D·PREP
SAFETY DIVISION
BIT/CARE STANDARDS

RECORD KEEPING

Documentation occurs in a variety of different aspects for BIT and CARE teams. Records of assessment and intervention efforts allow the team to better defend their actions and provide insight and direction for those picking up on a case where others may have left off. At the heart of quality documentation is the creation of a clear and consistent process that allows team members to work collaboratively and provide quality care and support to students, faculty, and staff. The old legal adage applies here: "If you don't write it down, it didn't happen."

The DPrep Safety standard on record keeping offers a succinct summary that should guide the BIT/CARE team in its documentation process:

> The Behavioral Intervention Team (BIT) follows a clearly designated process for record keeping that ensures all case documentation is accurate, up-to-date, clear, and consistent. The team utilizes a secure technology platform, such as Maxient or a comparable system, to manage case records efficiently and confidentially. To promote consistency and confidentiality, all case-related communications, including discussions, updates, and case assignments, are conducted and documented exclusively through the database. The team does not use additional methods of communication for case information, which helps maintain a clear, auditable record of all team activities related to each case.

Good documentation provides risk mitigation in the legal realm; allows for accurate oversight of cases over time; and increases continuity of care across service providers, positions, and during personnel vacancies. Behaviors that bring an individual to the attention of the team can pose risks and potential liability for both the student and the professionals working with them. Consistent and quality recordkeeping (from the initial intake document and informed consent through ongoing contact/case notes) provides documentation and a clear paper trail of what, where, when, why, and how services are offered.

What Goes in a Note?

The old story of Goldilocks applies here when considering notes. We want each note to be "just right," not too short and not too long. The basic information contained in most BIT/CARE notes should include:

- **Who is involved in the case.** Make sure to include clear details about who the stakeholders are in each case. This often includes the identified student of concern, those impacted, the person(s) making the report, and staff involved in the assessment and intervention of the case.
- **What happened.** Include a clear summary and timeline of what happened. When additional details are available in other documents, such as an incident report or case management note, refer to that location rather than repeating them in the note.
- **Where the event occurred.** Note clearly where the event(s) occurred in relation to the timeline.
- **When the events occurred.** Include times relevant to the case at hand, and make a note when these are estimated. Remember to document clearly and include the hour, day, month, and year, as notes are often read further in the future as cases develop.
- **Why the incident occurred.** Describe the potential motivations for the incident, but avoid subjectivity and opinion. When clear facts aren't known, make sure to explain that in the note. Think about creating a hypothesis rather than assuming how an incident occurred. Hypotheses should be educated guesses supported by the facts.

Quality record keeping:

Helps ensure quality, consistent, and well-informed service delivery.

Provides a safeguard for the team in the event of legal challenges.

Decreases liability exposure for the team.

Reduces the "silo" experience among team members.

Provides an opportunity to review completed cases to identify areas for improvement or best practices.

- **How the event or incident occurred.** Include observations related to the unfolding of the event relative to the overall context. Did some behaviors lead to additional behaviors over time? How are the elements of the incident related to each other?
- **Triage risk level.** The assessment of an initial triage risk level should be established for each case that comes to the BIT/CARE team. DPrep Safety recommends the use of the Pathways triage system.
- **Action items.** The note should always include steps taken by each assigned team member, with a date and time for the next contact or process.

Length of Notes

The length of the note depends on the nature of the case. Cases that involve multiple departments, suicidal or homicidal risk to others, or a unique or overly complex presentation will need longer notes than cases that are more straightforward, have limited connection to various campus departments, or are new cases where information still needs to be obtained. The average team note should be 5-7 sentences with the first two sentences describing the nature of the case, the second two sentences describing the team's assessment of risk and intervention, and the last few sentences describing next steps.

As part of our Inside CARE series, DPrep Safety demonstrated how a team might work through a case centering on a student experiencing suicidal thoughts and manic, erratic behaviors during a mental health crisis. As this is a complex case, the note might look something like this:

> *Annie Carter is a 20-year-old junior living on campus. Annie had previously been hospitalized for mental health issues and referred to counseling and case management. Recently, her behavior has again raised concerns, particularly regarding erratic and disruptive actions affecting her roommates and peers, including staying up all night, loud and pressured speech, and making passive and direct suicidal comments. Academically, Annie's performance has declined despite her previously strong GPA. Faculty and residence life staff have noted troubling social media posts and classroom disruptions, while financial issues and inconsistent medication compliance further complicate her situation.*
>
> *Interventions will focus on maintaining Annie's safety and supporting her continued engagement with campus resources. Counseling will increase outreach efforts when appointments are missed, and case management will maintain regular, informal check-ins. Her Pathways risk rating was rated high, reflecting new suicidal ideation and academic decline. A suicide risk assessment and a violence risk screening (DarkFox) will be conducted. The team emphasized the importance of balancing her autonomy with proactive safety measures, especially in housing and academic settings. Res life staff will be supported, and options such as changing her rooming situation were considered but not prioritized.*
>
> *Other action steps include continued engagement from counseling and case management, outreach to Annie's instructors for academic updates, and a parent notification by case management. The team will monitor her closely and reconvene next week to reassess progress and adjust interventions accordingly.*

An example of a shorter note comes from a new case involving a student who caused a disruption in his sociology class that included a threat to the professor.

> *Jordan, a sophomore, repeatedly disrupted Intro to Sociology classes with off-topic remarks and dismissive behavior. When asked to leave after using their phone, Jordan threatened the professor, stating, "You'll regret it." The incident caused concern among students and was reported to campus security. The CARE team assessed the risk as moderate on Pathways and will follow through with a violence risk assessment to determine the dangerousness and actionability of the threat. The assessment will be conducted by case management, and Jordan has been given a no-contact directive related to the professor and the class. Counseling will provide outreach to support Jordan, and the Dean of Students will contact Jordan's parents on this matter. Plan to meet again next week to discuss.*

Good BIT/CARE documentation should be structured, consistent, timely, provide a transparent account of the nature of the incident, and clearly describe the decision-making process with supporting justifications. All team members should be trained on this process to ensure consistency.

Format of Notes

As mentioned earlier, consistency is truly a central hallmark of good team documentation. This means that everyone on the team writes their notes clearly and consistently. There are several approaches to note-taking and documentation that are used in the medical and counseling fields that may be useful to consider in a BIT/CARE context. Whichever outline you use, make sure to use it consistently across all cases and train all team members on how to write notes through clear policy, training, supervision, and reflective feedback.

- **DAP notes:** The DAP process involves outlining the data related to the situation that occurred, an assessment of that data related to a level of risk, and a plan to address the behavior moving forward.
- **DART notes:** The DART process involves a description of the event that occurred, an assessment of those events related to the risk, the responses of the BIT/CARE or threat team to the event, and the treatment plan moving forward to address the behavior.
- **SOAP notes:** These notes include the team's subjective review of the case material (subjective meaning a review based on the initial facts of the case, understanding these are incomplete), an objective review of the facts without any summary or opinion, an assessment based on both the subjective and objective discussions, and a plan to move forward with the case.

Ground Rules for Notes:

Don't write too much or too little. Find the Goldilocks amount of "just right."

Be succinct. Good writing is simple and to the point.

Documentation is a learned process. It will improve over time with supervision, guidance, and feedback.

Avoid inflammatory or opinionated language in the notes.

Notes should be objective, consistent, and avoid emotional language.

Consider the use of direct quotes in the documentation.

Avoid the use of jargon or clinical diagnoses. Documentation should be easily read and understood by each member of the team. Items such as police codes or psychological diagnoses should be avoided.

Let's consider the case of Alexis, a first-year student who comes to the attention of the CARE team after her third alcohol infraction on campus. Here are some examples of how these case notes could be written in different formats.

Narrative Format:

Alexis, a 19-year-old first-year student, has been struggling with alcohol misuse since the beginning of the semester. She was documented by residence life staff for returning to her dorm visibly intoxicated on several occasions, including one incident that required emergency medical attention for excessive drinking. Professors have reported declining academic performance and frequent absences. Friends have grown concerned about her risky behavior at parties and emotional volatility. The CARE team became involved after a third alcohol-related referral. Alexis was offered support through the university's counseling center, enrolled in an alcohol education course, and placed on a wellness contract to help track progress and maintain accountability.

DAP/DART Format:

Data: Alexis is a 19-year-old first-year student who has had three alcohol incidents during her first semester on campus. Her drinking has occurred in the dorms and has resulted in one off-campus hospitalization. She is experiencing challenges with her academics, difficulty with her peers, and concern over her conduct case, potentially resulting in her leaving school.

Assessment: Alexis' Pathways assessment was rated high, and the team recommends a further alcohol assessment with the counseling department. There are no current suicidal behaviors or thoughts, but the team would like counseling to assess this risk more directly.

Plan/Response: Alexis will meet with counseling this week for her assessment. She has been enrolled in the campus alcohol education program, as directed and overseen by student conduct. Campus conduct will meet with Alexis and contact her parents. A behavioral contract will be used to outline other behaviors she can choose when she considers drinking. Clear expectations about her not consuming alcohol will be shared through conduct (notifying her that a future infraction would result in an immediate suspension).

Treatment: Following the alcohol and suicide assessment with counseling, Alexis will begin weekly counseling sessions to improve her coping skills and address ways to avoid future substance use. Counseling will discuss with her the availability and appropriateness of group supports such as AA.

SOAP Format:

[For this format, let's assume this note follows her counseling meeting]

Subjective: Alexis reported feeling overwhelmed and stressed since starting college. She stated, "I didn't think it would be this hard to adjust. Drinking just helped me feel less anxious, but now it's making everything worse." She acknowledged multiple alcohol-related incidents, including being transported to the hospital and receiving residence life warnings. Alexis expressed concern about falling behind academically and isolating from peers. She appeared motivated to make changes and open to receiving help.

Objective: Alexis arrived at her assessment on time, dressed appropriately, and was cooperative throughout the session. Her mood appeared low but stable. There were no signs of intoxication or acute distress. Her insight and judgment were fair. She demonstrated awareness of the impact of her drinking and a willingness to engage in services. No current suicidal ideation or safety concerns were reported.

Assessment: Alexis appears to be struggling with transitional stress and poor coping via alcohol use. Her behaviors are consistent with those adjusting to college and engaging in risky substance use. Her acknowledgment of the issue and readiness to change are positive steps, though continued monitoring and support are needed.

Plan: Alexis will begin weekly individual counseling to address stress management, substance use, and emotional regulation. She will complete the mandatory campus alcohol education program (confirmed start next Monday). She will develop and sign a wellness contract in coordination with Student Conduct. The CARE team will continue to monitor her progress.

One of our team members, Dr. Amy Murphy, suggests the following format for case notes. If we return to the Annie case mentioned in the previous section, this would be another example of how to capture that note. This note is a bit longer in its format, but it contains useful information needed for future follow-up by the team.

Name: *Annie Carter*
Date of Birth: *06/23/2005*
Classification: *Junior*
Academic Program: *Sociology? Did not specify, but the faculty team member knew her.*
Previous Case: *Referred in spring 2025 for mental health hospitalization.*

Referral/Report Information: *Residence life reported that roommates indicated erratic and disruptive behaviors such as outbursts, staying up all night, talking rapidly and loudly, impulsive behaviors, and concerning comments related to hopelessness and suicide.*

Additional Information:

- *Academic performance concerns – attendance, disorganization, 3.3 GPA*
- *Counseling informed consent on file, previous referral, some participation and connection, some missed appointments, medication adjustment, no prior attempts*
- *No conduct activity*
- *Case management relationship – financial concerns regarding medication*
- *Other financial concerns with spending and parking tickets*

Assessment: *The triage risk tool assessed the risk as high based on the following behaviors: suicide, academic, intense thoughts, financial insecurity, depression, paranoia. Recommends Suicide Wayfinder and Darkfox.*

Advanced assessment tool results:

- *Initial rating on Pathways is high with a recommendation for full violence risk assessment.*
- *Pending assessment completion with Counseling and Case Management.*

Interventions:

- *Case management and counseling take the lead, collaboratively work toward an updated assessment, parent notification, and continued and consistent counseling participation.*
- *Low-level conduct referral to reset expectations regarding disruptive behavior in the halls.*
- *Res life will follow up regarding the need for a room change and roommate support.*
- *Tammy is reviewing the academic situation and faculty observations.*

Future Case Management/ Mitigation: *Following the assessment, communicate to res life and the team any specific safety planning issues/needs*

Case Status: *Active – Discuss in next meeting*

What to Avoid

In our trainings, we offer a cautionary tale on documentation mistakes that teams should avoid. Having these core ideas in mind while writing your notes can help team members stay centered on completing the documentation process well.

Delay: One of the biggest concerns related to note-taking is ensuring that they are completed promptly. The standard is typically 24/48 hours. The longer we wait to write notes, the more likely we are to forget details.

Lavish Writing: Lavish notes have extra detail and length that make readability difficult and may allow bias to weave into the narrative in a way that could impact the assessment of risk and development of the risk mitigation plans. Avoid using too many adjectives and adverbs in your writing and focus on a more objective (rather than subjective) summary of events.

Here is an example of an overly lavish note created by a BIT/CARE team member clearly working on their career as a fiction writer.

> *Maya, a bright but quietly struggling biology student, found herself drowning in a sea of loneliness and despair, her pain hidden behind polite smiles and fading classroom presence. When her unspoken cries for help surfaced in a chilling note discovered by her RA, the campus CARE team sprang into action with urgency and compassion. They found Maya in the aftermath of a suicide attempt, her dorm room heavy with the silence of suffering too long ignored. In the days that followed, a carefully woven net of support: counseling, psychiatric care, academic adjustments, and peer mentorship, was wrapped around her like a life-saving blanket. The team didn't just treat Maya's symptoms; they acknowledged her humanity, her pain, and her healing potential. Slowly but powerfully, Maya began to reclaim her place on campus, turning her story of despair into one of resilience and hope.*

Sparse Details: Overly short notes that lack any detail or direct information are equally problematic as the overly lavish notes. Short notes are often created quickly because the team member is running behind, or a misplaced fear that longer notes open the team up for liability issues. Failure to document your process in an appropriate amount of detail shows a lack of care and attention to detail that creates a negative view of your team's process.

Here are two examples of notes created in a terse and sparse manner by a BIT/CARE team member who is behind in keeping their notes updated. Both notes lack critical details about the case, the assessment of risk, and who on the team will be responsible for follow-up.

> *After receiving a failing grade, a college student issued a threatening remark toward his professor during class, prompting a campus-wide threat assessment and resulting in his emergency suspension and referral for psychiatric evaluation.*

> *Maya, a 20-year-old college student struggling with severe depression and suicidal ideation, came to the attention of the CARE team after a suicide attempt. She received immediate intervention and ongoing support to help her begin the journey toward recovery.*

Technical Language: CARE team notes should not include diagnoses or coded language. Abbreviations, when used, should be clearly explained so that anyone reading the notes can follow them easily.

This example is written in an overly technical fashion from a law enforcement/student conduct perspective.

> *On the afternoon in question, a verbal threat was issued by a male college subject during a scheduled academic instruction period. The subject, upon receiving a failing grade, stood and made a statement that multiple witnesses perceived as a targeted threat toward the instructor. The incident constituted a potential violation of campus policy and criminal statutes pertaining to intimidation and terroristic threats. Immediate notification was made to campus security and the BIT, triggering a multidisciplinary threat assessment in accordance with established protocols. Data gathering included collateral interviews, a review of digital communications, and a welfare check, which identified multiple psychosocial stressors but no imminent threat indicators (e.g., means, intent, or plan). Based on the SPJ framework, the subject was placed on interim suspension under emergency administrative authority and referred for a comprehensive psychiatric risk evaluation, with conditions for potential reentry pending clinical stabilization and compliance with institutional mandates.*

This example is written in an overly technical fashion from a psychological and counseling perspective.

> *Maya, a 20-year-old female college student, presented with symptoms consistent with Major Depressive Disorder (MDD), including anhedonia, persistent low mood, impaired concentration, social withdrawal, and academic decline over a period exceeding two weeks. Her behavior escalated to a suicide attempt via intentional overdose, indicating active suicidal ideation with a specific plan and means, meeting criteria for a severe depressive episode with high risk for self-harm. A third-party report triggered institutional intervention, and the BIT initiated a welfare check, resulting in emergency psychiatric hospitalization under criteria for danger to self. Upon discharge, Maya engaged in outpatient treatment involving CBT and pharmacological management, likely with an SSRI, to address her depressive symptoms. Maya's prognosis improved with structured psychosocial support, therapeutic compliance, and protective campus factors, allowing for gradual recovery and increased engagement in pro-social activities.*

Emotionality: Notes should not have a negative tone or contain subjective opinions. Notes should explain the facts as they are presented to the team, describe a risk rating, and outline a plan of action without a negative tone or attitude.

In the following examples, the team member's feelings about the case are very easy to discern from their tone in writing.

> *Maya had been falling apart for weeks, skipping class, barely speaking, and basically disappearing in plain sight. It took a panicked RA stumbling across a heartbreaking note for anyone to sound the alarm, and by then Maya had already attempted to end her own life alone in her dorm room. The CARE team swooped in with protocols and treatment plans. She finally got the therapy and support she needed.*

> *Jeremy completely lost it in class after getting a grade he didn't like. Instead of taking responsibility for his failure, he stood up, made a creepy, low-voiced threat toward his professor, and stormed out like a ticking time bomb. The whole class sat there in stunned silence while this guy acted like the victim, as if the world owed him something. It was terrifying and unacceptable that someone could make a direct threat and walk out like that without consequences. The campus had the sense to call security and get the CARE Team involved. The school let him take a voluntary withdrawal.*

Documentation Wisdom

They say wisdom comes from experience. Our team of subject matter experts provided the following advice borne of their years of experience.

- **Know your audience.** Students may be able to request access to notes written about them. Records can also be obtained by subpoena or shared with others via a release of information. Keep a broader audience in mind when writing notes.
- **Keep notes secure.** Avoid taking notes home with you or saving notes on thumb drives or other portable media. Learn to access your BIT/CARE database from home (if this is an option) and keep your notes secure in this fashion.
- **Avoid duplicate notes.** Team members should not keep private notes during the meeting. While they may want to jot down some ideas about the case, the unintended effect here is creating a second set of "books" that could be discoverable by the student, parents, or even the media. If you keep scrap notes during the meeting, discard these notes in the normal course of business as you enter the information into your database.
- **Close the loop.** When notes are audited, they are read chronologically by the external investigator. If you mention a serious issue like suicide or harm to others in a BIT/CARE note, make sure you address that issue in the next chronological contact with the student. This may seem like common sense, but often students will resolve an issue and show up again to the attention of the team with a brand-new dilemma, forgetting all about their past problems.
- **Be consistent.** Each team member should have access to the database to enter their notes into the system and should be trained in what they should include. Some teams use a single person to enter all notes into the database during a BIT/CARE meeting. While this can create a higher level of consistency across various cases, it can lead to a team becoming overly dependent on that one scribe to do all the writing.