

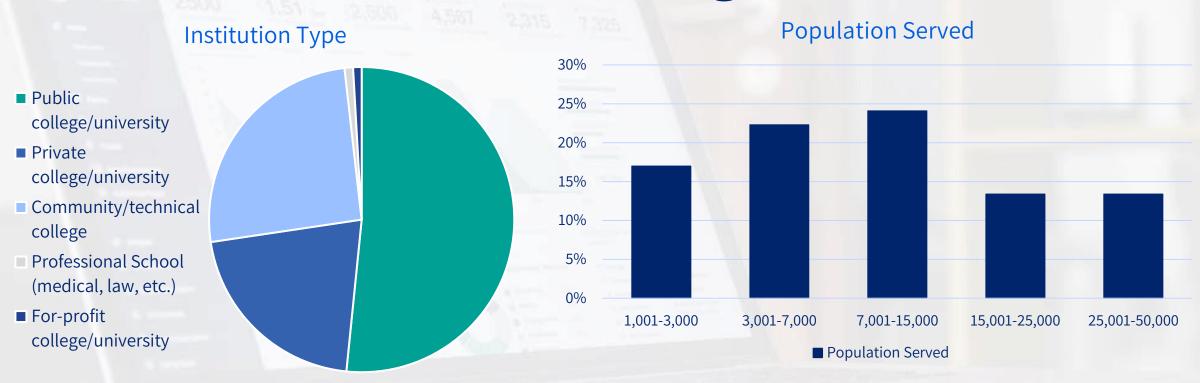
## **NABITA's State of the Field Survey**



\*In 2024, NABITA significantly revised the survey questions.



## **Participant Demographics**



#### Sample

We solicited responses from NABITA and ATIXA members and to all contacts within the TNG email list.

464 **Participants** 

66.5%

Non-Residential



60%

Satellite Location (s)



65.5%

BIT at/for Satellite

## **Structural Elements**

**2024 NABITA Survey Results** 

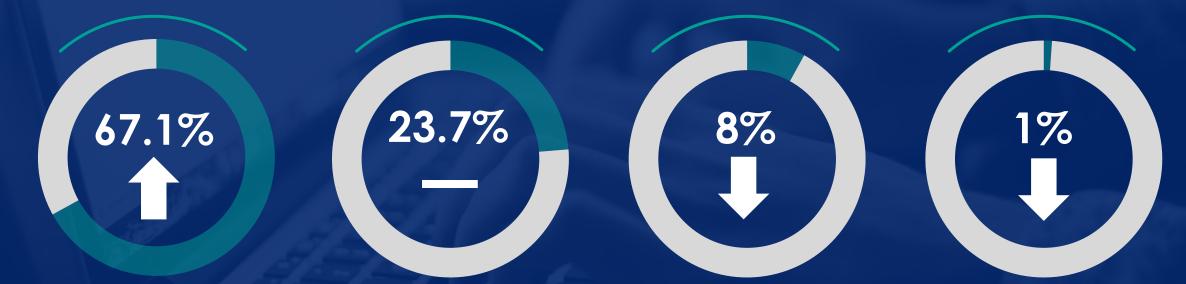
## **Structure of Teams**

One integrated team that addresses behavior ranging from low level concerns to threats or high-risk behaviors

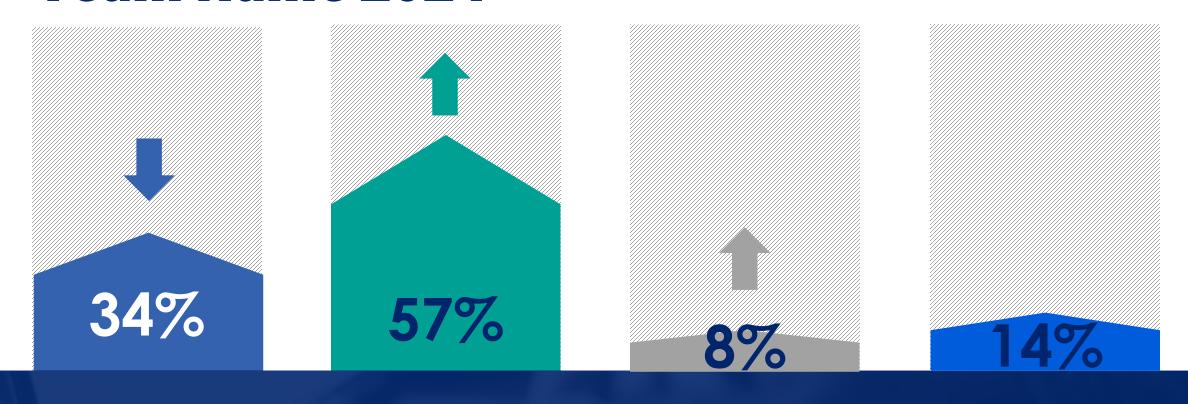
Two separate teams: one that addresses threats or high-risk behaviors and one that addresses early alert or low risk behavior

One team that only addresses threats or high-risk behavior

One team that only addresses low-risk behavior



## **Team Name 2024**



BIT

CARE

SOC

TAT

## **Team Leadership**

56.7% 20% 15.4% 12.4%

Dean of Students

Case Manager **Student Conduct** 

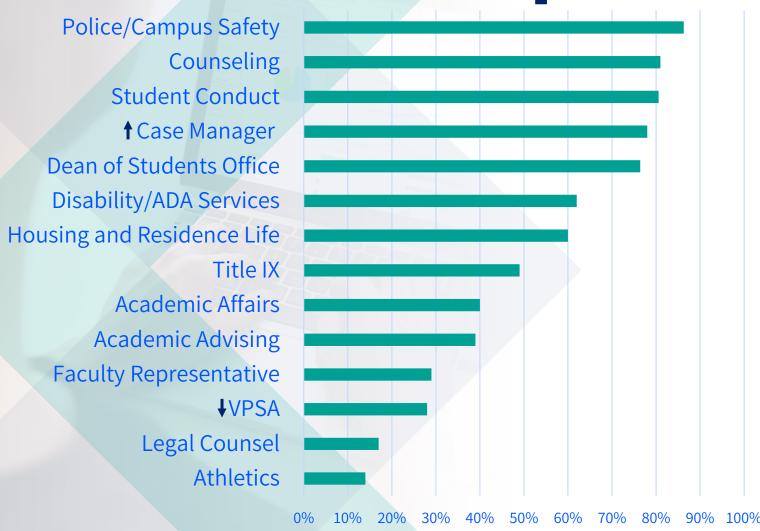
**VPSA** 

This slide is related to who leads the team. Historically was VPSS. Now more student facing folks.

0

5 - 9 members are recommended by NABITA Increase in non-clinical case managers participating regularly in CARE Team The same is not true for clinical cm

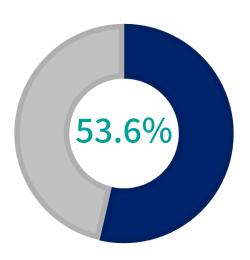
**Team Membership** 



**Average Team Size** 

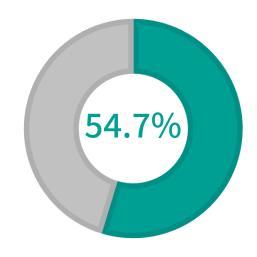
**86.3%** of teams classify their membership by categories

## **Operational Structures**



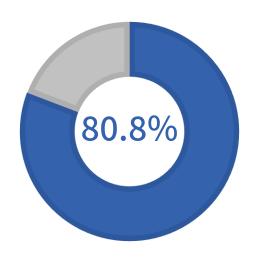
#### Procedure Manual

About half of teams have a proceudre manual and the manual tends to be updated every 2 years.



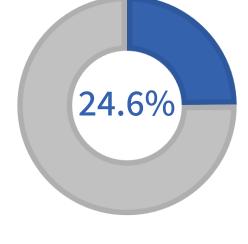
### Institutional **Policy**

Institutional policies tend to outline team membership, scope, mission, and authority.



#### **Team Training**

Most teams receive training via webinars, NABITA cert courses, tabletop exercises, books/journals, and the NABITA conference.



#### **Budget**

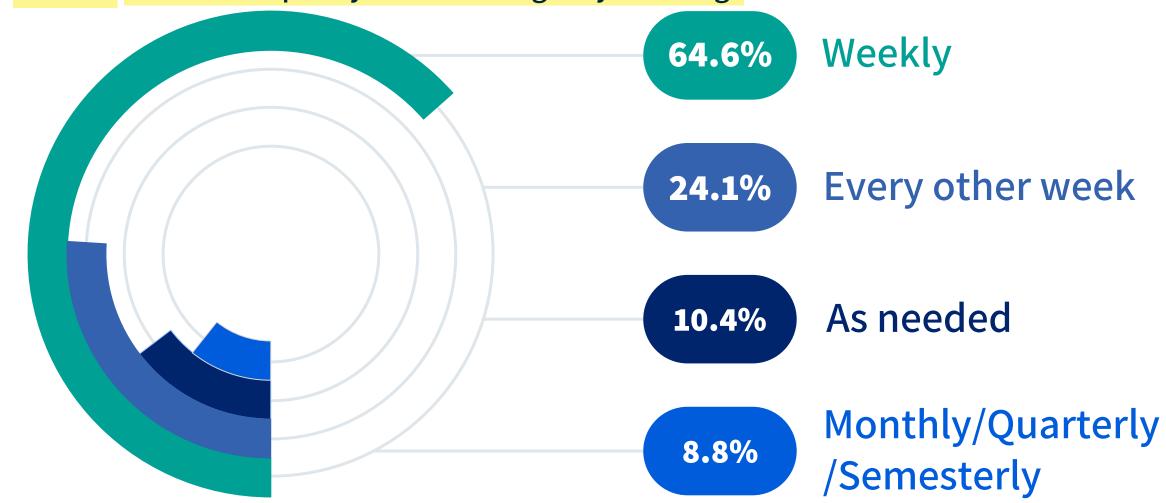
Most teams do not have a budget. Those that do, tend to be funded through student affairs.

## **Process Elements**

**2024 NABITA Survey Results** 

# **Meeting Frequency**

94.6% Have the capacity to call emergency meetings



Majority of reported cases are "low concern" and the team is used for prevention. Most teams use agendas that are sent out ahead of time for indiv prep time. People should come prepared to participate. Online referrals auto-feed to Maxient.

## **Team Referrals**



#### **Receive referrals online**



80% of teams

Use an agenda to outline which referrals/cases will be discussed at meeting



Send the agenda to team members in advance of the meeting



**Report members familiarize** themselves with referrals in advance of meeting

### **Common Risk Rating and Reason for Referral**

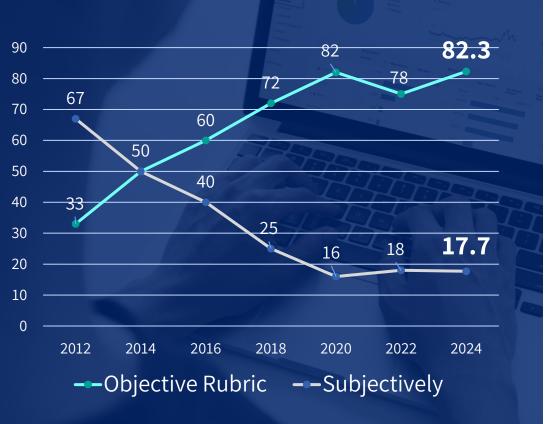


**General** emotional and mental health concerns





# Risk Assessment





76.8% of teams use an objective risk rubric on EVERY NEW REFERRAL



92% of teams
use the NABITA Risk Rubric

## **Advanced Risk Assessment Practices**

**68%** of teams Ask or require individuals to participate in an interview to further assess risk.

85% of teams Coordinate threat assessments

37.3% of teams Require violence risk assessments

**27.2%** of teams Require psychological assessments

#### **Psychological Assessments**

tend to be conducted by inhouse clinicians (59.3%)

#### **Violence Risk Assessments**

tend to be conducted by institutional staff or team members(91.2%)

#### **Violence Risk Assessors**

tend to be trained and use a specific, standardized tool (89.4%)

## Interventions

Recommended: Use rubric for both assessment and interventions.

#### Intervention Requirements

**Removal Decisions** 

**DO NOT** require compliance 20%



**25.3%** of teams do not have the authority and do not make official recommendations

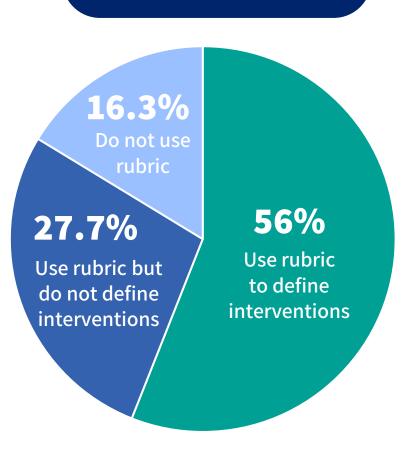


**48.5%** of teams make official recommendations



**20.2%** of teams have the authority to issue a removal

#### **Risk Rubric**



## Case Management as a Process

**45.1% 6** of teams

Mix of case manager and others based on expertise, relationship, etc.



No case manager, cases assigned based to team members and staff based on expertise, relationship, etc.



Have a case manager who is assigned all cases



Assign cases to a team member or staff to coordinate follow-up and interventions



Other

NOT recommend to hand every case to a case mgr. Thinking about burning out case mgrs, who has best relationship with student of concern, who has expertise.

FTE CM is growing. The majority 90.5% are non-clinical. Non-clinicial is typically housed in Dean of Students. Challenges of non-clinical case managers reporting clinical providers. There are concerns about perceptions of confidentiality, administrative tasks, amount of info that can be shared

# Case Management as a Position

**72.5%** of teams have a staff member whose primary role is to serve as case manager

#### **Organizational Placement**

Dean of Students	57.1%
Stand Alone Office or Department	15.3%
Student Conduct	4.1%
Clinical - Counseling or Health Services	13.9%
Other	.9%





**Full-time** 

<b>Population Size Served</b>	CM: Yes	CM: 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

## **Record Keeping System**

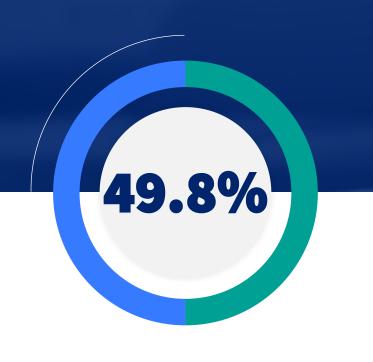
85.5% Of teams give records access to all core and inner (fixed team) members



# **Quality Assurance and Assessment Elements**

**2024 NABITA Survey Results** 

# Team Audit, Team Effectiveness, and End-of-Semester/Year Reporting



**Conduct a Team Audit** 



**Assess Team Effectiveness** 



Produce an end-ofsemester/year report





tim.cason@tngconsulting.com

makenzie.schiemann@tngconsulting.com/

