2024 NABITA State of the Field Survey Results

NABITA Whitepaper

National Association for Behavioral Intervention and Threat Assessment

Makenzie Schiemann, PhD; Partner, TNG; President, NABITA

Linda Abbott, LMHC; Consultant TNG; Advisory Board Member, NABITA

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Executive Summary

Background

Every two years, the National Association for Behavioral Intervention and Threat Assessment (NABITA) administers a survey to assess the state of the field related to behavioral intervention and threat assessment. The first iteration of the survey occurred in 2012, making the 2024 survey the seventh opportunity to assess the field's practices. This report serves as the summary of the findings from the 2024 survey.

Key Findings

STRUCTURAL ELEMENTS

- About one-third of institutions address faculty, staff, and employee concerns in addition to student concerns.
- Most institutions have one integrated team that addresses all levels of risk, ranging from low-level concerns to threats of harm to self or others. Two separate teams—one for threats or high-risk behavior and one for early alert or low-risk behavior—are less common.
- Most teams have an institutional policy or charter granting them the authority to fulfill their mission and perform their functions.
- CARE team is now the most common choice for team name.
- Teams are most commonly led by a Dean of Students or a Case Manager.
- On average, teams consist of eight members, most often including representatives from the Dean of Students, counseling center, police or campus safety, student conduct, disability/ADA services, housing and residence life, and case management.
- Approximately 20% of respondents report that their team receives no training.
- Nearly all teams share information in a manner that promotes effective case discussions, with most doing so while remaining compliant with FERPA. Similarly, most clinical professionals on teams share information in a way that promotes team discussion while maintaining appropriate client privilege.
- Most teams educate their community and market their services. This is most often accomplished through in-person training, published training and marketing materials, and a team website.
- Nearly half of teams lack a procedure manual.

PROCESS ELEMENTS

- Teams consistently use an online referral form as the most common method for receiving referrals, and most designate a staff member to review referrals each workday.
- Teams receive referrals for general emotional and mental health concerns most often, followed by academic/financial/basic needs.
- Most teams report mild or moderate on the NABITA Risk Rubric as the most common risk rating for referrals.
- Most teams use an agenda, make it available to their team in advance of the meeting, and have team members review the agenda and gather information from their respective areas to prepare for the meeting.
- Nearly all teams meet every other week or weekly, with most teams meeting weekly.
- Most teams objectively assess risk using a risk assessment tool for all new referrals. The NABITA Risk Rubric remains the most used tool.
- Respondents continue to engage in practices related to mandated assessments and interventions that NABITA does not endorse. Examples include BITs making determinations on issuing a mandated assessment without relying on an objective risk rubric, using BITs to require compliance with interventions, issuing findings or sanctions for disciplinary actions, or determining readiness to return to campus.
- Nearly three-quarters of schools have a staff member whose primary role is to serve as Case Manager, and nearly all are full-time. Case Managers tend to be non-clinical, present at all institution sizes and types, and work out of the Dean of Students' office or a stand-alone department.
- Nearly all respondents described using some type of electronic database or software program to track BIT referrals and cases, and most give access to the team records to their fixed team members who are expected to attend all team meetings.

QUALITY ASSURANCE AND ASSESSMENT ELEMENTS

- Teams demonstrate mixed levels of engagement in team auditing practices, as about half of respondents report that their team audits their structure and process while the other half do not.
- Most teams do not assess the team's effectiveness.
- About half of teams do not produce an end-of-semester or end-of-year report.

SECTION ONE

Research Background and Methodology

An Overview of the Research Project

Research Background and Methodology

Research Objective

NABITA sought to better understand the common characteristics of teams who engage in behavioral intervention and threat assessment work, including their structure, practices, and methods of quality assurance. To understand these characteristics, NABITA developed and implemented the State of the Field Survey. The research survey aimed to answer the following research questions:

1. What are the common characteristics of teams who do behavioral intervention and threat assessment work?
2. How do these common characteristics align with national standards of practice?

Survey Design and Administration

The State of the Field Survey was developed by the NABITA President and a TNG[1] consultant in collaboration with other TNG staff with expertise in survey development, behavioral intervention, and threat assessment. The 2024 State of the Field Survey represents a complete redesign of the survey to better align the survey questions with the 2023 NABITA Standards for Behavioral Intervention Teams (the Standards). In this iteration, the survey asked questions to assess teams' functioning across all 21 NABITA Standards of Practice, including the team structure, process, and quality assurance. The survey included four sections:

1. Demographics
    a. The survey collected information about the institution and the respondent's team. While individual respondent demographics were not collected, each respondent was asked a series of questions related to the make-up of their institution and team.
2. Structural Elements

[1] TNG Consulting is a risk management solutions firm serving higher education institutions, K-12 schools and districts, and workplaces. Experts in Title IX, behavioral intervention, and threat assessment, including creating systems-level solutions for prevention and risk mitigation, investigations, expert witness testimony, custom training, and more, TNG is considered the gold standard for educating people on the myriad topics related to Title IX, behavioral intervention, and threat assessment.

    a. Respondents were asked to report on the structure of their teams, including:
        i. Team authority, scope, mission, and philosophy
        ii. Team leadership and membership
        iii. Team name
        iv. Team training
        v. Information sharing
        vi. Team budget
        vii. Community education and marketing
        viii. Procedure manual
3. Process Elements
    a. Respondents were asked a series of questions related to the operational procedures of their team, including:
        i. Referral receipt and review
        ii. Meeting frequency and operations
        iii. Objective risk assessment
        iv. Interventions and case management
        v. Case review
        vi. Recordkeeping
4. Quality Assurance and Assessment Elements
    a. Respondents were asked to report on how they assess their team's functioning and effectiveness, including:
        i. Team audits
        ii. End-of-year reports
        iii. Program effectiveness assessments

The 2024 State of the Field survey recipients were all NABITA and/or Association of Title IX Administrators (ATIXA) members, as well as contacts within the TNG email list. This included individuals who previously participated in a NABITA or ATIXA training or signed up to receive communication from NABITA, ATIXA, or TNG. NABITA also shared the invitation to participate in the survey on various social media platforms, including Facebook and LinkedIn. Weekly giveaways from NABITA served as an incentive to participate in the survey.

Anyone who accepted the invitation, whether by email or via a social media post, received the survey link and information related to the survey's risks and benefits. The survey asked respondents to limit their participation to one survey per school or institution. Additionally, response data would remain anonymous, but respondents could volunteer their contact information for the survey giveaways.

Data Analysis

Data cleaning and analysis involved several steps to ensure accuracy and relevance. In the data cleaning process, pairwise deletion addressed missing data by including all available responses in each analysis, even when some data points (respondent answers) for certain questions were absent. Rather than exclude entire cases due to incomplete responses, only the missing data points were excluded from each calculation. This method was chosen to maximize the use of the dataset and retain as much information as possible, helping to maintain a larger sample size and improve the precision of our estimates. However, it is important to note that the sample size may vary across different questions and analyses depending on the availability of data for the variables involved. Additionally, the survey used skip logic so that only relevant questions were presented to each respondent. When the survey presented follow-up questions to respondents based on a previous answer, not all respondents chose to answer the follow-up questions, thus again changing the sample size in some follow-up questions. The decision to use pairwise deletion, despite variable sample sizes across questions, was made to effectively handle missing data while preserving the overall integrity and richness of the dataset.

Additionally, the survey excluded eleven participants beyond the initial questions as they indicated they do not have a team that addresses concerns or risks.

To handle “other” responses, reviewers categorized individual open-ended responses under one of the given options (e.g., an entry of care manager as an open-ended “other” response was categorized under the “Case Manager” option).

Researchers used descriptive statistics to calculate response frequencies on each survey question, providing a clear overview of trends and patterns. For certain questions, the researchers conducted further analysis by controlling for individual variables, such as institution size, type, and residential status. This was not done for all variables or on all questions. Instead, the researchers used professional judgment to determine which comparisons would yield the most insightful and actionable results, ensuring that the findings would be both robust and practically useful for informing future BIT practices.

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 having teams focused on behavioral intervention and threat assessment work and employing practices that NABITA endorses. Additionally, without an accurate measure of the total population of BITs/TATs/CARE teams, it is challenging to determine an accurate sample size. This impacts the ability to conclude that the data is generalizable to the entire population of these teams.

Another limitation of the 2024 State of the Field Survey is its comprehensive rewrite. Comparing survey data year over year becomes challenging when a survey is redesigned, as direct comparisons between questions cannot be made. The variations in question phrasing, format, and response options

complicate the distinction between true shifts in attitudes and behaviors versus artifacts of the redesign. Where appropriate or possible, this report will make comparisons between the 2024 findings and historical trends, but opportunities to make comparisons will be limited and should not be interpreted as direct comparisons.

Organization of this Report

This report organizes the survey findings into five sections: Survey Respondents, Structural Elements, Process Elements, Quality Assurance and Assessment Elements, and Discussion and Recommendations. The Survey Respondents section presents the data on who responded to the survey. The Structural Elements, Process Elements, and Quality Assurance and Assessment Elements present the survey findings related to the associated survey questions and offer a discussion that draws conclusions about this data and its implications for practice. Finally, the Discussion and Recommendations section explores what the data tells about the field of behavioral intervention and threat assessment and makes recommendations for improving the work of teams in the future.

SECTION TWO

Survey Respondents

A Presentation of Survey Respondents

Survey Respondents

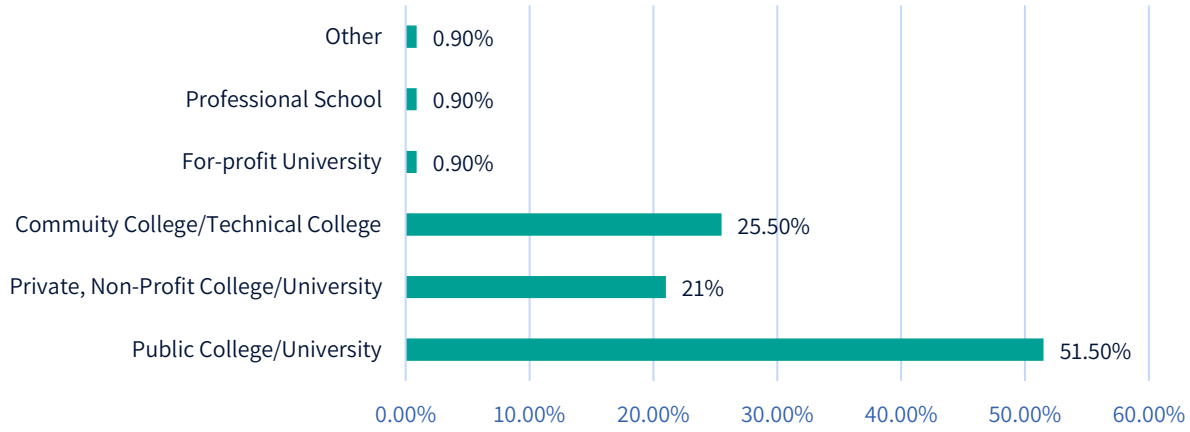
In total, 464 individuals participated in the survey. Calculating the response rate is difficult because the survey link was available publicly on social media. Eleven respondents were excluded from the survey as they indicated they do not have any team that meets to discuss potential risks, threats, and/or individuals or concerns (e.g., Behavioral Intervention Team, CARE Team, Student of Concern Team, Threat Assessment Team). While most institutions have a single team addressing the full spectrum of risk, some have multiple teams (e.g., one focused on low-level behaviors and another on high-level behaviors). For simplicity, this report uses the term "team" rather than "team/teams" unless intentionally discussing the concept of one team vs. multiple teams. Similarly, this report uses the term BIT to refer to all teams tasked with responding to concerning behavior except in cases where the survey specifically asked about other common team names (e.g., CARE, TAT, Student of Concern).

The survey asked respondents to provide information about their institutions and the teams responsible for behavioral intervention and threat assessment. This information included the type of institution, its residential population, the team structure for institutions with multiple sites, the age of the team, and the size of the population served by these teams.

Institutional Demographics Type

Survey respondents reported that they are affiliated with a *public college/university* (51.5%, N=229), *private, non-profit college/university* (21%, N=94), *community college/technical college* (25.5% N=109), *for-profit university* (0.9%, N=4), *professional school (e.g., medical law)* (0.9%, N=4), or *other* (0.9%, N=4).

Institution Type



When asked about the residential status of their institutions, 66.5% (N=296) of respondents reported that their institution is *primarily non-residential*, 32.6% (N=145) are *primarily residential*, and 0.9% N=4 are *fully online*.

The data showed that teams have been in existence for an average of 11 years.

SATELLITE LOCATION

The survey defined a "satellite location" as a campus/location/branch that is part of the larger school/institution/organization but is geographically separate from its own staff/services.

Among respondents, 60% (N=238) reported having a satellite location(s). Of those respondents with a satellite location and who provided additional data about the team structure at the satellite location, 34.9% (N=83) reported having *no BIT/CARE team or representative for a satellite location*, 25.6% (N=61) reported *having a representative from the main location assigned to the satellite location*, and 19.3% (N=46) reported *having a specific BIT/CARE team that serves the satellite location(s)*. Another 20.2% (N=48) reported that *the satellite location sends a representative to the main BIT/CARE team.*

Population Size

The survey asked respondents about the size of the population that their team serves. Survey respondents represented diverse institutional populations served by behavioral intervention teams, ranging from *fewer than 1,000* individuals (3.5%, N=14) to *more than 50,000* (5.6%, N=22). The table below presents the populations served by respondents' teams.

Population Size Served by Team	**%**	**N**
Less than 1,000	3.5%	14
1,001-3,000	17%	67
3,001-7,000	22.3%	88
7,001-15,000	24.1%	95
15,001-25,000	13.4%	53
25,001-50,000	13.4%	53
50,000+	5.6%	22
Unsure	0.76%	3

SECTION THREE

Structural Elements

An In-depth Analysis of the Structure and Formation of Teams

Structural Elements

Respondents were asked to assess the structure and formation of their team. These structural elements include the scope of the team's work related to the location of behavior, type of behavior, and the role of the individuals referred. The survey also considered team membership, team size and membership structure, team name, team leadership, whether the team has written and formalized standard operating procedures, team training, how members of the team share information, team budget, and how the team markets themselves and educates their community about their role.

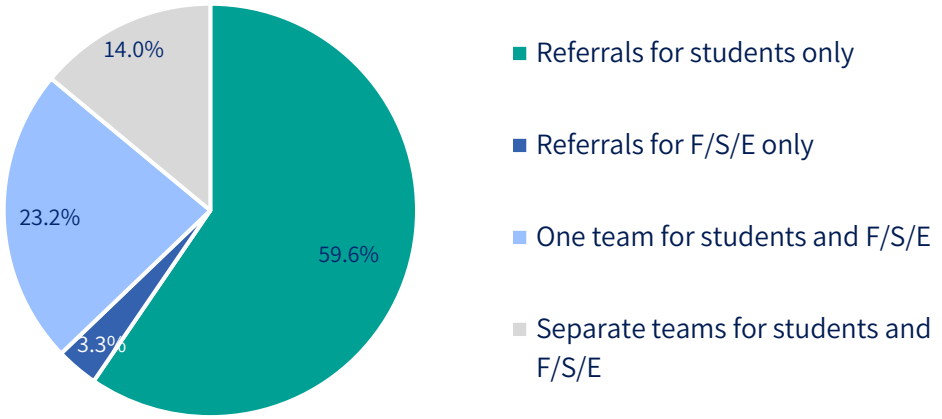
Team Mission and Scope

Respondents were asked about the scope of the team's work and mission.

SCOPE: POPULATIONS REFERRED TO TEAM

When asked about the scope of the populations served by the team, most respondents reported that they receive *referrals for students only* (59.6%, N=234), while merely 3.3% (N=13) receive *referrals for only faculty/staff/employees (F/S/E)*. A total of 37.2% (N=146) address *referrals for both students and faculty/staff/employees*. Specifically, 23.2% of respondents (N=91) reported having *one team to address referrals for both students and faculty/staff/employees,* and 14% (N=55) reported having two *separate teams*, one for *student referrals* and one for *faculty/staff/employees.*

Populations Referred to Team



When controlled for population size, respondents from larger schools, specifically those serving populations of 15,000-50,000+, were more likely to have a separate team to address *referrals for faculty/staff/employees*. A total of 45.5% (N=10) of respondents whose teams serve populations greater than 50,000 had a *separate F/S/E team*, compared to 20.8% (N=11) of those serving a population of 25,001-50,000, and 18.9% (N=10) of respondents whose teams serve 15,001-25,000. On average, only

8.8% of respondents whose teams serve populations of fewer than 1,000 to 15,000 reported having a *separate team for F/S/E referrals*.

This data suggests that most teams only respond to concerns or risks from students. The Standards recommend that teams serve all students, faculty, staff, and employees. Addressing concerns across all groups ensures a comprehensive approach to campus well-being and safety, promotes a culture of care, and fosters a healthier, more inclusive environment where everyone can thrive. By supporting faculty, staff, employees, and students, BITs help create a cohesive, resilient campus community.

SCOPE: LOCATION OF BEHAVIORS REFERRED TO TEAM

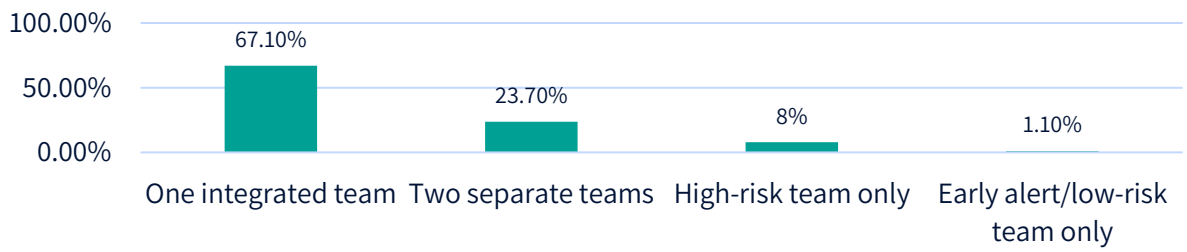
Respondents were asked where the behaviors that the team addressed occurred, and most respondents reported that their teams addressed behavior, whether it occurred on-campus or off-campus. Specifically, 98.2% (N=388) reported addressing behaviors on campus, and 77.7% (N=307) reported that they addressed behavior *off campus*. A smaller percentage (44.1%, N=174) reported addressing behavior that occurred abroad.

This data is encouraging because students' well-being and safety are interconnected across all aspects of their lives. Off-campus incidents can impact a student's on-campus behavior, mental health, and academic performance, potentially posing risks to themselves or others. By addressing on- and off-campus behavior, BITs can provide comprehensive support, intervene early, and help maintain a safe and supportive environment for the entire campus community. This holistic approach ensures that students receive consistent care and guidance, regardless of where the behavior occurs.

SCOPE: TYPES OF CONCERNS ADDRESSED

Respondents reported that 67.1% (N=235) have *one integrated team that addresses behavior ranging from low-level concerns to threats of harm to self or others*, while 23.7% (N=83) have *two separate teams: one that addresses threat or high-risk behavior and one that addresses early alert/low-risk behavior.* Only 8% (N=28) of respondents reported having *one team that only addresses threatening or high-risk behaviors (e.g., aggressive behavior, concerns for safety, perceived threats, actual threats of harm to self or others),* and another 1.1% reported having *one team that addresses early alert/low-risk behaviors (e.g., basic needs, stressors, academic concerns, need for support resources).*

Number of Teams and Concerns Addressed by the Team(s)



When controlled for population size, respondents whose team serves 25,001-50,000 individuals were most likely to have *two separate teams: one that addresses threat or high-risk behavior and one that addresses early alert/low-risk behavior*, suggesting that larger institutions may be more inclined to create two separate teams.

This data demonstrates that most teams align with the Standards by having one integrated team that responds to a full spectrum of risk. Having one team that receives and responds to referrals across the spectrum of risk has a diffusion of benefits; by addressing lower-level concerns, teams increase opportunities for early intervention/prevention and individual support while also addressing community safety. Having one team also reduces potentially duplicative work for staff by having one procedure manual, one team meeting, and one team to market to the community. It also eliminates the often-complicated process of moving cases back and forth between teams as risk inevitably changes over time and as additional information is gathered.

MISSION STATEMENT

A total of 71% (N=279) of respondents reported that their team has a mission statement, while 29% (N=114) do not. When asked about what is outlined in the team's mission statement, respondents who had a mission statement reported the following:

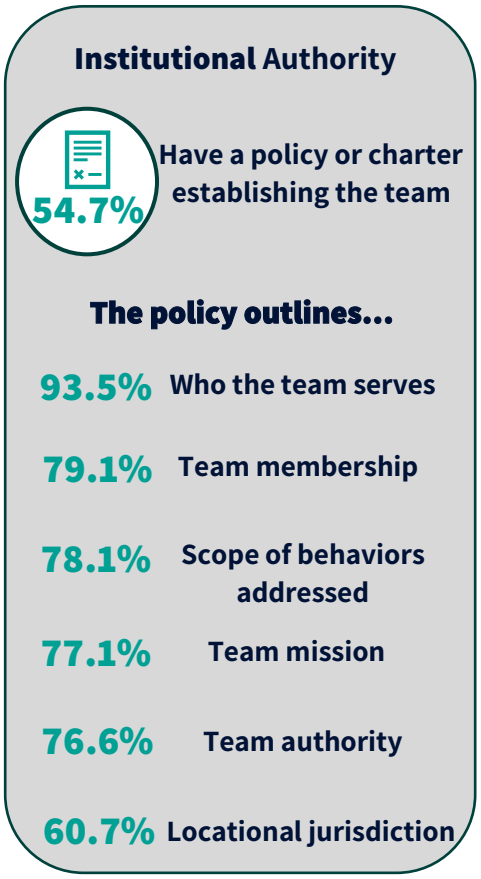
- 88.3% (N=242) included a commitment to supporting individuals in crisis
- 83.2% (N=228) outlined a commitment to addressing early intervention/low-level concerns
- 81% (N=222) included a commitment to addressing high-risk behaviors or threats
- 62.4% (N=171) connected the team mission to the academic mission of the institution
- 6.2% (N=17) responded *other*. Those who responded *other* tended to note that their mission statement included a commitment to be culturally responsive, care for and show consideration of the team's work, focus on equity and integrity, and use a multidisciplinary approach.

Most teams align with the Standards by having a mission statement that provides a sense of direction and guidance. By outlining the scope of the team's work, including what types of referrals the team receives and what populations the team serves, the mission statement also informs the community of what the team sets out to accomplish and can offer risk mitigation following a crisis.

Institutional Authority

The survey asked respondents if their school/institution/organization has a written policy/charter establishing the team. Slightly more than half of survey respondents (54.7%, N=208) reported that they do. For those that have an institutional policy, 93.5% (N=188) included *who the team serves* within the policy, and 79.1% (N=159) included *team membership*. Another 78.1% included the *scope of the behaviors the team addresses,* and 77.1% included the *mission of the team.* Most institutional policies also included an explanation of what the team has the authority to do (76.6%, N=154) and the team's locational jurisdiction (60.7%, N=122). Only 8% (N=16) selected *other* to indicate additional inclusions in the institutional policy.

When asked how the team's policy is made available, more than half (50.3%, N=99) indicated that the policy is *published online and available openly.* Almost one-third (32%, N=63) reported that the policy *is not published for availability outside of the team*, and 17.8% (N=35) reported it as *only available internally to students, faculty, and staff via intranet or other internal mechanisms.*



Just over half of respondents aligned with the Standard pertaining to the inclusion of an institutional policy. It is recommended that institutions have a publicly accessible policy or charter that establishes and authorizes the team and sets its mission, membership, and scope.

Team Name, Leadership, and Membership

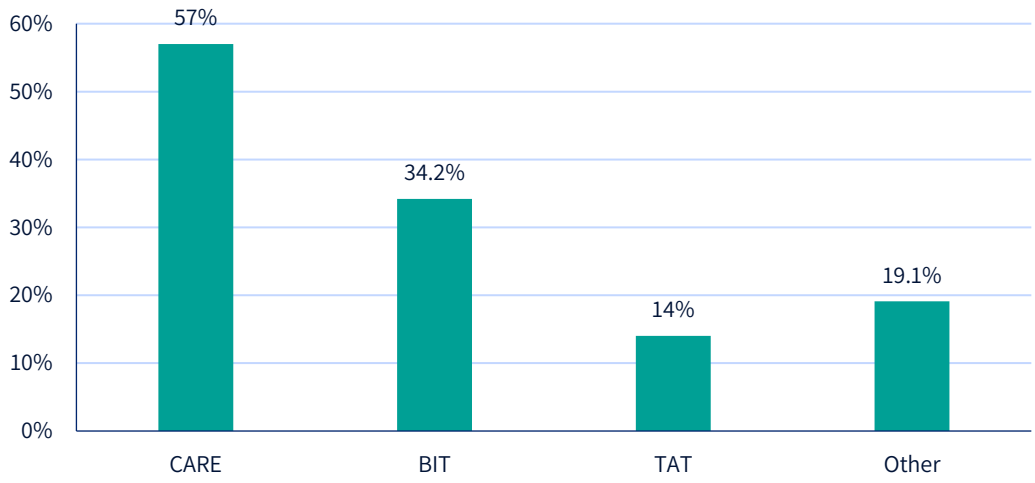
The survey asked respondents about various characteristics of their team, including the team's name, who oversees or leads the team, and the composition of team membership.

TEAM NAME

While the survey results indicated some variation in team name, *CARE Team* (57%, N=200) and *Behavioral Intervention Team (BIT)* (34.2%, N=120) were reported as being used most frequently. *Threat Assessment Team (TAT)* was reported at 14% (N=49), and *Student of Concern Team* was the lowest at 8.3% (N=29). An additional 19.1% (N=67) of respondents reported other names, many of which were individualized for a specific institution, including the use of various acronyms and the occasional inclusion of a school mascot.

The high number of teams using either CARE or BIT indicates that most teams align with the Standards by adopting names that communicate their role and function. The use of these well-known team names can foster community buy-in and encourage referrals across the full spectrum of risk. The use of names like Threat Assessment Team (TAT) and Student of Concern is less consistent with the Standards and may be reflective of the institutions that have only one team responsible for responding to high-level concerns. Threat Assessment implies that the team is overly focused on threats or high-level concerns, potentially discouraging referrals across the full spectrum of risk. The term "Student of Concern" can be viewed as stigmatizing and may convey a negative connotation. Whatever name a team chooses, it should resonate with the community, reflect the seriousness of the team's work, and be distinct from other teams at the institution.

Team Name



TEAM LEADERSHIP

Respondents were asked to identify who chairs the team by selecting the department that most closely aligns with the individual in the chair or leadership position. Most respondents (56.7%, N=199) identified the *Dean of Students (including assistant or associate Dean of Students)* as the team chair. The second most common response was *non-clinical Case Manager* (20%, N=70). The third most common team chair was *student conduct* (15.4%, N=54), followed by *vice president for student affairs (VPSA)* (12.5%, N=44). Some respondents also reported chairs from other departments, including *police/campus safety* (8.3%, N=29), *counseling* (6%, N=21), and *Title IX* (5.4%, N=19).

Deans of Students and non-clinical Case Managers as team chairs align well with the Standards, given their ability to share information, coordinate resources, and connect easily with all students. However, respondents who reported having a chair in a clinical or confidential role, such as counseling, do not align with the Standards. This misalignment occurs because the confidentiality requirements inherent in clinical roles restrict information sharing, which is necessary for the chair's duties.

TEAM MEMBERSHIP AND ORGANIZATION

To better understand team makeup and organization, the survey asked how teams categorize their membership, how many members the teams have, and who serves on the team. The survey defined the following categories of membership

- Core Circle Members: Attend every meeting and have a trained backup
- Inner Circle Members: Attend every meeting but do not have a trained backup
- Middle Circle Members: Consult the team and attend as needed
- Outer Circle Members: Do not attend meetings, trained to refer incidents, may be tasked to help with interventions

On average, respondents reported eight members of the team's core and inner circle. Most teams (86.3%, N=302) classify their membership into categories, of which 62.3% (N=218) reported having *core circle members,* 52% (N=182) reported having *inner circle members,* 37.4% reported *middle circle* membership, 32.6% (N=114) reported *outer circle* members, while 2.9% (N=218) reported *other.*

Survey respondents were asked to identify the departments represented as part of their core and inner membership (the members expected to attend every meeting). Most respondents reported the following departments as fixed team members: police/campus safety (86.3%, N=303), *counseling* (81%, N=284), *student conduct* (80.6%, N=283), *Dean of Students* (76.4%, N=268), disability/ADA services (62.7%, N=220), and *non-clinical Case Manager* (60.7%, N=213). Of all survey respondents, 60.4% (N=212) reported *housing and residence life* as part of the core and inner membership; however, when controlled for residential status, *Housing and Residence Life* representation on the core or inner circle of the team increased to 81.2% (N=99). This means that schools with a predominantly residential population tend to frequently have housing and residence life represented on their core or inner team. The table below presents the full results for core and inner team members.

Respondents were also asked to report on the departments or positions that may be asked to attend meetings as needed to represent a specific area, also known as middle circle members. The most common department reported as a middle circle member was *athletics* (40.8%, N=118), followed by *legal counsel* and *Title IX* (each at 33.6%, N=97), and *disability/ADA services* (33.2%, N=96). The table below presents the full results for middle circle members.

Core/Inner Circle Team Membership and Middle Circle Team Membership

Department	Core/Inner Circle Member	Middle Circle Member
Police/Campus Safety	86.3%, N=303	16.3%, N=47
Counseling	81%, N=284	12.5%, N=36
Student Conduct	80.6%, N=283	11.8%, N=34
Dean of Students	76.4%, N=268	11.1%, N=32
Disability/ADA Services	62.7%, N=220	11.1%, N=32
Non-Clinical Case Manager	60.7%, N=213	10.4%, N=30
Housing and Residence Life *When controlled for residential status	60.4% (N=212)/ *81.2%(N=99)	14.9%, N=43
Title IX	49%, N=172	33.6%, N=97
Academic Affairs	40.5%, N=142	31.5%, N=91
Academic Advising	39%, N=137	24.2%, N=70
Faculty Representative	28.8%, N=101	28.7%, N=83
Vice President of Student Affairs	27.9%, N=98	21.8%, N=63
Clinical Case Manager	17.7%, N=62	9.3%, N=27
Legal Counsel	17.4%, N=61	33.6%, N=97
Athletics	14.3%, N=50	40.8%, N=118
Human Resources	12.3%, N=43	27.7%, N=80
Student Activities	12.5%, N=44	24.6%, N=71
International Student Services	7.7%, N=27	31.3%, N=90
Admissions	6.3%, N=22	13.5%, N=39
Veterans and Military Services	4.3%, N=15	29.4%, N=85
Fraternity and Sorority Life	3.2%, N=11	17%, N=49
Graduate Student Representative	1.7%, N=6	3.1%, N=9
Undergraduate Student Representative	0.6%, N=2	2.8%, N=8

The survey data related to team membership largely aligns with the Standards, which emphasize that core/inner circle members should include police/campus safety, counseling, student conduct, and the

Dean of Students, while excluding graduate and undergraduate student representation. Most respondents reported the expected core departments—police/campus safety, counseling, student conduct, and Dean of Students—within their team, indicating strong adherence to these recommendations. The inclusion of additional departments, such as disability/ADA services (62.7%, N=220) and non-clinical Case Managers (60.7%, N=213), as core members suggests some variability in team composition, which may reflect institutional needs. Of note, 1.7% (N=6) and 0.6% (N=2) of teams reported that they include graduate and undergraduate student representatives in core membership, respectively. If these representatives are students rather than staff representatives of these populations, these respondents should consider adjusting their membership not to include students. Middle circle data also reflects appropriate representation, with specialized departments like athletics, international student services, veteran and military services, and legal counsel included as needed, which aligns with the Standard's guidance. Additionally, an average team size of eight aligns with the Standards, which outline that teams should have between five and ten members. Teams with less than five members likely do not have enough perspectives represented on the team, while teams larger than ten likely have too many members to facilitate an effective and efficient team meeting.

Respondents were asked if team members' job descriptions include their responsibilities as official members of the team, and 68.4% (N=240) reported that either some or all members' job descriptions do include their work on the team. The remaining 31.6% (N=111) of respondents reported that no team member's job description included team responsibilities.

Most respondents demonstrate alignment with the Standards by explicitly including team responsibilities in staff members' job descriptions. The inclusion of BIT duties underscores the importance and prioritization of this work, which is essential for both individual well-being and the overall safety of the community.

Team Training and Information Sharing

The survey asked respondents to report on how their team engages in professional development and training, as well as how they share information both within the team and with non-members.

TEAM TRAINING

Of the survey respondents, 80.8% (N=282) reported that their teams received some form of training related to their BIT work. Another 69.5% (N=226) of respondents reported some form of onboarding for new team members.

The survey asked how teams access training. Respondents reported receiving training in the following formats:

- Webinars (65.3%, N=181)
- NABITA certification courses (59.6%, N=165)

- Tabletop exercises (43.7%, N=121)
- Books and/or journals (32.1%, N=89)
- Annual NABITA Conference (29.6%, N=82)
- Other consultants or training groups (27.8%, N=77)
- NABITA Case Management Summit (27.1%, N=77)
- Higher Education Case Managers Association (HECMA) Conference (17%, N=47)
- TNG consultants (14.4%, N=40)
- Association of Threat Assessment Professionals (ATAP) training (9.4%, N=26)
- Sigma Threat Assessment Services (2.5%, N=7)
- Protect International Services (1.8%, N=5)
- Other (18.1%, N=50), including internal training opportunities and other professional organizations

The survey asked respondents to provide information on the content of the training the team received. Respondents reported receiving training on the following topics:

- Threat assessment foundational skills (68.6%, N=181)
- Suicide and self-harm protocols (57.7%, N=152)
- Case management practical skills (54.6%, N=144)
- Case management processes and philosophy (52.7%, N=139)
- Information sharing (FERPA/confidentiality/privacy) (49.6%, N=131)
- Team member best practices (48.1%, N=127)
- Recordkeeping and documentation (41.7%, N=110)
- De-escalation practices (40.5%, N=107)
- Cultural bias/microaggressions (36%, N=95)
- Threat assessment advanced skills (31.1%, N=82)
- Case management program implementation (28%, N=74)
- Team dynamics (18.9%, N=50)
- Social media concerning behavior (18.2%, N=48)
- Community education and marketing of the team (17.4%, N=46)
- Team leadership (14.8%, N=39)
- Annual report writing/assessment (14.4%, N=38)
- Classroom management (12.5%, N=33)
- Other (8.3%, N=22)

The data on training was promising, as it shows that most teams actively participate in both comprehensive team training and new member onboarding, using various training methods to address a broad range of pertinent topics. The most common barriers to training were reported as *budget*

(44.7%, N=146) and *time* (25.7%, N=84). Other barriers reported were *coordination/oversight* (14.1%, N=46) and *lack of awareness of training resources* (5.8%, N=19). Almost 10% of respondents (9.8%, N=32) chose *other*, and many cited multiple barriers, including those listed above.

INFORMATION SHARING

The survey asked respondents how teams share information both internally and externally and about the culture around intra-team communication.

Internal Information Sharing

Among survey respondents, 90.9% (N=299) indicated that team members share information among BIT members in a manner that promotes effective case discussions. Further, 83.99% (N=278) reported that supervisory or positional power within the team does not impede the team's ability to discuss cases candidly.

When asked how those with privileged relationships, such as mental health counselors, share information with the team as applicable under state law and ethical standards, 78.9% (N=258) of respondents reported that *they share information by speaking in hypotheticals, sharing general mental health expertise, and sharing more details only if a release of information is in place.* Unfortunately, another 8.9% (N=29) reported that the mental health employees *do not attend meetings at all*, 7.03% (N=23) *only share information on specific cases if a release is in place but provide no other guidance to the team*, and 5.2% (N=17) reported that mental health employees *do attend the meeting but do not share any information or participate in team discussions.*

Some counseling centers make use of an Expanded Information Consent (EIC), which students can choose to sign, allowing counselors greater latitude to share information (e.g., a student is receiving counseling services) with the team when the counselor determines sharing the information would be in the best interest of the client. When asked about EIC usage, 35.1% (N=115) of respondents reported that their counseling center uses an EIC, 29% (N=95) do not use one, and 36% (N=118) were unsure.

Regarding team members with privileged relationships, such as mental health counselors, the survey data revealed that most respondents reported that they comply with applicable state laws and ethical standards by sharing information hypothetically or with a release in place. This aligns with the Standards, which require mental health professionals to share information within legal and ethical boundaries. However, the data reveals some challenges, as 8.9% (N=29) reported that mental health counselors do not attend meetings, and 5.2% (N=17) indicated that counselors attend but do not share information, which could impede the team's ability to have holistic discussions.

External Information Sharing

When asked how the team shares information with other staff or faculty who are not on the team, most (86.2%, N=282) reported that *the team shares information [with non-BIT members] when there is a legitimate educational interest and a need to know the information.* Eleven percent (N=36) reported

that the team considers its information confidential and does not share it outside of the team, and 2.8% (N=9) reported *other*.

The data generally aligns with the Standards related to FERPA and information sharing within BITs. A significant majority of respondents reported that team members share information in a manner that promotes holistic case discussions, adhering to FERPA's guidelines of dismantling information silos and providing diverse perspectives. The 86.2% of respondents who stated that information is shared with those who have a legitimate educational interest is in alignment with FERPA's stipulations. However, the 11% who indicated that their teams keep information confidential and do not share it outside the team may be limiting cross-campus collaboration and misinterpreting information-sharing guidelines under FERPA.

Team Budget, Community Education and Marketing, Procedure Manual

Respondents were asked to report information about their team's standard operating budget, community education and marketing efforts, and use of a procedure manual.

TEAM BUDGET

Of the survey respondents, 24.6% (N=80) reported that they have a standard operating budget (exclusive of term-limited grant funding). Those who reported having a budget were asked follow-up questions related to their budget, including budget amount, source, and use.

The size of the team's operating budget (excluding salary/benefits) ranged from $0 to over $30,000. Respondents reported the following budget amounts:

- $0-$5,000 (25.3%, N=20)
- $5,001-$10,000 (11.4%, N=9)
- $10,001-$15,000 (11.4%, N=9)
- $15,001-$20,000 (11.4%, N=9)
- $20,001-$30,000 (0%, N=0)
- More than $30,000 (3.8%, N=3)
- Unsure (29.1%, N=23)

Survey respondents who reported having a budget were also asked about the source of their budget. The following sources were reported:

- Student affairs (59%, N=46)

- Academic affairs (10.3%, N=8)
- Case Management (9%, N=7)
- Student Conduct (9%, N=7)
- Police/Campus Safety (7.7%, N=6)
- Shared/pooled across multiple departments (7.7%, N=6)
- Counseling (5.1%, N=4)
- Housing and Residence Life (5.1%, N=4)
- Title IX (5.1%, N=4)
- Disability Support Services/ADA (5.1%, N=4)

Of those with a standard operating budget, 60.3% (N=47) reported that the team's budget is sufficient to meet the ongoing needs of the team and the community it serves. Respondents reported using the budget to support the following:

- Professional development (e.g., conference attendance, NABITA certification courses/training, webinars) (91.1%, N=72)
- Professional association membership (65.8%, N=52)
- Institutional community education (57%, N=45)
- Electronic recordkeeping system (45.6%, N=36)
- Consulting services (29.1%, N=23)
- Prevention efforts (e.g., basic needs resources, emergency funds, student programming) (29.1%, N=23)
- External assessment needs (e.g., violence risk assessments, psychological assessments) (25.3%, N=20)

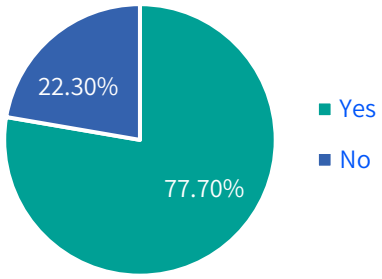
The Standards recommend that teams have a dedicated budget that adequately addresses the needs of both the team and the community. The data suggests that the majority of teams do not have a dedicated budget. BITs lacking a dedicated budget may experience challenges, as financial resources are essential for the effective functioning of these teams. A budget allows BITs to access necessary training, tools, and resources to respond appropriately to behavioral concerns, conduct thorough assessments, and provide interventions. Adequate funding is crucial for BITs to operate efficiently and in accordance with best practices.

COMMUNITY EDUCATION AND MARKETING

The survey asked respondents how they market the team and educate the institutional community about their processes and purpose. Most respondents (77.7%, N=255) reported that the team trains the institutional community on making appropriate referrals, and most respondents (82.6%, N=209) reported adapting their training to specific audiences. The most common type of training to the

community reported was *in-person* (89.8%, N=230), followed by *published materials* (62.5%, N=160), *online trainings* (46.9%, N=120), and *videos* (14.5%, N=37).

Community Training



Training Type	%	N
In-person	89.8%	230
Published materials	62.5%	160
Online training	46.9%	120
Videos	14.5%	37

Respondents who reported delivering training to the institutional community were asked to provide information on the specific audiences who received the training. Respondents who deliver training reported delivering training to the following audiences:

- Faculty (94.1%, N=239)
- Student affairs staff (84.7%, N=215)
- Academic advisors (73.2%, N=186)
- Residence life (62.2%, N=158)
- Police/campus safety (53.2%, N=135)
- Students (52%, N=132)
- Counseling (49.2%, N=125)
- Athletics (45.7%, N=116)
- International student services (36.6%, N=93)
- Fraternity and sorority life (17.3%, N=44)
- Parents (16.5%, N=42)
- Other (6.7%, N=17)

When asked about specific topics the team trains the community on, respondents who train their communities most often reported training them on *how to make a referral/report to the team* (98%, N=246) and *recognizing concerning behaviors* (88.5%, N=222). Other training topics reported included *bystander engagement/how to support an individual in distress* (57%, N143), *cultural competency related to BIT referrals/reports* (13.6%, N=34), *recognizing leakage* (11.2%, N=28), and *other* (3.6%, N=9).

All respondents were asked whether the team engages in marketing efforts to increase awareness of the team. A total of 54.1% (N=177) reported they do engage in marketing, and 43.7% (N=76) reported

that they *adapt these marketing efforts to specific audiences (e.g., students, faculty/staff, parents, individual departments, key stakeholders)*. Respondents who engage in marketing efforts reported using the following methods to market the team:

- Website (80.2%, N=142)
- Brochures or flyers (66.7%, N=118)
- Marketing at student orientation (49.7%, N=88)
- Email campaigns (39%, N=69)
- Exhibit booth/table (34.5% (N=61)
- Promotional items (e.g., stress balls, pens, magnets) (26.6%, N=47)
- Posters (25.4%, N=45)
- Social media (18.1%, N=32)
- Mobile app (7.9%, N=14)
- Videos (7.9%, N=14)
- Newspaper (1.7%, N=3)
- *Other (10.7%, N=19)* and 56.3% (N=98) do not.

Most respondents (80.3%, N=260) reported that the team *does not have a logo*, with only 19.6% (N=64) reporting that it *does.*

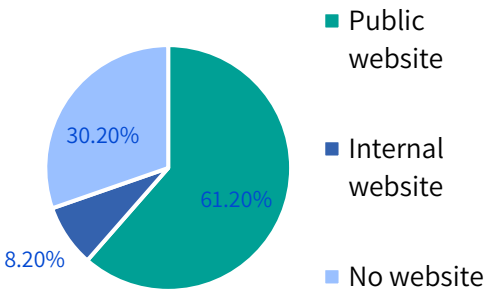
While many teams engage in community education and marketing efforts, only 12.7% (N=41) of respondents reported having a strategic education and marketing plan. This suggests that teams may engage in marketing and education efforts as needed or as opportunities arise rather than as part of an intentional strategic plan.

Of the survey respondents, 61.2% (N=202) reported that their team has a *publicly available website*, 8.2% (N=27) reported their team has a *website that is accessible internally via intranet*, and 30.2% (N=99) *do not have a website at all*.

Team Website

Respondents who reported having a website were asked what information was included on the website. Respondents reported the following information as included on team websites:

- Contact information for the team (83.7%, N=190)
- Online referral/reporting form link (78%, N=177)
- Examples of concerning behavior to refer/report to the team (72.7%, N=165)
- What happens after a referral/report is submitted (63.9%, N=145)
- Team mission statement (63%, N=143)
- Team membership list (54.2%, N=123)
- Privacy/confidentiality statement (33.5%, N=76)
- Team FAQ (32.6%, N=74)
- Team policies and/or protocols (30.4%, N=69)
- Classroom guide for faculty (26.9%, N=61)
- Risk rubric (8.4%, N=19)
- End-of-semester and/or annual reports (5.7%, N=13)
- Syllabus statement (3.1%, N=7)
- *Other* (4%, N=9)



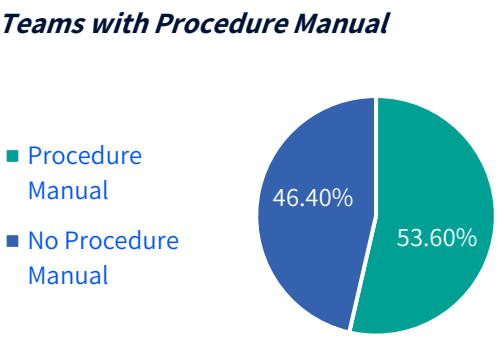
The data suggests mixed adherence to the Standards related to community and education. While the majority of teams engage in some form of training for their school communities, only about half of teams engage in marketing and awareness efforts. Training and educating the school community on the team and its functions is essential to fostering a safe and supportive environment. When the school community is well-informed about the role and functions of the team, it is better equipped to recognize and refer concerning behaviors early, enabling the team to intervene before issues escalate. Education helps to demystify the process, encouraging collaboration and trust between students, staff, and the team. By raising awareness, the BIT empowers the school community to actively contribute to the identification and support of individuals in need, ensuring that appropriate measures are taken to address potential threats or behavioral concerns. This collective effort not only enhances the team's effectiveness but also promotes a culture of care and prevention, where everyone plays a role in maintaining the well-being and safety of the school.

PROCEDURE MANUAL

Respondents were asked to report on whether they have a procedure manual to guide the work of the team. Notably, slightly more than half (53.6%, N=173) reported having a procedure manual. Of those who have a procedure manual and who provided additional details related to their procedure manual, 89.7% (N=157) reported that it is available to all team members.

The survey also asked respondents who reported having a procedure manual how often the manual is updated. Respondents reported the following schedules for updating the manual:

- Annually (60.8%, N=101)
- Every two years (16.3%, N=27)
- Other (22.9%, N=38). Some respondents mentioned that the manual is never reviewed/updated, while others noted that the procedure manual is new and has not yet needed review or that it is reviewed/updated "as needed" or "ad hoc."



This data related to procedure manuals identifies where many teams could make changes to align more with the Standards. Teams should have a written, formalized procedure manual that is accessible to all team members. The manual should provide clear guidance for team operations and be reviewed annually to ensure any necessary updates that may result from changes in team process, institutional policy, or applicable federal or state laws.

SECTION FOUR

Process Elements

An In-depth Analysis of How Teams Function

Process Elements

The survey asked respondents questions to assess their team's process. Process elements relate to *how* a team works through a case, including the procedures they follow to implement an objective, equitable, and effective response to referrals. The elements assessed in this section include referral receipt and review, meeting operations, risk assessment, interventions, case management, case review, and recordkeeping.

Referral Receipt and Review

Respondents were asked how they receive, review, and triage referrals.

REFERRAL RECEIPT

When asked how individuals make referrals to the team, nearly all respondents (93.8%, N=301) indicated that they use an *online referral/reporting form.* More than half of respondents also indicated that they receive referrals *emailed directly to the team* (64.2%, N=206), through a *phone call to the chair or member of the team* (60.8%, N=195), or a *face-to-face conversation with the chair or member of the team* (52.7%, N= 169). Very few (4.1%, N=13) respondents reported using a *mobile app* to receive referrals.

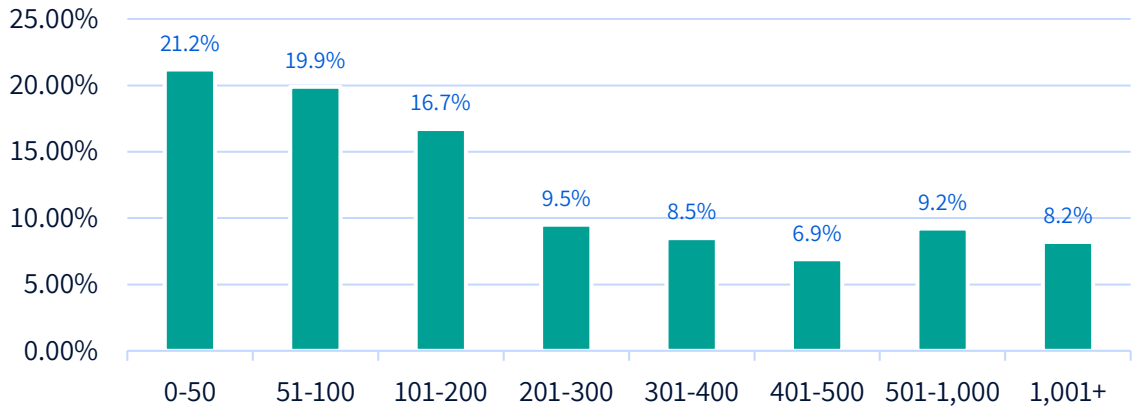
Receiving referrals through an online form allows teams to quickly disseminate information to team members, often via automatic routing rules, and store all case information in one place. The Standards outline the best practice of storing all referrals in an electronic record using an electronic form. This means that even when referral information is received in some other manner (e.g., face-to-face conversation), the team member who received the information should complete the referral form to ensure it is stored in the correct manner.

Respondents tended to allow anonymous referrals when receiving referrals, with 81% (N=260) indicating they do and 19% (N=61) indicating they do not. While teams should train referrers on the disadvantages of anonymous referrals and address the referrers' underlying concerns about identifying themselves in a referral, it is often better for a team to receive information about an individual who may be struggling, even if it is provided anonymously.

Respondents were also asked how many referrals they receive per year. Most commonly, survey respondents indicated receiving *0-50 referrals/reports* (21.1%, N=67) and *51-100 referrals/reports*

(19.9%, N=63), with fewer respondents reporting higher volumes of referrals. The full results related to the number of referrals per year are presented in the graph below.

Number of Referrals Per Year



When controlled for the size of the population served, the data showed that teams serving smaller populations tended to report receiving low numbers of referrals per year, while teams serving larger populations tended to receive high numbers of referrals per year. For example, 89.7% of respondents whose teams serve populations larger than 25,000 individuals reported receiving more than 500 referrals per year, compared to only 30% of respondents whose teams serve 7,000 or fewer individuals.

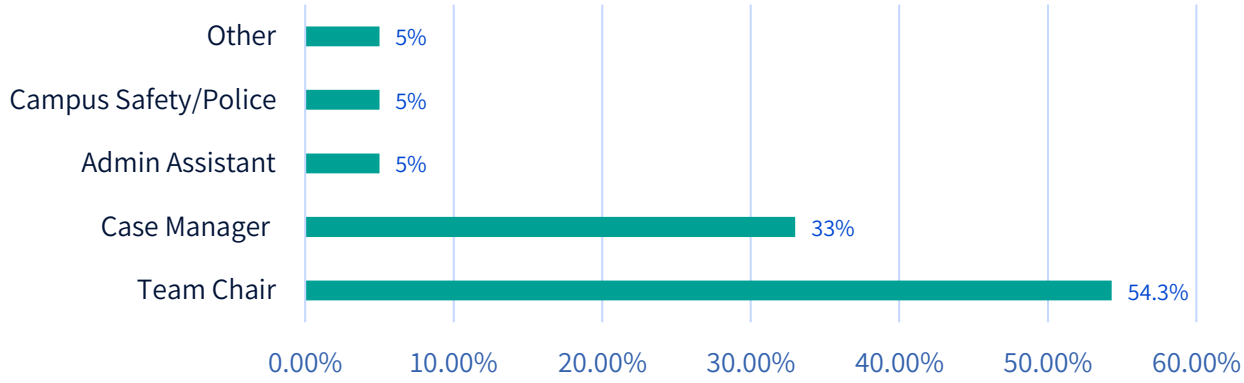
REFERRAL REVIEW

Survey respondents were asked how they review and triage the referrals, and 87.2% (N=298) of respondents reported they have a *designated staff member responsible for reviewing and triaging team referrals/reports for urgent needs each workday*. Respondents who reported having a designated staff member who reviews and triages referrals or reports identified the following staff members as responsible for this task:

- *Team Chair* (54.3%, N=152)
- Case Manager (who is not the team chair) (33.9%, N=95)
- Administrative assistant/office manager (5%, N=14)
- Campus safety/police (5%, N=14)
- *Other* (5%, N=14) responses tended to indicate a diffusion of referral review responsibilities (e.g., “all team members receive a copy of the referral and are expected to review it”) rather than assigning the task to a designated staff member

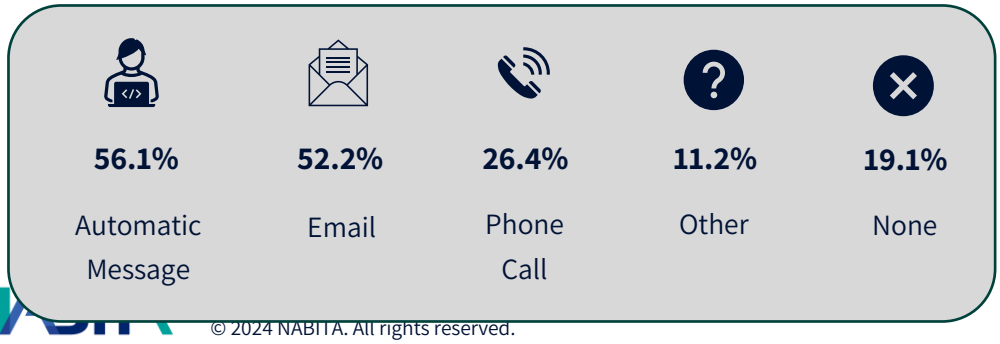
Most respondents demonstrated alignment with the Standards by having a designated staff member responsible for reviewing and triaging referrals each workday. It is important that teams designate a staff member so that referrals with more urgent needs can be addressed in a timely, safe manner. Diffusing this responsibility to all team members who may receive copies of the referrals risks everyone assuming someone else is completing the task. While the data shows that the team chair most commonly performs this task, other staff members can be trained to screen referrals for urgent needs. The data demonstrates that some respondents train administrative assistants or office managers to perform this task. These staff members may be a good resource for team chairs who do not have time to dedicate to screening referrals daily.

Who Reviews and Triages Referrals Each Workday



Respondents also provided information related to communication with the referral source, including gathering more information from them and providing updates. Nearly all (92.8%, N=298) respondents indicated that they have a process for *getting additional information from referral sources.* When asked to describe how they provide updates to referral sources, 56.1% (N=176) reported using an *automatic message once a referral is received*, 52.2% (N=164) reported sending an *email with general information on a case*, 26.4% (N=83) reported having a *phone call,* and 11.2% (N=35) reported *other*. An additional 19.1% (N=60) reported that they do not provide updates to referral sources. It is encouraging that nearly all respondents have a process for getting additional information from referral sources, and many follow up with referral sources to provide updates. Gathering additional information and providing updates builds trust in the team and can encourage future referrals.

How Updates are Provided



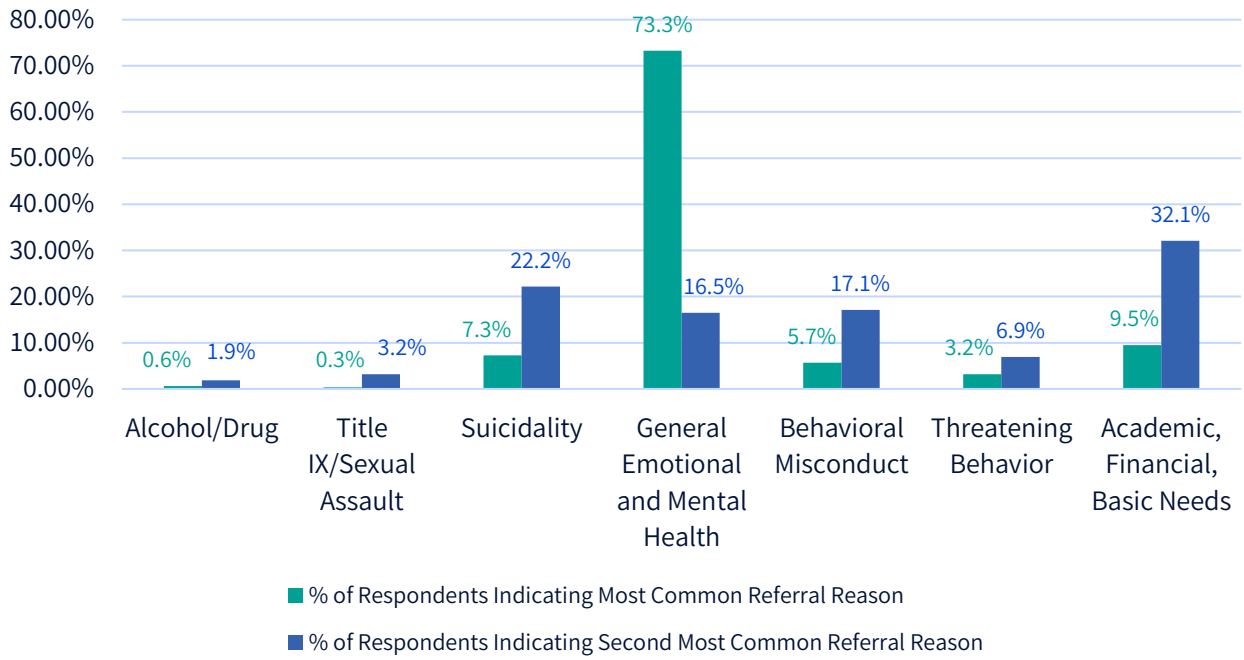
The survey also asked respondents to report on their most common reasons for a referral/report to the team. When asked to report their most common reason for a referral, respondents indicated the following:

- General emotional and mental health concerns (e.g., anxiousness, interpersonal concerns, social difficulties, disconnection from reality, depressed mood, and difficult life events) (73%, N=231)
- *Academic, financial, basic needs, etc*. (9.5%, N=30)
- *Suicidal ideation/gestures/attempt* (7.3%, N=23)
- Behavioral misconduct (e.g., vandalism, classroom disruption) (5.7%, N=18)
- Threatening behavior (e.g., threats of harm to others) (3.2%, N=10)
- Alcohol/drug concerns (0.6%, N=2)
- Title IX and/or sexual assault (0.3%, N=1)

The survey also asked respondents to report their second most common referral/report reason. Respondents reported the following as the second most common referral reason:

- *Academic, financial, basic needs, etc*. (32.1%, N=101)
- Suicidal ideation/gestures/attempt (22.2%, N=70)
- *Behavioral misconduct* (17.1%, N=54)
- General emotional and mental health concerns (16.5%, N=52)
- Threatening behavior (7%, M=22)
- Title IX and/or sexual assault (3.2%, N=10)
- Alcohol/drug concerns (1.9%, N=6)

Most Common Referral Reasons



This data is encouraging as it demonstrates that teams most often get referrals for low-risk behavior and can focus on preventing a crisis before it emerges. Such an approach supports the overall prevention and threat assessment work of teams. Teams who most often receive referrals for high-risk behavior (e.g., suicidality, behavioral misconduct, or threatening behavior) should work to educate their referral sources about how to recognize and refer any earlier indicators of concern (e.g., general emotional health difficulties, academic concerns, financial needs).

Meeting Operations

Meeting operations elements include how teams facilitate their meetings, including how members prepare, the use of an agenda, meeting frequency, and case discussions.

MEETING PREPAREDNESS

To assess how team members prepare for meetings, survey respondents answered questions on the use of meeting agendas and team members' pre-meeting work. Most survey respondents (79.9%, N=251) reported using an *agenda to identify the individuals to discuss at the team meeting.* Of those who use an agenda, 89.5% (N=229) reported *distributing or making it available to team members in advance of the meeting.* Additionally, of those respondents who reported using an agenda, 72.3% (N=183) reported that their *team members prepare for the meeting by reviewing the agenda and gathering information from their area in advance of the meeting.* The table below presents items that are commonly included in respondents' team agendas.

Common Agenda Items

Agenda Item	%	N
Referred individual's name, identification number, or case number	96%	239
Classification (first-year, sophomore, faculty, staff)	39%	97
Date of referral/report	62.7%	156
Issue of concern	71.5%	178
Residential status	36.6%	91
Referral source	42.6%	106
Other (common answers: risk rating, team member assigned)	13.7%	34

In addition to the use of an agenda, respondents were asked to describe how their team members familiarize themselves with the referrals that will be discussed at the team meeting. While most (52.7%, N=165) respondents reported that their team members prepare for the meeting *by reading the referrals/reports in advance of the team meeting*, approximately a quarter (26.8%, N=84) reported that their team members *do not read the referrals/reports in advance of the meeting and instead learn about the information for the first time in the meeting.* Some respondents (16.6%, N=52) also reported that their team members familiarize themselves with the *referrals/reports by reading them in real/live time as they are received.*

Preparing for team meetings is a key function of a team's success. The Standards outline how to facilitate member preparedness by providing access to referrals and case information and distributing meeting agendas. Additionally, the Standards encourage team members to dedicate time to preparing for the meeting. As demonstrated by the data, many teams have seen success in this practice and adopted it into their process. Team chairs (or designees) should prepare an agenda and make it available to team members in advance of the meeting. At a minimum, the agenda should indicate who will be discussed at the upcoming meeting; however, as shown in the data, many teams include additional details, such as what prompted the individual to be referred to and who referred them. Having this information in advance of the team meeting allows the team members to prepare by reviewing the referral and gathering the appropriate information from their area related to the individuals that will be discussed. Team members' preparedness makes case discussions more efficient and better informed.

MEETING FREQUENCY

The survey asked respondents how often their teams meet and what case discussions in team meetings include. Respondents reported the following meeting frequency for their team:

- *Weekly* (64.6%, N=204)
- Every other week (24.1%, N=76)
- *As needed* (10.4%, N=33)
- Once a month (7.9%, N=25)
- Once a semester (0.6%, N=2)
- Once a quarter (0.3%, N=1)

In addition to the regularly scheduled meetings, 94.6% (N=299) reported they *have the ability to call emergency meetings to discuss urgent issues.*

The 88.7% of teams that meet weekly or every other week demonstrate alignment with the Standards. Respondents who report meeting less frequently should consider increasing the meeting frequency to better enhance team communication and effectiveness. Additionally, teams should have the ability to call emergency meetings, even if these meetings are conducted via tele/video conferencing, to discuss urgent or imminent issues that need more immediate attention.

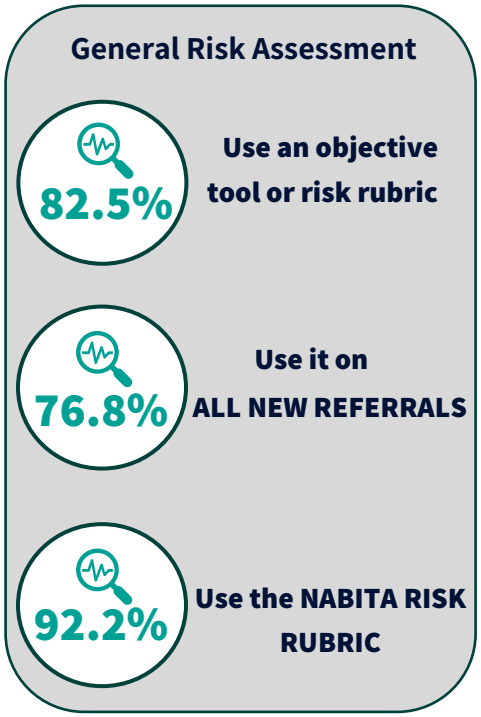
Risk Assessment

The survey asked questions to assess the use of objective risk assessment processes, including general risk assessment and advanced assessments, such as psychological, threat, and violence risk assessments.

GENERAL RISK ASSESSMENT

Survey respondents reported how their teams engage in general risk assessment, and 82.5% (N=260) reported that they use an *objective measurement tool or risk rubric,* while 26.7% (N=84) reported *subjectively/without a formal risk assessment tool.*

Survey respondents who reported objectively assessing risk using a rubric were asked follow-up questions about their usage. Of those who reported assessing risk objectively, 57.5% (N=134) reported using an objective rubric *for every new referral/report and every time a case is discussed,* and 19.3% (N=45) reported they use the objective rubric *for every new referral/report but not for case updates or discussions*. Nearly a quarter of respondents (20%, N=47) reported that they use the objective tool *for certain cases under specific circumstances,* and 3% (N=7) indicated *other.*



To better understand the 20% of respondents who use an objective rubric only in certain cases under specific circumstances, we asked these respondents to define the circumstances under which they would apply the rubric. Of these respondents, most (57.8%, N=26) reported applying it to *only more serious or time-consuming cases*, 2.2% (N=1) applied it to *only threat-to-self cases*, 15.6% (N=7) applied it to *only threat-to-others cases*, and 24% (N=11) indicated *other*. When reviewing the *other* responses, many respondents described that they apply the rubric on both threat-to-self and threat-to-others cases.

Respondents who reported objectively assessing risk were also asked to describe how they document the risk rating in the case record. Of those who objectively assess risk, 69.6% (N=160) reported they *document all risk ratings for every case,* while 23% (N=53) *document the risk ratings in some cases.* Another 7.4% (N=17) of respondents reported they *do not document the risk rating in any case record.*

Using an objective tool or risk rubric, applying it to all referrals and case discussions, and documenting the risk rating is an important practice for teams. By objectively measuring risk, teams mitigate bias, reduce the likelihood they will over- or under-react to a case, and create a shared language for case discussions. The use of an objective tool or risk rubric can help streamline team meetings and decisions related to interventions by providing members with a consistent, objective measure for interpreting risk and taking actions to reduce the risk. Teams should select a generalized risk rubric, like the NABITA Risk Rubric, to triage the level of concern associated with all referrals to the team—regardless of how serious or minor the concern may seem. When teams choose to apply a rubric in *some* cases, they risk subjectively deciding which cases warrant the use of an objective assessment tool, thus undermining the objective nature of the process.

Most commonly (92.2%, N=214), teams who assess risk objectively use the NABITA Risk Rubric to assess the risk of the cases referred to the team. Teams who use the NABITA Risk Rubric were asked to provide information about the level of risk assigned to cases. When asked to report on the most common risk rating assigned to cases, respondents reported the following:

- *Mild* (46.3%, N=100)
- *Moderate* (46.3%, N=100)
- *Elevated* (6.9%, N=15)
- *Critical* (0.5%, N=1)

The survey also asked respondents who objectively assess risk using the NABITA Risk Rubric to report on the least common risk rating. Respondents reported the following as the least common risk rating:

- *Critical* (85.3% (N=185)
- *Mild* (12% (N=26)
- *Moderate* (1.4%, N=3)
- *Elevated* (1.4%, N=3)

This data further supports that most teams receive referrals predominantly for low-risk concerns and proactively address concerns before they escalate to a crisis or threat.

ADVANCED RISK ASSESSMENT

In addition to providing information about their general risk assessment practices, the survey asked respondents to provide information about their use of advanced risk assessments, including psychological, threat, and violence risk assessments. Survey respondents indicated whether their teams use psychological, threat, or violence risk assessments (individualized interviews to assess psychological functioning, credibility or actionability of a threat, and/or likelihood of engaging in violence based on risk and protective factors), and 68% (N=214) indicated that *yes, individuals may be asked or required to participate in an interview further assess risk based on contents of referral to the BIT.*

Respondents who reported that they use advanced risk assessments were asked a series of follow-up questions about how they implement these assessments. Definitions were provided for each assessment type to assist respondents in asking questions about advanced assessment practices. The assessments were defined as follows:

- **Threat Assessment:** Assessments that establish immediate safety by assessing the credibility or actionability of a specific threat of harm to self or others (e.g., welfare checks, mobile crisis units, law enforcement checks)
- **Psychological Assessment:** Assessments conducted by a clinical provider evaluating an individual's mental health and behavioral functioning
- **Violence Risk Assessment:** Non-clinical, objective assessments designed to better understand the risk and protective elements that influence an individual's likelihood of violence or harm to others

Threat Assessments

Of the respondents who indicated that they use threat, psychological, or violence risk assessments, 85% (N=265) report that they coordinate *threat assessments* when the referral indicates immediate concern for safety. It is important that teams have the ability to coordinate threat assessments when there is information that individuals pose a potentially immediate concern for harm to self or harm to others. Coordinating threat assessments often includes working with local law enforcement or mobile crisis units so that they can contact the individual and determine if they meet the criteria for hospitalization or arrest. Without the ability to coordinate these types of assessments, teams will struggle to establish immediate safety.

Psychological and Violence Risk Assessments

While threat assessments establish immediate safety, teams often need to gather additional information about the broader risk an individual may pose. Psychological assessments and violence risk assessments provide an opportunity to do this. Of the respondents who indicated that they use threat, psychological, or violence risk assessments, 27.7% (N=86) reported that they *require individuals to engage in psychological assessments*, and 37.3% (N=114) reported that they *require individuals to engage in violence risk assessments.*

Psychological Assessments

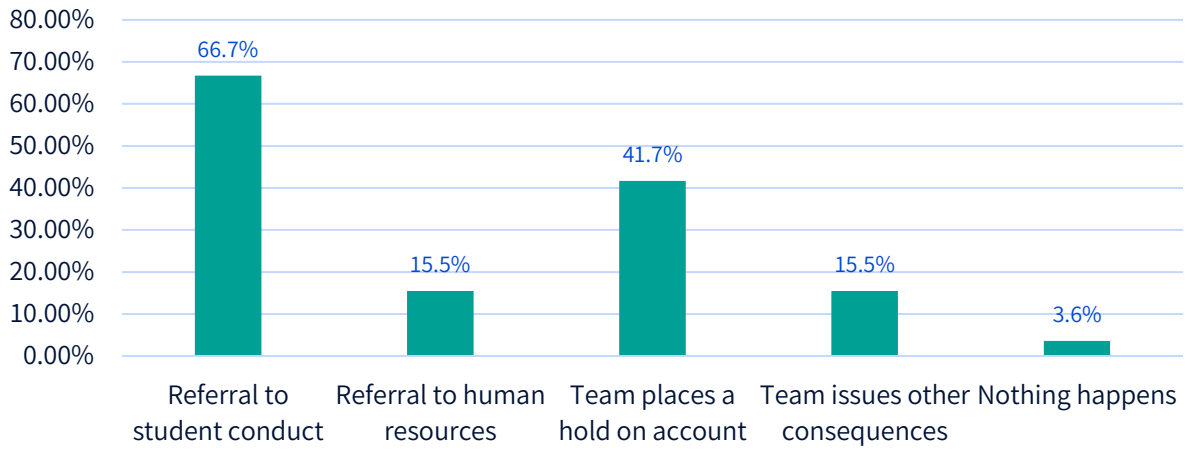
Most commonly, respondents who require individuals to engage in psychological assessments do so by using an objective risk rubric to determine when *the team needs to understand the risk an individual poses to themselves because of suicidal ideation, self-harm, disconnection from reality, or other mental health condition* (62.4%, N=53), when *the team needs to understand the risk an individual poses to others and how to mitigate it* (55.3%, N=47), and when *the team needs to gain a deeper understanding of an individual's general functioning, emotional health, or well-being based on the riskiness of behaviors* (44.7%, N=38). Less commonly, respondents reported deciding to require individuals to engage in a psychological assessment on a case-by-case basis without an objective evaluation using a risk rubric when *the team needs to understand the risk an individual poses to themselves because of suicidal ideation, self-harm, disconnection from reality, or other mental health condition* (27.1%, N=23), when *the team needs to understand the risk an individual poses to others and how to mitigate it* (24.7%, N=21), and when *the team needs to gain a deeper understanding of an individual's general functioning, emotional health, or well-being based on the riskiness of behaviors* (16.5%, N=14).

Reasons for Psychological Assessment Requirement

Reason	As determined by Risk Rubric	As determined without Risk Rubric
The team needs to understand the risk an individual poses to themselves because of suicidal ideation, self-harm, disconnection from reality, or other mental health condition	62.4%, N=53	27.1%, N=23
The team needs to understand the risk an individual poses to others and how to mitigate it	55.3%, N=47	24.7%, N=21
The team needs to gain a deeper understanding of an individual's general functioning, emotional health, or well-being based on the riskiness of behaviors	44.7%, N=38	16.5%, N=14

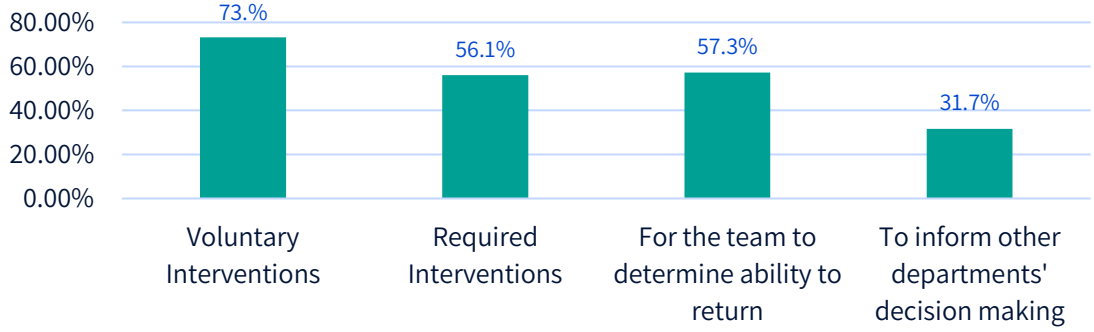
Respondents were asked to provide additional information about what happens when individuals do not comply with the requirement to participate in the psychological assessment, how the results of the assessment are used, and who conducts the assessment. Most respondents reported that when an individual does not comply with the requirement to participate in a psychological assessment, they send a *referral to student conduct* (students) (66.7%, N=56). Additionally, 41.7% (N=35) reported that *the team places a registration hold on the student's account*, 15.5% (N=13), makes a *referral to human resources (faculty/staff/employee),* 15.5% (N=13) *issues other consequences,* and 3.6% (N=3) reported *nothing happens.* An additional 20.2% (N=17) selected *other.* A review of the other responses revealed various restrictions or separations when an individual does not comply.

Non-compliance with Psychological Assessments



Respondents most commonly use the results of psychological assessments *to determine appropriate interventions offered by the team that are* ***voluntary*** *to the individual* (73.2%, N=60). Many respondents also use the results *to determine* ***required*** *interventions or ongoing actions issued by the team* (56.1%, N=46) or *for the team to determine the individual's* ***ability*** *to return to campus following hospitalization, voluntary leave, or other* removal (57.3%, N=47). An additional 31.7% (N=26) use the results *to help inform student conduct, Title IX, or other offices in their decision-making.*

How Results of Psychological Assessment Are Used



When asked who conducts the psychological assessments, most respondents reported *in-house clinicians* (59.3%, N=48), while 44.4% (N=36) reported *external clinicians paid by the institution* and 33.3% (N=27) reported *external clinicians paid for by the individual being assessed/parent/guardian.* An additional 11% (N=9) indicated *other.*

Violence Risk Assessments

Most commonly, respondents who require individuals to engage in violence risk assessments do this by using an objective risk rubric to determine when *the team needs to understand the risk an individual poses to others and how to mitigate it* (83.8%, N=93), *the team needs to understand the risk an individual poses to themselves because of suicidal ideation, self-harm, disconnection from reality, or other mental health condition* (52.3%, N=58), and when *the team needs to gain a deeper understanding of an individual's general functioning, emotional health, or well-being based on the riskiness of behaviors* (46.9%, N=52). Less commonly, respondents reported deciding to require individuals to engage in a violence risk assessment on a case-by-case basis without an objective evaluation using a risk rubric when *the team needs to understand the risk an individual poses to others and how to mitigate it* (17.1%, N=19), when *the team needs to understand the risk an individual poses to themselves because of suicidal ideation, self-harm, disconnection from reality, or other mental health condition* (12.6%, N=14), and when *the team needs to gain a deeper understanding of an individual's general functioning, emotional health, or well-being based on the riskiness of behaviors* (12.6%, N=14).

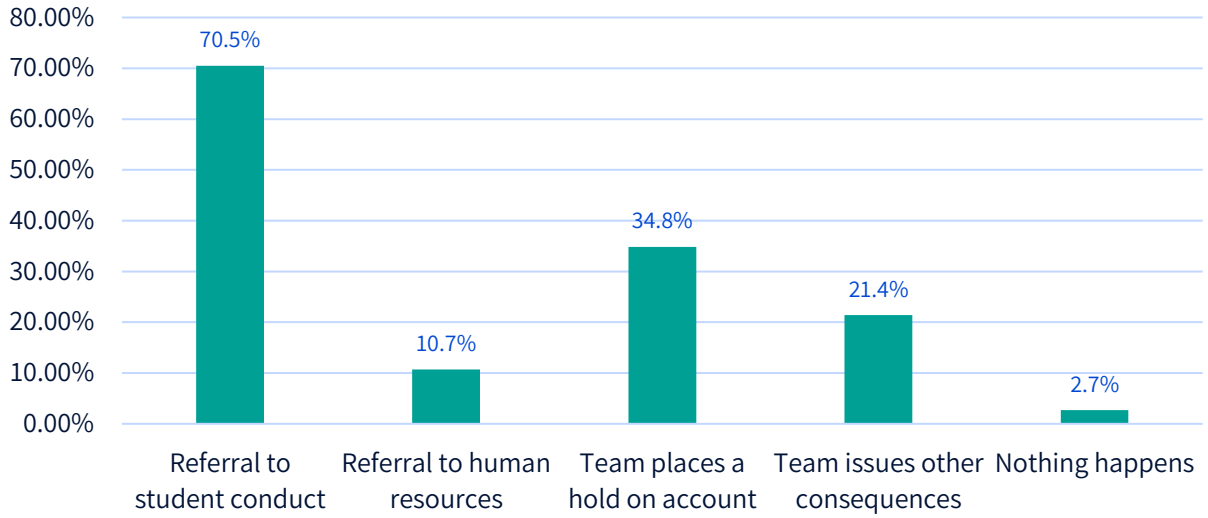
Reasons for Violence Risk Assessment Requirement

Reason	As determined by Risk Rubric	As determined without Risk Rubric
The team needs to understand the risk an individual poses to others and how to mitigate it	83.8%, N=93	17.1%, N=19
The team needs to understand the risk an individual poses to themselves because of suicidal ideation, self-harm, disconnection from reality, or other mental health condition	52.3%, N=58	12.6%, N=14
The team needs to gain a deeper understanding of an individual's general functioning, emotional health, or well-being based on the riskiness of behaviors	46.9%, N=52	12.6%, N=14

Respondents were asked to provide additional information about what happens when individuals do not comply with the requirement to participate in the violence risk assessment, how the results of the assessment are used, and who conducts the assessment. Most respondents reported that when an individual does not comply with the requirement to participate in a violence risk assessment, they

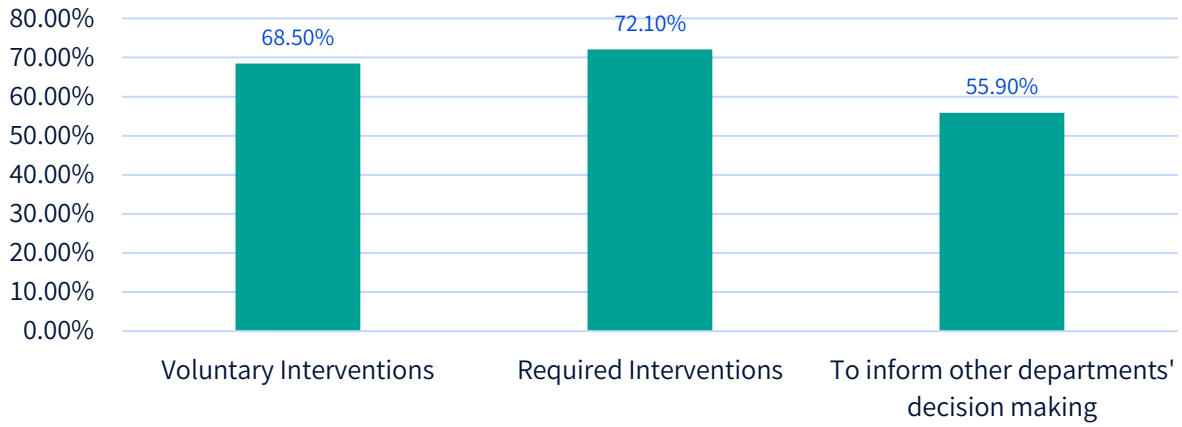
send a *referral to student conduct* (students) (70.5%, N=79). Additionally, 34.8% (N=39) reported *the team placed a registration hold on the student's account*, 21.4% (N=24) reported *the team issued other consequences,* 10.7% (N=12) made a *referral to human resources (faculty/staff/employee),* and 2.7% (N=3) reported *nothing happened.* An additional 17% (N=19) selected *other.* A review of the other responses revealed that respondents had not encountered non-compliance and, therefore, do not have a process, or various restrictions or separations occur when an individual does not comply.

Non-compliance with Violence Risk Assessments



Respondents most commonly use the results of violence risk assessments *to determine **required** interventions or ongoing actions issued by the team* (72.1%, N=80). Many respondents also use the results *to determine appropriate interventions offered by the team that are **voluntary** to the individual* (68.5%, N=76) or *to help inform student conduct, Title IX, or other offices in their decision-making* (55.9%, N=62).

How Results of Psychological Assessment Are Used



When asked who conducts the violence risk assessments, most respondents reported using *in-house staff or team members* (91.2%, N=103). Some respondents reported using an *external assessor paid for by the institution* (15.9%, N=18) or an *external assessor paid for by the individual being assessed/parent/guardian* (8.9%, N=10). When asked whether the individual who conducts the violence risk assessment is trained in a standardized, objective violence risk assessment tool (e.g. SIVRA-35, WAVR-21, HCR-20), 89.4% (N=101) reported *the individual is trained and uses a standardized tool to conduct the interview and assess the risk*, 1.8% (N=2) reported the *individual is not trained and conducts a generalized interview without a standardized tool,* and 8.9% (N=10) were *unsure*.

It is important that teams base their decision to require any type of assessment on an initial, general assessment of risk. The NABITA Risk Rubric is a valuable tool for determining whether an assessment is required, as it helps teams engage in objective and consistent decision-making. When an objective, generalized risk assessment tool, such as the NABITA Risk Rubric, is applied to all cases, teams can use the risk rating to determine whether further assessment is necessary. For example, when cases score at either Elevated or Critical (the top two levels of risk on the NABITA Risk Rubric), further assessment is warranted to better understand the risk. In this way, teams engage in a decision-making process that is consistent and standardized based on risk rather than on speculation or assumption.

When choosing what type of assessment to require, teams should carefully consider whether a psychological assessment is the appropriate option. Psychological assessments evaluate an individual's mental health functioning and often produce a diagnosis and treatment plan. Therefore, psychological assessments are most appropriate when the team wants to know how the student is functioning related to a mental illness and what types of treatment would be most appropriate. Psychological assessments are often not helpful in understanding what type of risk an individual poses to others and what interventions would mitigate the risk, as having a mental condition (what a psychological assessment assesses for) is not synonymous with posing a risk to others. When the team wants to better understand what type of risk an individual poses to others, the appropriate assessment would be a violence risk assessment.

If the team requires an assessment and the individual chooses not to comply, the team has reached the limit of its authority and should refer the case to the appropriate office (student conduct for students, human resources for employees) for further action. In most cases, the appropriate action would be to engage the process for a "failure to comply" charge and issue a requirement to engage in the assessment as a sanction for failing to comply. The BIT should not issue consequences to individuals who do not attend the assessment, as this exceeds the BIT's scope and likely denies the individual due process or a fundamentally fair process. Additionally, placing a hold on a student's registration is not a recommended practice as it may take too long to result in any action by the student. Teams should issue a requirement to attend an assessment when information is urgently needed related to the safety of the individual or the community. A registration hold may take months to have any impact on the individual, thus failing to address the urgency of the situation.

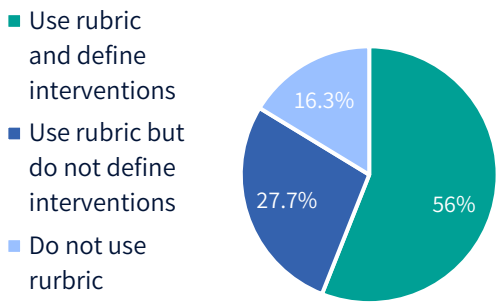
Whether the team chooses a psychological or a violence risk assessment, the results of the assessment should not be used for the team to require the individual to comply with ongoing interventions or to determine whether the student is ready to return to campus following hospitalization, voluntary leave, or other removal. Such actions are beyond the BIT's scope, as they require due process and move beyond the supportive, collaborative nature of the BIT's work. The assessment results can inform the procedures and determinations of other offices that may require individuals to engage in actions (e.g., student conduct, human resources, Title IX) and can guide voluntary interventions from the BIT.

Interventions

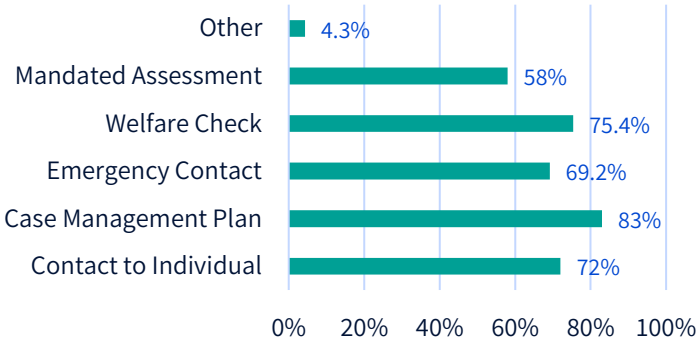
The survey collected information on how respondents describe their team's use of interventions. Specifically, respondents provided information on how the team determines the appropriate intervention and what type of involvement the team has in determining interim actions, returns from hospitalizations, and other required actions.

To better understand how respondents define and determine interventions, the survey asked whether interventions are available or appropriate and how the rubric guides interventions. Of the survey respondents, 56% (N=168) reported they *use a rubric to assess risk, and there are defined interventions available or appropriate at each level of risk,* while 27.7% (N=83) reported they do *use a rubric but do not have interventions defined at each risk level*. Another 16.3% (N=49) reported they *do not use a rubric.* Related to how risk assessment guides interventions, respondents reported that they use risk ratings to guide the following: *development or adjustment of a case management plan* (83%, N=229), *whether and how to conduct a welfare check* (75.4%, N=208), *whether and how to contact the individual* (72%, N=199), *whether to connect with the individual's emergency contact* (69.2%, N=191), *whether to mandate an assessment (psychological, threat, or violence risk)* (58%, N=160), and *other* (4.3%, N=12). Individuals who selected *other* tended to describe a practice of not using a risk rubric or not using the risk rating to guide any decision-making.

How Risk Rubric Informs Interventions



What the Risk Assessment Guides

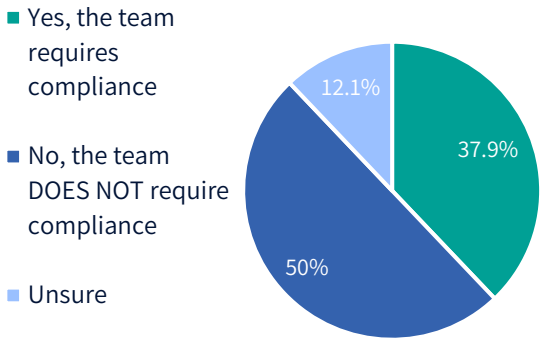


Teams are more likely to deploy appropriate interventions when guided by an objective risk assessment. Teams should consider using an objective rubric for all cases and defining available and appropriate interventions for each level of risk associated with the rubric. Further, teams should use the risk rating to guide decision-making related to implementing mandated assessments, conducting welfare checks, contacting emergency contacts, developing case management plans, and determining the appropriate method and frequency for contacting the referred individuals. When an objective risk assessment does not guide these decisions, they may be guided by speculation, assumption, or bias.

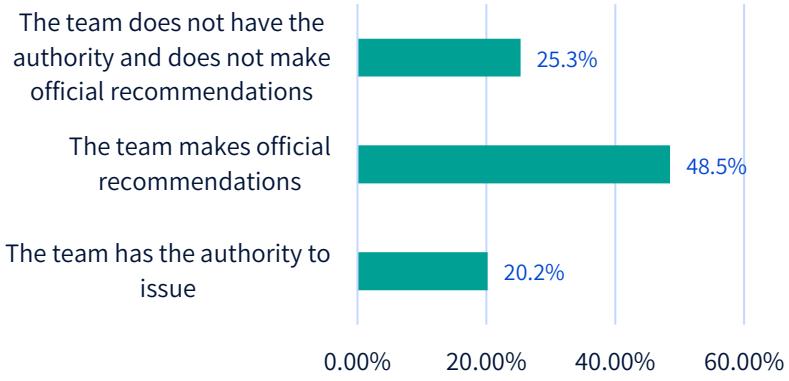
The survey also asked respondents about their team's role in decision-making for implementing required interventions or requiring compliance from the referred individual. When asked whether their team requires ongoing compliance with interventions (e.g., ongoing meetings with a Case Manager or counselor, required to comply with treatment recommendations or medications), most respondents (50%, N=149) reported that their team does not engage in this practice, while 37.9% (N=113) reported they do. Another 12.1% (N=36) were unsure. Interventions and actions from the BIT should be voluntary. Teams who require ongoing compliance with interventions should reconsider this practice and instead leverage BIT members or Case Managers to engage with students in a collaborative, solution-focused way to motivate voluntary engagement in resources or interventions that could be helpful.

Regarding team interventions and actions, the respondents also described their team's involvement in interim suspension, administrative leave, or other temporary requirements/restrictions. Of the survey respondents, 20.2% (N=60) reported that their team *has the authority to issue an interim suspension, administrative leave, or other temporary requirement/restriction,* and 48.5% (N=144) reported that their team *does not have the authority to issue an interim suspension, administrative leave, or other temporary requirement/restriction but they make official recommendations to those with authority to engage in such action*. An additional 25.3% (N=75) reported that their team *does not have the authority to issue an interim suspension, administrative leave, or other temporary requirement/restriction as any decision lies in other areas, and they do not make official recommendations to these areas*.

Required Compliance with Interventions



Role in Removal Decisions



The Standards outline that BITs should not have the authority to issue an interim suspension, administrative leave, or other temporary requirement/restriction. While certain team members or departments represented on the BIT may have the authority to make these decisions given their role at the institution, the decision should be made by that staff member or department within the scope of their role and not by the BIT itself. For example, a Dean of Students or the conduct office may have the authority to issue an interim suspension, but they should make that decision as outlined within the scope of the appropriate process, rather than through the BIT as the decision-making entity. Similarly, the team should avoid making formal recommendations to the offices that do have the authority to make the decisions, as formal recommendations imply a level of oversight or influence from the BIT on existing procedures that go beyond the BIT's authority. Instead, BITs should provide information and updates to these departments that allow them to make the most informed decisions available. While the distinction between providing information and making formal recommendations is nuanced, it is an important distinction to make to ensure that procedures and processes related to interim suspensions, administrative leaves, or other temporary requirements/restrictions remain fair, unbiased, and rooted in due process/fundamentally fair processes.

Case Management

The survey asked respondents how their teams assign cases to staff members for follow-up and what type of access the team has to a designated Case Manager.

CASE MANAGEMENT AS TEAM PROCESS

To understand how respondents' teams manage cases as part of their team activities, the survey asked if teams assign individuals to coordinate follow-up on cases and interventions. Of the survey respondents, 89.5% (N=265) reported they do, 8.1% (N=24) reported they do not, and 2.4% (N=7) were unsure. It is important for teams to engage in the process of assigning cases to individual staff members who coordinate the follow-up. This helps increase the likelihood of successful interventions and connection with the referred individual. Ultimately, it allows the team to address the presenting issues.

Those who reported assigning cases to individuals for follow-up were asked how they decide who serves as Case Manager on a case. Most respondents, even those with a designated Case Manager, reported that the expertise of available team members informs their decision, whether someone has a relationship with the individual of concern, and other individualized factors. Specifically, respondents reported assigning cases as follows:

- 45.1% (N=125) reported having a Case Manager. They are assigned some cases, but the team also assigns cases based on the expertise of team members, relationship with the individual of concern, and other factors
- 22.7% (N=63) reported that they do not have a Case Manager. They assign cases to team members or other staff based on the expertise of the team members, their relationship with the individual of concern, and other factors
- 21.3% (N=59) reported that they have a Case Manager who is assigned to all cases
- 10.8% (N=30) indicated *other*

While having a Case Manager allows for a well-trained expert to be available to the team, it is recommended that not all cases go exclusively to this staff member for follow-up. Not only does this practice contribute to potential burnout for the Case Manager, but it does not leverage the multidisciplinary nature of BITs and consider whether other staff may have expertise or a relationship with the individual that would make them better suited to coordinate follow-up and interventions.

CASE MANAGEMENT AS A POSITION

To understand the prevalence of case management positions, the survey asked respondents whether their team has access to a staff member whose primary role is serving as a Case Manager to students needing resources or help coordinating services. NABITA recognizes that this position may have different titles at different institutions; however, this whitepaper will henceforth use the term Case Manager for simplicity and consistency. Of the survey respondents, 72.5% (N=219) reported having access to a Case Manager. Of those who have access to a Case Manager, 89.1% (N=197) reported that this position is full-time.

When controlling for the size of the population served by the team, Case Managers were prevalent at all institutions except those who served a population of fewer than 1,000. Of the following population

sizes served, 7,001-15,000, 15,001-25,000, 25,001-50,000, and 50,000+, each had more than three-quarters of respondents report that they had at least one staff member whose primary role is to serve as Case Manager. While Case Managers were most common at these larger institutions, more than half of the respondents whose teams served populations of 1,001-3,000 and 3,001-7,000 also had a Case Manager. Nearly all respondents in all population sizes reported that the role is full-time. The full results of the presence of a Case Manager based on the population size served are presented below.

Percentage of Respondents Reporting a Case Manager by Population Size Served

Population Size	Case Manager: Yes	Case Manager: No
< 1,000	100%, N=2	0%
1,001 – 3,000	80.6% N=29	19.4%, N=7
3,001 – 7,000	90.7%, N=39	9.3%, N=4
7,001 – 15,000	82.1%, N=46	17.9%, N=10
15,001 – 25,000	97.1%, N=33	2.9%, N=1
25,001 – 50,000	97.1% N=34	2.9%, N=1
50,000+	93.3%, N=14	6.7%, N=1

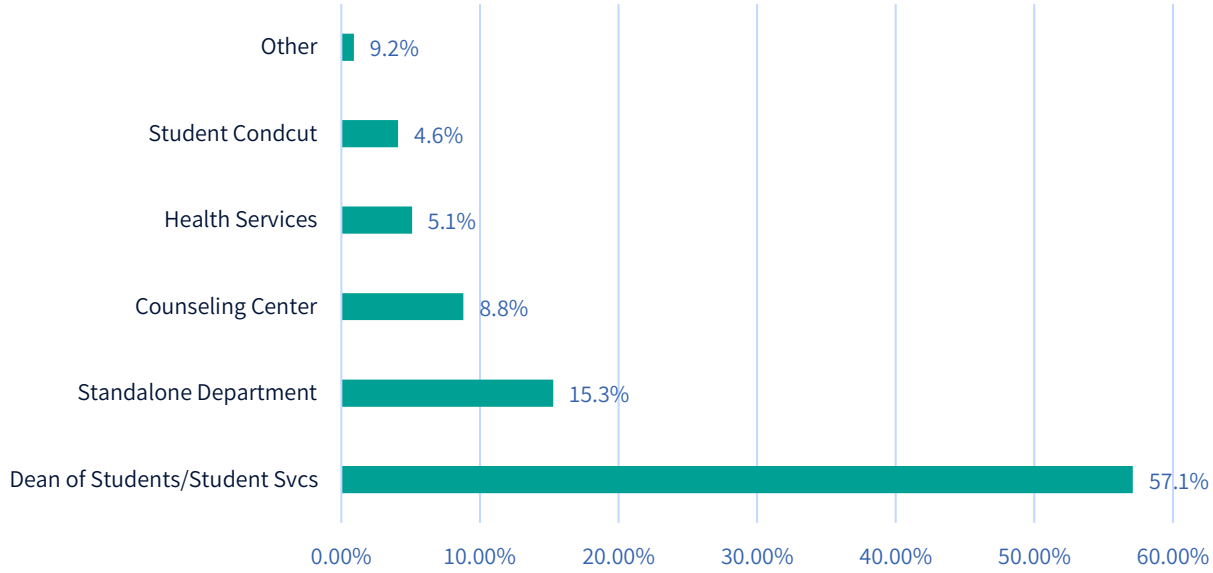
When controlling for institutional type, over 90% of respondents from public and private non-profit colleges and universities reported having a Case Manager, compared to 76.2% of respondents from community or technical colleges. This suggests that Case Managers may be less common at community or technical colleges than at other types of institutions. There were too few respondents from other institutional types with a Case Manager to include them in the comparison.

The survey asked those respondents with a Case Manager a series of follow-up questions to learn more about the specifics of the case management role. Case Managers tend to be operating in a non-clinical capacity (90.5%, N=199) rather than in a clinical capacity (7.3%, N=16), while some respondents were unsure (2.3%, N=5). The survey defined a clinical role as someone licensed to provide mental health treatment/services and hired by the school and a non-clinical role as someone who may or may not be licensed but is hired by the school to provide general support and resources.

Most Case Managers (57.1%, N=124) are structured within the Dean of Students/Student Services office. Additionally, 15.2% (N=33) are structured as a standalone department in the Division of Student Affairs, 8.8% (N=19) in the counseling center, 5.1% (N=11) in health services, 4.6% (N=10) in student conduct,

and .9% (N=2) in residence life. An additional 8.3% (N=18) indicated *other*. Those who indicated *other* tended to report that their Case Managers were organizationally located in police/campus safety, a wellness or CARE department (which may be similar to a stand-alone department, depending on the structure), or as a decentralized service.

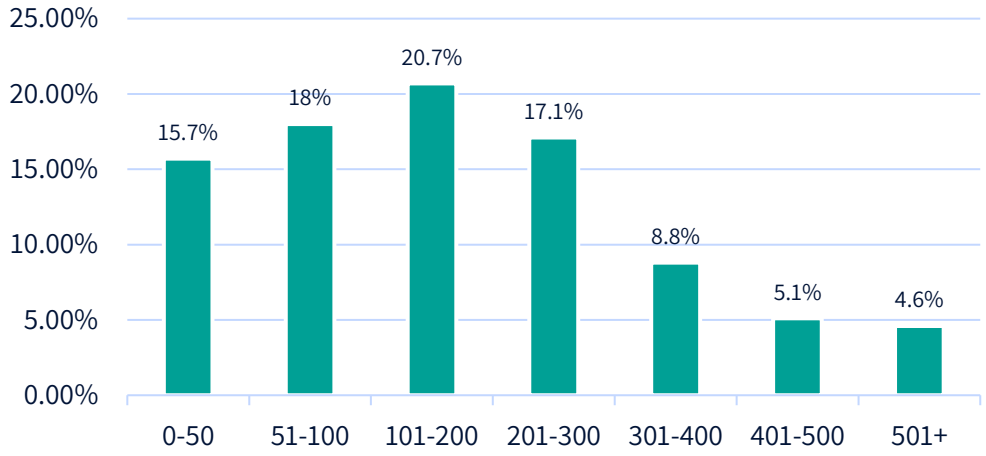
Organizational Structure of Case Management Positions



A Case Manager's organizational location appears influenced by whether the Case Manager is clinical or non-clinical. Clinical Case Managers are predominantly organized within the counseling center or health center, while non-clinical Case Managers tend to be in the Dean of Students/student services or as a stand-alone office. Notably, 19 non-clinical Case Managers reported that they are situated within the counseling center or health services. This organizational structure may create challenges regarding the perception of confidentiality and the scope of services. This is particularly important because a non-clinical staff member operates under FERPA guidelines and provides general support within a department where the staff typically maintains privilege and offers medical or mental health treatment. Similarly, the four clinical Case Managers organized within the Dean of Students/Student Services may experience challenges with the perception of their services given their organizational location.

To assess caseload, respondents were asked to report how many cases are assigned to each Case Manager per year. Most commonly (20.7%, N=45), respondents reported that *101-200 cases* were assigned to each Case Manager per year. The data did not suggest a connection between the size of the population served and the number of cases per Case Manager per year, suggesting different influences on caseload than simply the size of the institution. The full results for the number of cases per Case Manager per year are presented in the graph below.

Number of Cases Per Case Manager Per Year



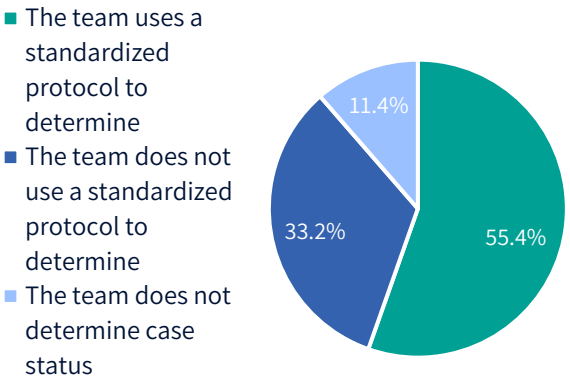
Appropriate caseload ratios can be a difficult number to articulate. Setting a fixed caseload number or ratio can be both misleading and overly simplistic. While having a specific number to guide caseloads might seem useful, the reality is far more complex than any simple ratio can represent. A balanced caseload requires careful consideration of the time needed for all essential tasks in effective case management. Case Managers should have a workload that allows them to meet with students, identify and address their needs, provide necessary follow-up services, complete required documentation, attend BIT meetings, and participate in committees as necessary. It's also crucial to factor in the nature of the cases being managed and the associated risk levels. Supervisors and Case Managers should evaluate the complexity of each case to ensure that the Case Manager can deliver high-quality services.

Case Review

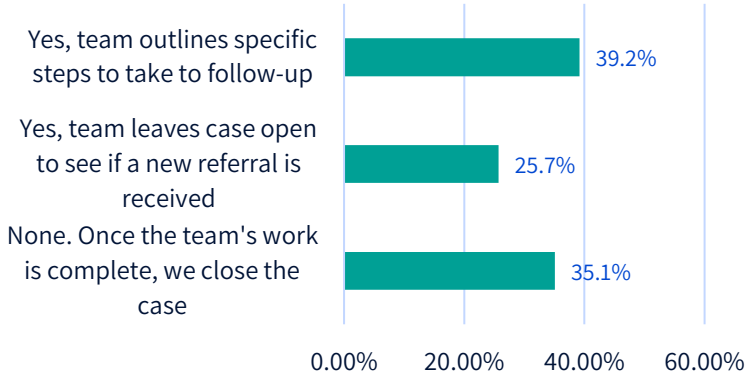
The survey asked respondents questions to determine whether and how they determine case status (e.g., open, closed). Most commonly (55.4%, N=165), survey respondents indicated that their team *uses a standardized protocol to determine case status (e.g., open, closed)*. An additional 33.2% (N=99) of survey respondents indicated that their team *does not use a standardized protocol to determine case status,* and 11.4% (N=34) *do not determine case status*.

To further assess how teams handle the status of high-risk cases, survey respondents were asked if their team has a process for long-term monitoring of high-risk cases once the team's work with the case is complete. Of the survey respondents, 39.2% (N=116) reported that *the team outlines specific long-term steps they or a designated staff member will take to monitor the individual (e.g., email the individual to check in, consult with referral sources, check grades)*. Additionally, 25.7% (N=76) reported that they *leave a case open after the team's work is complete to see if anything new is referred to the team*. Of the survey respondents, 35.1% (N=104) reported that *once the team's work is complete, they close the case.*

Determining Case Status



Long-Term Monitoring Practices



Teams should decide when and how to close a case or keep the case open. The Standards explain that the team should regularly use a standardized protocol to engage in this decision-making process and should document the decision to keep the case open or move it to a closed status. The 11% of respondents whose teams do not determine case status should adopt the practice of case review, and the 33.2% of respondents who determine case status without the use of a standardized protocol should formalize their procedures through a written protocol.

Engaging in intentional monitoring of cases that were once high risk but are now resolved allows the team to intentionally check for the efficacy of interventions and reduce risk levels over time. This long-term monitoring should be actionable and individualized, with an intentional plan developed by the team or Case Manager outlining how they will identify indicators that the individual is struggling, whether the individual has disengaged from the supports to which they were referred or has otherwise increased their risk level. In many instances, this monitoring plan may be overseen by the Case Manager, but respondents whose teams do not engage in this practice should consider implementing a practice of monitoring the risk level of individuals after active BIT work is complete, even if this is executed through case management.

Recordkeeping

Survey respondents answered how they store team records, who has access to them, and what is included in them.

Nearly all respondents described using an electronic database or software program to track BIT referrals and cases. Most commonly (67%, N=201), respondents reported using Maxient, followed by 16% (N =48) who reported Symplicity. Only 4% (N=12) of teams reported using an electronic recordkeeping system that is not an online software, such as MS Access, Excel, or Google-based programs. No respondents reported using pen and paper files. Nearly all respondents were aligned with the Standards, which state that teams should use an electronic database. Teams using MS Access,

Excel, or Google-based programs may find these platforms lacking in their data storage and retrieval capabilities, thus limiting how they can document their work on a case.

Recordkeeping Systems

Recordkeeping System	%, N of Respondents
Maxient	67%, N=201
Symplicity	16%, N=48
MS Access, Excel, Google Docs, etc.	4%, N=12
Guardian	3%, N=9
In-house, IT designed	2.3%, N=7
Members maintain their own records	1%, N=3
Pharos 360	0.3%, N=1
Starfish	0%
Pen/paper files	0%
The team does not keep records	0%
Unsure	2.3%, N=7
Other *(common response was Navigate 360)*	4%, N=12

The survey also asked respondents to indicate what information is included in the team's records. Respondents reported the following as team record content:

- Issue of concern (95.9%, N=282)
- Individual's name (93.2%, N=274)
- Records of referrals to the team (90.8%, N=267)
- Ongoing notes (e.g., meeting dates, case discussions, phone calls, emails) (86.1%, N=253)
- Intervention plan and/or next steps (81.3%, N=239)
- Assigned Case Manager/team member (78.6%, N=231)
- *Risk rating* (69.8%, N=205)

NABITA considers it best practice to include each of these items in the team's record, as it helps teams document and track their work. Some of these elements are crucial in understanding the basics of the case, such as the individual's name, the issue of concern, and the records of their referrals. Other items, such as ongoing case notes, the intervention plan, who is assigned, and the risk rating, provide details about the team's actions in responding to the concerns. Detailed documentation provides a valuable

historical reference if the individual is referred again in the future and ensures that the team can demonstrate that each case was handled appropriately.

Respondents also provided information related to team record access. Respondents reported the following access to team records:

- *All core and inner circle members* (fixed members who are expected to attend meetings regularly) have access to team records (85.5%, N=254)
- Middle circle members (invited as needed) also have access (13.4%, N=40)
- Only the team chair or designee has access (12.5%, N=37)
- Non-team members (e.g., academic advisors, counselors, faculty) (3%, N=9)

It is important that the fixed members who are expected to be at the team meeting have access to team records. Currently, 85% of respondents indicated that their team is aligned with this recommended practice. Middle circle members (those who are invited as needed) shouldn't have full access to the team records, as they likely do not have an educational need to know under FERPA to know the full details of every student referred to the team. This is especially true for non-team members, such as academic advisors, counselors, and faculty. Additionally, limiting access to just the chair or designee silos information from team members who do have an educational need to know the information to fully participate in team meetings, assess risk, and participate in the deployment of interventions.

SECTION FIVE

Quality Assurance and Assessment Elements

An In-depth Analysis of How Teams Assess Their Work

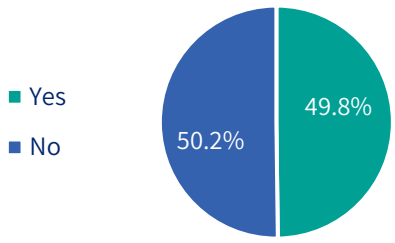
Quality Assurance and Assessment Elements

The survey assessed how teams engage in quality assurance and assessment efforts. Questions in this section explored how respondents engage in an ongoing assessment strategy through supervision, semester and/or year-end reports, and team audits. Additionally, the survey asked how respondents share the information collected through these assessment efforts and how it informs future decision-making and planning.

Team Audit

Respondents were asked if their teams engage in an audit of the team structure and process to ensure it is functioning effectively and in alignment with best practices. The survey results suggest mixed levels of engagement in this practice, as 49.8% (N=145) of respondents reported *yes,* and 50.2% (N=146) reported *no.* Of those who reported engaging in a team audit, most conducted the team audit *annually* (62.9%, N=93), followed by 20.3% (N=30) who reported conducting it *every 2 years,* and 16.9% (N=25) who reported *every 3 years or more*.

Conduct a Team Audit



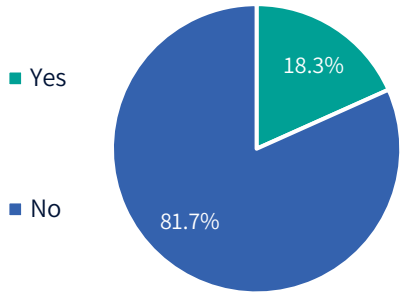
Frequency of Team Audits

It is crucial for BITs to regularly audit their structure and processes to ensure they are effective and aligned with best practices. The Standards call for teams to engage in a team audit of their practices at least every two years. By assessing alignment with best practices, the team can adapt to evolving trends and challenges, improving their ability to mitigate risks and improve support and wellness. Additionally, regular audits foster continuous improvement, helping the team maintain a high standard of care and accountability.

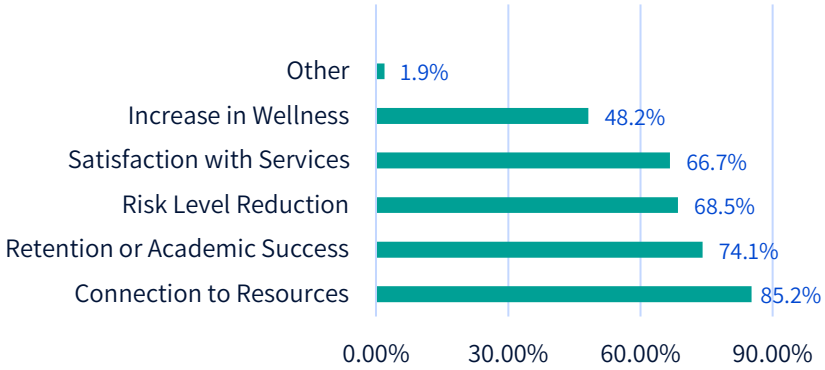
Team Effectiveness Assessment

The survey asked respondents whether they used research methods to assess the team's effectiveness. Most respondents (81.7%, N=236) reported they do not, and 18.3% (N=53) reported they do. Survey respondents who reported using research methods to assess their team's effectiveness reported they conducted research to asses *connection to resources* (85.2%, N=46), *retention or academic success* (74.1%, N=40), *risk level reduction* (68.5%, N=37), *satisfaction with BIT or case management services* (66.7%, N=36), *increase in wellness scores* (48.2%, N=26), and *other* (1.9%, N=1).

Assess Team Effectiveness



What Effectiveness Measures are Assessed



Respondents also provided information on how they use the findings from their assessment efforts. Respondents who engage in assessment efforts report using the findings to inform decision-making and to improve the following:

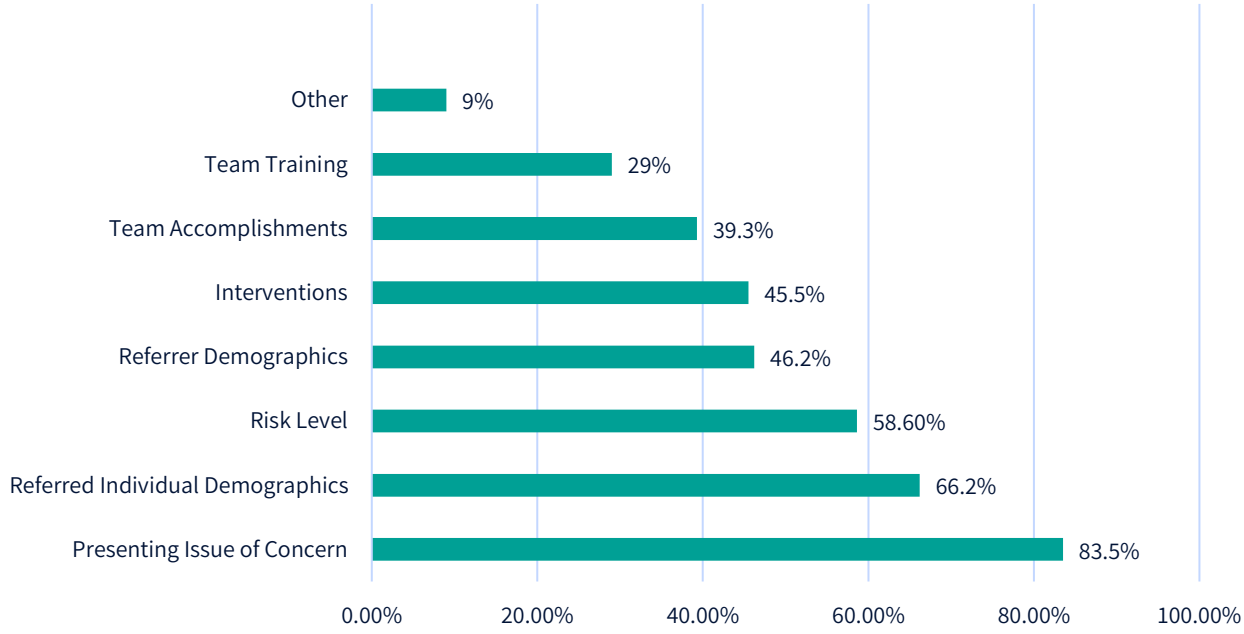
- *Programming* (55.6%, N=30)
- *Services* (88.9%, N=48)
- *Team training* (75.9%, N=41)
- *Team resources* (63%, N=34)
- Community education (63%, N=24)

The Standards outline that teams should engage in assessment efforts to understand their effectiveness. This requires teams to set measurable goals that demonstrate their efforts are effective and then use research methods to assess whether these goals have been met. Unfortunately, very few (18%) respondents indicate that their team currently engages in this practice.

Team Reports

The survey asked respondents about their end-of-semester or end-of-year reporting practices. Survey respondents were evenly split in producing an end-of-semester or end-of-year report, as 50% (N =147) reported they did, and 50% (N=147) reported they did not. Those respondents who endorsed producing a team report indicated that their reports typically include data related to *presenting issues of concern* (83.5%, N=121), *demographic information about the referred individuals* (66.2%, N=96), *cases referred at each risk level* (58.6%, N=85), *demographic information about the referral sources* (46.2%, N=67), *commonly used interventions or actions* (45.5%, N=66), *team accomplishments* (39.3%, N=57), *team trainings* (29%, N=42), and *other* (9%, N=13).

What is Included in Team Reports



Survey respondents tend to use the data from end-of-semester or end-of-year reports to make decisions about allocating team resources, as evidenced by 66.7% (N=998) of respondents who endorse this practice.

Most respondents who produce a report do not make it available on the team website, but they do make it available to key stakeholders. Expressly, the respondents who produce an end-of-semester or end-of-year report indicated they make a report available in the following ways:

- 8.2% (N=12) *make it available on the website*
- 77.6% (N=114) *make the report available to key stakeholders*

The Standards outline that teams should produce end-of-semester or end-of-year reports to share data related to team practices and trends. As these reports should include de-identified, aggregate data, the Standards recommend sharing them on the team's website and with key stakeholders. It is crucial for teams to use data to write semester or annual reports to capture and analyze team trends, as this practice ensures a clear understanding of the challenges and issues faced by the population. Data-driven reports allow teams to identify behavior patterns, assess interventions' effectiveness, and make informed decisions about resource allocation and program development. Sharing these reports with stakeholders, such as campus leadership, faculty, and student affairs professionals, fosters transparency, collaboration, and awareness, ultimately enhancing campus safety and well-being. Moreover, regular reporting helps demonstrate the team's impact, secure continued support, and justify the need for additional resources or changes in approach. By leveraging data, teams can proactively address emerging trends and ensure that their interventions are both responsive and effective.

SECTION SIX

Discussion of the Trends

An Exploration of the Findings and How They Compare to Prior Years

Discussion of the Trends

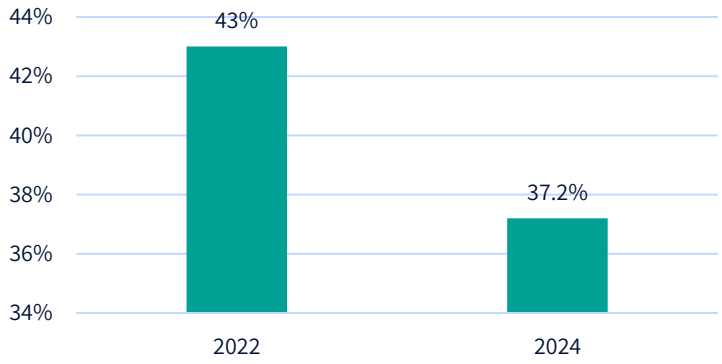
This section will compare the 2024 survey findings with those of prior iterations, where possible, to identify trends and shifts in team practices over time.

Structural Elements

TEAM SCOPE

In 2022, 43% of respondents reported that their team(s) addressed concerns for *faculty/staff/employees* in some way. This number declined in 2024 to 37.2%. This shift reflects a diversion from recommended practices, as the NABITA Standards recommend that team scope extends to faculty/staff/employees to help mitigate risk and offer support to all campus community members, not only students.

Teams Addressing Faculty/Staff/Employee Concerns: 2022 to 2024 Comparison



The recent survey data related to team scope also reveals a significant positive trend, with an almost 10% increase in respondents reporting *one integrated team* addressing concerns across the entire risk spectrum. In 2022, 58% of respondents indicated having such a team, rising to 67.1% in 2024. Having one integrated team fosters the de-siloing of information, which is essential to the work of behavioral intervention teams, enabling a more holistic and coordinated approach to risk management.

Additionally, there was a slight increase in respondents reporting *two teams*, from 22% in 2022 to 23.7% in 2024. Conversely, the number of respondents with *one team dedicated solely to threat assessment* decreased from 13% in 2022 to 8% in 2024, and those with *one team addressing low-level concerns* dropped sharply from 7% in 2022 to just 1.1% in 2024.

These shifts reflect an increased commitment to supporting students across the spectrum of risk. While NABITA recommends having one integrated team rather than two separate teams, it is encouraging to

see increasingly more teams move away from a singular team that only addresses one type of concern and toward having either an integrated team or two teams committed to the spectrum of risk.

Team Structure: 2022 to 2024 Comparison

	2022 NABITA Survey	2024 NABITA Survey
One integrated team	58%	67.1%
Two teams	22%	23.7%
One team for threat assessment	13%	8%
One team for low-level concerns	7%	1.1%

TEAM NAME

CARE Team continues to be the most widely used team name, increasing from 44% in 2022 to a full majority in 2024 at 57%. *Behavioral Intervention Team (BIT)* is still widely used but decreased to 34.2% in 2024 from 37% in 2022. 2024 also saw an unusual rise in the use of *Student of Concern (SOC)* to 8.3%, up from 3% in 2022. Similarly, the use of *Threat Assessment Team (TAT)* also appears to have increased significantly from 2022 (1%) to 2024 (14%). However, in the 2022 survey, TAT was included in the "other" option, which may contribute to the apparent rise, as might the slight increase in teams dedicated solely to responding to high-risk cases.

Overall, using CARE and BIT as the most common team names aligns with the NABITA Standards, as both options can be viewed as more inclusive and open to receiving referrals across the risk spectrum. CARE Team, in particular, frames the team's work as supportive and inclusive, and this more positive connotation is likely why more teams are choosing to use CARE in the team's name. On the other hand, Student of Concern is often viewed as a stigmatized term that might unintentionally create a negative or limited perception of the team's purpose and scope. Similarly, TAT risks sending the message that the team only receives high-risk referrals or concerns involving actual threats, which can cause the team to miss early intervention and prevention opportunities.

Team Name: 2022 to 2024 Comparison

	2022 NABITA Survey	2024 NABITA Survey
CARE Team	44%	57%
Behavioral Intervention Team (BIT)	37%	34.2%
Student of Concern (SOC)	3%	8.3%
Threat Assessment Team (TAT)	1%	14%

TEAM LEADERSHIP AND MEMBERSHIP

Regarding team leadership, the Dean of Students continues to be the most common position cited as team chair. Survey responses demonstrated an increase in the Dean of Students serving as chair at 56.7% in 2024, up from 51% in 2022. The second most common position reported as team chair continues to be a Case Manager, consistent at 20% in the last two surveys. This data shows that staff members who lead teams are likely centrally positioned in student affairs and have the most substantial working knowledge of cases.

Team size also remained consistent from 2022, with average team size reported at eight members in 2022 and 2024. Additionally, representatives from the Dean of Students, mental health, police/safety, and student conduct remained the most commonly reported team members. The most significant change in member representation came from Case Managers (combined clinical and non-clinical), which increased from 70% in 2022 to 78.4% in 2024. The entire increase came specifically from non-clinical Case Manager participation. In contrast, the participation of vice presidents of student affairs (VPSA) decreased to 27.9%, down from 36% in 2022.

TEAM TRAINING

Another positive trend reported by respondents was related to team training. The number of respondents who reported that their team receives no training decreased to 19.2% in 2024, down from 26% in 2022. While this is a move in the right direction, training is crucial for teams to stay current with best practices, enhance their threat assessment and de-escalation skills, and adapt to evolving campus challenges. Continuous learning ensures that teams remain effective in identifying, addressing, and mitigating risks while supporting the individual's well-being.

COMMUNITY EDUCATION AND MARKETING

The data on community education and marketing is not directly comparable due to changes in the survey; however, it suggests a decline in efforts by teams to educate and promote their work within the community. Educating and marketing the work of teams is vital to fostering awareness and trust within the community, encouraging early reporting, and ensuring that individuals know how to access support. Effective outreach enhances collaboration and helps prevent potential escalation of concerns by promoting the team's role in maintaining the safety and well-being of individuals and the broader community.

Process Elements

REFERRAL RECEIPT AND REVIEW

Teams consistently use an online referral form as the most common method of receiving team referrals. Generally, respondents reported receiving the same number of referrals per year as they were

receiving two years ago. However, there was a slight decrease in respondents who reported receiving 0-50 referrals, alongside a slight increase in respondents who reported receiving 401-500 referrals, from 3.5% in 2022 and 8.5% in 2024.

Number of Referrals Received Per Year

Number of Referrals	NABITA Survey 2022	NABITA Survey 2024
0-50	30%	21.2%
51-100	18%	19.9%
101-200	15%	16.7%
201-300	10%	9.5%
301-400	8%	8.5%
401-500	3.5%	8.5%
501-1,000	10%	9.2%
1,000+	8%	8.2%

There was a 20% increase in respondents identifying *general emotional and mental health concerns* (53% in 2022 versus 73.3% in 2024) as the most common reason for referrals to the team. Conversely, all other presenting issues, including *suicidality* and *academic/financial/basic needs*, were reported less frequently as primary referral reasons. This shift suggests a growing focus on lower-level mental and emotional well-being in referral patterns. This data suggests a positive trend of teams receiving more low-level concerns, which increases opportunities for early intervention. This promotes a proactive approach to student support, fostering a healthier and safer community.

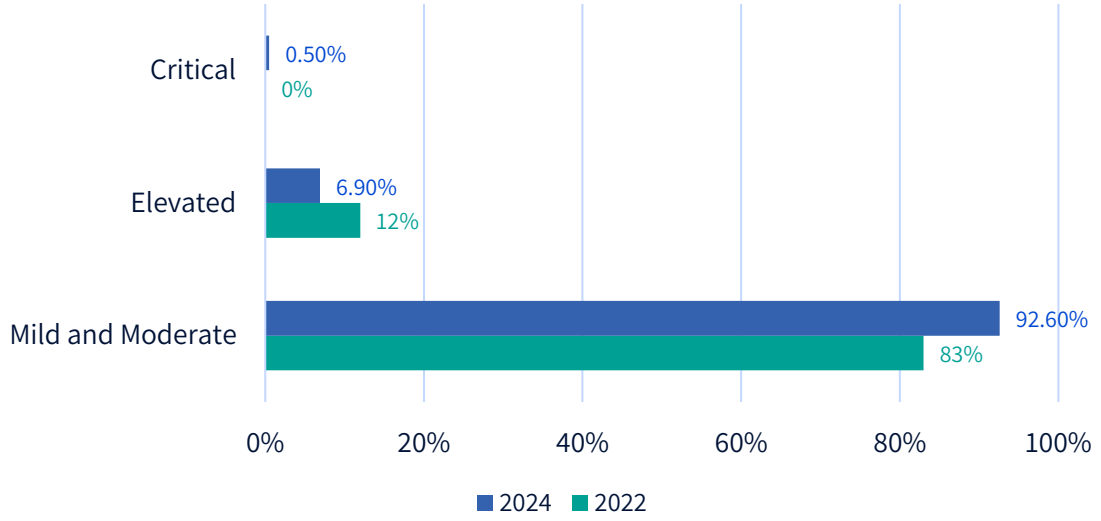
Most Common Referral Reasons to the Team

Referral Reason	NABITA Survey 2022	NABITA Survey 2024
General Emotional/Mental Health	53%	73.3%
Academic/Financial/Basic Needs	17%	9.5%
Suicidality	13%	7.3%
Behavioral Misconduct	11%	5.7%
Threatening Behavior	6%	3.2%

Another positive trend that emerged is the number of respondents who reported *mild* and *moderate* as the most common risk ratings of the referrals coming to the team. This increase from 83% in 2022 to

92.6% in 2024 shows that more teams are engaging in early intervention work to help individuals increase their well-being, connect to appropriate resources, and hopefully avoid escalation of concerns. Respondents also reported a decrease in referrals at *Elevated* (12% in 2022, 6.9% in 2024) and a slight increase in *Critical* referrals (0% in 2022, 0.5% in 2024).

Most Common Risk Rating 2022 to 2024 Comparison



MEETING OPERATIONS

The number of respondents who reported using an agenda for their team meetings stayed consistent at around 80% from 2022 to 2024, but the most recent data showed an increase (75% in 2022 vs. 89.5% in 2024) in the number of respondents who make the agenda available to team members in advance of the meeting. A BIT agenda before the meeting ensures a more structured, focused discussion, allowing the team to work more efficiently. This preparation fosters better collaboration and more effective decision-making during the meeting.

The data also demonstrated an upward trend in meeting frequency, with more teams aligning to NABITA's recommended standard of meeting weekly or every other week. In 2022, 58% of respondents reported meeting weekly, which increased to 64.6% in 2024. Similarly, teams that met every other week rose slightly from 24% in 2022 to 25% in 2024. This shift toward more frequent meetings suggests a stronger commitment to regular monitoring and timely intervention.

OBJECTIVE RISK RUBRIC

The most recent survey data indicates consistent use of objective risk rubrics, with 82.3% of 2024 respondents reporting their use, compared to 81% in 2022. Applying a risk rubric on every new referral has increased slightly, from 73% in 2022 to 76.8% in 2024, suggesting a stronger emphasis on

systematic risk evaluation. Notably, the NABITA Risk Rubric remains the most widely used tool, significantly rising from 74% in 2022 to 92.2% in 2024, reflecting its growing popularity and perceived effectiveness in objective risk assessment.

ADVANCED RISK ASSESSMENT

The questions in the advanced risk assessment section differed significantly from those in previous surveys, preventing a direct data comparison. Despite this, notable trends emerged, revealing a concerning number of teams engaging in practices not endorsed by NABITA or aligned with the Standards.

One-third of respondents reported that their teams do not request or require individuals to participate in interviews to assess risk further. For teams to be most effective at assessing risk related to potential threats, it is vital to have a process that allows for gathering additional information to gain a deeper and more holistic understanding of any risk present. While some respondents reported requiring individuals to engage in a *psychological assessment*, many indicated using it to better understand the risk of harm an individual may pose to others. Potential risk of harm to others is better assessed using a *violence risk assessment* rather than relying on a clinical or psychological assessment. Additionally, many of the respondents who reported engaging in further assessment, either psychological or violence risk assessment, are making this determination subjectively, without using an objective rubric.

Some respondents also reported engaging in concerning practices related to team response when an individual does not comply with a mandated assessment, including having the team place a hold on a student's account or issue other consequences to force compliance. These practices would be considered outside the BIT's scope or authority. If an individual fails to comply with a mandated assessment, the appropriate response is a referral to student conduct for a "failure to comply" or similar charge. Student conduct has the authority to issue sanctions if the individual is found to be in violation of policy and can use the sanctioning process to require engagement with the assessment. Non-compliance for employee concerns should be handled through human resources or another applicable department.

Notably, several respondents reported using the results of psychological or violence risk assessments to mandate compliance with ongoing interventions or to determine a student's readiness to return to the institution—practices that fall outside the intended scope of the team's work. Assessment results should guide the voluntary interventions from the BIT and inform decisions from other departments, such as student conduct, Title IX, and human resources. The team should refrain from making direct

recommendations to these departments, and the team itself should not require ongoing compliance with interventions.

INTERVENTIONS

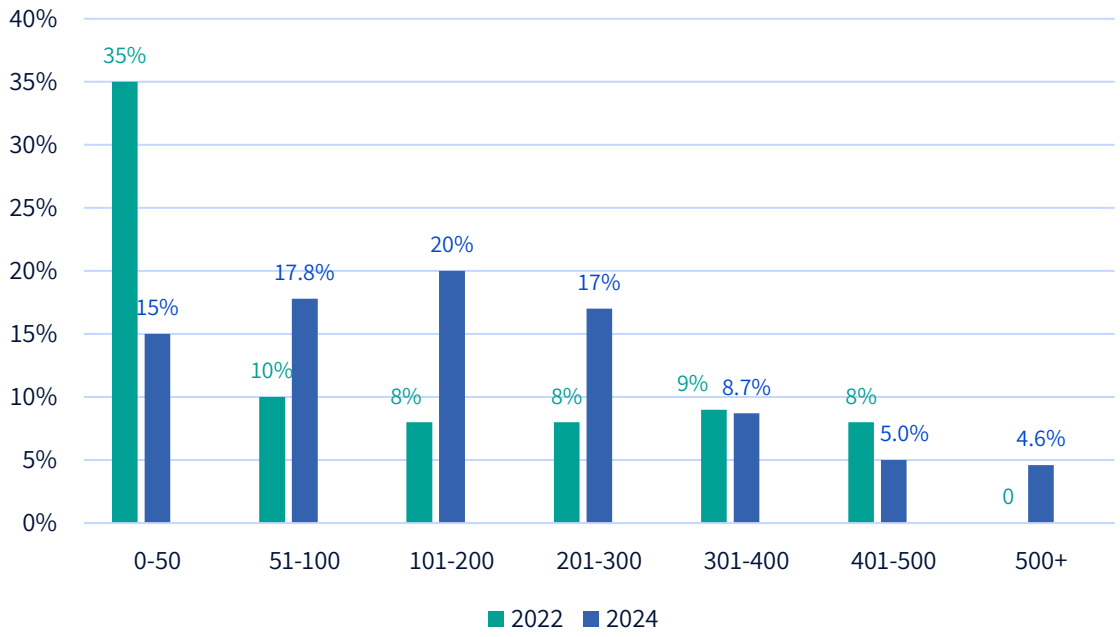
Like the advanced assessment section, the questions related to interventions were not directly comparable to previous survey results due to significant changes in the wording. However, this section still yielded interesting and discussion-worthy findings. More than one-third of respondents reported that ongoing compliance with interventions from the team was required. Compliance with interventions should be voluntary, and teams are encouraged to motivate voluntary engagement rather than mandating compliance. As mentioned above, only student conduct, Title IX, or human resources can require compliance via sanctions, and only if the individual has been found responsible for violating policy.

Especially concerning, 20.2% of respondents reported that their team can issue interim suspensions or restrictions, and 48.5% reported making official recommendations for these actions. BITs should not have direct authority over such actions, and these decisions should be made by the appropriate office, allowing for due process or fundamental fairness.

CASE MANAGEMENT

Much of the case management data cannot be directly compared to previous surveys, but the current survey data suggests that more schools are investing in Case Managers as full-time positions. The data also showed that most Case Managers serve more students per academic year. In 2022, 35% of respondents reported a yearly caseload of 0-50 referrals. That number declined to 15%, while the number serving 101-200 referrals per year increased from 8% in 2022 to 20% in 2024.

Case Manager Caseload Per Year: 2022 to 2024 Comparison



Conclusion

The biennial NABITA survey provides one of the few comprehensive datasets on BIT characteristics and practices. This report summarizes the descriptive data gathered, highlighting national trends and their effects on team operations. We aim for teams to leverage these insights to pinpoint areas of strength and opportunities for improvement. Combined with the NABITA Standards for Behavioral Intervention Teams, this document is intended to support the development of best practices. For additional resources, such as the NABITA assessment tools referenced here, please visit the NABITA website.