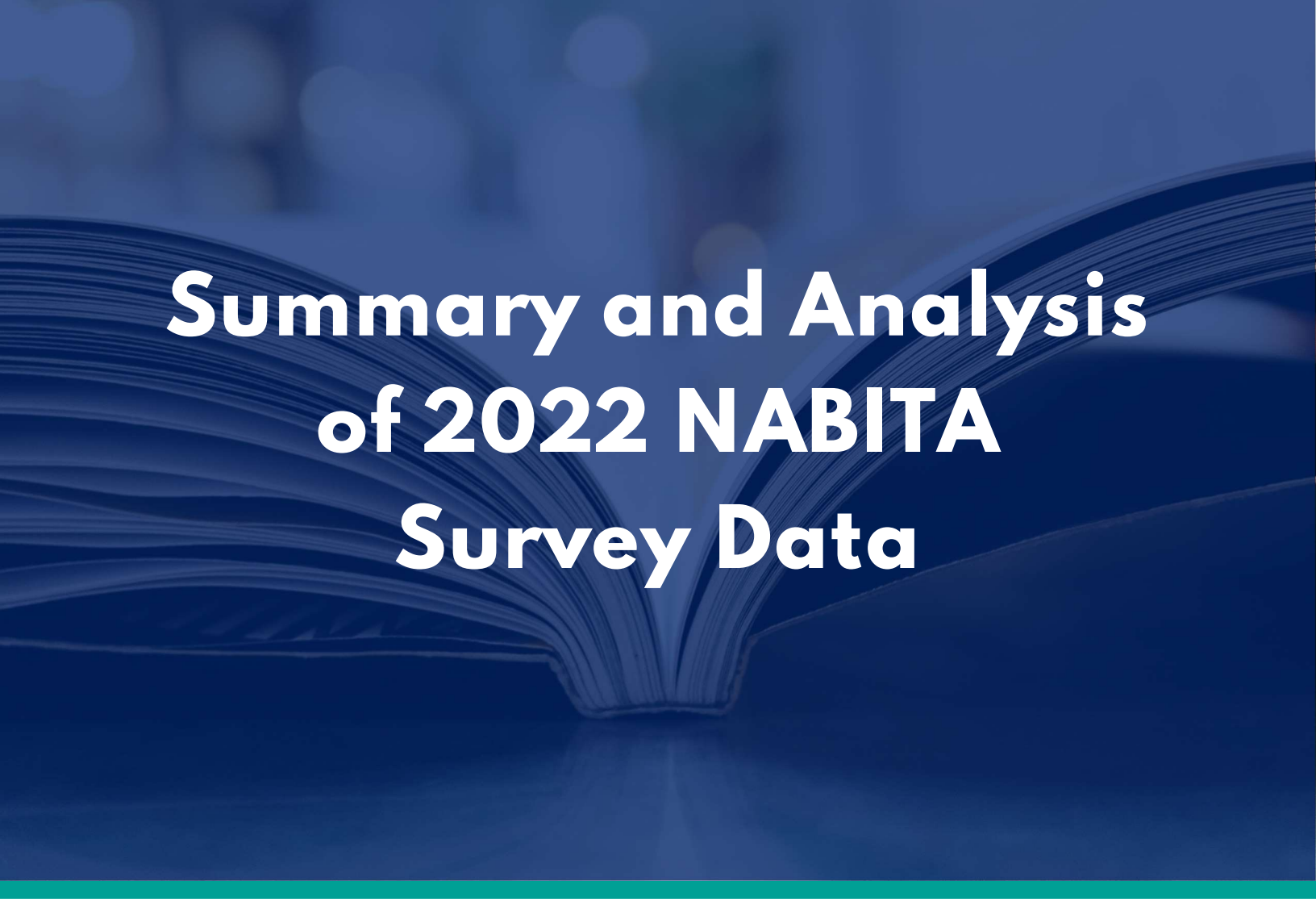


Summary and Analysis of 2022 NABITA Survey Data

National Association for Behavioral Intervention and Threat Assessment

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TABLE OF CONTENTS

1 **Introduction 3**

2 **Limitations 4**

3 **Demographics 5**

Institutional Type 5

Institutional Size 6

4 **Overview of Team Characteristics 7**

Team Prevalence, Name, and Longevity 7

Team Scope 8

5 **Team Leadership and Membership 9**

Leadership 9

Membership 9

6 **Team Processes 11**

Meeting Frequency 11

Team Referrals 12

Agendas 13

Risk Management 13

Recordkeeping 15

7 **Team Resources and Policies 16**

Case Management Resources 16

Mandated Assessments and Withdrawals and Return to Learning 17

Education and Marketing 19

Team Training 20

Team Strengths and Weaknesses 21

8 **Discussion 22**

9 **Conclusion 30**

10 **NABITA Standards for Behavioral Intervention Teams 31**

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1 INTRODUCTION

The National Association for Behavioral Intervention and Threat Assessment (NABITA) administers a biennial national survey to practitioners in education settings to identify common Behavioral Intervention Team (BIT) characteristics, practices, and trends. This document provides a summary and analysis of the 2022 survey results. The analysis and discussion offer evidence-informed guidance for the direction of the behavioral intervention field.

NABITA disseminated invitations to complete the 2022 survey through the NABITA email listserv, several student affairs Facebook groups, to Higher Education Case Managers Association members, via the NABITA and TNG social media accounts, and to TNG email contacts. 398 individuals representing both K-12 and postsecondary education institutions participated in the survey.

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2 LIMITATIONS

The survey data is limited by the way participants were recruited and invited to take the survey. The invitation to participate was sent primarily to NABITA members; therefore, the data are likely to trend toward the use of BITs and the use of NABITA-related assessment tools. Additionally, to improve the usability of the data and clarity of the questions, changes were made to the survey design and question wording, which limited the ability to compare responses to prior survey results. It was also noted that many participants did not finish the survey, limiting the amount of information collected.

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3 DEMOGRAPHICS

Institutional Type

The survey provided participants with a set of demographic questions regarding their institution. Fifty-eight percent of participants reported being affiliated with a four-year postsecondary institution, 33 percent reported being affiliated with a two-year postsecondary institution, and 4 percent reported being affiliated with a K-12 school or district. Additionally, 4 percent of participants reported that they are affiliated with community or workplace BIT. Due to a low survey response rate from K-12 schools/districts and community or workplace BITs, all data reported below represents the frequencies from the total sample rather than an analysis of the data by organization type. Where appropriate, specific K-12 analysis or recommendations are provided.

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Participants were also asked if they were affiliated with a public or private institution. Sixty-four percent of participants reported affiliation with a public institution, 21 percent reported affiliation with a private institution, and four percent identified as working for a for-profit institution. The survey also collected information related to the schools' residential status. Specifically, participants were asked whether their institutions were primarily residential or primarily non-residential. The majority (76 percent) of participants reported that their institutions are primarily non-residential, while 21 percent reported representing a primarily residential institution. Eighty-seven percent of participants indicated that they have some residential capacity at their institution.

For postsecondary institutions with a satellite campus, 17 percent of the satellite campuses have their own team dedicated to that location, while 16 percent of the satellite campuses send a representative from the satellite location to serve on the main campus BIT. [1] Another 18 percent of participants indicated that a member of the main team is assigned as a liaison to the satellite campus. Concerningly, 49% of participants indicated their satellite location does not have a separate team or send a representative to the main campus team.

Institutional Size

Survey participants represented diverse institutional sizes, ranging from less than 1,000 students (10 percent) to more than 50,000 students (6 percent). Additionally, the following institution sizes were represented: 1,001–3,000 students (12 percent), 3,001–7,000 students (19 percent), 7,001–15,000 students (23 percent), 15,001–25,000 students (16 percent), and 25,001–50,000 students (11 percent).

[1] For the purposes of this survey, a satellite campus is defined as a campus/location/branch that is part of the larger school/institution/organization, but geographically separate with its own services/staff.

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Section 4

4 OVERVIEW OF TEAM CHARACTERISTICS

Team Prevalence, Name, and Longevity

Ninety-eight percent of participants reported that their institution has a team that meets regularly to address potential risks, threats, and/or individuals of concern. While the survey results indicate some variation in team name, Behavioral Intervention Team (BIT) and Campus Assessment, Response, and Evaluation (CARE) Team are the most common, representing 81 percent of participants' team names. Specifically, 37 percent of participants indicated using "BIT" for the team name and 44 percent reported using "CARE." Additional team names, including Students of Concern (SOC) and Behavioral Assessment Team (BAT) each represented 3 percent of the respondents' team names, while Threat Assessment Team and Assessment and Care Team (ACT) each represented 1 percent of participants.

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On average, participants identified that their team has been in existence for nine years. Some participants indicated that their institution does not yet have a formalized team, while other teams have existed for as long as 30 years.

Team Scope

Fifty-eight percent of participants indicated they have one integrated team that addresses behavior ranging from low-level concerns to threats of harm to self or others. Twenty-two percent indicated having two teams: one that addresses threat or high-risk behavior and one that addresses early alert/low-level concerns. Additionally, some participants indicated having only one team at their institution with a narrower scope. Thirteen percent indicated their institution has one team that addresses threat assessment (e.g., referrals for threat of harm to self or others or threatening behavior) and no team for addressing low-level concerns, while seven percent indicated having one team that addresses early alert/low-level concerns (e.g., referrals for basic needs, support resources) and no team for addressing threats. The scope of populations served by these teams indicates 43 percent of teams jointly monitor student, faculty, and staff concerns, while 57 percent reported that they only monitor students.

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5 TEAM LEADERSHIP AND MEMBERSHIP

Leadership

Participants identified the closest job title for the chair of their teams. Most commonly (51 percent), participants reported that someone in a dean of students role chaired the team. The second most common (20 percent) response was case manager. Other teams reported chairs with job titles like vice president for student affairs (13 percent), student conduct (16 percent), and counseling staff (5 percent).

Membership

On average, teams have eight core and inner circle members. Core and inner circle members are those who are expected to attend every meeting. Among the core and

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inner circle membership, teams tend to have representatives from counseling (84 percent), law enforcement or campus safety (85 percent), dean of students (77 percent), student conduct (75 percent), and case management (70 percent). Of participants who classified themselves as primarily residential institutions, 85 percent indicate that a representative from housing and residential life served on the core team. Other core team members who may be added based on institutional characteristics and team scope include academic affairs (42 percent), faculty (35 percent), vice president for student affairs (36 percent), human resources (19 percent), student activities (19 percent), and legal counsel (22 percent). While the number of K-12 survey participants was too low to produce generalizable results or statistical significance, common roles on K-12 BITs include principal, assistant principal, school resource officer, school counselor, and special education representative.

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6 TEAM PROCESSES

The survey also included questions about BIT processes and functions. These questions collected information related to referrals, BIT meetings, agendas, recordkeeping, and the use and application of a risk assessment rubric.

Meeting Frequency

The majority of respondents reported that their team meets either weekly or bi-weekly. Specifically, meetings occur weekly (58 percent), bi-weekly (25 percent), monthly (9 percent), once a semester (none), and as needed (8 percent). Participants reported that on average, the team canceled four meetings per year.

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Team Referrals

Receiving referrals from concerned individuals is a core team function. As such, the survey included several items related to referrals and referral processes. Participants reported that concerning behaviors and/or threats could be reported to the team in a variety of ways. Predominately, participants reported that they used an online reporting form (97 percent) to receive referrals and 47 percent indicated they accept anonymous online reports. Additionally, participants reported receiving referrals via email (84 percent), phone (70 percent), direct communication with the chair (61 percent), and notification to the central office in charge of the team (37 percent). A smaller percentage of teams (3 percent) have started using a mobile app to receive referrals. In the open-ended response, participants indicated that when referrals come in through other channels (face-to-face conversation, phone, email, etc.), they complete the online referral form to document the referral.

Referrals tend to come from across the institution and the larger community, and 69 percent of participants indicated that their teams track referral sources. Of those participants who track referral sources, 61 percent reported faculty or teachers as the most common referral source, and 12 percent reported residential life staff members were the most common referral source. Other participants reported counseling staff (11 percent), peers/students (5 percent), academic advisors (4 percent), mental health resources (4 percent), campus safety/police (3 percent), student affairs staff (3 percent) and tutoring/academic advising (2 percent) as the most common referral source.

Regarding reasons individuals are referred to the BIT, 53 percent of participants reported that the most common referrals are for general emotional and mental health concerns. Additionally, 17 percent of participants reported academic, financial, social stress, or other social service needs were the most common referral reason followed by suicidal ideation, gesture, or attempt (13 percent), behavioral misconduct (e.g., vandalism, classroom disruption) (11 percent), and threatening behavior (6 percent). No respondents reported alcohol or other drug concerns as the most common reason for a referral.

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Agendas

Eighty-one percent of teams reported using an agenda for their team meetings. Of those using an agenda, common agenda items included individuals of concerns' names (70 percent), presenting issues of concern (50 percent), referral source (33 percent), year in school (21 percent), and whether they live on or off campus (19 percent). Five percent reported including the individual's risk rating on the agenda. Seven percent of participants noted that they either use the Maxient Care Report[2] to generate agendas or send a list of case numbers linking to an electronic case record. Of those participants indicating that their team uses an agenda, 75 percent indicated that the agenda is distributed to the team before the meeting day and 25 percent indicated that agendas are not distributed to the team prior to the meeting.

In addition to sending agendas in advance of team meetings to help members prepare for the team meeting, 77 percent of participants reported that their members read the referrals in live time as they come in or in advance of the meeting to prepare. Only 23 percent reported that their members read the referrals for the first time during the team meeting.

Risk Measurement

In terms of assessing and measuring risk, 78 percent of participants indicated that their team uses an objective, standardized rubric to assess risk, while 18 percent indicated that they measure risk subjectively, or on a case-by-case basis, and eight participants indicated that they do not measure risk at all. Participants were also asked how often their teams apply the standardized rubric to their cases or referrals. Of participants who use a risk assessment tool, 75 percent report using it for every referral the team receives, while 16 percent indicated that they only apply the rubric to the more serious or time-consuming cases. Additionally, some participants indicated that they only apply the rubric to specific cases involving threats to others (8 percent) or mental health (1 percent).

[2] The Maxient Care Report is a standard report available through the Analytics section of the Maxient software and was written in as an "other" response on the survey.

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Of participants that measure risk, 88 percent reported using the NABITA Risk Rubric.[3] Participants were able to select multiple tools used by the team and reported the following as additional tools used to measure risk: the Structured Interview for Violence Risk Assessment (SIVRA-35) (34 percent), the Violence Risk Assessment of the Written Word (VRAWW) (17 percent), the Workplace Assessment of Violence Risk (WAVR-21) (10 percent), and the Extremist Risk Intervention Scale (ERIS) (3 percent).

Most commonly (77 percent), participants who assess risk reported that their teams used risk ratings to determine the case management plan. Additionally, 68 percent reported using risk ratings to determine how and when to contact the person of concern. Risk assessments are also used to determine the need for a welfare check (68 percent), a mandated assessment (53 percent), and or outreach to an emergency contact (68 percent). Concerningly, four percent of participants reported that their team does not use the risk rating to guide next steps.

Participants using the NABITA Risk Rubric reported that their team received referrals for lower-level cases most frequently. Specifically, eighty-eight percent of respondents indicated the team assesses cases to be at either the mild or moderate rating most commonly, while only 12 percent reported using elevated most commonly. No one indicated that critical was the most common rating. Similarly, 80 percent of participants indicated that critical was their least common risk rating while only 18 percent indicated the least common risk rating was mild or moderate.

Participants were also asked to report the number of cases referred to the team per year. Participants that knew the team's caseload reported the following number of referrals per year:

- Up to 50 cases: 30%
- 51-100 cases: 18%
- 101-200 cases: 15%
- 201-300 cases: 10%

[3] https://www.nabita.org/resources/the-nabita-risk-rubric/.

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- 301-400 cases: 8%
- 401-500 cases: 4%
- 501-1000 cases: 10%
- 1000+ cases: 8%

Recordkeeping

Ninety-two percent of participants indicated that their team keeps centralized records and 6 percent of participants indicated that team members keep individual records. Concerningly, the survey results indicate that five participants reported keeping no team records at all. Most commonly, participants indicated that their BIT records include the name and demographics of the referred individuals (81 percent), a summary of the incidents or chief problems (91 percent), intervention plans and details about which staff member(s) followed up (75 percent), a risk rating (69 percent), and a case log, which includes meeting dates, case discussion notes, phone call summaries, emails, etc. (77 percent).

The survey also included questions about how these records are kept and who has access to view and edit them. Most participants (61 percent) indicated that they use Maxient to store their team records.[4] Nineteen percent reported using Symplicity[5] software products, and another 9 percent of participants indicated that their team uses Microsoft Access or Excel. Five percent of schools reported using a platform that was designed in-house by their information technology department and 3 percent reported using pen and paper files.

Teams approach records access differently; however, most participants (86 percent) indicated that all core and inner circle team members have access to the database but only 52 percent report that the core and inner members update information throughout the week. Concerningly, 10 percent of participants indicated that only the team chair can view the team records and that the core and inner circle members do not have access.

[4] https://www.maxient.com/
[5] https://www.symplicity.com/

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7 TEAM RESOURCES AND POLICIES

Case Management Resources

Participants were asked to provide information related to the case management infrastructure and other resources available at their institutions.

As indicated in the membership section, 70 percent of respondents indicated having a case manager as part of their team. Case managers assigned to teams tend to be non-clinical, as 53 percent of participants reported having a non-clinical case manager as part of their core membership compared to 17 percent who have a clinical case manager.

Case management positions range from full to part-time. Eighty-one percent of participants indicated their team had access to a full-time case manager. The scope of this position and

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where it is housed varies across teams. Case managers accessible to the team most commonly work through the dean of students office (57 percent) or through a stand-alone department (14 percent). Case managers can also be found in student conduct (6 percent) and counseling/clinical departments (14 percent). Thirty-nine percent of participants indicated that the team did not have access to a full-time case management position at their institutions.

Participants were also asked to report the number of cases assigned to each case manager. Participants able to report on case manager caseload reported the following number of cases percase manager per year:

- Up to 50 cases: 45%
- 51-100 cases: 12%
- 101-200 cases: 10%
- 201-300 cases: 11%
- 301-400 cases: 12%
- 401-500 cases: 11%

Participants were also asked to share information about the team's financial support, exclusive of designated salary lines and benefits. Seventy percent of participants report having no financial support, or no financial support outside of salary and benefits. Of teams with financial support outside of salary and benefits, participants most commonly report funding up to $5000 (70 percent) while another 22 percent reported funding in the $5-10,000 range. Of teams with financial support, 63 percent indicated the dean of students office funds the team.

Mandated Assessments and Withdrawals and Return to Learning

The survey included questions related to the capacity to use mandated psychological and violence, risk, or threat assessments. Seventy percent of responses indicated institutions use some form of mandated assessment. While this will be covered in more detail in the discussion section, it should be noted that not all of the following practices are in line with recommended best practices and may create legal risks for institutions related to disability law and discriminatory action. Most commonly (41 percent), participants indicated that they may

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require the student participate in a mandated violence risk or threat assessment prior to returning[6] to the institution if the student's behavior has been threatening to others. Thirteen percent of participants indicated that they require students to complete a mandated psychological assessment if they are suicidal or prior to a return from a psychological leave. Additionally, 18 percent of institutions that reported that in higher risk threat or suicide risk cases, students are often placed on interim suspension[7] and required to complete an assessment as a condition for return. Aligning with recommended practice, only 21 percent reported that they require mandated assessments once students cross the elevated risk level threshold on the NABITA Risk Rubric or equivalent risk assessment tool.

Additional questions assessed the type of mandated assessment or treatment services schools' mental health resources provide. Participants reported the following mandated services available through their counseling or mental health services:

- Mandated assessment for suicidal students: 24%
- Mandated assessment for psychological issues with treatment recommendations: 19%
- Mandated assessment for threats or violence: 31%
- Mandated assessment for alcohol or other drugs with treatment recommendations: 20%
- Mandated treatment for suicidal students: 6%
- Mandated treatment for alcohol or other drugs: 9%
- Mandated treatment for violence risk: 7%
- None of these: 41%

According to the Americans with Disabilities Act (ADA), individuals taking a voluntary leave for psychological reasons should be treated the same as anyone taking a voluntary leave for any other reason. Fifty-five percent of participants indicated that their institution's policy for voluntary leave is consistent with ADA guidance. Another 10 percent of participants reported that, although not set forth as a requirement for the individual, BIT members meet with the

[6] The survey did not distinguish whether the student was returning from an interim separation, suspension, voluntary, or involuntary withdrawal.
[7] The survey did not define interim suspension. The participants answered the survey questions based on their institutional understanding of the term.

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individual of concern and emergency contact in a case management-style meeting to discuss their return from leave. Concerningly, 28 percent of participants indicated that they require a meeting, 20 percent of participants indicated that they require medical documentation, and 5 percent reported that they require a student to complete a detailed checklist as conditions for return.

Education and Marketing

The survey also included questions aimed at understanding how teams market themselves and educate their institutional communities about their processes and purpose. This included questions related to team websites, logos, and other marketing strategies, as well as how teams encourage the community to make referrals.

Sixty-eight percent reported that their team has a website and 21 percent of participants reported that the team has a logo. Of those with a website, 8 percent report that the website is only available internally or on the school's intranet. Participants with a website report the following information is most commonly included on the site:

- Contact email: 64%
- Online report form: 73%
- Concerns/behavior to report: 66%
- Contact phone: 62%
- Mission statement: 64%
- Team membership list: 51%
- Frequently asked questions: 30%
- Next steps after referral: 23%
- Privacy/confidential information: 17%
- Faculty classroom guide: 17%

Eighty-two percent of participants reported engaging in some form of marketing while 18 percent of participants reported that their teams do not advertise or market their team. Most commonly, participants reported advertising the team on a website (69 percent) and through in-person training (62 percent). Other ways included: student and/or parent/family orientation (44 percent), brochures and flyers (34 percent), email to stakeholders (29 percent), student

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programming (23 percent), tabling or exhibit booths (17 percent), parent/family programming (16 percent), posters (17 percent), and promotional items (11 percent). Seven percent of survey participants reported using the creative approach of promotional videos.

To assess the community's perception of the team, some teams (5 percent) request feedback. The most common perception concerns teams face are:

- The community is unsure what happens after the referral is submitted: 58%
- Lack of awareness of the team's availability to help: 47%
- Lack of clarity about what the team actually does: 39%
- Lack of providing updates or sharing of the process to the reporting party: 36%
- Unsure of how to make a referral: 30%
- Feel the team is about punishment and reaction, rather than helping and advocacy: 20%
- Worried about the team being too related to student conduct and law enforcement: 16%
- Dual relationship conflicts from team members and their corresponding departments: 9%
- The team lacks diversity in its membership (e.g., skin color, age, sexual orientation, gender, social economic status): 7%
- The referral process is too difficult to find, navigate, or asks too many identifying questions: 4%

Team Training

Participants were also asked to report information related to how their teams engaged in ongoing education and development. The most common team training method was webinars, with 47 percent of participants reporting using them as a resource to train their teams. NABITA-sponsored trainings were also a common resource for teams, as 66 percent of participants reported attending the NABITA Annual Conference, NABITA Case Management Summit, or another NABITA certification event. Additionally, 10 percent reported using NABITA's resource library to train their teams. Participants also reported using resources from other professional associations for training their team, as 13 percent reported attending the Higher Education Case Managers Association Roundtable, and 20 percent attended other

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conferences. Participants also cited books and journals (18 percent), tabletop exercises (29 percent), and the use of TNG consultants (8 percent) as training opportunities for their teams. Concerningly, 26 percent reported engaging in little to no training at this time.

Team Strengths and Weaknesses

Participants were asked to discuss what makes their teams most effective when working through cases. The most commonly reported strengths were:

- Diverse team membership: 26%
- Strong communication and collaboration: 25%
- Sense of care for students: 22%

Additionally, seven percent indicated team members' unique professional expertise from their respective areas contributed to the team's effectiveness, while five percent of participants indicated their teams could navigate difficult discussions well, disagree in a healthy manner, and have honest conversations within the team when working through cases.

The following weaknesses were most commonly reported:

- Lack of time for training: 27%
- Too many responsibilities to maintain caseload: 17%
- Lack of budget: 16%

Additional weaknesses were also described. Twelve percent indicated the team does not have standardized operating procedures, and 11 percent indicated the lack of a dedicated case manager to provide support and resources were their team's biggest challenges. Also notable, seven percent of participants indicated that inconsistent use of risk assessment and lack of stakeholder support (six percent) were their teams' weaknesses.

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Section 8

8 DISCUSSION

The NABITA survey continues to be the most comprehensive survey for the behavioral intervention field to date. Preceding surveys allow NABITA to compare responses from year to year to identify trends; however, some survey items were adjusted for increased clarity in the question wording and thus prevent year to year comparison. Throughout the discussion section, where possible, data will be compared year to year to reflect changes and trends in the field. Interestingly, some data points have shifted in the wrong direction. In other words, fewer schools are aligning with NABITA's recommended best practices in those areas. It is possible this trend is related to the growth in NABITA membership. When the survey was administered in 2020, NABITA had 1,393 members. At the time of the 2022 survey, NABITA had 4,752 members. This membership growth indicates the survey sample included new NABITA members who may not be as familiar with NABITA's recommended practices. Also of note, the

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small percentage of K-12 participants prevents the generalization of the data to K-12 audiences.

Although direct comparison to prior years is not possible due to a change in the question wording, in 2022, 58 percent of participants indicated having one integrated team that addresses behavior ranging from low-level concerns to threats of harm to self or others. Similarly, teams reported focusing their efforts on addressing primarily lower-level concerns as their most common risk rating is mild and moderate. Aligning with NABITA's recommended practice to address all levels of risk, with a focus on early intervention, we anticipate this trend will continue. One integrated team is a recommended practice, as the integrated team allows administrators to identify and respond to behaviors along a continuum of risk, supporting students who are experiencing barriers or stressors while also addressing more concerning or threatening behaviors as they arise. This approach is consistent with prior research indicating that individuals who engage in mass violence are often experiencing a noticeable crisis days to years prior to more direct, threatening behavior and that traditional threat assessment focused-models miss opportunities for critical intervention.[8]

The average team size remains at eight, and counseling, law enforcement/campus safety, dean of students offices, and student conduct roles have maintained consistently high representation in team membership since 2012. This data trend is consistent with NABITA's best practice that counseling, law enforcement/campus safety, a dean of students representative, and student conduct staff serve as the core members, as they each offer information and perspective critical to team functioning. These administrators' varied expertise assists the team in balancing supporting emotional health issues, safety concerns, impacts to the campus community, and potential policy violations. The expertise brought by these four critical areas allows teams to have a balanced, holistic analysis of the risk and comprehensive conversations about interventions available to the team. Additionally, the average team size of eight aligns with recommended practice, as it is important that teams keep team size between five and 10. A team with less than five members is too small and likely

[8] https://www.theviolenceproject.org/mass-shooter-database-3/key-findings/.

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has limited diversity, perspectives, and areas of expertise, while a team with more than 10 members is too big and likely sees diminishing group dynamics and efficiency.

The most notable change in team membership is the increased case manager presence. In 2012, only 18 percent of survey participants reported having a case manager as part of their core or inner circle membership. By 2018, this number increased to 39 percent, and in 2022, 70 percent indicated having a case manager as a core or inner circle member. Additionally, more teams are now being chaired by a case manager. In 2018, only seven percent of teams were chaired by case managers, and by 2020 this increased to 18 percent. Now, in 2022, 20 percent of participants indicated their team is chaired by a case manager. This increase in teams chaired by a case manager appears to align with the increased presence of case managers on teams and with the field's growing emphasis on direct intervention services and connections to supportive staff. Case managers being on the and chairing team may enhance team functioning, as a dedicated staff member, who is likely to have the most information on individuals referred, and on the services available for those referred, can streamline the case discussion during team meetings and deliver interventions for individuals referred to the team.

As indicated, case management is a growing trend in the field of behavioral intervention. Due to a change in the wording of the survey question from 2020 to 2022, we cannot directly compare the frequency of case manager positions or where they are housed organizationally but there is some indication that an increasing percentage of schools are investing in full-time case management resources. Most full-time case are housed in a dean of students office or in a stand-alone case management department or office and although not able to be directly compared to prior years, there is some indication that case management is more frequently being implemented as its own department or program within student affairs. The alignment of case management within student affairs, and as a non-clinical role, supports the overall team because case managers are connected with resources within the institution and community, provide non-clinical services which may reduce stigma related to clinical treatment, and may communicate with the team, referral sources, support resources, etc. without privacy law (e.g., FERPA, HIPAA) or licensure concerns. The presence of case management was often cited as a contributing factor in teams' effectiveness and the lack of a case manager was a weakness for

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some teams. Although having a full-time case manager is certainly ideal, at a minimum, teams should consider formalizing case management functions into their team operations.

As teams continue to report investing more heavily in case management as a process or a position, we also see teams meeting more frequently and cancelling fewer scheduled meetings, which may indicate that the presence of increased case management has led to more productive meetings and more organized tracking of referrals. In the 2016 NABITA survey report, there was concern that more than 12 teams indicated canceling 50 percent of their meetings. Beginning in 2018, and continuing through the most recent survey, the average number of cancelled meetings has dropped to four. The survey data also show positive trends related to meeting frequency, as the percentage of teams meeting weekly or bi-weekly remains stable. Although a consistent percentage of participants from 2020 reported meeting weekly/bi-weekly (83 percent), that distribution in 2022 leans more heavily toward teams meeting bi-weekly. Fewer participants indicating meeting weekly may be related to the number of new members who are still building teams and creating a referral and intervention structure that requires weekly meetings. It is important that teams meet weekly or bi-weekly, and have the capacity to hold emergency meetings when necessary, as regular, frequent meetings promote a strong sense of communication and collaboration while allowing teams to respond in a timely manner and practice their processes. Teams meeting bi-weekly should monitor the number of referrals per week, the "wait time" to discuss a case, and the amount of staff energy and time going into addressing referrals in between meetings to determine whether a weekly meeting schedule would be more effective and efficient.

Teams also continue to deploy best practices for keeping BIT records. Since 2012, the data have shown an 18 percent increase in the those who keep centralized records and pen/paper file practices have fallen from 24 percent in 2012 to 3 percent in 2022. This increase in both centralized and electronic records align with best practice recommendations. Teams that keep individual team member records, no records at all, or who store these records in Excel, using pen and paper, or in another format that is not easily retrievable, searchable, and secure, should consider using the best practice recommendation of centralized, electronic records to enhance the Team's statistical reporting capabilities, provide quick access to complete information in a crisis situation, and to ensure record consistency.

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The survey data also offered insight into how records are shared and edited among team members. It is promising that 86 percent of respondents indicate that their core and inner circle team members have access to the records. Remembering that the goal of a BIT is to de-silo information, increase communication, and streamline intervention efforts, the 10 percent of respondents who indicated only the chair can view the records should consider expanding access to their core and inner circle members. When only the chair, or a limited number of core or inner circle members, can view the records, information sharing becomes limited, and the team runs the risk of not having all the information about individuals when they need it. Further, allowing all team members to add and/or update the notes promotes team buy-in and creates a collective effort in teams' processes.

Because teams are keeping more records than ever, it is also possible to compare incidents across institutions in this survey. In 2022, survey questions were added regarding weeks of the semester that completed suicides and threats of harm to others occurred at schools. The most frequently reported weeks of the semester for completed suicides were weeks 7-9 (55 suicides) with weeks 4-6 and 13-15 closely behind at 50 suicides each. Additionally, the most threats of harm to others (268 incidents) seem to occur in the middle of the semester (weeks 7-12). These data may help teams prepare for and provide resources ahead of time to potentially decrease the number of these incidents.

An increasing number of teams are also adopting the best practice of using a standardized risk rubric. In 2012, only 33 percent of survey participants indicated that their teams used a standardized, objective rubric to assess risk. In 2020, that number more than doubled to 81 percent. In 2022, the percentage dropped slightly to 78 percent indicating a shift away from best practices since 2020 but an overall increase since the first implementation of the survey. As mentioned above, this shift may be reflective of the large percentage of new members who are still receiving training on the importance of using a risk rubric and other BIT best practices. Reflective of this theory, several participants noted in the comments section that their teams are in the process of NABITA Risk Rubric certification and implementation. Concerningly, 18 percent of teams continue to subjectively assess risk and 8 schools reported that they do not assess risk at all. Subjectively assessing risk opens the door for bias, fatigue, fear, or other factors to drive the process, as opposed to allowing standardized and research-based

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indicators to drive the process. An objective risk rubric is critical to accurately assessing risk and ensuring consistent BIT processes.

While the overall percentage of teams using an objective risk rubric dropped slightly in 2022, there was a slight increase in the appropriate application of the objective risk rubric. Of participants who use an objective risk rubric, 75 percent report using the risk rubric on every case referred to the team. This aligns with the NABITA recommended best practice of applying an objective rubric to every case regardless of how serious or how minor the case may seem. This practice promotes consistency in the process, creates equity in assessment and interventions, and allows for teams to handle all referrals objectively. Subjectively using a standardized tool only when cases seem serious, such as mental health crises or threats to others, is problematic because it undermines the objective nature of the risk rubric; thus, leaving the institution exposed, if challenged, for being arbitrary or capricious in its practices.

Survey results regarding returning to learning and mandated assessments were the most concerning; however, a comparison to previous surveys shows positive movement toward best practices in this area. Specifically, in 2018, 50 percent of participants indicated that their team either placed students on interim suspension for suicide risk or required an assessment to return to campus following a psychological leave. In 2022, that dropped to 30 percent. This drop is trending in the right direction, as the decision to place a student on interim suspension should lie within the student conduct office and should not be a practice used by BITs. Adverse actions taken against a student, including an interim suspension, must involve due process and be grounded in an alleged policy violation that presents a significant safety concern.

Additionally, institutions who treat the return from a psychological leave differently than the return from other types of leave may be engaging in discriminatory practices, as they are addressing disability related leaves of absence differently than non-disability related leaves. Instead, schools should adopt a process that treats returning from a leave of absence for any reason the same. Since 2018, more participants (36 percent in 2018; 55 percent in 2022) align with this recommendation of allowing students who voluntarily leave for psychological reasons to return in the same way as students who take a voluntary leave for medical issues. For students returning from leave related to a known emotional health concern, administrators should adopt a position of care and support, offering voluntary resources to

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help the student transition back to campus. Surprisingly, in 2022, only 10 percent of participants indicated that they used such an approach for those returning from voluntary leave for psychological reasons.

Similar concerns arise when looking at the data related to mandated assessments. The decision for a BIT to issue a mandated assessment should be tied directly to the objective assessment of risk. However, only 21 percent reported that they require mandated assessments once students cross the elevated risk level threshold on the NABITA Risk Rubric or equivalent risk assessment tool. To tie the decision to suicidality, a mental health concern, or hospitalization exclusively presents challenges as this decision may be considered disparate treatment for students with disabilities or who are regarded as having a disability. Issuing a mandated assessment should be tied to risk rating. The risk rating is based on the level of concern present in the behavior. That behavior might be based on lethal self-harm or suicide, but not always. Thirteen percent of participants indicated that they require students to complete a mandated psychological assessment if they are suicidal. While this suicidality may present risk that would place the individual at an elevated or critical risk level, there may be cases where it doesn't. Across the D- and the E-Scales, students can be rated at elevated and critical for a host of reasons, many having nothing to do with suicidality, disability, or mental health.[9] An assessment is not mandatory following suicidality or a hospitalization. The assessment is mandatory after the behavior is risky in such a way that the student is rated at elevated or critical. A student could certainly experience vague suicidal ideation and not demonstrate behavior that would place them at elevated or critical. Similarly, a student's behavior could place them at elevated or critical without suicidality or a hospitalization. Although the survey did not specifically ask whether the assessment was a requirement to return to classes or housing following suicidality or a hospitalization, it is important to note that institutions should avoid requiring students go through additional clearance prior to return and instead focus on offering them connection to ongoing support resources. The student should not be prohibited from returning to campus, classes, or accessing other institutional services or facilities pending the outcome of the assessment as part of a clearance to return. The goal of the assessment is to determine risk and options available to

[9] The D- and E-Scales are specific sections of the NABITA Risk Rubric.

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mitigate the risk – not to require clearance to return, documentation of treatment, compliance with a support plan, etc.

The field of behavioral intervention is always evolving, and as new NABITA members are added, we learn more about common practices across the nation. This discussion serves as a touchpoint for institutions to evaluate themselves against the practices of other schools but also against NABITA's recommendations related to observed trends in the field. The data from the 2022 survey show that while some trends are moving the right direction, or at least remaining stable, such as meeting frequency, team membership, and mandated assessments, other areas, such as the use of objective risk assessments and what the risk assessment determines, are shifting away from best practice. This analysis offers insight into the current practices of BITs and presents evidence-informed guidance as to the direction of the field. Practitioners should use these research findings to infuse scholarship into their practice and ensure their BIT operations are informed by empirical research.

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Section 9

9 CONCLUSION

The biennial NABITA survey represents one of the only comprehensive datasets available regarding BIT characteristics and common practices. This document summarizes the descriptive information gathered from the survey, including national data trends and how these trends impact practice. In doing so, we hope teams are able to use the information to identify areas of efficiency and needed growth for their teams. This document, in conjunction with the NABITA Standards for Behavioral Intervention Teams, are designed to encourage the development of best practices. Additional resources, such as the NABITA assessment tools described in this document, may also be found on the NABITA website.

Thanks to all the teams out there for the good work you do. We look forward to hearing from you again soon!

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Standards for Behavioral Intervention Teams

PART 1. Structural Elements

Standard 1. Define BIT: Behavioral Intervention Teams are small groups of school officials who meet regularly to collect and review concerning information about at-risk community members and develop intervention plans to assist them.

Standard 2. Prevention vs. Threat Assessment: Schools have an integrated team that addresses early intervention cases as well as threat assessment cases.

Standard 3. Team Name: Team names communicate the role and function in a way that resonates with the campus community.

Standard 4. Team Leadership: A team leader serves to bring the team together and keep discussions productive and focused while maintaining long-term view of team development and education.

Standard 5. Team Membership: Teams are comprised of at least 5, but no more than 10 members and should at a minimum include: dean of students and/or vice president of student affairs (principal or assistant principal in K-12), a mental health care employee (adjustment counselor or school psychologist in K-12), a student conduct staff member, police/law enforcement officer (school resource officer in K-12).

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Standard 6. Meeting Frequency: Teams have regularly scheduled meetings at least twice a month with the capacity to hold emergency meetings immediately when needed.

Standard 7. Team Mission: Teams have a clear mission statement which identifies the scope of the team, balances the needs of the individual and the community, defines threat assessment as well as early intervention efforts, and is connected to the academic mission.

Standard 8. Team Scope: Teams address concerning behavior among students, faculty/ staff, affiliated members (parents, alumni, visitors, etc.) and should work in conjunction with appropriate law enforcement and human resource agencies when needed.

Standard 9. Policy and Procedure Manual: Teams have a policy and procedure manual that is updated each year to reflect changes in policy and procedures the team puts into place.

Standard 10. Team Budget: Teams have an established budget in order to meet the ongoing needs of the team and the community it serves.

PART 2. Process Elements

Standard 11. Objective Risk Rubric: Teams have an evidence-based, objective risk rubric that is used for each case that comes to the attention of the team.

Standard 12. Interventions: A team clearly defines its actions and interventions for each risk level associated with the objective risk rubric they have in place for their team.

Standard 13. Case Management: Teams invest in case management as a process, and often a position, that provides flexible, need-based support for students to overcome challenges.

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Standard 14. Advertising and Marketing: Teams market their services as well as educate and train their communities about what and how to report to the BIT through marketing campaigns, websites, logos, and educational sessions.

Standard 15. Record Keeping: Teams use an electronic data management system to keep records of all referrals and cases.

Standard 16. Team Training: Teams engage in regular, ongoing training on issues related to BIT functions, risk assessment, team processes, and topical knowledge related to common presenting concerns.

Standard 17. Psychological, Threat and Violence Risk Assessments: BITs conduct threat and violence risk assessment as part of their overall approach to prevention and intervention.

PART 3: Quality Assurance and Assessment

Standard 18. Supervision: The BIT chair regularly meets with members individually to assess their functional capacity, workload and offer guidance and additional resources to improve job performance.

Standard 19. End of Semester and Year Reports: Teams collect and share data on referrals and cases to identify trends and patterns and adjust resources and training.

Standard 20. Team Audit: Teams assess the BIT structure and processes and ensure it is functioning well and aligning with best practices.

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