of MR on those it is designed to protect, specifically as it relates to adolescent survivors of sexual violence. Table 1 succinctly presents the critical findings from this review, alongside specific implications for policy, practice, and research.

Limitations

While this review advances our understanding of history of, variations in, and challenges in MR in the context of adolescent sexual assault, our review is necessarily limited because no studies exist to date that focus specifically on this exact phenomenon. This review highlights this significant gap in the literature and provides guidance as to what we must explore going forward.

Implications for Practice, Policy, and Research

MR is important as it can end ongoing abuse, prevent future abuse, and connect victims and their families to much-needed

services. Providers face incredible challenges, though, in implementing the mandatory report. This review highlights, though, that providers face significant challenges in implementing the mandatory report. Additionally, this review highlights that MR may have unintended consequences as it has the potential to result in further harm and to deter adolescents from seeking much-needed care. Individuals and agencies that are deemed as mandatory reporters need additional training and education on when and how to file a mandatory report, and the many different factors that should be taken into consideration when deciding whether MR applies to a given context. Providers should also be trained to be contentious of the effect MR can have on individuals, families, and communities, so they can prepare themselves and those they serve for what might happen next after a mandatory report is made. Child protection agencies and policymakers should also review existing policies and guidance to identify and correct ambiguities in how MR is to be implemented. Particular care and attention must be given to how such policies and their implementation disproportionately impact select communities and have the potential to continue to operate in racist and discriminatory ways. Of course, this is a big ask for systems and agencies that are already overburdened and underresourced. Additional funding will needed to ensure that such agencies and providers can meet current demands while developing additional training, education, and policy review opportunities.

Based on the current literature, it is difficult to offer more specific recommendations for practice and policy change for MR in the context of adolescent sexual assault as there is currently a dearth of literature in this area. Instead of reporting on what we know, this literature review largely reported on what remains unknown for MR in this particular context. While we know that there is variation and providers do exercise discretion in making a mandatory report for an adolescent sexual assault, we do not know the extent of this variation and the specific factors that inform provider decision making. Future research should catalogue and assess MR and other protection models in the context of adolescent sexual assault. This should include an empirical examination of the specific challenges providers face in completing mandatory reports for this population in this context. Once different MR and other protection models are identified, future research should also examine the extent to which they increase not only reporting but additional desired outcomes. This might include the extent to which MR in this context leads to substantiated cases or survivors being connected to needed services. In jurisdictions in which the MR process includes other providers, like police or prosecution, future research should also examine the extent to which MR leads to higher rates of successful prosecution.

Future research should also seek to understand more about the experiences of adolescents who interface with the MR process. To date, there are no studies that examine how MR influences adolescent survivors' postassault help-seeking expectations and experiences. Changes to MR practices and policies in the context of adolescent sexual assault will directly affect teen survivors. It is critical that adolescent survivors' voices are informing these change decisions. Additionally, such research should strive to explore these phenomena with diverse samples, as we know that survivors' experiences with responding agencies and systems vary widely depending on their race, ethnicity, and other aspects of their intersectional identities.

Given the high rates of sexual assault among adolescents, their low likelihood of seeking care, the promise and the pitfalls of MR, and the associated long-term negative impacts of these experiences, it is clear that we have much work to do in understanding more about MR in the context of adolescent sexual assault and how we can best support all survivors.

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ORCID iD

Jessica Shaw https://orcid.org/0000-0003-3286-5570

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Author Biographies

Caroline Bailey, MSW, is a doctoral student in the Community Prevention and Research Program at the University of Illinois at Chicago. Her research interests include system responses to survivors of sexual and domestic violence as well as community-based research and evaluation that can influence policy and practice.

Jessica Shaw, PhD, is an assistant professor in the Psychology Department at the University of Illinois at Chicago. Her research focuses on understanding and improving system responses to sexual assault through collaborative, multidisciplinary efforts. She is committed to developing responsive and relevant research and evaluation projects, so findings can be used to inform policy and practice.

Abril Harris, MSW, is a doctoral student at the Boston College School of Social Work. Her research focuses on the utility of oppressive ideologies and beliefs in the legitimization of structural violence (i.e., police brutality, sexual violence) against marginalized communities and persons.