NaBITA

BIT STANDARDS AND BEST PRACTICES

COMPANION GUIDE

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History of BIT

Notes

Behavioral intervention teams (BITs) 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" (NaBITA Advisory Board, 2019, p.4). These teams are a well-established, research-based, best practice for the prevention of violence and the promotion of student wellness in schools and universities.

The tragic shootings at Virginia Polytechnic Institute and State University (Virginia Tech) in 2007 created seismic shifts in how higher education administrators identify and provide support to students of concern. One of the key post-tragedy efforts was the creation of a panel tasked with reviewing the incident in detail and providing recommendations for how institutions can work to prevent violence in the future. The Virginia Tech Review Panel (2007) produced several recommendations as part of their final report including the need for administrators to establish a formal process for information sharing and to identify a formal process for recognizing and supporting students in distress. The report emphasized the need for administrators to create a centralized location for reporting concerning behavior in order to implement the recommendations. Based on the Virginia Tech Review Panel report, administrators developed what is now known as behavioral intervention teams in order to respond to these recommendations (Sokolow & Lewis, 2009)

In 2009, NaBITA (National Behavioral Intervention Association) formed as a means of support for institutions implementing the recommendations made by the Virginia Tech Panel (NaBITA, 2019). Behavioral intervention teams (BITs) became the best practice standard for coordinating response to threatening behavior (National Threat Assessment Center, 2018; Federal Commission on School Safety, 2018; MSD Public Safety Commission, 2019). Initially, these teams were created as a response to campus threats and high-risk behaviors. They were often reactionary in nature, only responding once there was a threat made. However, as more college campuses began creating and implementing these teams, and higher education developed a stronger awareness of BITs and how it offered support, referral numbers grew and the scope expanded to include providing support at all levels of risk (Sokolow, Lewis, Van Brunt, Schuster, Swinton, 2014).

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Foundational Principles of BIT

A foundational principle related to working with a BIT is knowledge and understanding of the three-phases of BIT processes, which are 1) data gathering, 2) risk analysis, and 3) interventions (Sokolow, Lewis, Schuster, & Swinton, 2014). Like three-sides to a triangle, no one phase is more important than another. A strategic approach to each phase ensures the best opportunity for a BIT to identify, assess, and intervene with issues of concern. As the BIT member, an intricate working knowledge of the team's approach to each phase is necessary in order to navigate the BIT process with confidence and effectiveness.

Phase 1: Data Gathering

The first aspect of BIT activity is based on the principle that in order to provide truly valuable interventions for concerns and prevent the escalation of risk, the BIT must become a

centralized place for all information and data related to an individual concern (Sokolow et al., 2014). This requires a two-fold approach to data gathering: 1) cultivating a caring reporting culture throughout the school community and 2) having access to multiple data points and records related to individuals.

The first is achieved through strategic marketing and communications efforts by the BIT. In order to receive accurate and timely information about students experiencing distress, BITs must train their communities to make good referrals (Federal Commission on School Safety, 2018). This includes efforts such as a BIT website, a recognizable logo, materials providing helpful information about how and what to refer to the BIT, and training presentations by the BIT to stakeholders and departments across the school community (Schiemann & Van Brunt, 2018).

Additionally, BITs should choose a team name that communicates the overall mission and philosophy of the team (NaBITA Advisory Board, 2019). BITS often embrace team names that are affiliated with the institutional culture and communicate a purpose of care and support for those who are referred to the BIT. An example is Arkansas Tech's BIT that has incorporated their beloved school mascot, Jerry the Bulldog, into their team name and logo with Jerry Cares (Arkansas Tech University, 2019). The idea is that the campus community watches out for one another and refers individuals for support and assistance from the BIT when they see something of concern. These marketing and communication strategies are considered part of the BIT data gathering phase as it is what empowers community members to submit referrals, which provides data points to the BIT.

The second aspect of data gathering occurs after a referral is received. Following a referral, BITs need the ability to quickly access other information about the situation and the individual being discussed. Often there are indicators across an individual's interactions and experiences that lend clues to the BIT about how to best support and intervene in the situation. When we look back across incidents of violence, there are often warning signs and communications alerting us to concerns, but that information is either not shared or it is shared to a place where it is looked at in isolation and without access to a more complete picture of what is occurring (Virginia Tech Review Panel, 2007; Sokolow et al., 2014).

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The BIT will gather all of the available information and incorporate this into Phase 2, the objective risk analysis. The type of information a BIT will collect and review includes:

- Formal student record information such as conduct/discipline records, admission records, and academic transcripts
- Observable information such as information from faculty, academic advisors, department staff (financial aid, residence life, student organizations, etc.), interacting with the student in and outside of the classroom
- Social media and online information such as Facebook posts, Instagram, online communities, and blogs Information available through informed consent processes such as counseling or health-related interactions
- Information available from students, other community members, or parents and family members

Phase 2: Risk Analysis

The second phase of BIT work is the application of an objective risk rubric in order to analyze and decide on a level of risk presented by an individual. Applying an objective risk rubric to every case referred to the BIT, and not just the ones that seem complex or threatening, is critical. When a team receives information about a concern, if they simply discuss information and decide what actions to take without an objective analysis, they engage in subjective decision making (Sokolow et al., 2019). It "feels" like we should do "xyz." In this more subjective decision making by the team, a number of variables can influence why the decided action is not well informed.

For example, an individual team member's implicit bias regarding a particular case or student may influence a team's decision on a case even though the nature of the risk and behaviors were virtually identical to other cases with which they've dealt. Teams can also be influenced by variables such as individuals repetitively being referred to the BIT, the most recent case they've reviewed, or even just team members' level of energy and focus at the time they discuss the case. While an objective risk rubric is certainly not perfect, it helps to keep the team focused on the same set of indicators when reviewing each case.

This is not to say that there is no room for tailoring interventions and actions to an individual. We want the BIT to be culturally competent and refine interventions in order to receive the best response from an individual related to an intervention, but we do not want the BIT referring an individual to the police in one case when a similar case is only documented and closed. When subjective, potentially biased decision making occurs, we risk several things. First, the team risks making discriminatory decisions on the bases of disability, mental health status, or other individual characteristics. Second, the team can miss important elements indicating higher levels of risk.

In phase two of the BIT process, the team will review the information available on each individual, including previous BIT referrals. Then, as a group, they will review how the

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information aligns with the objective risk rubric. The NABITA Risk Rubric, which includes a scale to assess both life stress/emotional health and hostility/violence, in detail (Sokolow et al., 2019). The team documents the risk rating determined by the team in the BIT recordkeeping system during each discussion. This helps to track the escalation and de-escalation of cases. The risk rating is also used to inform a decision about interventions in Phase 3 and provides guidance to the team and the case manager regarding what actions to take.

Phase 3: Interventions

Phase 3 of the BIT process is to determine, based on the objective risk rating determined by the team, the appropriate set of interventions and actions needed by the team to stabilize or deescalate the risk present. Interventions for the BIT represent a spectrum of activities, resources, communications, and actions depending on the level of risk as determined in Phase 2.

Interventions incorporate both a prevention and threat management approach. While some referrals feel minor, low-risk and lack any type of threat to individuals or the community, an effective BIT understands that referrals on the lower end of a risk assessment are important for early interventions before concerns can escalate to a higher level of risk (NaBITA Advisory Board, 2018). Once a threat is actually made or present in a team's analysis of information, the opportunities to intervene are often more limited and include more severe actions related to law enforcement intervention, student conduct processes, or involuntary hospitalizations. The goal of seeking referrals across the full spectrum of risk during Phase 1 is to identify more lower level issues so that the team can deploy earlier, less disruptive interventions, such as counseling support, parent and family notification, and resource referrals.

Diversity on the Team

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"If you want to go fast, go alone. If you want to go far, go together."

African Proverb

During a crisis and emergency, a campus community relies on individual departments working in tandem to address all the elements of the crisis. This can involve counseling staff providing mental health treatment to those affected by the crisis, residential life staff supporting students in the halls through discussion and education, and campus safety/police increasing presence around the community to reassure a sense of control and calm.

As the proverb suggests, we do better when we work together and across various disciplines. BITs should focus on encouraging multiple opinions during team discussions and building a team that has a diverse membership. Ideally, BITs should have 5-10 members on the team. When building a diverse team, consider focusing on:

- Positional: having representation from various departments around campus such as Title IX, residential life, student conduct, ADA/504, athletics, counseling…)
- Generational: if you team is made exclusively of people over 50 or under 30, you are limiting your perspective.
- Political: If everyone on your team voted for Clinton in the last election or voted for Trump, this can limit perspective when working with students with more diverse political views
- Socio-economic: is there a diverse membership of the team that matches the societal and campus populations experience?
- Race/Ethnicity: does the team have membership that represents the students experience
- Sexual orientation: Ensure the team reflects the differences in sexual orientation we see on campus.

While not an exhaustive list---working together means working with individuals in the team with different perspectives. While this can be challenging to build, it is a noble goal in terms of equity and inclusion and helps keep the team from developing blind spots where they are unable to take full perspective of the student's experience.

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Team Leadership

What are some of the Best Practices a good BIT leader should engage in as they coordinate and run the team? This question is a frequent one we receive at NaBITA certification trainings and it may be helpful here in this Tip of the Week to explore in a little more detail some of the activities team leaders can engage in to create a team that is effective and on target when it comes to formation and operations.

- Develop a training schedule for the team that cover a variety of issues in order to keep members up to date on recent cases and best practices. A sample training schedule can be found here [link to sample training schedule we developed].

- A team leader should be well versed in the NaBITA tool and ensure that each case that is discussed by the team has risk level associated with it. These risk levels then inform our intervention measures. A good example of this can be seen by Scott Lewis as he leads out hypothetical BIT in the training scenario Window into BIT [link to Window into BIT]

- Identify potential hot spots and rough patches between departments and individual team members that may have a negative impact on internal communications. This might involve holding team members over after a meeting and talking about ways to improve communication. This may involve more intentional mediation between members in more tense situations. In either case, it is the team leader's responsibility to ensure the team is functioning at top capacity.

- The team leader should invest some time each year to find ways to improve communication and build trust among team members. This may involve group exercises in team communication or individual assessments such as the Myers Briggs or StrengthFinder to determine how team members can function better.

- Finally, a team leader should ensure the team creates an end of semester or end of year report. These reports are critical to ensure the team is assessing the effectiveness and utility of its interventions. Like the dashboard of a car, these reports give critical information useful for team course corrections.

Budget

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When it comes to budgets, most teams don't have them. NaBITA has been committed to assessing the teams that do have budgets and exploring how to increase the number of teams that have access to an operating budget to assist their work. Based on incoming 2016 data from the NaBITA survey, we learn the average budget for teams range from zero to $20,000. Approximately 20% of the teams reporting have a budget and the average budget of these teams is $9000. So, given the budget situation is bleak one, how should a team proceed to develop an operating budget? The following steps give teams some guidance on how to approach this challenge.

1. Call your accounting or purchasing department on campus and create a budget line for the team. This should be a specific line, typically under the student affairs organization line. Most schools have the ability to create an account where money can be housed an used through a purchase order or university procurement card. It doesn't matter that you don't have any money yet, create a space for the money to live.

2. Now it is time to pass the plate, so to speak. The team leader should have a discussion with each department represented on the team and request the department transfer an annual amount into the BIT budget. It isn't important that each department contribute an equal amount, some departments might have more ability to transfer money, some may have less ability to do this. The amount is less important than the ability to have each department contribute something. If there are six core departments on the team, can each transfer $100 into the budget? While this $500-$600 amount may not be significant at the start, it begins the process and the expectation that the members of the team are beginning to contribute to a shared budget.

3. The next step is a little more challenging and dependent on your college or organization. Typically, there are groups on campus that may be willing to contribute one-time funds or annual funds to assist the team. Some examples include:
    a. Parent organizations; student activities
    a. Women's center or violence center
    a. VPSA, president or DOS discretionary budget line
    a. Alumni organizations; state and federal grants
    a. Violence prevention organizations

Once the budget line is created, there is the opportunity to grow the budget amount from year to year. This budget can then be used to advertise the team, provide training through webinars, books, journals, professional organizations or annual conferences. It is important to include budget information in the BITs end of the semester/year report and clearly identify where the money spent. It is also important to understand the college or university rules related to carry-over from year-to-year in order to not lose money that should be spent down by the end of the fiscal year.

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Advertising

Advertising and marketing the BIT/TAT/RAT allows the college or university to accomplish several positive goals. It increases knowledge about the team and provides the community a sense of reassurance that there is a group tasked with assessing potential threats, supporting students, and seeking to prevent behavioral deterioration. Advertising the team helps the community understand what kind of information they should be reporting and how best to share these reports. This advertising could consist of an article for the school paper, trainings for resident advisors and student leaders, training during faculty orientation and the development of flyers, brochures and contact cards that inform the community about how the team works and the best way to make a report. It is important to note here, while student staff and leaders may be trained, they should never be members of the team. The information is too sensitive, and the transient nature of students can be contra to the team's consistency.

Communicating with the campus community about a BIT may invite criticism and outcries of "big brother." There may be demands to interview team members concerning how decisions are made to protect civil liberties. While potentially time consuming, and certainly frustrating for those who already are trying to balance multiple job responsibilities, this increased scrutiny is a good thing. Teams should be asked to demonstrate and communicate their thinking process and how at-risk cases are reviewed and handled. Remember, one of the main functions of an institute of higher education is to educate and teach its students why certain processes are done the way they are. Advertising and clearly spelling out how a BIT approaches its responsibility also demonstrates a level of investment in training, forethought and effort to protect the campus, that could be useful when responding to media concerning how your school addresses potential threat.

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Assessment Tools Overview

For those new to the NaBITA process of assessment, it might be helpful to hear a little bit about how our assessment tools are most frequently used by teams. An excellent starting place would be visiting our website page for the assessment tools here: www.nabita.org/tools

The NaBITA Risk Rubric is our central assessment tool for teams. It is designed as a triage process to be used on every student, faculty, or staff member that comes to the attention of the BIT. This triage assessment is completed based on the CARE/BIT report and/or other information shared with the team. It is rarely completed through an in-person meeting, rather it is done by distance based on the information shared with the team. The rubric then provides a risk level of mild, moderate, elevated, or critical to better assist teams in reducing bias (both implicit and explicit) and ensuring the assessment matches the interventions.

The Violence Risk Assessment of the Written Word (VRAW2) is applied to any student, faculty, or staff member who shares written content that has causes a concern or contains a threat to others. This may be a statement on social media, a set of emails sent to a person, or a writing assignment completed for a class. The VRAW2 gives the team insight into how concerned they should be about the material based on five risk factors. As with the NaBITA Risk Rubric, this is often applied without a direct student interview.

The SIVRA-35 is NaBITA's face-to-face interview for the BIT/CARE team to calculate harm to others by assessing 35 factors for targeted violence. This is always done in-person as a formal assessment (although, the factors could be used as an initial review of a case) and provides a low, moderate, or high level of risk to better informed the interventions. Important to note, the SIVRA-35 is used when there is an elevated or critical rating on the NaBITA Risk Rubric. NaBITA recommends three to four members of the team make up the 'bench' of SIVRA-35. These often include conduct or student discipline, counseling, law enforcement, and case management.

The Extremist Risk Intervention Scale (ERIS) is used by teams to augment a SIVRA-35 interview. This measure focuses on an individual who have a hardened, fixed, passionate belief on a topic (such as religion, politics, or social justice) who may justify violence to others in order to meet their ideological goals.

When applying these tools, it may be useful to see a summary of common applications. If a BIT saw 100 cases during a given semester, it would be reasonable to see the following:

- 100 individuals scored on the NaBITA Risk Rubric. On average, 80 cases will be at mild/moderate, 15 at elevated, and 5 would be critical.
- 25 individuals having written content on social media, emails, or writing.
- 5 individuals scored on the SIVRA-35 (remember, only those elevated or critical with harm to others or E-scale focus on the NaBITA Risk Rubric)
- 1-2 cases of the above SIVRA-35 cases using the ERIS to further explore the risk

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Using the Risk Rubric

Step 1:

Use the D-Scale to Identify the Nature of the Life Stress and Emotional Health Risk

The D-Scale is the left side of the NaBITA Risk Rubric. This scale is used to review disruptive and concerning behaviors related to life stress and emotional health with four progressive levels: 1) developing, 2) distressed, 3) deteriorating, and 4) decompensating (Sokolow et al., 2019). As you progress up the scale, the risk is more concerning and serious with the potential for affective violence and aggression and/or self-harm (Sokolow et al., 2019).

This scale often overlaps with mental health concerns as it focuses on difficult life events, emotional health, suicide and self-harm and disruptive behaviors (Sokolow et al. 2019). Additionally, it addresses incidents or threats of affective violence (Sokolow et al., 2019).

Affective violence is often a biological reaction to aggression, fear, or attack, and is adrenaline-

driven (Howard, 1999). This type of violence is reactive and impulsive, so while it is certainly an issue of concern for a case manager or BIT, it is different than the predatory, targeted violence addressed in the E-Scale.

The team reviews all information available about the case and decides which level of the D-scale the case fits into based on the descriptive items listed on the NaBITA Risk Rubric.

The team should note the level determined on the D-Scale and move to Step 2. If a situation does not exhibit any indicators aligning with the D-scale, the team should skip this first step and proceed to Step 2.

Step 2:

Use the E-Scale to Identify the Nature of Hostility and Violence Risk

The E-Scale is the right side of the NaBITA Risk Rubric. The scale is used to review hostility and violence to others with four progressive levels: 1) empowering thoughts, 2) escalating

behaviors, 3) elaboration of threat, and 4) emergence of violence (Sokolow et al., 2019). As you progress up the scale, the risk for engaging in violence becomes increasingly imminent (Sokolow et al., 2019). This scale is more often associated with harm to others that is rooted in hostility, hardened thoughts, and predatory behaviors (Sokolow et al, 2019).

This scale considers targeted, or predatory, violence. When compared to affective violence, described in the D-scale, this violence is more planful, intent-driven and more common to incidents of mass violence (Sokolow et al, 2019). Because this type of violence develops over time, it is of particular importance for BIT and the case manager to attend to potential leakage, or observed behaviors, statements, or other indicators that a student is considering engaging in violence (O'Toole, 2014).

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The team reviews all the information available about the case and decides which level of the E-scale the case fits into based on the descriptive items listed on the NaBITA Risk Rubric. The team should note the level determined on the E-Scale and move to Step 3. If a situation does not exhibit any indicators aligning with the E-scale, the team should skip this step and proceed to Step 3.

Step 3:

Use the D-Scale and E-Scale Ratings to Determine Overall Summary of Risk

The overall summary of risk is in the center section of the risk rubric. The summary provides an overall risk level determination of four progressive levels: 1) mild, 2) moderate, 3) elevated, and 4) critical (Sokolow et al., 2019). Each level of the D-Scale and E-Scale correspond to a level of risk in the Overall Summary scale. When the D-Scale and E-Scale have differing levels of risk, the team should use the higher point on the Overall Summary scale as the final risk rating. For example, if the D-Scale is a Level 2: Distressed and the E-Scale is Level 1: Empowering Thoughts, then the overall summary level is Moderate as it is the highest level present between the two scales. Additional examples are provided below:

Example 1:

- D-Scale Level 3 Deteriorating
- E-Scale Level 2 Escalating Behavior
- Overall Summary Level 3 Elevated 70

Example 2:

- D-Scale Level 4 Decompensation,
- E-Scale Level No Rating
- Overall Summary Level 4 Critical

Example 3:

- E-Scale Level 3 Elaboration of Threat
- D-Scale Level 2 Distressed
- Overall Summary Level 3 Elevated

The highest D-Scale or E-Scale rating results in the overall summary. This overall summary level is documented in the case notes for the individual each time it is discussed. By rating the individual each time the BIT discusses a concern, it creates a pattern that indicates if an individual is on a positive or negative trajectory or not changing dramatically. As the staff member most likely to have direct interactions with the student and thus become aware of changes in risk, the case manager must be prepared to make new referrals to the BIT, or bring case updates to the meetings, in order to allow the team to re-apply the NaBITA Risk Rubric and determine the new level of risk.

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Step 4:

Use the Overall Summary to Determine Level of Interventions

The back of the risk rubric offers a range of actions for each of the four overall risk levels. There are a few key elements to remember related to the use of the risk rubric in deploying interventions. First, the interventions should always match the overall summary of risk level. Next, cases identified at Level 3: Elevated automatically have a more expansive set of interventions available because this is where a threat has emerged based on the team's evaluation of the situation. This expanded set of interventions includes actions such as mandated assessments, parent notification, and welfare/safety checks. Last, teams are not restricted to just one, or to all the interventions in the list. The team should tailor a set of interventions and actions based on their understanding of the case and the risks discussed by the team. The interventions determined by the team should be clearly documented alongside the risk level each time the team discusses the case.

Additional Assessment Tools:

Historical Clinical Risk Management-20 (HCR-20)

The HCR-20, which is in its third version, is a structured professional judgment instrument used to assess risk and develop mitigation plans. The measure is well researched and evidence-based. The authors of the measure explain that risk and threat are always incompletely understood due to the uncertainty inherent in individuals' choices. The HCR-20 is commonly used in psychiatric settings to determine release criteria, admission screenings, and inpatient psychiatric management, as well as to monitor risk in probation and parole settings. The HCR-20 is a process rather than a singular tool producing a quantitative score or measure. The seven-stage process includes: 1) gathering information, 2) identifying the presence of risk factors, 3) determining the relevance of the risk factors, 4) formulation of the motivators for violence, 5) the development of risk scenarios, 6) management, and 7) final opinions. For more information about the HCR-20, visit http://hcr-20.com.

Workplace Assessment of Violence Risk-21 (WAVR-21)

The WAVR-21 is a workplace violence risk assessment designed to assist human resource and threat assess¬ment professionals to work through a structured set of dynamic and static risk factors to better estimate the likelihood of violence by an employee. Though designed with a workplace setting in mind, the WAVR-21 offers some guidance to those working in a higher education environment when it comes to identifying potential risks with students, faculty, and staff. For more information about the WAVR-21 visit www.wavr21.com.

Interventions and Referrals

Notes

Once the level of risk is established, the BIT should maintain a complete list of referral options in both the campus and surrounding community. The BIT should invest in building relationships with these potential referral sources in advance of needing to make their first referral. These relationships will make the process of a "warm hand-off" easier and will foster a strong connection for the student to the referral source.

Counseling Services

When students are experiencing life stress and emotional health struggles on the D-scale, the BIT should consider the need for a referral to counseling for mental health support. It is equally important for students moving up the E-scale to be considered for a counseling referral if appropriate. For example, students demonstrating hardened perspectives and ongoing grievances can benefit from counseling support as much as a student experiencing anxiety and depression. For mild and moderate risk levels, the referral may just be the need for short-term support and assistance from counseling. Here, the BIT members doing intervention is likely "doing with" the student by providing them contact information for the counseling center, discussing it as a resource option and offering to help them make an appointment. As with any referral, it is important that the BIT follow up with the student to ensure that they made the connection with the counselor and that they referral went well.

At elevated and critical, the counseling referral may also be made to help contribute to an optional or mandatory mental health assessment and/or violence risk assessment. As risk levels increase, the counseling unit may provide longer term counseling support or facilitate referrals and ongoing communication to off campus service providers. At these more increased levels of concern, the BIT is likely "doing for" the student by walking them to the counseling center, calling the clinician in to join the case management, or securing a same day appointment at an off-campus provider. Given the risk levels present, the BIT needs to ensure immediate connection to a licensed provider. It can also be helpful for the case manager to speak with the clinician prior to the student's appointment, or to initially join the session, so that the case manager can provide the warm hand-off, express the concerns or risk factors present, and secure the connection to the counselor.

To help facilitate communication between the counselor and the BIT, the BIT should secure a release as part of their referral process. The release provides permission for the counselor to share information with the BIT (remember though, the BIT does not need a release to share information with a counselor, as long as that counselor is a staff official). It is helpful for the BIT to secure this release while they have the student is early in the process. Often, students forget to talk to their counselor about the release. By securing the release before the student leaves the initial BIT intervention, the BIT is ensuring that communication can occur between the counselor and the team occur seamlessly. Consider keeping releases on hand in your office so that they are readily available when you make the referral.

Counseling units can also consider the use of expanded informed consents that allow for limited communications to the BIT about participation in counseling sessions and/or other specified aspects of the counseling relationship. These expanded informed consents are helpful for counselors to be able to share information with the team.

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Medical or Psychiatric Referrals

In addition to counseling, some students may need medical and/or psychiatric supports for concerns. These services can range from basic physical exams to determine if there are underlying medical concerns impacting a student's experience to more advanced psychiatric referrals for medication assessment and treatment. It is never the role of the BIT to suggest a medical diagnosis or mandate medication compliance. However, when a student is experiencing indicators of a medical or psychiatric concern, it is the role of the BIT to make referrals to medical providers who can assess and treat these concerns. As with referrals to counseling services, it is important to determine the need for a release to allow communication back to the BIT from the medical provider. Often the case manager does not need detailed medical history communicated back to them but rather a simple overview of the treatment plan or just a confirmation of attendance and cooperation. It is important to remember that the medical information or records, once documented in the BIT notes, become FERPA records.

Disability Services

An overlooked resource important to the BIT is a referral to disability services. Many students struggling with mental health concerns or other difficulties may qualify for accommodations and support from an institution's disability services office. While the BIT can work with professors to request flexibility around due dates, absences, etc., only the disability support services office can require accommodations. These accommodations can be a crucial piece in mitigating the concerns and assisting the student in reducing the barriers to their success. BITs should be familiar with the process for obtaining and submitting documentation of a disability – especially psychiatric disabilities. Students often are not aware that they can receive accommodations and it is the role of the BIT members to explain disability support services as an option and to connect the student with a staff member in that office for further support and assistance.

Social Service Needs

For many students, lack of basic needs are the barriers for their success: finances, housing, food, school supplies, etc. While some BITs may have resources such as food pantries, clothing closets, or emergency funds within their institution for these issues, others will need to leverage resources in the community to assist students.

Tips for Making a Strong Referral

As BIT members use resource referrals as an intervention for students, they must consider how they coordinate the referral to best achieve an effective outcome for the student. An

effective referral means the student is informed about resources unknown to them or unused by them and chooses to access the services for assistance.

To facilitate an effective referral, the BIT should incorporate the following steps:

1. **Discuss the referral with the student.** Be sure to explain how the referral might help them and what they can expect from the referral source.
2. **Assist the student in securing an appointment.** This may be done via phone with the student in your office, by walking them to the resource, or by providing them the contact

information and asking that they connect with the resource before your next follow up appointment.

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3. **Obtain a release of information, if necessary.** Remember, the BIT does not need a release to speak with staff officials who have an educational need to know but they do need a release to speak to any resource outside of the institution. Furthermore, the BIT often make referrals to licensed mental health or medical providers who need a release to communicate back to the team.
4. **Provide a "heads up" to the referral source.** It is often helpful to let the referral source know why you've referred the student and how you're hoping they can help. Students can struggle articulating this to the referral source themselves and by providing the information to the referral source ahead of time you are able to maximize their ability to help.
5. **Follow up with the student.** It is important to have at least one appointment (and more if needed) with the student after you've made the referral. This allows you to confirm that the connection to the resource was successful and helpful.

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Policy Considerations

Zero-Tolerance Policies

These refer to a straight-forward separation based on a single incident of weapons possession or violent threat/rhetoric. Simply separating a subject from school or work under the authority of a zero-tolerance policy creates the potential to take an upset, frustrated individual and escalate them into a rage-filled and potentially vengeful attacker. Careful assessment, intervention and monitoring are the tools that are most effective in mitigating threats of violence in the community. While separating a subject from campus or work may give an illusion of safety, there are numerous examples where angry, disgruntled and disempowered individuals come back to campus or the workplace to seek their revenge. O'Toole (2000) writes, "In a knee-jerk reaction, communities may resort to inflexible, one-size-fits-all policies on preventing or reacting to violence" (p. 2). The FBI writes, "Do not rely on expulsion except as a last resort and unless absolutely necessary to ensure campus safety; authorities should avoid the temptation to simply expel students of concern to quickly resolve a risk. Isolated from other contingency and safety planning, this strategy sometimes can worsen matters. The final humiliation of expulsion may serve as a precipitating, or triggering, stressor in the subject's life and propel the marginalized and hostile individual toward violence" (Scalora, Simons & Vansly; 2010, p. 7).

FERPA

Private information, in a higher education or school context, is information protected by the Family Educational Rights and Privacy Act (FERPA). Private information can be shared internally when there is a legitimate educational interest, often referred to as a "need-to-know." Private information can be shared externally when an exception to FERPA is met, such as in cases of emergencies, dependency, and consent. FERPA protections extend only to records kept by college officials in a written or recorded medium. Information you learn of or know of from in-person interactions that is not made into a record is not protected by FERPA. A right to privacy has also been recognized by the courts outside of statute when there is public revelation of information in which an individual would have a reasonable expectation of privacy. A lawsuit, resulting financial damages, or loss of a professional license could occur from this kind of breach of privacy.

Confidentiality

A more protective layer of legal insulation is confidentiality. Confidentiality, whether conferred by statute or ethical codes, is the right of a client/patient to control how information they share with a professional is protected. Because the client has the right of confidentiality, the professional has a commensurate duty to maintain that confidentiality. Confidentiality is most often conferred in the relationship between therapist and client, or between a health care provider and patient. It can also be formed between advocates and victims, or in some states, between athletic trainers and athletes. Confidentiality is more protective than privacy, because there is no authorized "need-to-know" basis for breaching confidentiality. Instead, confidentiality is bounded by consent of the client or patient, by statute and exceptions to statutes, and by court-made doctrine, as in situations of a duty to warn (e.g., the Tarasoff v. Regents of University of California, 1976 case). Exceptions to confidentiality vary from state to state and can pertain to child abuse disclosures, HIV+ status, elder abuse, substance abuse, and other statutorily-created health or safety risks. Additionally,

confidential records may be subpoenaed and/or may be accessible by an employer in the event of litigation. A confidential relationship is often demarcated by the creation of an informed consent that explains the protections afforded by the relationship.

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Privilege

Finally, the most sacrosanct level of protection under the law is that of privilege. Privileged communication is secret and protected from disclosure which can only be pierced by a court order or waiver of the owner of the privilege. Privilege is rarely in play for the BIT, but would readily be found in the relationship of lawyer-client, spouses, journalist sources, and the confessional (though clergy may only have the protections of confidentiality in some jurisdictions). There are many nuances to what kind of communication, even within the relationships described as privileged, can actually be legally protected. There is also some bleed between categories. For example, courts recognize doctor-patient privilege in most jurisdictions, while statutes and ethical codes may also protect the doctor-patient relationship with confidentiality. Additionally, a medical records privacy act (the Health Insurance Portability and Accountability Act or HIPAA) also confers patient privacy.4 Privilege and confidentiality protect the relationship, whereas HIPAA (and FERPA in a college environment) protect only the records of that relationship.

Use of Behavioral Agreements

A behavioral agreement outlines the institution's expectations as articulated in the school's code of conduct regarding student behavior. This kind of agreement should never precede or supplant the conduct process or used in this way implies that select students are held to different standards and are not afforded due process regarding their compliance with the terms of the agreement. Instead, if schools use a behavioral agreement, it should be an advocacy-based set of expectations, including a focus on helping the student understand any sanctions administered through the conduct process and a roadmap of how they can behave differently in the future to avoid further conduct actions.

NaBITA also prefers the term "statement of expectations" over a "behavioral contract" or "behavioral agreement," as the contract terminology can imply a binding legal relationship or duty. There is no effectiveness data to support framing the document as a contract, with respect to compliance, and a contract raises the risk that a court will ask at some point whether the institution failed to uphold its end of the bargain, and whether all students are held to the same expectations and standards for behavior. Typically, these expectations can and should be elaborated upon as part of the conduct sanctioning process, not as a diversion around it.

With the statement of expectations, the student does not need to sign the document as it is designed as a collaborative process and a further explanation of what has resulted from the conduct process. An example of this may be a student with a developmental disorder or Autism Spectrum Disorder who has frequently approached members of the community with a desire to hug them and then repeatedly asked them out. If this behavior continued over time, the student would be in clear violation of the code of conduct, and the student would have a set of sanctions resulting from the conduct process.

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Following the conduct process, it could benefit the student to have an advocacy-based case management meeting in which the student and the staff member outline ways the student could avoid this behavior in the future and engage in appropriate conduct when interacting with others on campus. An interactive dialogue with the student could also help to ensure they understand the school's expectations and sanctions resulting from the conduct process.

Moving forward, consider:

1. Use an evidence-based risk rubric to ensure each case is reviewed based on objective criteria to assess severity of behavior and immanency of risk, and to assure that interventions applied line up with the gravity of the concern.
2. Use a collaborative, case-management centered process that works with the student, family, and emergency contact to identify what is in the best interests of the student.
3. Avoid threatening a student with separation (or conduct code action) for airing suicidal thoughts, and don't threaten or leverage involuntary withdrawal as a condition of non- compliance.
4. Take a stance of working with the student through an interactive process, and develop a plan based on a good-faith desire for the student to be successful at the college or university.
5. Collaborate with disability services, or the school's ADA Coordinator as a middle circle member of the BIT who is invited to meetings as needed and consults on specific case
6. Use the conduct process appropriately, rather than as an arbitrary agreement or contract, to address and sanction behavior that violates the code of conduct. The BIT is not supposed to be a diversion from student conduct consequences.
7. Review and revise disciplinary, conduct, and withdrawal policies to bring them into compliance with the requirements of Title II and the standard of a legitimate safety risk.
8. Carefully weigh any restrictions placed on students discussing mental health issues with others on a case-by-case basis with an eye to reasonable accommodations and how to help the student be successful and remain on campus. Preventing a student from talking about suicidal ideation with others may be a way to prevent copycatting, but it can also deprive the student of the lifeline relationships that are known protective factors in the prevention of suicide.

Release of Records

Schools often struggle to find the line when it comes to a record request by a student to view their BIT records. While this request is an infrequent one, when it does come to a team, there often is some question about what exactly needs to be supplied to the student. Is this all the attachments and mental health records and incident reports? What about faculty who have emailed the team a concern about a student? How much is too much when it comes to record requests?

In the end, records kept by the BIT are governed by FERPA. Once a record is released from a more privileged relationship (such as from a licensed counselor or nurse practitioner) the record become part of the FERPA record and could be available to the student.

Given that the entire record is potentially discoverable by the student, it is essential to ensure that

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the record itself is objective and professional, avoiding subjective descriptions, diagnoses, slang phrases or has an offensive tone. If a faculty reports a student behavior in class via email and types "I want this crazy bi-polar student out of my class. I'm tired of his rambling chatter. It is disrupting my ability to teach" it would be advisable for a BIT member to contact the faculty and encourage them to resubmit their concerns in a more professional manner and, ideally, within the online submission form.

In some cases, it can be helpful if the team's online report form use checkboxes or multiple choice options to help the reporter remain more objective and professional as they express their concerns. In the end, the student has access to these reports if they push for them hard enough and the team should strive to have reports be free from overly casual or insulting reports. Likewise, well-meaning reporters may also share information they believe to be useful related to mental health diagnoses regarding the student. Even if the faculty is trained in psychology, this kind of report is inappropriate and should be sent back to the faculty to be re-written.

Parent/Emerency Contact Notification

Given the range of responses from parents, and the range in willingness of students to have their parents involved, case managers often struggle with how and when to use this intervention. A thorough understanding of the Federal Education Records and Privacy Act

(FERPA), combined with strong BIT practice, can provide clarity for this dilemma.

First, it is important to understand that FERPA defines parents as "a natural parent, a guardian, or an individual acting as a parent in the absence of a parent or guardian" (FERPA, 1974). Generally speaking, FERPA requires that students give written consent prior to releasing education records to parents, unless certain conditions have been met.

BITs can and should use a variety of strategies to obtain a student's consent to release of records. Gaining consent may be a valuable tool for building rapport and trust with students even if the consent is not technically required in all situations. BITs should seek to partner with students by building rapport and working collaboratively toward established goals. Often, parents can be allies in this process. If a BIT believes bringing the parents into the intervention process would be helpful, or is necessary, they should discuss this with the student in a way that motivates the student toward signing a release. Here, delivery is everything. The following strategies are helpful in motivating the student toward involving their parents.

- *First*, explain to the student why you believe communicating with their parents is important and beneficial. Here, look for the hook, or the catch that will appeal to the student. Perhaps involving the parents will provide them with access to additional resources for accessing appropriate levels of care (for example, access to health insurance, financial support, transportation, etc.) Similarly, involving the parents may provide emotional support to the student when they are feeling otherwise isolated. BITs should find the element that "sells" the concept of involving the parents so that the student sees the benefit in providing consent.
- *Second*, define what information you think it would be helpful to communicate. Even with a signed, written consent, case managers do not have to provide all information from the student's education record. Clarifying these boundaries with the student by discussing exactly

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what type of information you would like to share often alleviates some of the student's fear and hesitation.

Although the simplest way to release any information to parents is with signed, written consent, FERPA does provide conditions under which institutions can disclose information without consent. FERPA outlines many specific exceptions to the consent requirement, not all of which are relevant to the BIT. Here we cover the two exceptions which most commonly apply. First, if the student is a dependent for tax-purposes and second, when there is a health and safety emergency. Under FERPA, institutions may share education records without the student's consent with parents of students who are considered "dependents" for tax purposes (FERPA, 1974). Although this tax status may be quite common, especially among traditional college-age students, case managers should always verify tax dependency status. This is typically coordinated with colleagues in Student Financial Aid; however, BIT team members can also request tax documentation from parents directly. Consider whether communicating with

the parents helps the student, increases safety and support, or aids in working toward BIT goals. Just because you can communicate with the parent doesn't mean it is always the right decision.

FERPA's exception for health and safety emergencies is a more commonly used exception for the BIT. Under FERPA, institutions may share education records without the student's consent to any individual, including parents, when there is a specific and articulable threat (FERPA, 1974). Generally speaking, the U.S. Department of Education, which is responsible for enforcing FERPA, has always deferred substantially to institutional officials' judgment of what constitutes an emergency so long as the determination is specific, articulable, and significant. In other words, a school official must be able to explain the basis for the belief that a health and safety emergency exists. Some common health and safety exemptions include hospitalization, risk of hospitalization, suicide attempt, significantly/dangerously disruptive incident, demonstrated disconnection from reality and inability to care for oneself, and imminently life-threatening health risks due to substance use, disordered eating, etc.

To aid in making this determination, consider using an objective risk rubric such as the NaBITA Risk Rubric (Sokolow et al., 2019). Use of an objective rubric will provide teams guidelines for determining when a health and safety emergency exists and the language for articulating that determination. Parental contact or notification should be tied to this rubric so that you are always discussing the possibility of parental contact once a student has reached a certain threshold on your rubric. If using the NaBITA Risk Rubric, parental contact under a health and safety emergency becomes an option at elevated or higher. Once the student has reached the threshold on the rubric to discuss parental notification, the BIT needs to decide whether this is an appropriate intervention for the student or case. Some additional elements to consider would be the level of health and safety risk present and whether the parents are a known support or a known risk factor.

Once the determination has been made to contact the parents, the BIT must consider the best strategy for making the contact. If possible, tell the student that the contact is forthcoming to avoid catching the student off guard or feeling as though the BIT violated their trust. Consider at this point whether to allow a student to make the first contact with their parent, with the BIT call to follow or whether to make the call to the parent together with the student. Additionally, allow a student to recommend which parent to contact (if there are two involved). These strategies can be

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helpful in cases where the student needs support and mentorship regarding communicating with the parent, when the student has a positive relationship with both the BIT member and the parent, or if the student needs help advocating for themselves to the parent. This can also be helpful when all parties need to get on the same page and have the same information at the same time in order to avoid either miscommunication or false information.

Always remember that the health and safety exception is time limited to the period of the emergency. This means the BIT needs to make timely and sound decisions related to invoking the health and safety emergency. Additionally, the disclosure should be limited to information required to address the emergency. Remember too, that although emergency disclosures can be made to parents when circumstances require, the disclosure can also be made to any appropriate parties who need the information in order to protect the health and safety of the student or community (law enforcement, medical professionals, public health officials, mental health professionals, etc.)

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Addressing Suicide

There is not a single cause or factor for suicide but rather a multitude of stressors that converge and can lead to suicidality. Suicidal thoughts and behaviors are thus on a spectrum, ranging from no risk (no suicidal ideation) to high risk (specific suicide plan), and depend on a combination of individual, environmental, and social factors. Suicide assessment and prevention should therefore be comprehensive, seeking to understand the individual holistically, and assessment should include the following key factors (Suicide Prevention Center, 2011): 1) protective factors (characteristics that protect someone from suicide), 2) risk factors (characteristics that increase the likelihood an individual will die by suicide), 3) warning signs (factors that indicate immediate risk of suicide).

Risk and protective factors can be identified in several levels of a person's life, including individual, relationships, community, and society at large, all of which contribute to the potential for suicide. These factors can either be fixed (those things that cannot be changed, such as a family history of suicide) or variable (those things that can be changed, such as depressive symptoms) (Suicide Prevention Center, 2011). Risk factors are not direct causes for suicide, but rather a combination of characteristics that contribute to the risk of suicide (National Center for Injury Prevention and Control, 2019). Case managers want to identify all potential risk factors, as the more risk factors are present, the higher the risk becomes.

- Important risk factors to consider include (McLean, Maxwell, Platt, Harris, & Jepson, 2008):
- Previous suicide attempt(s)
- Family history of suicide
- History of trauma or abuse
- History of alcohol and substance abuse/dependence
- Mental health diagnosis, particularly mood disorders, schizophrenia, anxiety disorders, and certain personality disorders
- Physical disability/illness
- Relationship Issues
- Access to lethal means
- Recent loss (e.g. family, friend, job, finances)
- Bullying
- Barriers to accessing mental health treatment
- Feelings of hopelessness
- Impulsivity/aggressiveness
- Cultural and religious beliefs, such as the belief that suicide is a noble resolution of a personal dilemma
- Isolation/lack of social support
- Local epidemics of suicide
- Exposure to others who have died by suicide

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Protective factors can be personal or external and include skills, attitudes, and beliefs that promote resiliency and help individuals manage stressors. The more protective factors that can be identified for an individual, the lower the risk for suicide.

Important protective factors include (McLean, et al., 2008):

- Resiliency/coping skills
- Seeks support
- Access to mental health services
- Cultural, religious or spiritual beliefs that discourage or prohibit suicide
- Hopefulness
- Attitudes, values, and norms prohibiting suicide
- Strong peer support
- Connected to community
- Positive self-image
- Restricted access to means
- Ability to regulate emotions
- Strong sense of purpose

While risk and protective factors help to paint a comprehensive picture of the individual's current state, suicide warning signs are more severe and indicate a need for immediate intervention. A key distinction is a sudden change of behavior or a set of entirely new behaviors exhibited within a short amount of time.

When assessing for suicide risk, the fundamental elements to identify are ideation, intent, plan, and method. Ideation refers to thoughts about death or wanting to die.

Individuals in significant distress may have thoughts of not wanting to live, but this does not necessarily indicate they have intent to complete suicide and/or a specific plan to do so. Seeking clarification on ideation helps the BIT to determine appropriate next steps. Here are some key definitions to remember in assessment:

- Suicidal Ideation - the student is thinking about suicide
- Suicidal Intent - the student identifies a purpose or goal of the behavior
- Suicide Plan - the student has identified a strategy for engaging in suicide behavior
- Suicide Method - the student has decided the method or means by which they will complete suicide

Post-Assessment Interventions

The primary goal of the BIT's assessment is to determine if there is an immediate need for safety, as the potential treatment options for NSSI and/or suicide vary depending on the intensity, fre-

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quency and severity of the behavior, the intent of the behavior, and identified risk and protective factors. While referral into many of these programs will likely occur as a result of an assessment by a clinical treatment provider, BIT members should familiarize themselves with the various treatment options associated with risk level:

Involuntary Hospitalization:

Involuntary hospitalization should only occur as a last resort. It is defined as hospitalizing a person with a mental disorder without their consent due to imminent danger to their own life, health and safety as well as the lives, health and safety of others in their surroundings (Simonović, et al. 2011). This can only be initiated by a licensed mental health provider, licensed physician, or law enforcement. Non-clinical case managers, even if licensed, should not be making the decision about involuntary hospitalization. Instead, the case manager should be screening for warning signs. If it is determined that there is a potential for imminent risk and high probability of substantial harm, then the case manager should coordinate immediate intervention with professionals that can make that formal assessment and mitigate the risk. For institutions with on-campus counseling centers, case managers can walk the student directly to the center and ask that a student be seen immediately for assessment.

It is recommended that BITs develop a strong relationship with their counseling centers so as to ensure seamless transfer and facilitation of services. This includes establishing the process in which the BIT notifies the counseling center when there is a safety concern as well as the communication flow between offices if a student is (or is not) hospitalized. Alternatively, if on-campus counseling is not available, the case manager can call university law enforcement and request support. For institutions that do not have either of these services available on campus, the case manager should contact local law enforcement to assist with establishing immediate safety for the student. Again, case managers must develop positive relationships with both on-campus and off-campus law enforcement to ensure the trauma to the student and disruption to the campus as a result of the process is minimal.

Partial-Hospitalization Programs (PHP):

PHP programs are the most intensive non-residential care available after inpatient hospitalization. They are designed to act as a structured, step-down outpatient support program once inpatient treatment for mental health or substance use disorder is completed and there is a continued need for intensive care to prevent relapse or full hospitalization. Services generally include individual and group therapy, family therapy, and medication management. As PHP programs are non-residential, the individual must be stable enough to participate in all therapeutic interventions and capable of living independently.

Intensive Outpatient Programs (IOP):

IOP programs are less restrictive then PHP and inpatient treatment programs. They are non-residential and are most suitable for individuals whose needs are beyond weekly or biweekly therapy sessions, but the severity of the issues does not rise to the level of more intensive programs. They allow flexibility for work and school schedules while also addressing significant mental health concerns.

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Voluntary Outpatient Counseling:

This is the least restrictive and least intensive treatment option that is best suited for individuals with lower risk. Outpatient counseling includes meeting with a therapist weekly, biweekly, or even monthly for therapy sessions. This can be accessed through professionals in private practice or through a local community agency. If a student is already engaged with a provider and is engaging in high-risk behaviors, the case manager should secure a release and connect with the provider to strategize on risk reduction.

Psychiatry:

Many mental health disorders benefit from medication management. Psychiatrists are medical doctors and the only mental health professionals that have the authority to prescribe psychotropic medications. Psychiatrists are found in a variety of settings, including hospitals, agencies, and private practice. Many campus health centers have psychiatry programs available to students. If a student is already working with a psychiatrist, whether on or off campus, the case manager should secure a release and communicate with the psychiatrist as needed. If the student needs medication management but does not have a provider, the BIT can assist the student with connecting to a local provider.

Notes

Harm to Others/Threat

Disruptive Behaviors:

When addressing behavior, it can be helpful to start with some examples of disruptive behaviors that often do not involve any larger kind of threat. While odd, frustrating and often difficult for faculty and staff to manage, these examples rarely escalate into any type of situation that involves hurting or killing others. Often, the behaviors listed under disruptive may include mental illness symptoms that are concerning to manage but present no true threat.

Dangerous Behaviors:

A better way to address violence is to identify and understand the motivation for dangerous behaviors encountered by faculty, staff and case managers in their professional roles. The list that follows highlights some common examples of dangerous behaviors encountered by those working in these roles.

Affective Violence:

Affective violence is the result of a progressive, biologically driven path towards physical violence. It is poorly planned and a reaction to environmental stressors. Affective violence is based upon the primal instinct of fight or flight, fueled by adrenaline and characterized by someone losing control and ultimately attacking a victim. Howard (1999) describes it this way: "A potential aggressor channels his appraisal into some form of coping. The strength of the reaction is a direct function of the validation of the threat and the degree of certainty that the threat will thwart an objective or a goal. It is the emotion of being threatened and the inability to cope with that threat that initiates aggression. The common thread throughout this process is the release of adrenaline" (p. 353-354).

Grossman and Siddle (2000) have conducted landmark studies looking into how aggression can induce adrenaline's (or epinephrine's) influence on the heart rate, body language, behavior, and communication (Grossman, 1996). The adrenaline rushing through a subject's system has also been well studied by Hart (1995). He illustrates that when an individual cannot cope with their anxiety, their mind perceives this anxiety as a threat. As the individual starts to produce adrenaline, this triggers the affective violence response.

Predatory/Targeted Violence:

Predatory violence, in its extreme form, is described as an intent-driven, planned attack. This aggression occurs when an individual becomes isolated, disconnected, lacks trust, and often feels threatened and frustrated by a perceived attack. They plot and plan their revenge and execute their plans with a militaristic, tactical precision. This violence is a result of a planned, intent-driven action that is more commonly exhibited by a subject engaging in mission-oriented, instrumental violence such as a mass shooting (National Threat Assessment Center, 2018; Van Brunt, 2012). Predatory violence involves a more strategic, focused attack and a desire to complete a mission.

Notes

A key aspect of understanding risk factors is the importance of seeing these in combination, like puzzle pieces coming together to create a larger meaning. As with a puzzle, one piece alone is not particularly useful. It's when these pieces combine the factors begin to be more useful in understanding risk.

Risk Factors related to Targeted/Predatory Violence:

Direct threat	Indirect threat	Lack mental support	End of relationship
Access to weapons	Lack peer support	Explosive reactions	Inability to date
Hardened thoughts	Lack family support	Intimidates others	Hopelessness
Social isolation	Loss of job	Lacks empathy	Last act behavior
Victim of bullying	Decline in academics	Polarized thoughts	Legacy token
Substance abuse	Acquiring weapons	Glorifies violence	Feeling persecuted
Authority conflict	Suicide attempt	Lacking remorse	Leaking attack plan
Fixation on target	Focus on target	Action plan for attack	Time frame for attack
Fantasy rehearsal	Rejection	Financial loss	Catalyst event
Feeling trapped	Poor anger outlets	Fame seeking	Objectification

When conducting a threat assessment, it is essential to balance risk fac¬tors against the protective factors that exist for an individual. These protective factors often "take the temperature down" regarding the concerns (Van Brunt, Murphy, & Zedginidze, 2017).

Protective Factors related to Targeted/Predatory Violence:

Social support	Empathy to others	School engagement	Religious supports
Family support	Perspective taking	Work engagement	Non-violent outlets
Positive future view	Intimate relationship	Positive self-esteem	Problem solving
No weapon access	Sense of identity	Consequence aware	Emotional stability
Social/political safety	Housing stability	Resiliency	Lacks reactivity

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Mental Illness and Violence

Unwinding the issue of mental illness from gun violence is not an easy task. These issues become complicated when the public is exposed to repetitive terrorist events and clamor for answers from the government and those in charge of schools. The assumption that persons with mental illness are a high-risk population relative to gun violence lacks supportive evidence (Knoll & Annas, 2016; Van Brunt & Pescara-Kovach, 2018). Research shows that the kind of targeted mass casualty violence we see in school settings is the result of a host of complicated factors (National Threat Assessment Center, 2018; Jarvis & Scherer, 2015). The Federal Bureau of Investigation, Secret Service, and the Department of Homeland Security have said repeatedly that there is no singular profile for a school shooter, but rather a complicated set of factors moving an individual toward an attack against a backdrop of evaporating protective factors.

A mental health diagnosis is rarely the sole cause of targeted school violence, though media coverage and public opinion often portray those with mental health problems as more likely to commit these acts. Mass shootings by people with serious mental illness represent one percent (1%) of all gun homicides each year (Knoll & Annas, 2016). So why the disparity between the data and the opinions? When the community is in fear and their emotions are on high alert, people in panic focus on the reoccurrence of the horrible event itself regardless of whether or not it is likely to happen again. This phenomenon is called "probability neglect" and was described by Sunstein in 2003 when the public demanded legal interventions from the government or seeks clear answers for the cause. When mental illness is given to a community hungry for answers, the public sees it as the most common-sense reason to explain the event and create the illusion of a solution. At a minimum, there should be a differentiation between diagnoses and acute issues or other nuances.

Even if mental illness was a risk factor, it's not a particularly helpful factor. For example, we also know that most targeted violence attacks are committed by men, but we don't suggest that all men are capable of such an attack. BITs should take care not to confuse a mental health assessment with a violence risk assessment. A mental health assessment is primarily about giving a diagnosis, assessing the level of care (does the student need to be hospitalized) and developing a treatment plan such as taking medications, continuing therapy and reducing mental illness symptoms. A violence risk or threat assessment is informed by workplace violence literature and primarily focuses on assessing the likelihood of the subject behaving violently in the future. While a violence risk or threat assessment does not have to be performed by clinical mental health staff, the mental health expertise of this professional could very well be useful in informing the violence risk or threat assessment.

When addressing cases of harm to others, NaBITA recommends a mandated violence risk or threat assessment, rather than a mental health assessment, when the behavior crosses the "elevated" threshold on the NaBITA Risk Rubric.

Human Resources and the BIT

Notes

One of the challenges for colleges and universities when it comes to developing a BIT is the consideration of how to address faculty and staff concerns. There are typically two schools of thought here, the first is to develop a separate team through Human Resources that would need to match the process of the student facing team (e.g. using a database, advertising to the campus, using an assessment rubric on each case, having a threat assessment and suicide assessment capacity). The other option is to invite HR onto the existing student facing team. While there won't be as many cases for faculty and staff (typically, we see a 1 to 10 ratio, if not higher)---having HR present on the student facing team improves training, consistency and developing a streamlined process.

Having HR staff familiar with the BIT process from gathering data, applying a risk rubric and creating interventions, whether they sit on the student facing team or are part of their own, is useful to ensure a clear, consistent and equitable process. Assuming HR is on the student facing team, there are often a few orientation concepts that can be helpful.

- **Finding the Filter:** A common challenge for both student affairs and human resource staff is establishing a filter on what is reported to the team and what is handled internally within HR. This is a common problem that student conduct officers face as well. When the filter is set too low, the BIT becomes overwhelmed and struggles to function with so much data. If the filter as set to high, individual departments silo information from the team, creating challenges to operate in a prevention,
- **Applying the Risk Rubric:** Another area of concern, for both student and faculty/staff teams is applying the rubric equally to ever case that comes in. This means for both harm to self and harm to other's cases. Some teams have used the rubric just on cases where a threat to others exists. This drastically limits the use of the NaBITA Risk Rubric and is a problematic course of action for both student and faculty/staff facing teams.
- **Confidential Information:** When HR is blended with a student focused team, it can be challenging to address how information is shared. FERPA guides student facing teams, and when a faculty/staff report comes in, this is governed by employment law and HR policy. Similarly, most BITS keep their student records in a database like Maxient or Simplicty. Faculty and staff records are typically kept within HR. There is also an expressed concern when other faculty/staff share a concern with the team, there is a violation of privacy or confidential expectations that other faculty/staff have. As with students, the conversations that occur around the table of the BIT have an expectation they are based on equality, an evidenced based rubric and a respect for the privacy of the information shared. Issues of gossip, information sharing or inappropriate humor need to be addressed by the team chair in regards to any report shared with the team.
- **Conduct & Job Performance:** In the same way the student conduct process is separate from the BIT, the HR job performance or discipline policy is separate from the BIT. This is often a push back NaBITA hears from Human Resources to bring faculty/staff and behavior to the team. As a reminder, the BIT/CARE is a consulting body that rates the risk and suggests interventions. The BIT/CARE team is not a replacement for the conduct or human resources discipline process. The BIT/CARE model helps support and augment decisions from an evidenced-based, assessment process.

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While each college and university are unique in terms of its resources, policies and practices, having human resources on the BIT makes sense. Ideally, there would be a singular marketing campaign for the BIT, encouraging students, faculty and staff to share concerns forward to the team. Having a singular marketing approach creates simplicity in terms of reporting culture. Leaning into the team's expertise in addressing suicidal behavior, threat, mental health concerns provides the college and university a streamlined process to consult on cases. If there are concerns about privacy and staff/faculty concerns would be handled or talked about inappropriately at the meeting, this leaves the chair with three options: 1) address the team's culture of information sharing and appropriateness, 2) following the initial report that comes into the BIT, a smaller group could be meet and place the case on the rubric and develop interventions, 3) following the initial report that comes into the BIT, the BIT applies the rubric and then HR moves forward with interventions based on the risk level.

Notes

Advice on Notification During an Emergency Transport

When a student is being transported to the hospital for psychological assessment, danger to others or a medical emergency, staff from the BIT, student affairs office or housing are often in a position of needing to call the parents or emergency contact on file. Remember, FERPA allows these notifications under the emergency exception policy. While there are some risks sharing information with parents, guardians or emergency contacts related to negatively impacting their rapport, trust and connection on campus, the risks are greater when it comes to the student being hurt and the parent, guardian or emergency contact is not made aware. Involving parents when it come a student in crisis is permissible under FERPA and a best practice. When making a call:

1. Keep it short and to the point: This is the not the time for a lengthy introduction or longer conversation. Avoid discussion of conduct actions, speculations, or what lead up to the event. The parent, guardian or emergency contact needs to know:
    a. Ensure you are talking to the right person.
    b. Introduce yourself (who you are and what your contact information is).
    c. Basic overview of what happened (if known)
    d. Current status (are they conscious, injured, talking about suicide)
    e. Where are they headed (what hospital, what address)?
    f. Who is the charge nurse? Doctor on Duty? Phone number?
    g. Will a staff member be meeting them at the hospital?
2. If the emergency contact, guardian or parent are far away---consider:
    a. Establishing a point person for contact to reduce them having to call around campus. Make sure to give them a direct phone number (ideally cell phone).
    b. Assist with travel plans such as hotel reservation, food vouchers or financial.
    c. Offer to have a staff on site at the hospital to assist the student.
3. If calling in the middle of the night:
    a. Give them a moment to wake up. Consider having them have a class of water and find a pen and paper to write things down.
    b. Repeat things as needed.
    c. Have them share back with you the phone numbers you share to assess they are retaining the information.
    d. Ask if there is someone else you can call or other ways you can assist.

Sample script: Hello, My name is Brian Van Brunt, I am a member of the campus CARE team. Your daughter Makenzie is currently in transit to North Hospital. She is awake and safe, but has been talking about wanting to kill herself tonight. She will be talking to a doctor to determine if she needs to stay at the hospital. I have the number of the hospital and the name of the charge nurse at the Emergency Department. I'd like to give that to you know if you have a pen and paper.

Notes

Case Studies

Max

- Max is a first-year student who struggles with homesickness, sadness, and isolation in his residence hall.
- Residential life staff have been "keeping an eye on him" and his case has come up to the campus care team. They have asked him to use counseling services.
- He does not attend counseling, and his roommate finds him after Max takes a handful of pills.
- Max is transported to the hospital and treated for depression for several days.
- The hospital calls and says he is ready to return to campus.

What should you do?

Sarah

- Sarah struggles with suicidal behavior.
- She has been seeing a counselor at the on-campus counseling center, and the behavioral intervention team has twice reviewed her case.
- She has a 3.5 GPA.
- She reported to a professor feeling of suicide and was brought to the counseling director. She was voluntarily admitted to the local psych hospital unit.
- Sarah was discharged four days later and worked with her on-campus counselor during admission. The BIT and conduct office were not involved.
- The hospital did not share much information, and Sarah showed up at class and returned to counseling.
- Sarah continues to cut herself daily; however, these injuries are not life-threatening. Sarah's friend shared with a staff member: "I can't stand her anymore. She is always talking about killing herself."
- Sarah is hospitalized again after being found by campus safety; she had been sitting in her car for hours thinking of driving it into a telephone pole.
- The hospital treats her for two days and is ready to release her.
- She is no longer suicidal and wants to come back to campus.

What should you do?

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Notes

Appendix

Parkland Shooting. On the afternoon of February 14, 2018, a former student, Nikolas Cruz, walked into a building at Marjory Stoneman Douglas High School in Parkland, Florida.. Approximately six minutes later, after navigating three floors of classrooms while killing 17 people and wounding 17 more, he put his weapon down and exited the building among the chaos he had started. There were numerous opportunities to detect the escalation to the attack. On February 5, 2016, a neighbor's son told the sheriff's office that Cruz, pictured with guns on Instagram, "planned to shoot up the school." A deputy responded, discovered that Cruz owned knives and a BB gun, and informed the high school's resource officer, Scot Peterson. On September 28, another student informed Peterson that Cruz may have ingested gasoline a week earlier and was cutting himself. In September 2017, A blogger in Mississippi warned the FBI that someone named "Nikolas Cruz" wrote on his YouTube page: "I'm going to be a professional school shooter." On November 1, 2017, Katherine Blaine told the sheriff's department that her cousin, Nikolas' mother, recently died. She said Cruz had rifles and requested that the agency recover them. A close family friend agreed to take possession of the weapons. On November 30, 2017, a caller told the sheriff's department that Cruz was collecting guns and knives and "could be a school shooter in the making." On January 5, 2018, a person close to Cruz contacted the FBI to report concerns about him, including his possession of guns.

Freedom High Attack (Averted). On August 18, 2011, Jared Cano was arrested for planning an attack at his high school. Cano was expelled from Freedom High School in 2009, and planned an attack that was stopped after an anonymous tipster notified the police. He had a history of drug charges and burglary. Police found fuel, shrapnel, plastic tubing, timing and fusing devices for making pipe bombs, along with marijuana and marijuana cultivation equipment. They also found a detailed journal with statements about killing specific administrators and students who may be in the vicinity of his attack, as well as detailed schematics of rooms. There are reports of him being bullied at school. He created a manifesto about the attack.

Freeman High Shooting. On September 13, 2017, Caleb Sharpe flipped a coin that came up heads and he entered his school with an AR-15 and a handgun in a duffel-bag. The AR-15 jammed, and he used the handgun to shoot a fellow student, who was trying to stop the shooting. Caleb continued to shoot down the hall and then surrendered to a custodian. He told detectives that he wanted to "teach everyone a lesson about what happens when you bully others." Around the time classes started, Caleb gave notes to several friends indicating plans to do "something stupid" that might leave him dead or in jail. One of those notes was reportedly passed on to a school counselor. He also bragged to several friends when he figured out the combination to his father's gun safe, and again when he learned to make bombs out of household materials. He acted out violent scenarios on his YouTube channel and spoke openly about his fascination with school shootings and notorious killers like Ted Bundy. He messaged a friend over Facebook, asking if the friend could get him gasoline, tinfoil, and fuses. The friend reported "I said, 'No,' and asked him why. He said, 'For a science experiment.' I said, 'Why are you doing a science experiment?' and he said, 'Nevermind.'

Notes


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