Using Case Management Referral Data to Develop Trainings for the Campus Community

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Abstract

This article is a summary and review of the University of South Florida's Case Management Office and Behavioral Intervention Team referral data across the 2014–15, 2015–16, and 2016–17 academic years. The data collected includes the total number of referrals received during the academic year, in addition to respective referral sources. These data sets provide a comprehensive analysis of areas of concern identified for each referral and of the level of concern rating for each referral. Moreover, data from the current study provides a comparative analysis between the 2014–2015 academic year (pre-campus training) and the 2015–2016 and 2016–2017 academic years when trainings were implemented for campus partners and community health providers on how to identify and refer students of concern. Results show a significant increase in overall referrals and a shift toward early intervention after these trainings were conducted. Recommendations regarding developing trainings for campus communities, assessing referrals, and conducting data analysis are also provided.

Literature Review

Behavioral intervention and case management functions have long existed on college campuses (Sokolow & Lewis, 2009). Traditionally operationalized informally, these functions tended to be embedded in the daily work of full-time college administrators (e.g., the Dean of Students or the Vice President of Student Affairs) (Sokolow & Lewis, 2009). The inconsistency and lack of formal protocol and procedures created a challenge for colleges and universities, as mental and emotional health needs began exceeding the capacity of college counseling centers, resulting in the need to establish new processes for managing distressed students (Wilson et al., 2013).

While the first formal case manager position was created in 2000 at the University of Miami, the tragic shootings at Virginia Tech (April 16, 2007) and Northern Illinois University (Feb. 14, 2008) catapulted the trajectory of case management and behavioral intervention services (Sokolow & Lewis, 2009; Van Brunt et al., 2012). The Virginia Tech Review Panel brought about some of the largest shifts in the field, as it published recommendations on specific areas of campus safety and mental health concerns for students on campus. The report provided recommendations regarding how colleges and universities should share information when health and safety issues exist, and how they should review and/or revise their existing policies related to recognizing and intervening when a student is in distress (Wilson et al., 2013). Based on these events and subsequent recommendations, postsecondary institutions recognized the need for a formalized approach to students in distress and began establishing Behavioral Intervention Teams and formalized case management programs (Sokolow & Lewis, 2009; Van Brunt et al., 2012).

As the demand for campuses to establish BITs grew, colleges and universities came to realize the importance of having dedicated, full-time staff members to provide the direct service functions of the BIT, and thus the field of case management has also grown (Van Brunt et al., 2012). Such focus on direct services and having dedicated staff who can promptly and effectively respond to students' needs has alleviated considerable burden from the work of the BIT (Sokolow, Lewis, Van Brunt, Schuster, & Swinton, 2014). Where these direct case management services are housed and how they interface with their campus BITs can vary from institution to institution. At some institutions, all referrals first come into the BIT and then get referred to a case manager, while at others, the case management office is the central point of referrals, which may then be taken to the BIT (Van Brunt et al., 2012). How this referral workflow is arranged can depend on where the Case Management Office is housed and whether it follows a non-clinical or clinical model.

Although BITs and case management programs evolved out of a response to campus shootings and greater need for threat assessment, "case management today isn't limited to those struggling with mental health challenges," and BIT work is not limited to reacting to threats (Van Brunt et al., 2012). The Higher Education Case Manager Association defines "case managers" as individuals who "serve their university and individual students by coordinating prevention, intervention, and support efforts across campus and community systems to assist at-risk students and students facing crises, life traumas, and other barriers that impede success" (HECMA, 2013). Similarly, Van Brunt et al. (2012) define "case management" as a "solution-focused approach to assisting students with a wide variety of needs." Similar to case management, modern Behavioral Intervention Teams also respond to a wide variety of needs; as such, threat assessment should become a subset of the work being done by BITs and should be done proactively and preventatively within the scope of the BIT's overall work (Sokolow et al., 2014). The purpose of a BIT is to provide "caring, preventative, early intervention with students whose behavior is disruptive or concerning" (Sokolow et al., 2014).

In order to engage in preventative threat assessment and comprehensive case management services, campuses should be engaged in soliciting referrals for a wide range of issues, even low-level concerns. The Jed Foundation (2011) recommends that teams "identify early symptoms in individuals and intervene to prevent exacerbation of a problem." Early intervention red flags should include indicators such as academic difficulty, loneliness, personal loss, change in behavior, peer rejection, classroom disruption, substance abuse/misuse, excessive absenteeism, etc., as these can all serve as early signs that a student may be experiencing distress (Jed Foundation, 2011; Sokolow et al., 2014). When teams address these early indicators of distress, they engage in "intervention and support that prevents a behavioral concern from rising to the level of a threat or crisis" (Sokolow & Lewis, 2009). When teams are engaged in preventative efforts, and develop a mechanism for identifying early "red flags," they can shift from putting out fires to preventing them, allowing more time and resources to go toward other important university efforts (Sokolow et al., 2014).

For case management programs and BITs to receive referrals for early-level indicators, the campus community must be trained on what to report and when (Sokolow et al., 2014; Van Brunt et al., 2012). BITs and case management programs can create a comprehensive culture of reporting by emphasizing that each staff member that interacts with a student holds a piece of the puzzle (i.e., evidence of indicators). When all puzzle pieces are given to the BIT, and not scattered across campus through non-centralized referral processes, the BIT is able to assemble the pieces and establish a full picture of what may be going on with a student of concern (Sokolow et al., 2014).

It is much more likely for a student of concern to interact with residence life staff, academic advisors, faculty members, coaches, and other student affairs staff on a daily basis and for these members of the community to become holders of the puzzle pieces (Jed Foundation, 2011). The BIT and case management program must therefore actively educate these members of the community about behaviors of concern through workshops and trainings, brochures, folders, etc., that empowers them to be able to identify and refer students to the BIT or case management program (Sokolow et al., 2014).

USF Case Management and BIT History

The University of South Florida's Tampa campus established its BIT, the Students of Concern Assistance Team (SOCAT), in 2010. The team includes a representative from the following departments: the Dean of Students Office, Counseling Center, Student Health Services, Undergraduate Studies, University Police, Housing and Residential Education, Office of Student Rights and Responsibilities, and Graduate Studies. Representatives from the Center for Victim Advocacy, Students with Disabilities Services, and Veteran Success may also be included in SOCAT meetings if a student receives support from one of these offices and the representatives from these units can provide information that facilitates in sharing and interlocking pieces of evidence (i.e., puzzle pieces).

Building upon the implementation of SOCAT, a full-time case management position was created to chair the team and to provide outreach and direct support to students of concern. As awareness and demands of this CM position increased, the university created a formalized department, Student Outreach and Support (SOS), to house the growing case management needs of students. The office now includes a director and three full-time case managers. The SOS/SOCAT case manager performs the tasks of reaching out to students of concern, providing support and linkage to appropriate resources, both on and off campus, and developing action plans based on students' needs. Additionally, the SOS Director remains responsible for driving the SOCAT by chairing team meetings and reviewing all referrals made to SOS and SOCAT. Having the case management office chair the SOCAT and drive the referrals was an important decision that helps USF maintain a harmonious balance between SOS case management needs and the larger goals of SOCAT.

All referrals made to SOS and SOCAT are initially reviewed and screened by the SOS staff. Upon receipt of a new referral, the SOS staff: a) checks for evidence of prior referrals, b) conducts an initial screening of the level of concern, and c) determines if the case should be formally discussed during the SOCAT meetings or remain an internal case management referral. This process prompted the need for objective classification of referrals so that each case would be reviewed based on a standard set of criteria and given an assigned "rating."

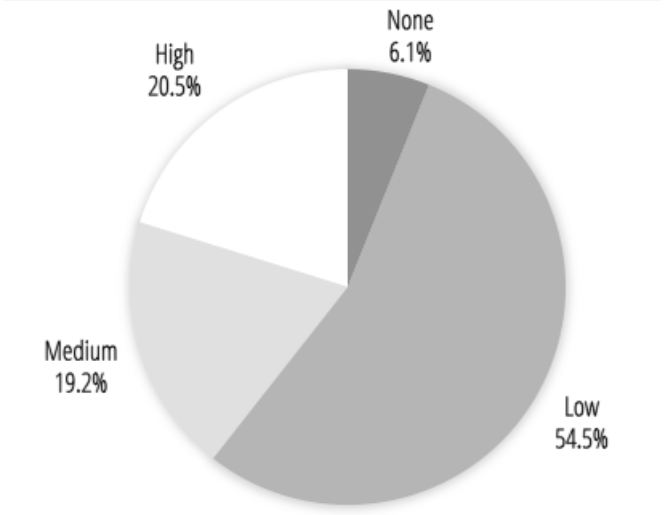
Based on the need for an objective standardized rating system, a referral rubric was developed. In its initial stages, the rubric used by USF was a three-tier scale that included the ratings of "low," "medium," and "high." The current rubric used by USF, The Case Management and Student of Concern Referral Assessment Scale, is a four-tier scale that includes the ratings of "mild," "moderate," "elevated," and "severe." *(See Appendix A for a copy of The Case Management and Student of Concern Referral Assessment Scale.)* In addition to a concern scale rating, each referral is also screened for "areas of concern." SOS and SOCAT use a standardized list of possible presenting issues and assign each referral the appropriate areas of concern as described in the description of why the student is referred.

Referral Data and Training to Campus Community

Pre-Training Academic Year 2014–2015 Data

Pre-Training Level-of-Concern Data: At the start of the 2014–2015 academic year, SOCAT and the SOS office began using Symplicity Advocate (*www.symplicity.com*) to store and track all of our SOCAT and SOS referrals and cases. This allowed us to collect robust referral data, run comprehensive end-of-year reports, and begin to analyze the data related to referrals. During this academic year, SOCAT and SOS used the three-tier referral rating scale described above to rate all referrals made to the program. SOCAT and SOS received 633 referrals during the 2014–2015 academic year. The majority of these referrals (54 percent) were rated as "low" on the concern scale, while 19 percent were rated as "medium," and 20 percent were rated as "high."

Figure 1: Percentage of Each Concern Level for All Referrals to SOS/SOCAT during the 2014–2015 Academic Year



Pre-Training Area-of-Concern Data: Each referral to SOS and SOCAT is also assigned areas of concern as described in Figure 1. The most common areas of concern during the 2014–2015 academic year are identified in Table 1. It should be noted that "mental health concern" is used as the area of concern when the referral source explicitly indicates that the student has a mental health diagnosis and is experiencing distress or a crisis related to that diagnosis. "General well-being" is used when a mental health diagnosis is not known, is not indicated, or is not evidenced in the behavior of the student, but instead the student seems to be experiencing personal or emotional difficulty.

Table 1: 2014–2015 Total Areas of Concern

Areas of Concern (*Each referral can have more than one)	12014–15
Adjustment issues	1
Bullying/harassment	1
Food insecurity	1
Arrest/conduct/other legal issues	5
Disordered eating	7
Violence/domestic/partner relationship	7
Aggressive behavior	8
Violence/threat of harm	8
Relationship/interpersonal conflict	14
Suicide attempt	15
Homeless/displaced	18
Acute intoxication	20
Self-harm/self-directed violence	20
Disruptive behavior	26
Alcohol/Other drug related issue	31
Family issues	35
Family/friend/SO death/illness	38
Medical concerns	40
Financial issues	42
Psychiatric/medication issues	45
Suicidal ideation/thoughts	80
General well-being concern	195
Academic issues (significant)	231
Mental health concerns	252

Pre-Training Academic Year 2014–2015 Discussion

In reviewing the 2014–2015 data, we became concerned that the overall number of referrals to SOS and SOCAT was too low given that our student population exceeded 41,000 in that academic year. The total SOS and SOCAT referrals made up only 1 percent of the student population. Additionally, students seemed to be referred to SOCAT and SOS either in the midst of a crisis, or after the crisis had already occurred. Our concern scale ratings and our areas of concern data supported these conclusions. The most common reason for a referral during the 2014–2015 academic year was a mental health issue(s), meaning that by the time the referral was made, a mental health concern or crisis was already evident and documented. Additionally, on the three-tier scale, we found that while 54 percent did fall into the "low" category, the "low" category seemed to capture students who were already in what could be defined as a crisis and perhaps not truly experiencing a low-level concern. For example, on the three-tier scale, some of the behavioral indicators for "low" included:

- "Showing signs of distress;"
- "Disruptive or concerning behavior is starting to impact others;" or
- Engagement in "self-medicating or substance abuse."

Perhaps even more concerning, a significant percentage (20 percent) of the referrals were classified as "high." The concern scale indicators that would classify a referral as "high" included:

- "Hostile, aggressive or abusive to self or others;"
- "Profoundly disturbed;"
- "Detached view of reality or gravely disabled;" or
- "A concrete, plausible, and direct threat has been made"

With one in five students presenting with high risk, and with the majority of referrals being for a mental health area of concern, we were often getting our referrals after a crisis was already occurring, making it difficult to employ effective interventions for the students. We found ourselves spending more time putting out fires and establishing safety for students, rather than engaging in preventative, comprehensive care that fostered student success and linked students to resources that could prevent a crisis from occurring.

After reviewing the 2014–2015 end-of-year data, it became clear to our team that we needed to do four things:

1. Increase the overall numbers of referrals to SOS and SOCAT;
2. Change the concern scale rating from a three-point scale to a four-point scale, so that each level of the scale was more specific and provided a narrower scope of behavioral indicators for the given level;
3. Shift our referrals to focus on early intervention efforts. Decrease the number of referrals rated on the higher end of the scale and decrease the number of referrals specifically for mental health concerns; and
4. Create better transition plans for students returning from a

behavioral health hospitalization, due to the large number of "high" cases.

Training Creation and Implementation

In order to achieve the outlined goals outlined in the previous section, we identified key campus partners who have daily contact with students and who could benefit from training on how and when to make a referral. Knowing that we did not have the infrastructure in place to deliver campuswide trainings or to respond to the potential influx of new referrals as a result of the trainings, we limited our pilot year of the trainings to the following campus groups: academic advisors, counseling center staff, student health services, and new student programming. In the following academic year (2016–2017), we expanded the training to include additional student affairs departments, graduate and teaching assistants, INTO (an academic Pathway and English language program to help international students), housing and residential education, and the faculty. Additionally, we partnered with each of the three major behavioral health hospitals in the area to increase the collaboration and continuity of care between the hospitals and the SOS office.

The training that was given to the campus groups identified in the earlier paragraph was a standardized presentation titled, "Students of Concern: How to Identify, Support, and Refer." This training included a brief overview of the history of case management and Behavioral Intervention Teams across college and university campuses. The majority of the training was focused on "red-flag" indicators of students in distress. These red flags included items that the SOS office identified as common presenting issues within referrals, as well as early warning signs as outlined by the Jed Foundation (2011) and NaBITA (2014). The red flags in the training included but were not limited to:

- "Change in behavior/appearance;"
- "Academic decline;"
- "Difficulty regulating emotions;"
- "Experiencing a difficult life event;"
- "Mention of emotional or personal difficulty;"
- "Expression of hopelessness/worthlessness/themes of wanting to die;"
- "Direct mention of a mental health/substance abuse/disordered eating concern;"
- "Direct threat of harm to self/others;" and
- "Behavior that appears strange, bizarre or disconnected from reality."

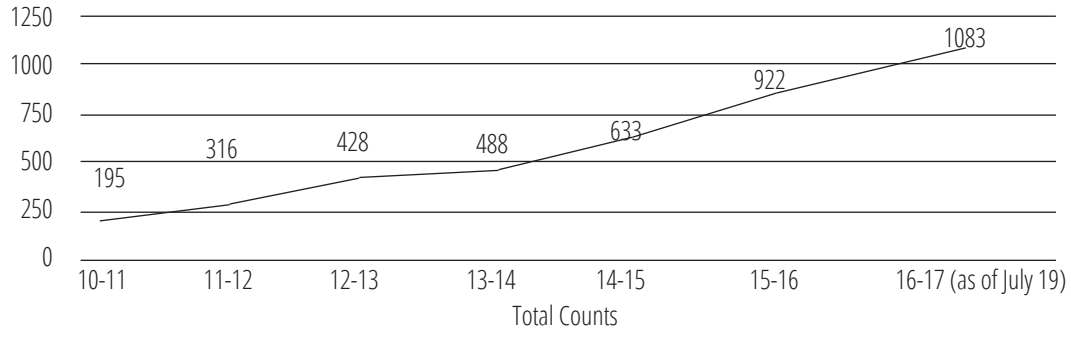
The trainees completed a hands-on activity for which they were divided into groups and given scenarios of a student experiencing differing levels of distress. The groups were then instructed to identify the red flags, how to respond to the student, and what action steps they could take to support the student. This activity led into discussions on the importance of making a SOCAT referral even if the scenario was a lower-level concern, because doing so adds to the larger "puzzle" for the student of concern. The trainees were also given step-by-step instructions on how to complete the SOCAT referral and were told that "no referral is a bad referral."

The training that campus groups received was notably different from the training given to community health providers, because of the difference in their relationship to SOS/SOCAT. The presentation to local behavioral health hospitals focused on the role of SOS case managers in assisting students who were hospitalized and returning to the university setting.

Post-Training Academic Years 2015–2016 and 2016–2017 Data

Post-Training Referral Source Data: In the first year of providing trainings, the 2015–2016 academic year, SOS and SOCAT experienced a 45 percent increase in total referrals, followed by an 18 percent increase in the referrals for the second year of trainings, the 2016–2017 academic year (as of July 19, 2017). Figure 2 demonstrates the trend line of total referrals from the start of SOS and SOCAT through July 19, 2016.

Figure 2: Total Referral to SOS and SOCAT



Referral source data was also analyzed. Referral groups that received a training demonstrated an average 355 percent increase from 2014–2015 to 2016–2017, while those who did not receive the training demonstrated an average 110 percent increase over the same time span. Figure 3 (below) provides the referral data for each population that received trainings for the both the 2015–2016 and the 2016–2017 academic years and includes the dates on which the training occurred.

In the pilot year of the training (2015–2016), academic advisors had a strong impact on the overall numbers. In the 2014–2015 academic year, they were already the second largest referral group behind faculty. After receiving the training in September of 2015, their total referrals increased by 87 percent, making them the largest referral group by a margin of 94 referrals. Additionally, student health services and the counseling center experienced 150 percent and 135 percent increases respectively. New Student Programs also received training in this pilot year, and although they experienced an increase from one referral in 2014–2015 to eight referrals in 2015–2016 after receiving the training, their referral numbers are low enough that they did not populate the chart in Figure 3.

In the second year of training delivery, academic advisors and student health services received a "refresher" training that was offered to new employees or to those who did not receive the training during the prior year. There was again an increase in referrals, of 1 percent from academic advisors and 20 percent from student health services after receiving the refresher training. Although Figure 3 shows a decline in the overall number of referrals from the counseling center, this decline became evident in the data at the end of the fall 2016 semester, and we realized that the counseling center needed the same "refresher" course that the academic advisors and student health services employees received. Following the January 2017 refresher course, there was a 94 percent increase from the fall to the spring semester in referrals from the counseling center, but this was not enough to demonstrate an increase in the total yearly referrals. As demonstrated in Figure 3, the newly targeted populations, INTO, housing and residential education, graduate and teaching assistants, and faculty, also demonstrated an increase in the number of referrals to SOS and SOCAT after receiving the training. It was also a goal to create better transition plans for students returning from a behavioral health hospitalization, and therefore local behavioral health hospitals received training on the SOS and SOCAT services tailored for their specific population's needs. This training was implemented throughout the fall 2016 semester and resulted in a 154 percent increase in referrals from behavioral health hospitals between the 2015–2016 and 2016–2017 academic years from the prior year.

Post-Training Level-of-Concern Data: The final goal of the training efforts was to shift the SOS model toward an early intervention, preventative approach. Unfortunately, due to changing the concern scale ratings from "low," "medium," and "high" in 2014–2015 to "mild," "moderate," "elevated," and "severe" in the 2015–2016 and 2016–2017 years, we cannot compare the 2014–2015 referral ratings to those of the two subsequent years. However, in comparing just 2015–2016 to 2016–2017, the data demonstrates higher numbers of referrals rated as "none" and "mild," nearly consistent number of referrals rated as "moderate" (a difference of one referral), and a decrease in referrals rated as "elevated" and "severe." Figure 4 demonstrates the percentage of referrals rated at each concern scale rating for the 2015–2016 and 2016–2017 academic years.

Post-Training Area-of-Concern Data: To get a more holistic view of the referrals coming to SOS and SOCAT, and to further establish if they are early intervention referrals, we looked at the identified areas of

Figure 3: Referral Counts by Referral Source

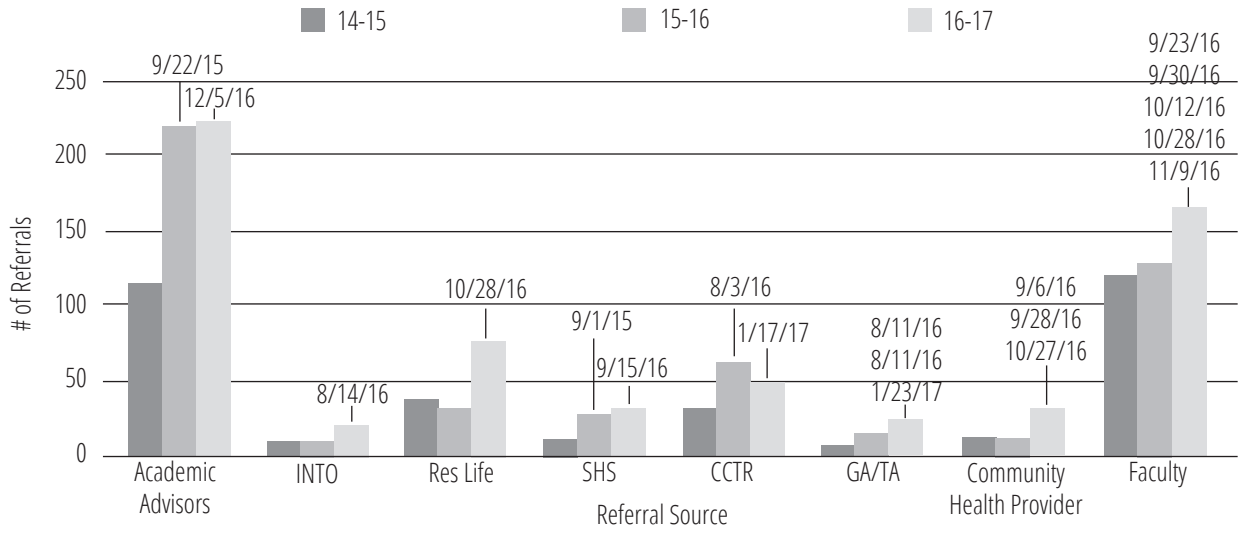
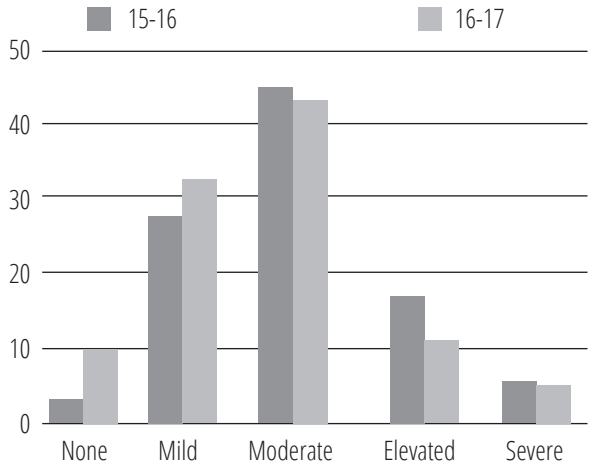


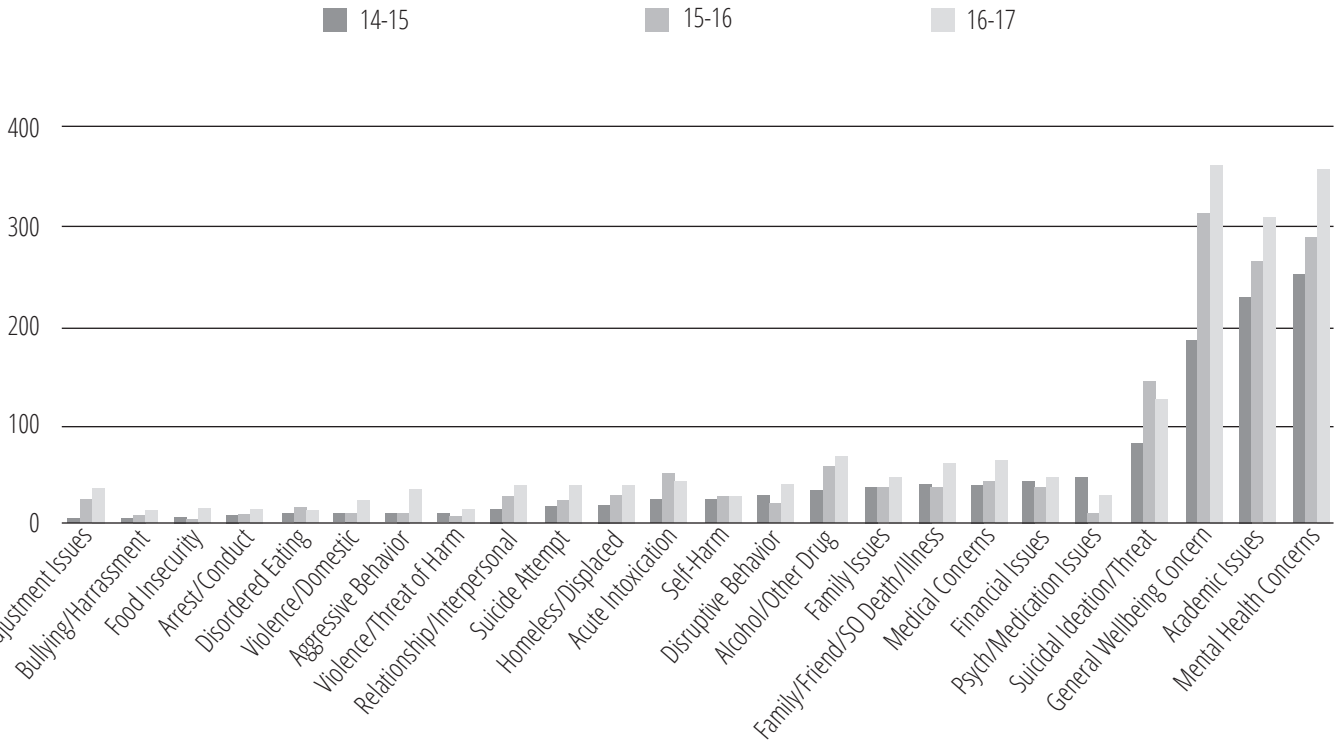
Figure 4: Percentage of Referrals for Each Concern Scale Rating



concern for each referral. Figure 5 provides the total number of referrals categorized in each area of concern for the 2014–2015, 2015–2016, and 2016–2017 academic years. In both the 2015–2016 and 2016–2017 academic years, "general well-being" exceeded "mental health concern(s)" as the most common reason for a referral, which was a shift from "mental health concern(s)" being the most common referral in the 2014–2015 academic year.

Additionally, there were notable percentage increases in several categories of areas of concern. "Adjustment issues" represent the largest percentage increase (3,800 percent) from 2014–2015 to 2016–2017, as there were initially no referrals for this issue in 2014–2015, but 23 in 2015–2016, and 39 in 2016–2017. Table 2 shows the areas of concern that experienced the largest percent increases over the span of the 2014–2015, 2015–2016, and 2016–2017 academic years.

Figure 5: Areas of Concern Year-to-Year Comparison



Limitations

We recognize that the findings in our training efforts do not imply causation; however, we believe that the interpretations of our pre- and post-training referral data is significant and reveals important trends in referrals to SOS and SOCAT office.

Our decision to implement targeted training to our referral sources was a collaborative, departmental process. Since these training efforts were transparent to our staff and an intentional effort to increase our goals and scope of services, we are aware that our data and findings may be subject to implicit biases in the post-training stage and the way that our

Table 2: Percentage Increase Between Fall 2014 and Summer 2017 for Areas of Concern

Concern	Percentage
General well-being concern	86
Disruptive behavior	88
Suicide attempt	120
Alcohol/other drug related issue	125
Violence/domestic/partner relationship	128
Arrest/conduct/other legal issues	140
Relationship/interpersonal conflict	142
Bullying/harassment	1,000
Food insecurity	1,300
Adjustment issues	3,800

data was interpreted. As stated before, the SOS office reviews and rates all referrals received to SOCAT. Therefore, we predict that a degree of bias may be present in the way referral levels were rated after training began. These changes in referral ratings can be seen in Figure 4. The SOS staff reviewing referrals and determining which rating on our four-tier rubric is appropriate may have been more likely to rate at a lower level of concern, knowing that our training efforts were targeting earlier "red flag" students.

Additionally, as shown in Figure 5, our "areas of concern" ratings may have been affected by implicit biases, with our staff categorizing more referrals on a "general wellbeing concern" as opposed to a "mental health concern." To reduce the level of bias in these findings based on our classification of referrals and areas of concern, our office developed a collaborative approach to rating all referrals submitted. Each referral was reviewed and rated by the team as a whole, so that any one individual staff member would not be determining these classifications single-handedly, therefore hopefully decreasing the occurrence of this bias in our data. Additionally, all referrals that were determined to meet the threshold for a SOCAT review were rated at our weekly SOCAT committee meetings and voted upon by all members of the team.

Discussion And Implications For Practice

The pre- and post-training referral data suggests that training potential referral sources on how to identify, support, and refer students of concern can influence overall referral numbers, the number of early intervention referrals, and the reasons for which students are referred. Therefore, we believe the trainings were successful in helping SOS and SOCAT achieve the four goals outlined after reviewing the 2014–2015 referral data. As indicated in the data reported earlier, the population groups that received the training were much more likely to make a referral to SOS and SOCAT than those groups that did not. Among each of the populations that received the training, there was an increase in the number of referrals to SOS and SOCAT for each year they received the training. The only exception to this was from the counseling center in 2016–2017.

As explained previously, this group did not initially receive a refresher course in the fall semester, and its referral numbers declined. After receiving the refresher course in the spring semester, SOS and SOCAT again saw an increase in the referrals from this population. This suggests that it is important to deliver initial trainings to referral sources, and then to also offer refresher courses to train new staff members and to remind returning staff of the key elements of how to identify, support, and refer. These data sets suggest that having the training not only gives the referral sources the skills and knowledge about what to look for as early signs of distress, but it also reminds them of the services overall and prompts them to make referrals for students with whom they may have been working but did not think to refer.

Our findings also suggest that the trainings were effective in shifting the culture around when to make a referral to SOS and SOCAT. In the 2014–2015 academic year, the data showed that SOS and SOCAT received one in five referrals for students experiencing extreme distress, direct threats, and primarily mental health concerns. After implementing the trainings, SOS and SOCAT experienced notable changes in the types of referrals they received. Overall, the most common referral shift was from mental health concern(s) to general well-being concern, indicating that referral sources were no longer waiting until they knew it was a mental health crisis before making a referral. Instead, referrals were observed to be at the stage where the individuals simply had reason to believe the students of concern might not be doing well and could benefit from general support.

Additionally, referral sources began making referrals for adjustment issues, food insecurity, relationship difficulties, and feelings of being bullied/harassed, at much higher rates. As explained in the literature and recommendations from the Jed Foundation (2011) and NaBITA (2014), these are key early indicators that students may be experiencing difficulties, and can serve as early intervention points to assist students before a crisis occurs.

Based on our findings, we recommend that case management programs and BITs engage in the following practices:

1. Assess all referrals and assign a level of concern to each.
2. Screen all referrals for presenting issues and/or areas of concern.
3. Conduct data analysis and create data reports at least annually.

4. Design and implement a training for campus and local community providers on your scope of services, and on how to identify, support, and refer students of concern.

It is important for case management programs and BITs to assign levels of concern and areas of concern to each referral. These should be assigned based on an objective tool such as a rubric or concern scale, and tracked through official recordkeeping so that end-of-year or end-of-semester reports can be generated. This type of data collection will allow teams to identify overall trends and to develop programmatic and or policy changes accordingly. It is also imperative that case management programs and BITs intentionally train their communities about how and when to make referrals. A well designed and thoughtfully implemented training can impact the number of referrals that ha team receives, as well as the scope of early intervention versus crisis referrals the team receives.

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Appendix

	Concern For General Wellbeing And Harm-To-Self Scale * Developed by: Makenzie Schiemann and Lori Makin-Byrd	**Possible Action Items/Goals**
MILD	• No threat made or present. • Behavior is appropriate given the circumstances. • Experiencing situational stressors. • No indicators of current significant mental health, substance abuse/misuse, eating disorder, etc. • No history of mental health issue, substance abuse/misuse, eating disorder, etc., and no prior referrals. • Experiencing limited or no impact of areas of functioning (e.g., mood, social, academics, etc.).	• Offer meeting to student. • Refer to campus or community resources. • Communicate with faculty regarding potential academic impacts. ENCOURAGED CONTACT
MODERATE	• Threat may be present but is indirect or through engagement in risky behavior, including non-life threatening self-harm. • Behavior is somewhat disruptive/concerning and indicates distress, • Impaired ability to regulate emotions and actions, and possible presence of mental health issue, substance abuse/misuse, eating disorder, etc. • History of mental health issue or prior referral. • Hospitalization related to acute intoxication. • Experiencing some impact in more than one area of functioning (e.g., mood, social, acad., etc.).	• Offer meeting to student. • Deliver ongoing case management services. • Connect with campus/community resources. • Consult with the campus/community resources. • Communicate with faculty regarding potential academic impacts. • Assist in facilitating course reduction/withdrawal. ENCOURAGED OR REQUIRED CONTACT

ELEVATED	• Threat is made with possible intent, student is engaging in potentially dangerous threatening self-harm behavior, or student is engaging in risky behavior that creates concern for safety. • Behavior is disruptive, unusual/out of place, concerning/unsafe, and starting to impact others. • Observable, present difficulty with significant mental health issue or significant and unsafe substance abuse/misuse. • History/recent behavioral health hospitalization, hospitalization related to drug/controlled substance, or frequent reports over a short period of time. • Significant impact on multiple areas of functioning, making it difficult to function in a healthy way or to be academically successful.	• Perform wellness/safety check. • Meet with student. • Deliver ongoing case management services. • Connect/consult with resources. • Create follow-up plan for ongoing monitoring. • Notify parent/guardian. • Issue mandated assessment. • Assist in facilitating course. ENCOURAGED OR REQUIRED CONTACT
SEVERE	• Threat on life has been made that is likely to be carried out or threat has been carried out unsuccessfully, or student is engaging in significant and life threatening self-harm. • Behavior is actively dangerous to self. • Inability to care for oneself and function autonomously in a safe way. • Behavior appears disconnected with reality and is profoundly disturbed/distressing. • Hostile, aggressive, or severely alarming to other. • Recent behavioral health or drug-related hospitalization.	• Perform wellness check/initiate hospitalization. • Meet with student. • Notify necessary parties (SRR, DOS, UP) to create plan for safety and/or interim measures. • Deliver ongoing case management services. • Connect/Consult with resources. • Create follow-up plan for ongoing monitoring • Notify parent/guardian. • Issue mandated assessment and/or facilitate withdrawal. REQUIRED CONTACT
	Concern for Disruption to Community and Harm to Others Scale * Developed by: Makenzie Schiemann, Nicole Morgan, Maria Zale, and Dominick Marckese	**Possible Action Items/Goals**
NONE	• No threat made or present. • Engages in debate and arguments without causing disruption. • Appropriately disagrees, the comments made are on topic and relevant to the discussion, even if they are controversial or negative. • Responds appropriately to criticism or redirection. • May be expressing opinions which could be considered different than the "norm" or the majority.	• No contact. NO CONTACT REQUIRED
MILD	• Threat may be present but is indirect or is a perceived threat through engagement in disruptive comments or behavior. • Behavior is considered socially inappropriate or rude. • Expresses feelings of rejection, injustice, or being treated unfairly. • Has hardened or extreme point of view.	• Offer resources to student. • Offer meeting to student. • Provide guidance and education to referral source. ENCOURAGED CONTACT
MODERATE	• Threat may be present but does not include possible target or intent. • Continues in disruption/debate/argument even after being redirected. • History of conflict with peers or authority or holds grudges. • Repeated verbalization of injustice or being treated unfairly, and/or holds grudges. • Overly attached to particular group or person.	• Request to meet with student. • Provide resources to student. • Provide guidance and support to referral source. • Consult w/UP. • Refer to SRR for review. ENCOURAGED OR REQUIRED CONTACT

ELEVATED	• Threat is made with possible target, intent, or access to weapon related to the threat. • Has moved from words to action (i.e physically intimidating or posturing versus yelling). • Has experienced "loss of face," humiliation, or has lost connection to meaningful activity or person. • Has begun to fixate on target by identifying specific groups, or person, or by expressing violent fantasies that include a target of a group or person. • Glorification of violence or violent events/actions.	• Consult w/UP. • Refer to SRR for possible conduct action or academic disruption. • Establish safety of involved parties. • Duty to warn to possible target. • Provide resources to referral sources and/or potential target. • Meet with student. ENCOURAGED OR REQUIRED CONTACT
SEVERE	• A direct threat has been made which includes a target, timeframe, and plan of attack. • Has engaged in rehearsal or "last-act" behaviors. • There is evidence of gathering a plan, tools, weapons, etc., to provide means to carry out attack.	• Call UP. • Refer to SRR. • Duty to warn to target. • Establish safety of involved parties. • Provide resources to referral source and/or potential target. REQUIRED CONTACT

Case Management and Student of Concern Referral Assessment Scale

The Case Management and Student of Concern Referral Assessment Scale contains two scale indicators, as well as corresponding charts for possible action items or goals. The team reviewing the referrals will utilize the appropriate scale given the presenting issues noted in the referral. For referrals which indicate concerns that fall under both scales, the reviewing team will issue two ratings, one from each scale.

Concern for General Wellbeing and Harm-to-Self Scale

This scale is to be used to classify the level of concern and to establish a potential response plan for students referred for issues related to general well-being concerns, mental health concerns, social service needs, emotional difficulty, psychiatric hospitalization due to harm to self or inability to care for one self, threats of harm to self, etc. This scale is not to be used when the referral indicates concern for threat of safety to others or disruption to campus.

Concern for Campus Disruption or Harm-to-Others Scale

This scale is to be used to classify the level of concern and to establish a potential response plan for students referred for issues related to significant disruption, aggressive behavior, and threats of harm to others.

Possible Action Items/Goals

This section of the concern scale is intended to guide the reviewing team in their decision making regarding potential interventions for the student. This list is not exhaustive or prescriptive and may vary based on the needs of the student and/or the campus community. Additionally, the possible action items/goals will change as the concern rating for the student changes.

For example, a referral may initially be rated as mild, but after the initial intake with the student or after working with the student over time, the concern rating may increase and therefore the possible interventions will also change.

Instructions for Issuing Concern Rating

When determining the rating for the concern scale, the reviewing team use the following guidelines:

1. The student will be classified in the category for which they meet the majority of bullets.

UNLESS

2. The student matches the threat bullet in a HIGHER rated category. Then the student will be increased into the higher rating based on the threat present.