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SPS CARE Manual

Concern Assessment Response Evaluation

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Introduction

Our SPS Concern Assessment Response Evaluation Team was launched in Fall 2022 under the leadership of Chief Student Affairs Officer, Jennifer Grace Lee and Carolee Ramsay, Director of Student Conduct and is well aligned with the SPS Strategic Plan of providing a "culture of care." The main intention was to provide SPS with a space to be proactive and reactive to behaviors that fall outside Student Conduct and engage in efforts and intervention plans that help students persist. CARE, as the name suggests, evokes compassion and community.

Our CARE Team is guided by National Asssociation for Behavior Intervention and Threat Assessment (NABITA), and uses its resources to objectively determine and assess threats, with a view to developing action plans to address the risk. It is the responsibility of faculty, staff, and students to immediately refer any situation that could result in harm to anyone at the university. Any member of the campus community may become aware of a person of concern or situation that is causing serious anxiety, stress, or fear. It must be noted, however, that behavioral assessment should not be confused with crisis management. A "crisis" may be defined as a situation in which a person may pose an active or immediate risk of violence to self or others. In these cases, SPS Public Safety should be contacted at PublicSafety@sps.cuny.edu or call 911.

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Team Mission & Scope

Our Mission: CUNY SPS Care Team is an appointed group committed to proactive, multidisciplinary, coordinated, and objective approach to the prevention, identification, assessment, intervention, and management of students' behaviors that pose, or may pose a threat to the safety and wellbeing of our campus community.

In addition, SPS CARE Team is committed to supporting and managing students' wellbeing. It is the responsibility of faculty, staff, and students to immediately refer any student who raises a safety concern, either because they appear to lack essential safety-related resources, appear to be in danger, or because they might pose a risk of harm to themselves or others. Self-referrals are also welcomed from students. Please see more information here.

Objectives:

- instituting a systematic and collaborative response to support students of concern, promote academic success, and facilitate an environment to reduce the likelihood of crisis, conflict, threat, and self-harm,
- supporting student success with a caring and proactive approach by recognizing when the need for a coordinated effort arises, and
- enhancing the emotional and physical safety of students, faculty, staff, and others to support the teaching and learning environment.

Team Goals:

- Provide a safe and supportive physical and emotional environment for members of the SPS community.
- Identify, assess, and intervene with individuals who are struggling or who demonstrate concerning or threatening behavior.
- Provide support and resources to community members who are concerned for another individual.

Team Responsibilities:

1. Developing and implementing educational and training programs for all members of the SPS community regarding behavioral assessment. This should include publications and promotional materials designed to create awareness and understanding of the CARE team and what to refer, as well as in-person trainings to develop deeper knowledge on how to identify, support, and refer an individual of concern.
2. Maintaining a current website, which can be easily accessed from SPS's home page and other relevant departmental pages. This site should include links to informational and referral sites and instructions for making a referral to the CARE team.
3. Receiving, coordinating, and assessing referrals received from faculty, staff, students, and others regarding individuals of concern.
4. Coordinating interventions and resource assistance for individuals of concern.

5. Assisting the Office of Student Conduct and other offices that are concerned about students' present or past experiences.
6. Providing periodic analytics and reports upon request.

Team Membership

The CARE team consists of university personnel with expertise in student affairs, mental and physical health, student conduct, disability services, faculty and student advising, and campus safety. CARE team membership represents an ongoing commitment to the CARE team's mission. Team members are critical to the functioning of the team. They are responsible for completing ongoing training, attending meetings, and assisting with follow-up and intervention as designated by their membership category. The CARE team is tiered based on the nature of the referral. All CARE members have signed confidentiality agreements that operate under Family Educational Rights and Privacy Act (FERPA) and applicable law.

Tier 1 MEMBERS

Tier 1 members attend every CARE team meeting and have access to the team's shared site. They meet as needed as first responders to a referral. As core members, they represent their departments and have authority to make independent decisions within their areas of responsibility. The departments they represent are crucial to the CARE team's ability to gather data, accurately assess risk, and deploy effective interventions. Many core members keep records in their own departments and can share this information with the team through the Family Educational Rights and Privacy Act's emergency exception clause or when a school official has legitimate educational interest. The counseling department operates under state confidentiality laws for their records and the Health Insurance Portability and Accountability Act of 1996.

The following individuals are Tier 1 members:

Chief Student Affairs Officer/ Dean of Students: The dean chairs/cochairs the team and attends all meetings.

Director of Student Conduct: The director of student conduct manages/chairs the meetings and attends the team meetings. The director consults on cases involving on- and off-campus conduct violations, criminal charges, and academic disruptions. Conduct records are protected under FERPA and shared with the CARE team by the director of student conduct under the legitimate educational interest clause of FERPA.

Information Sharing and Meeting Participation Responsibilities:

- Conduct history including prior charges, findings, sanctions, etc.
- Admissions information including reporting prior criminal or conduct history

- The director organizes and disseminates the agenda, performs a cursory rating with the NABITA Risk Rubric, ensures team members' attendance, ensures that a risk level is assigned to each case during meetings, and coordinates the selection and implementation of interventions and follow-up for cases. The director also ensures appropriate and complete records are maintained in the electronic recordkeeping database.

Public Safety: Public Safety representative attends each meeting. They serve as a liaison with local and federal law enforcement agencies, consults on CARE team cases that have criminal or law enforcement elements, contributes to the assessment of risk for referrals, and assists with interventions on campus requiring a police presence.

Information Sharing and Meeting Participation Responsibilities:

- Criminal history
- Law enforcement contact and reports
- Concealed carry permits or registered weapons information
- Social media check, looking for concerning or threatening posts

Director of Counseling: The director of counseling attends the meetings and acts as a consultant. The director of counseling receives information from the CARE team to inform them of the services delivered in the counseling center and to ensure collaborative communication. Additionally, the director consults on issues of mental health, crisis, and disruptive/dangerous behavior for cases discussed by the team. The director of counseling keeps privileged mental health treatment records in the counseling center's electronic recordkeeping system. These records are protected by state confidentiality law, and information is only shared with the CARE team when a student gives permission through a specific release of information or the expanded informed consent document. Exceptions to confidentiality law include danger to self and others on a need-to-know basis.

Information Sharing and Meeting Participation Responsibilities:

- Check records or history with the counseling center and share relevant information with the team when a release of information or expanded informed consent is in place.
- Consult on general issues related to mental health issues, risk assessment, and development of interventions.

Director of Student Services: The director of student services attends the meetings and represents departments that have frequent contact with students. The director is the main student service contact and takes the lead when a referral goes through grief/loss protocol.

Tier 2 MEMBERS

Tier 2 members attend regular monthly meetings. Tier 2 members represent departments that have frequent contact with students, are likely to be involved in either case updates or interventions for most of the CARE cases and can provide valuable insights to the team. Tier 2 members have access to the electronic recordkeeping database for CARE team cases.

Faculty/Academic Affairs/Academic Advisor: These individuals often serve as the primary contact in working with faculty, department chairs, provosts, and academic advisors. The representatives also provide information related to academic history and performance and insight into the academic experience.

Information Sharing and Meeting Participation Responsibilities:

- Academic transcript and history including any deviations from the student's traditional performance, withdrawn semesters, academic petitions, etc.
- Information or notes from academic advising
- Updates from current professors, advisors, etc.

Disability Services: The disability services representative consults and offers guidance on issues of academic, residential, and other accommodations. If this person is unable to attend a meeting, reports or other useful information should be sent to the chair of the CARE team. Records in the disability services office are protected under FERPA and exist in the disability services electronic record system.

Information Sharing and Meeting Participation Responsibilities:

- Update on registration with disability support services including accommodations offered and usage of accommodations
- Consultation related to disability issues and accommodations

CARE TEAM PARTNERS

CARE Team Partners serve the CARE team in a consultant capacity. They are invited in for cases that relate to their specific content areas and do not attend meetings regularly. To facilitate awareness of CARE team cases and prompt their attendance at the meeting, they are sent the agenda before the meeting so they can check the list of names for students that have overlap with their respective departments. When in attendance at the CARE meeting, they only attend the portion of the meeting where the case related to their department is discussed. They do not have access to the team's electronic database but are a common source of referrals for the team given their interactions with students in their departments. They include,
Veteran Student Services, General Counsel, and **Title IX Coordinator.**

Team Operations

THREE-PHASE PROCESS

The CARE team operations are guided by a three-phase process as demonstrated in the graphic below. The CARE team is tasked with receiving referrals from the community, reviewing them to determine the level of risk or concern, and then developing action plans to address the risk.

Gather Data: Gathering data occurs two ways: 1) through training the community on how to identify disruptive or concerning behaviors in their earliest stages, and 2) by team members collecting and gathering data on students referred to the team from their respective areas and discussing the information during team meetings. Information on how the CARE team trains the community is outlined in the *Community Engagement & Education* section of this manual and the internal data gathering as part of the team operations is discussed below.

Risk Rubric Analysis: The CARE team analyzes the information it receives to determine the level of risk present. To do this objectively, the CARE team applies the NABITA Risk Rubric to every case. Assessing the risk is critical to identifying the concerns present in the case and deploying interventions that align with the level of concern. The process for risk rubric analysis is described below.

Interventions: Finally, the CARE team creates a plan of action and a set of interventions to mitigate the concerning behaviors and/or provide support to the community and individual. These interventions are tailored to the level of risk assessed using the NABITA Risk Rubric and to the unique needs of the case. Development and deployment of interventions is described below. The intervention phase is often on-going and not seen as a "one-and-done" approach. As such, the team will continue to evaluate the effectiveness of their interventions and action steps, re-engaging in the three-phase process of gathering data, assessing risk, and adjusting interventions as needed for each case.

REFERRALS

The CARE team referral form is public-facing and any person, regardless of their affiliation with the university, may submit a referral to the team. The CARE team allows anonymous referrals.

All referrals to the CARE team are submitted through the public referral form. This includes instances in which a team member has a student they would like discussed by the team. Additionally, if a community member contacts a team member via an in-person conversation,

email, or phone, regarding an individual for whom they have concern or who they would like to refer to the team, the team member will direct the individual to the public referral form for them to complete and/or will complete the public referral form on their behalf.

Concerns for safety, including suicidal ideation, suicidal gestures, harm to others, or significant disconnection from reality, should be first reported to 911 and/or SPS Public Safety. Following a report to 911 or law enforcement, a referral form should be submitted to the CARE team.

The members of the campus community and those who interact with the CARE team possess critical information about at-risk members of the community, as well as those who may be becoming "at-risk." One of the challenges for the CARE team is to activate, create, and operate channels of communication that allow for a flow of information from those who have it to those who need it — CARE team members.

To this end, once a referral source submits a referral via the electronic referral form, the referral source receives an automated update confirming the receipt of their referral and providing expectations for next steps:

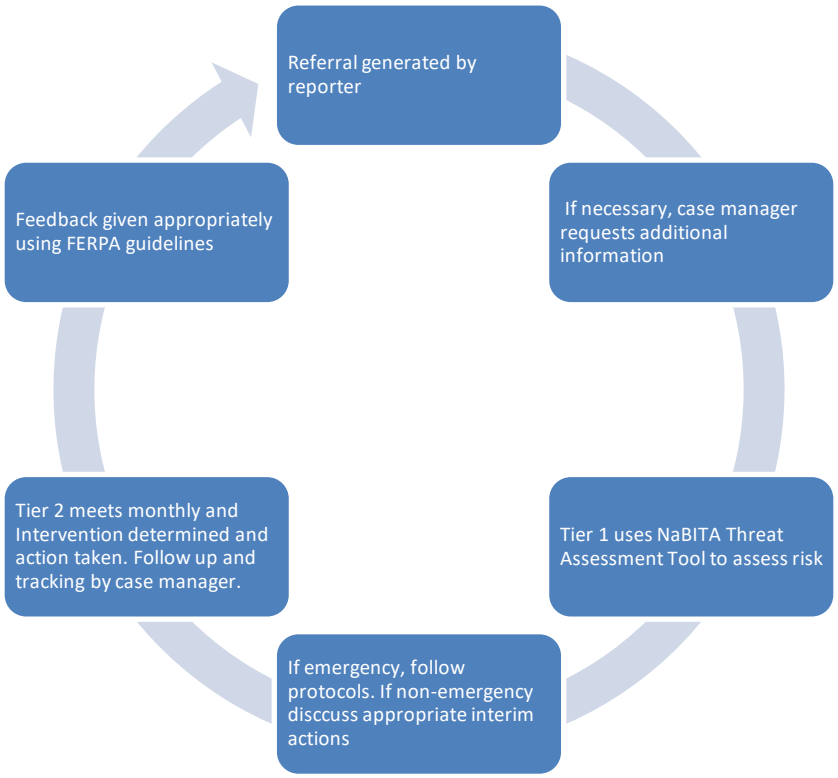
> *"Thank you for your referral to the CARE team. We screen referrals each weekday and Tier 1 members will meet as necessary to gather data, assess the level of risk, and determine appropriate action steps. Following the team meeting, we will begin taking action steps based on the level of risk assessed in the referral and through additional information that the team gathers. If you are a faculty member or staff member, or anyone else with an educational need to know updates from the CARE team as defined by FERPA, you may receive an update from a member of the team regarding the status of the individual and your referral.*
>
> *Should you continue to notice behaviors of concern, or have any follow up questions for our team, please feel free to submit another referral or contact carolee.ramsay@cuny.edu."*

If a referral lacks pertinent information for processing and/or assessing the referral, a member of the CARE team may attempt to contact the referral source to gather additional information. If additional information is not provided, the CARE team will follow its process with the available information.

For referral for students, following the team's assessment of risk and development of appropriate interventions, the team chair or a member of the team will reach out to the referral source to provide an update as permitted by FERPA. FERPA allows the team to disclose information to any staff official with a need to know and to anyone needed to help resolve a health or safety emergency. The team will always balance the need to provide helpful updates to the referral source with the need to maintain a student's privacy by sharing only the information that the referral source needs to know for the purpose of carrying out their professional or educational duties.

Other communications are tailored for specific situations and approved by the team chair. There are times when the team should consider bringing the referral source (faculty/staff) onboard to assist in the intervention process. FERPA gives the CARE team latitude to enlist relevant faculty or staff members as an aid to assist persons of concern. This helps to nurture the referral source and keep the faculty/staff member more connected to the team, and it also provides a collaborative approach to intervention and case management.

SPS CARE TEAM PROTOCOL



MEETINGS

Tier 1 meetings are conducted as necessary, usually virtually. CARE team monthly meetings with Tier 1 and Tier 2 are held on the second Wednesday of every month Tuesday afternoons from 3:00 p.m. – 4:00 p.m. Emergency team meetings may be called when a new referral or ongoing case presents an imminent threat, or other time-sensitive decisions need to be made, and team members must address the concerns prior to the next team meeting.

Before the meeting, the team chair circulates the agenda indicating the individuals to be discussed. Team members are expected to review the list and gather information from their respective areas to have the information available during the team meeting.

Regular team meetings consist of the following steps:

1. New Cases Discussion: For each new case, the team will engage in the three-phase process following a briefing on the preliminary response by the CARE team chair or designee (see Risk Assessment section below for details on preliminary response process)
    a. Gather Data: Each team member will provide a report of the information gathered from their respective area
    b. Risk Rubric Analysis: The team will engage in a discussion to determine the current level of risk for the individual of concern. The chair will guide the team to consensus to determine the risk rating (see the Risk Assessment section below for details on risk rubric analysis process)
    c. Intervention: The team will determine appropriate interventions based on risk level and assign each intervention to a team member for follow-up

2. Prior Cases Discussion: For each prior case, the team will engage in the three-phase process:
    a. Gather Data: Collect new information or updates
    b. Risk Rubric Analysis: Evaluate the need to adjust the risk level (see the Risk Assessment section below for details on risk rubric analysis process)
    c. Intervention: Determine the need for new or continued interventions or to move the case to inactive

RISK ASSESSMENT

For every case referred to the team, the team will engage in an objective risk assessment process. The team uses the NABITA Risk Rubric to facilitate this assessment. If the referral includes concerns for the content of written material (blog post, class writing assignment, social media post, etc.) then the team will also apply Looking Glass. When there is a need for further threat or violence risk assessment, the team applies additional tools as appropriate.

Preliminary Assessment: Referrals will be reviewed by the team chair or designee once per business day. During this review, the chair will determine a preliminary level of concern and possible first steps of action. If there are immediate concerns for safety, the chair or designee may initiate a welfare check, contact law enforcement, consult with other team members, and/or call for an emergency team meeting. Additionally, the chair or designee may assign information-gathering tasks or initial action steps to team or community members in order to gather more information or address immediate needs relevant to their department. All cases, whether action was taken during the preliminary assessment or not, will be discussed during the regular team meeting for a full assessment.

Team Risk Assessment: During the team meeting, the team will apply the NABITA Risk Rubric to every case discussed by the team. Using the information gathered as part of the preliminary assessment and during the data gathering phase of the team meeting, the team will come to a

consensus on the current level of risk for the case. Risk level will be reassessed each time the case is discussed at the team meeting and at the time of case closure.

INTERVENTIONS

As the third phase in the three-step process, teams develop and deploy interventions to reduce the risk and address the concerns identified in the case. The intensity and the scope of the interventions increase as the risk level increases. For each risk level, the team has a defined set of interventions appropriate for addressing the risk present, and each team member is trained to deploy interventions in a consistent, quality-controlled way. The CARE team utilizes the NABITA Risk Rubric set of interventions to guide the team decision making related to interventions.

The authority to take the recommended action or implement the intervention rests with the core members' official capacity at SPS as a CARE team member. As part of their duties as CARE team members, team members have the authority to carry out the interventions assigned to them.

Team Communication & Silo Reduction

Communication is the *sine qua non* (essential element) of an effective CARE team. Team members (core and inner circle) receive training to address barriers to effective communication. The CARE team operates more effectively when there is a sense of trust and connection among its members. This trust and connection are developed through ongoing conversations, frequent meetings, trainings, and discussions when tensions exist. The team chair watches over communication trends to ensure that problems are identified and addressed early and effectively.

Keys to Effective CARE Team Communication

1. Team members are encouraged to operate on equal footing when it comes to conversations. The CARE team avoids hierarchy or shutting down conversations based on supervisory authority or positional power. Conversations are egalitarian and all team members are encouraged to share their perspectives.

2. While conversation is encouraged, team members should also be careful about speaking outside of their areas of expertise or over-relying on unique personal experiences when making decisions. For example, conduct staff should not review health or mental health reports, and law enforcement should not be discussing the appropriateness of an emotional support animal accommodation on campus. This requires maintaining a balance, as the CARE team values diverse perspectives. This diversity of opinion is set against the backdrop of respect for each other's areas of expertise.

3. The CARE team avoids reaching decisions based on superficial concord. Diverse perspectives and "what if" scenarios should be essential to vetting the quality of an assessment and the likelihood of a successful intervention. This does not mean outright discord and harmful debate and disagreement are encouraged; rather, it means that team members make space at the table for alternative viewpoints.

4. The CARE team encourages team members to have dynamic discussions related to cases. These discussions should challenge conventional thinking and stress logic and solution-focused interventions. Team members are strongly encouraged to see each case as just that — a single event — and not to allow past frustrations or disagreements to impact future discussions.

In terms of silo-reduction, each department wrestles with the privacy (and sometimes privilege) of its information, and when and how it can appropriately be shared with the team. Most members within the core and inner circle of the team sign a confidentiality agreement, maintain records in accordance with FERPA, and are able to share information under the law's legitimate educational interest clause.

At the heart of this policy is the challenge between respecting the privacy needs of the individual while also ensuring the safety of the community. There will always be an appropriate tension between these two goals. This issue is more pressing for our counseling and student health departments, which must follow professional ethical standards and state confidentiality laws and/or HIPAA, in addition to FERPA, and these often have a higher standard of protection in terms of what information can be released.

Both health and counseling departments have requirements to share limited information when there is an imminent risk of suicide or harm to others. This is discussed in state law and the scope of practice for mental health clinicians, doctors, nurses, and other medical providers. The more challenging issue arises when the CARE team is discussing a student who is known to health services and/or counseling staff, and the privileged information kept within those departments would be useful for the team to guide its assessment and intervention, but it does not meet the standard for release. To this end, counseling has adopted an expanded informed consent document that permits the disclosure of information to the CARE team at a standard lower than imminent risk or *Tarasoff*,[1] or harm to others called the Authorization for Disclosure form.

[1] As of 2012, 33 states have adopted a mandatory duty to protect for mental health professionals in statute or common law, 11 states have a permissive duty, and six states are described as having no statutes or case law offering guidance. A duty to warn or protect is mandated and codified in legislative statutes of 23 states, while the duty is not codified in a statute but is present in the common law supported by precedent in 10 states. (*Tarasoff v. Regents of University of California*, 1976)

Psychological, Threat, and Violence Risk Assessments

The CARE team collaborates with CUNY to conduct psychological, threat, and violence risk assessments, when necessary, as part of its overall approach to prevention and intervention. Psychological, threat, and violence risk assessments provide information useful to better inform the interventions deployed by the team. Psychological, threat, and violence risk assessments are different than the risk assessments performed during team meetings using the NABITA Risk Rubric or Looking Glass, as psychological, threat, and violence risk assessments require an in-person/online interview.

Most mandated psychological assessments are conducted through CUNY Behavior-Related Medical Withdrawal and Re-enrollment Policy. Mandated assessment is an important tool for CARE teams and is conducted through this policy. **Mandated assessments are only considered when a person is rated at elevated or higher on the NABITA Risk Rubric and meets the requirement within the policy.** Psychological evaluation involves licensed clinicians and CUNY's Health Review Committee. Threat or violence risk assessments (VRAs) are non-clinical assessments designed to better understand an individual's likelihood of engaging in violence or harm to others. A threat assessment seeks to assess the risk of violence following a direct threat. A violence risk assessment is a broader term used to assess any potential violence or danger, regardless of the presence of a vague, conditional, or direct threat. These assessments are performed by either clinical or non-clinical staff, a trained member of CARE, or forensic professionals. These team members are trained by NABITA to use their tools. The evaluator uses techniques to examine risk to the greater community by asking contextual questions about the nature of the threat and risk, using computer-aided models, and assessing risk factors used to determine a level of potential dangerousness.

Threat and violence risk assessments take place when an individual is rated at elevated or higher on the D-Scale or E-Scale. The individual performing the threat or violence risk assessment must be trained in performing these assessments and will rely on a consistent, research-based, reliable system which allows the for the operationalizing of the risk levels. When a student is rated at elevated or higher as a result of behaviors on the D-Scale indicating significant emotional distress; detached view of reality placing them at risk of grievous injury, or other life-threatening, suicidal ideation or self-harm behavior; or risky behavior related to emotional health, the CARE team will use the Non-Clinical Assessment of Suicide Tool to asses risk of violence. When the individual is rated at elevated or higher as a result of behaviors on the E-Scale indicating threats of violence rooted in hostility or mission-oriented violence, the team uses a formalized approach to assessing risk of violence to others. Some examples of formalized approaches to the VRA process include: The Structured Interview for Violence Risk Assessment (SIVRA-35),[2] and NABITA's Violence Risk Assessment for the Written Word (VRAWW). These assessments can be performed by a trained member of the CARE team at no cost to the student.

[2] https://www.NABITA.org/resources/assessment-tools/sivra-35/

The results of a mandated assessment can provide decision-makers with insight into how the team can provide support or resources that improve the person's success on campus and/or that increases the safety of the individual and/or the community. Quality assessments begin with quality information. As such, the CARE team will gather information to provide to the assessor prior to the assessment. The CARE team may obtain and provide the following documents and information to CUNY/the person doing the assessment:

- **CARE Referrals and Notes:** The CARE team will gather any relevant CARE referrals and/or CARE notes. The CARE referrals and CARE notes provide context for the mandated assessment and information pertinent to the issues of concern.

- **Academic Schedule, Grade Point Average, and Transcript:** These documents provide a glimpse at students' past academic behavior, clues to periods of time that may have been more academically difficult, and information about their current professors, class locations, and frequency.

- **Criminal and/or Conduct History:** This provides some insight into the student's past behavior as it relates to following the law, code of conduct, and other policies. Information may shed light on parent involvement, substance abuse or dependence issues, and anger control and aggression.

- **Collateral Data:** When appropriate under FERPA, the CARE team will gather collateral information from relevant parties including but not limited to parents, professors, and other university staff. It provides a larger context for the student's concerning behavior. It also helps the institution manage risk when parents are involved at the start of the process, rather than calling them for the first time when their student has engaged again in violent or threatening behaviors.

- **Admissions and Course Materials:** The CARE team will check the admission or course materials for narrative essays that may provide some indication of motivation or insight into past behavior or the current issues of concern. An essay could help evaluators gain better context for understanding an individual's frustrations if they were unable to achieve their dreams or goals.

Team Training and Supervision

The CARE team is dedicated to the continuous improvement of the team through research and training. The CARE team's training approach is made up of central tenets. This is a dedication to planning and developing a training schedule to reinforce content knowledge. The goal of this tenet if for the team to develop and maintain knowledge of and engagement in best practices.

CONTENT KNOWLEDGE

Onboarding New Members: When new members rotate onto the team, the team chair will orient the new members to the team operations and protocols and to their responsibilities on the team. This orientation will include the following:

1. Reviewing the CARE Team Manual
2. Reading the NABITA Standards for Behavioral Intervention Teams
3. Reading the 2019 NABITA Risk Rubric Whitepaper
4. Watching the NABITA BIT Orientation Video Series for the appropriate team role

Ongoing Training: Each year, the CARE team will create a training schedule with content-based training and team-building opportunities. This training schedule identifies a different area of content focus each month of the year, with trainings focused on cultural and diversity issues, documentation, addressing siloed communication, mental health, self-care and team-care, threat assessment, educating the community with marketing and advertising, student death, and assessment and quality assurance. These topical trainings are facilitated by the use of whitepapers, webinars, articles, tabletop exercises, etc.

Certification: In addition to the onboarding and ongoing training, each team member will be certified in at least one behavioral intervention, threat assessment, or case management related certification course:

- NABITA's Standards and Best Practices
- NABITA's Advanced Strategies for BIT
- NABITA's Advanced Violence Risk Assessment
- NABITA's Case Management and Interventions courses
- Proactive Resolutions HCR-20 Training
- Association of Threat Assessment Professionals' Threat Assessment Training/Certification

Community Engagement & Education

The CARE team recognizes that educating the community about what to refer is one of the most essential aspects of having a successful and effective team. Driving a multi-faceted marketing and education strategy is the philosophy that community members should be equipped to identify, support, and refer an individual of concern.

It is the responsibility of faculty, staff, and students to refer any individual who is struggling academically, emotionally, or psychologically, or who presents a risk to the health or safety of the campus or its members. The CARE team therefore engages in efforts to increase the awareness of the team and to educate the community regarding who should be referred to the team and how to refer them.

When developing marketing and education content for the CARE team, the following information is a priority to communicate through all the various outlets:

- **What to Refer:** The CARE team provides information related to which behaviors, statements, or concerns should be referred to the team. This includes a list of observable behaviors or other indicators that demonstrate an individual may be in need of a referral.

- **How to Contact the Team:** There are many ways to contact the team. Ideally, community members would fill out the **electronic referral form.** This is ideal because it notifies Tier 1 team members quickly, and the information can be easily triaged or followed up on and recorded. The CARE team recognizes that community members will have different levels of comfort when sharing information. The CARE team is committed to allowing the community to refer through whatever means they feel comfortable, with the recognition that the CARE team member receiving the referral will then submit a referral through the electronic system containing the collected information. Please note that anonymous referrals may limit the team's effectiveness in dealing with concerning behavior.

- **Composition of the Team:** Community members have different levels of comfort sharing information with the team. Since gathering information is one of the most essential team functions, the CARE team acknowledges that some students, faculty, and staff members may be more comfortable approaching a CARE team member directly to make a referral. Members of the team are clearly communicated to the community and are outlined in the ***Team Membership*** section of this manual.

Documentation & Records

The CARE team maintains records in the electronic recordkeeping database, reported as **CARE** and apart from the student conduct records (which are also kept in the same electronic database). Records from CARE team meetings are entered primarily by the case manager or the CARE team chair to ensure consistency in the creation of records. Tier 1 members also have access to the individual cases kept on the campus shared Teams' site to update cases.

Records are maintained in accordance with CUNY's record and retention policy, unless there is a pressing issue that necessitates those specific notes be kept longer. This is done at the discretion of the CARE team chair. Examples of this would include a student completing extended study on campus beyond seven years, or a student with elevated or above risk who leaves campus and presents a likelihood of return in future years.

Records are kept secure, and team members are expected to keep records safely firewalled and protected. Records should not be kept on USB or thumb drives. Information kept on laptop and computer systems should be under password protection.

Data Management

A referral to the team, whether collected verbally, via email, or via phone will be input as an official referral through the electronic record keeping system. All referrals will be electronically forwarded to Tier 1 and the CARE team chair for review and discussion during a preliminary response meeting. The referrals will become part of the electronic record keeping database used for data gathering, assessment, and intervention. The referrals will be discussed with all members of the team at the monthly meeting.

Cases are not stagnant in nature and referrals to the CARE team represent a snapshot in time. What the team believes to be true today may change as a situation unfolds. Much care should be taken not to form judgments or use the information in decision-making outside of CARE team functions.

In addition, none of the data may be distributed or viewed by personnel outside the core or inner circle membership of the team without first consulting with the chair. Making notes in case files is limited to Tier 1 members of the team.

Data Reporting

The CARE team chair may compile an annual report to make publicly available on the website. This data collection and reporting allows the CARE team to understand how it is functioning and where there are potential weak spots in the team's processes and approaches. The annual report is the institutional record of the team's functionality and provides information on team

operations to campus administrators, referral sources, students, and SPS community members. The annual report can include information related to:

- Total number of referrals
- Referral numbers broken down by demographics (year in school, sex, etc.)
- Referral reasons
- Referral sources
- Risk ratings
- Interventions used
- Team training and professional development
- Team accomplishments
- Areas for improvement

Quality Assurance

The CARE team uses the NABITA Standards Self-Assessment Tool (SSAT) to engage in a team audit every two years. The SSAT is provided as a tool to complement the 2018 NABITA Standards for Behavioral Intervention Teams. Using this tool, the CARE team can assess their performance on each of the 20 standards in order to identify areas of best practice and opportunities for improvement.

An electronic, automated version of the Standards Self-Assessment Tool can be found here: https://www.NABITA.org/resources/assessment-tools/ssat/

The results of the assessment will be used to guide future training, professional development, and policy revisions for the CARE team.

Budget Considerations

There is a no set budget but budget requests made through the SPS Budget Office include but is not limited to the training needs of the team. The budget includes:

1. Marketing materials (if necessary)
2. NABITA annual membership
3. Electronic Recordkeeping Database annual fee (in conjunction with Office of Student [Conduct OSC])
4. Conferences, training, and other professional development.