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The Role of the Counselor on the Behavioral Intervention Team

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Abstract

Clinical staff wrestle with a wide variety of challenging scenarios where they are asked to share information and must decide what they can or cannot share with police, the BIT and law enforcement. Where do the rights of the client end and the rights to community protection start? Is there an assessment that would be helpful in determining the level of risk for the client in terms of hurting themselves or others? Should the counselor be in contact with the client's parents? Is there a duty to warn? This paper addresses

the role of the counselor on the Behavioral Intervention Team, and the sharing of concerning material from counseling sessions with the BIT.

Introduction

When information from counseling sessions does not reach the level of duty to warn others but is concerning nonetheless, it can be difficult to determine what counseling content can be shared with the Behavioral Intervention Team. The information potentially sits within the silo of the counseling center, and the campus BIT is limited and shielded from say, the fact that a student is having fantasies of killing his classmates. It places the counselor in a difficult position that could prevent forward progression.

This paper seeks to explore the clinical, ethical, and scope of practice issues related to the role of a mental health counselor on a BIT. We will explore the issue of information sharing between the counselor and the BIT.

History

Following the Columbine shooting on April 20, 1999, schools looked for ways to prevent this kind of tragedy from happening again. The Federal Bureau of Investigation, Department of Education, and Secret Service authorized studies to provide a template to better understand this violence and give professionals an approach to prevent targeted violence (O'Toole, 2000). This approach was further researched and expanded upon following the April 16, 2007 Virginia Tech massacre (Vossekuil et al., 2000, 2002; Virginia Tech Review Panel, 2007). The National Behavioral Intervention Team Association (NaBITA) was formed in 2007 to train and implement teams grounded in these recommendations and the long history of literature and research developed to prevent workplace violence such as the U.S. Post Office shootings that occurred in the 1980s. The most common names of these teams are BIT and CARE (Campus Assessment Response and Education). They will be used interchangeably throughout this paper.

About BITs

BITs work in three stages; they identify, assess, and manage threat and dangerousness in school communities (Sokolow, Lewis, Shuster, Swinton, & Van Brunt, 2014). These multidisciplinary teams solicit reports of concern from throughout the school community. A group of professionals with expertise in student behavior and discipline, security and law enforcement, and mental health gather this information and apply an objective risk rubric and violence risk or threat assessment. Once the level

of risk is defined, the team deploys coordinated interventions in collaboration with other school efforts. These teams offer something different from a "one and done" approach to threat and violence risk management by instead focusing on longer-term, collaborative interventions that remain in place until the risk has been reduced. BITs are not punitive in their approach, but rather preventative and focused on connecting those at risk to resources and moving them from the pathway of violence toward social integration.

Key Terminology

BIT and CARE teams consist of between seven and 10 individuals from counseling services, guidance, school resource officers, law enforcement, student affairs, and disability services (Sokolow, Van Brunt, Schuster & Swinton, 2014). They meet regularly to gather information from the community, process this information with a research-based, objective risk rubric, and develop interventions that are designed to mitigate the risk over time and keep the individual and community safe (Van Brunt, 2018). The role of the counselor on the BIT has long been a central area of debate and discussion.

Before addressing this multi-faceted issue, it is helpful to clarify what the field means by 'a counselor.' For the purposes of this paper, the term counselor will be used to identify a mental health clinician who has a license to practice in a given state and is hired by the school to provide mental health treatment. This includes psychologists, psychiatrists, and professional clinicians (e.g., clinical social workers, professional counselors, couples and family therapists, pastoral counselors/campus pastors, etc.). It is not enough to be a licensed mental health professional; rather, the employee must also be tasked by the school, under the scope of their license, to provide mental health treatment. This does not include licensed professionals who work in different capacities such as an instructor, academic advisor, or in other administrative positions.

With respect to the sharing of client information, there are three levels of legally conferred protection: privacy, confidentiality, and privilege. These protections can be created by statute, by courts, or by codes of professional ethics. This paper will refer to all three, using the specific understanding of those terms elaborated here:

- Private information, in a higher education or school context, is information protected by the Family Educational Rights and Privacy Act (FERPA, n.d.). Private information can be shared internally when there is a legitimate educational interest, often referred to as

a “need-to-know.” Private information can be shared externally when an exception to FERPA is met, such as in cases of emergencies, dependency, and consent. FERPA protections extend only to records kept by college officials in a written or recorded medium. Information you learn of or know of from in-person interactions that is not made into a record is not protected by FERPA. A right to privacy has also been recognized by the courts outside of statute when there is public revelation of information in which an individual would have a reasonable expectation of privacy. A lawsuit, resulting financial damages, or loss of a professional license could occur from this kind of breach of privacy.

- Confidentiality is more protective layer of legal insulation. Confidentiality, whether conferred by statute or ethical codes, is the right of a client/patient to control how information they share with a professional is protected. Because the client has the right of confidentiality, the professional has a commensurate duty to maintain that confidentiality. Confidentiality is most often conferred in the relationship between therapist and client, or between a health care provider and patient. It can also be formed between advocates and victims, or in some states, between athletic trainers and athletes. Confidentiality is more protective than privacy, because there is no authorized “need-to-know” basis for breaching confidentiality. Instead, confidentiality is bounded by consent of the client or patient, by statute and exceptions to statutes, and by court-made doctrine, as in situations of a duty to warn (e.g., the *Tarasoff v. Regents of University of California*, 1976 case). Exceptions to confidentiality vary from state to state and can pertain to child abuse disclosures, HIV+ status, elder abuse, substance abuse, and other statutorily created health or safety risks. Additionally, confidential records may be subpoenaed and/or may be accessible by an employer in the event of litigation. A confidential relationship is often demarcated by the creation of an informed consent that explains the protections afforded by the relationship.
- Finally, the most sacrosanct level of protection under the law is that of privilege. Privileged communication is secret and protected from disclosure, which can only be pierced by a court order or waiver of the owner of the privilege. Privilege is rarely in play for the BIT but would readily be found in the relationship of lawyer-client, spouses, journalist sources, and the confessional; though clergy may only have the protections

of confidentiality in some jurisdictions. There are many nuances to what kind of communication, even within the relationships described as privileged, can actually be legally protected. There is also some bleed between categories. For example, courts recognize doctor-patient privilege in most jurisdictions, while statutes and ethical codes may also protect the doctor-patient relationship with confidentiality. In addition, a medical records privacy act (the Health Insurance Portability and Accountability Act, HIPAA, n.d.) also confers patient privacy. Privilege and confidentiality protect the relationship, whereas HIPAA (and FERPA in a college environment) protect only the records of the relationship.

Sometimes, the terms privacy and confidentiality are intermingled, confusingly, as in the Department of Education’s Office for Civil Rights regular reference to confidentiality of Title IX proceedings. Yet, there is no statutory mandate for confidentiality under Title IX, so the protection is more accurately framed as that of privacy. In an even more challenging application, some states use different terms, and interchange confidentiality for privilege. Some states confer confidentiality, while others protect the same information as privileged. So, sometimes the terminology varies. But, where the distinction is strict, the most meaningful contrast is that ethics codes can only require confidentiality but cannot confer privilege. Only courts or statutes can confer privilege. The same information could thus be confidential by ethical mandate and privileged by state or federal law.

In keeping with the theme of various uses for the same terminology, the term “counselor” is often used to describe those who are neither licensed nor hired to practice mental health treatment by the school. In these cases, communication is governed by FERPA and allows for a broader sharing of information with the BIT than is permitted by those working within the scope of professional licensure. These might include non-clinical case managers, advisors, career counselors, and athletic support specialists. Client treatment records kept by licensed counselors who were hired to provide treatment are not protected by FERPA, as those records are already protected by state laws and/or ethical codes that include stricter confidentiality protections for treatment records (DOE, 2016).

Non-treating counselors are quite helpful to students in need of personal guidance, academic support, life coaching, and assistance in navigating crisis events and life stresses. However, they often do not possess the training, clinical experience, and

state support through licensing standards to provide mental health assessment and treatment required by state law. While non-treating counselors are helpful in a large range of services offered to students, they should not replace the role of licensed mental health clinical staff and are not the focus of this paper.

PreK–12 school counselors, and those with school counseling certificates, are also guided by FERPA and ethical standards in their profession, as opposed to the higher levels of confidentiality required of those with mental health licensure. Medical staff are similarly governed by confidentiality concepts, namely state laws and HIPAA (if the center or provider is a HIPAA-covered entity). In most cases, HIPAA does not cover school counseling centers or health centers, unless they are engaged in electronic insurance billing. Many schools over-comply with perceived HIPAA requirements that really don't apply, so legal counsel should always be consulted. Even if insurance is billed electronically, HIPAA still won't apply if only students are treated. In that case, FERPA applies.

Much of the discussion and advice offered in this paper applies to licensed doctors, nurses, nurse practitioners, psychiatric nurse practitioners, clinical nurse leaders, physician assistants, and those medical staff members who have a license and provide clinical care to students. Like clinical staff members who are licensed and hired by the school to provide mental health care, the discussion of their role on the BIT is very similar. The caveats are licensed medical staff who are in a teaching role, or who are supervising an internship or practicum experience, and are not hired by the school to provide direct clinical service to students. These staff members are not held to the same confidentiality standards as those in clinical roles, and only the lesser protections of privacy will pertain — and only to records. The same caveats exist for licensed mental health staff who serve in supervisory and teaching roles, student affairs leadership (e.g., orientation, advising, or staff overseeing a student organization), or other non-clinical roles. Having a counseling degree or license in a drawer does not protect anything if you are not operating within the scope of that degree or license.

Scope of the Question

A counselor is a critical, core member of the BIT. Nationally, close to 75 percent of cases discussed by BITs involve a psychological aspect (Van Brunt & Murphy, 2016). A counselor's expertise and experience are critical to the team's dialogue and providing information about psychological concerns. Their knowledge often affords them the ability to be the lead in a case management plan as the team moves toward a multi-faceted intervention. Case management integrates health care, social services, and other sector services and supports for people with complex mental

and physical health conditions. There are multiple components and variations of case management, depending on the context and client population. A counselor is perhaps best positioned to understand these considerations.

When considering the role of the counselor on the BIT, information sharing is a critical area, rife with conflict and confusion. For instance, what information is the counselor able to share with the team about the students they are treating, given the expectation of confidentiality? Can they let the BIT know that a student is being/has been seen? How treatment is progressing? If the student missed an appointment? Does the student pose a danger to the community? Is there truth behind the concern that a counselor sharing information will lose licensure? Some counselors are even worried about learning about their own clients from the team. Should they be? Can informed consents and/or a release of information be used to give counselors more latitude to share confidential information with the team?

There are two common forms that are often used by counseling centers and clinicians to navigate the challenges of information sharing. A Release of Information (ROI) is a straightforward document that outlines information sharing between the therapist/counselor and other departments or providers. An example of this document can be found at the end of the paper. An Informed Consent document is given in addition to an ROI at the start of treatment to discuss the rights and responsibilities of the client and the clinician. A more detailed version of this document might include a paragraph that gives the clinician permission to share some limited information with the BIT when there is an imminent risk or concern. NaBITA refers to this as the Expanded Informed Consent (EIC) document. Both of these documents and the adjoining processes are discussed in more detail later in this paper.

Information Sharing

In preface, it is important to note that counselors do not jeopardize confidentiality simply by having membership on a team or sitting in on a team meeting. In fact, learning about a client during a meeting is not unethical. Some counselors consider it vital and take information from the team back to the therapeutic relationship. This flow of information from the BIT to counseling is much less contentious and it allows the clinical staff to make addendums or notations in the charts for other clinical staff.

The converse is often the most complex issue for counselors serving on a BIT, with respect to the level of information to share with the team. Confidentiality is the bedrock of the counseling profession and is often the most complex issue for counselors

as they try to understand their role on the BIT. There are three primary considerations around information-sharing for licensed mental health and health care professionals.

First, as noted above, most professionals working at institutions of higher education are governed by FERPA when it comes to information sharing. State and federal laws and ethics codes, rather than FERPA, control when the information is considered part of the treatment or patient record. Licensed counselors and medical professionals, however, have licensure standards that supersede FERPA regulations, and as such, they are held to more stringent standards of confidentiality than everyone else on the BIT.

Second, in most states, mental health laws protect the information regarding an individual's treatment as privileged or confidential. Third, the ethics codes of mental health professionals have standards protecting the confidentiality of clients' treatment records, but also go beyond the legal standard to include participation in treatment (so-called "contact confidentiality"). This is addressed in the American Counseling Association (ACA) ethics code (B.1.b. & B.1.c.) requiring counselors to respect the privacy and confidential information of prospective and current clients (ACA, 2014).

When exploring the issue of clinical staff sharing information with the BIT, it is helpful to understand the various legal and ethics standards involved so that the full spectrum of options can be considered. To this end, let's review five possible stances or roles a mental health clinician or health professional might take on a CARE team or BIT.

1. "Disconnected and Silent": The counselor will not attend the BIT meeting, consult on cases, or be involved in any way. As the result of the limits of confidentiality, the counselor is not allowed to offer any information and therefore does not need to attend. They prefer to work in the confidential counseling center and view BIT work as outside their scope or role as a school employee. Alternatively, the counselor attends the BIT meeting, but refuses to participate actively. They acquiesce to attendance as it is a job requirement but share nothing and take nothing away from the meeting. Needless to say, this is not the most well-regarded approach.
2. "Consulting Counselor": The counselor attends the meeting and speaks only in hypotheticals. They consult on cases and share information about general mental health topics (e.g., the risk of a suicidal student after an inpatient hospitalization, the best treatment approaches for eating disorders, or how Autism Spectrum

Disorder responds to medication). They do not talk about active or past clients with the BIT or make diagnoses of students being evaluated by the BIT.

3. "Sharing Helper": The counselor makes use of an Expanded Informed Consent (EIC) that students can choose to sign, allowing counselors to have a wider latitude to share information with the BIT when the counselor determines it would be in the best interests of the client. Sometimes, the counselor will inform the client of the decision to share before doing so. The counselor shares information as outlined in the informed consent to support the work of the BIT and keep the community safe, while also valuing the confidential nature of the relationship with clients. The counselor may go so far as to offer the team hypotheses about concerning behaviors related to mental health or share informal assessments about student subjects of the BIT who are not clients.
4. "Out on the Limb": The counselor may or may not use the EIC, knowing that they may risk censure, but probably not loss of licensure. If they use the EIC, they use it more expansively and share information with the team that is not just in the best interest of the client, but also for protection of the community. This professional speaks in hypotheticals that are obviously not hypothetical, uses the "cannot confirm or deny" code, back channels information, and is often willing to share confidential information about whether someone is known to the counseling center and is attentive to their treatment program. They may hear a road map for an intervention, and simply signal assent or objection without offering much more. Alternatively, they may help to frame a road map for a student without letting the team know the student is a client. They mean well, trying to ensure their client is safe, but also share with the BIT in a way beyond which a typical client would likely be comfortable (regardless of the presence of an EIC).
5. "Unconditionally Open": Some counselors may not give their client a choice about an EIC, or don't create an EIC with the client, or act in violation of the terms of an informed consent. The counselor shares everything they know about a client with the BIT, usually without the knowledge of their client, without any deference to their license or state laws. They see job security as paramount and comply with whatever is required by the BIT, or they imaginatively view the BIT as a "treatment team" within the bounds of their confidentiality. This counselor may earnestly believe that ethical rules were framed for private practitioners, not those in a campus

context, where overzealous protection of information can get people killed. Or, the counselor may have convinced themselves that their administrative role, governed by FERPA, supersedes their ethical duties as a therapist. Sometimes a clinical director who serves on the team uses the rationalization that they do not have a treating role, but shares information known to their supervisee counselors.

It would be reasonable to argue that the first and last stances are the least desirable from the team perspective. “Disconnected and Silent,” the first stance, is extreme, engenders problems with job compliance, and undermines the role of the BIT. If the school needs a counselor on the BIT, the counselor has some duty to comply. Likewise, showing up to the meeting and doing nothing is equally problematic in terms of work performance, team effectiveness, and the relationship with the BIT. “Unconditionally Open,” the fifth stance, could violate state law and/or ethical practice guidelines for licensed clinicians, or at least subject the clinician to an ethics inquiry.

This leaves conversation associated with the question, “What can a counselor share with the BIT?” centered around three positions: 1) the “Consulting Counselor” (second stance), which allows the counselor to share hypothetical and consultative information, 2) the “Sharing Helper” (third stance), which creates a special condition that allows the counselor to practice within their scope of licensure, and 3) “Out on a Limb” (fourth stance), which may be highly desirable to the team, but too risky for many counselors or health providers. As a result of the proliferation of BITs at schools, we would argue that it is now the standard of care for counselors who have a responsibility to sit on the BIT to minimally adopt the Consulting Counselor stance. This allows the team to benefit from the counselor’s expertise and allows them to speak broadly about mental health issues, using their experience to better inform the team without running afoul of their client’s expectations, ethical boundaries, and/or state law.

An example of a Consulting Counselor would be one who says, “Typically, students who [specific information about the client’s situation] do [this].” This allows the clinician to speak hypothetically about students, within the context of a specific case. It could offer some specific guidance or insight about the student’s situation that is couched in a broader context. Counselors adhering to this approach can even share broad comments about mental health behavior and diagnoses throughout the meeting, rather than just when specific clients are mentioned. The Sharing Helper strikes a balance between the obligations of the counselor to maintain confidentiality and the team’s need for information. The simplest

and most streamlined way to achieve this is through asking the student in question to sign a Release of Information (ROI) form. This release of information allows the counselor to share attendance information, treatment, and clinical details within the client’s expressed and detailed permission. This can take the form of a full release of all information or a limited release of information to share things like attendance and an overall statement of progress.

One challenge associated with the Sharing Helper stance is the timeliness of information needed by the BIT. Often, BIT members want to know whether a student has followed up with the counseling center in order to decide the next best course of action. If the Expanded Informed Consent has not already been signed, this information will not be available in real-time. One way to address this challenge is by managing how students “arrive” on your BIT list. For instance, the counseling center could give copies of an ROI to the Dean of Students, CARE manager, counseling center, etc. for students who come into contact with their office, anticipating they may be called upon to give/receive information about a student. Multiple points of entry (asking for full or limited information) would make it less likely that a release would need to be signed on the spot.

A potential complication occurs when a faculty member refers a student to a BIT via a web-based anonymous “care report” that outlines the problematic or concerning behaviors. The members of the BIT have no way of knowing if that student has already accessed the services of the counseling center. Sending a student an ROI from the BIT, with or without explanation, might engender confusion or promote feelings that “big brother” is watching, and create greater alienation at a time when help is needed the most. Caution should be taken to ensure the department obtaining the release fully explains the document in a meaningful way and does not pressure or coerce the student into signing, but rather underscores the limitations and right of refusal. An example of this document is provided at the end of this paper.

Another way to approach this challenge is by providing all students who enter treatment the opportunity to sign an Expanded Informed Consent (EIC) form. The use of this form is a point of contention in the field and (see Table 1). More narrowly, an EIC could be used selectively with only those clients the counselor anticipates might need to come to the attention of the BIT, or could be offered later in the treatment process, if the student’s condition is not stabilizing. This stance is challenging, given that it may be hard for the counseling staff to assess this prior to the initial intake. From a pro-EIC position, this form allows the student’s counselor to share information with the BIT to keep

the client and/or others safe, even though the situation has not met the imminent “duty to warn” threshold. That said, it is not recommended to have all students sign such a release upon admission to the school, as true consent can only be given at the onset of treatment.

An informed consent document explains the nature of the counseling relationship and spells out the rights and responsibilities of both parties in the relationship (clinical staff and client). Most informed consent documents cover issues of cost of treatment, session limits, cancellation policies, what to do in case of an after-hours emergency, mandatory reporting laws related to minor and elder abuse, and how records are kept. The expanded consent supports the student’s journey through counseling and can mitigate issues that may arise in the greater community, or that could impact student success. It provides the student with the knowledge there will be a broader safety net should they spiral out of control. It allows for a “may share” condition for the clinical staff rather than an obligation; meaning they can share information if that makes sense in the clinical scenario, but they are not obligated to. It would also be advisable to give the consent a date of renewal that allows for a new consent to be obtained each year, providing the student a chance to be reminded of the process.

Example language of an Expanded Informed Consent (EIC) document:

Counseling and Psychological Services (CaPS) will release information from counseling sessions to outside parties at the request of the client. Records are confidential and will not leave CaPS unless there is an emergency situation. CaPS will not answer questions about any client from parents, family, friends, significant others, professors, employers, or anyone else outside of CaPS staff without permission from you. The only exceptions to this policy are for limited emergencies outlined below.

Parents and guardians are not contacted unless we have permission from the client or if there is a credible risk to the safety of the client or another member of the campus community (i.e., suicide risk/attempt, emergency room evaluation, and/or a threat to themselves or others), and CaPS has a reasonable belief that involving parents or guardians will aid the situation. If there is a risk, information may only be shared that aids in obtaining ongoing care and ensuring safety. In rare cases where there is a risk to the student or the community, CaPS reserves the right to notify the

Behavioral Intervention Team, especially if the student is an active danger to themselves and/or to others. In case of such a release, the information shared will be limited to only as much as is necessary to mitigate the risk. Where possible and practical, the client will be informed of such a release in advance.

An EIC may be put into use in a case where a client discusses recurrent fantasies about going to class and stabbing all the other students with his knife. He talks about this desire for 20 minutes with his counselor and alludes to a journal he keeps where he scripts what the attack would look like. He then assures the counselor that he would never do this, but just thinks about it a lot. This would be an instance where the counselor may wish to share information with the BIT to ascertain if the student is having problems in other areas around campus. Alternatively, the counselor could share a general concern and seek input from the team, allowing them to know the student is on the radar. No confidential information may be shared other than “I know this person.” While the BIT might not take any action, the information sharing may help initiate discussions about the client’s behaviors in other aspects of his student experience or round out information that has been previously brought to the team’s attention.

Another potential scenario could be a client who talks of trying to kill themselves by grabbing the gun out of a campus police officer’s holster. The student later says they would never do this, but just has these thoughts. In this case, the counselor might want to share this information with the BIT and law enforcement (if a representative is not already on the team) so the officers are aware in the event this client interacts with them. This sharing would be even more pressing if the student has a history of depression, impulse control problems, access to weapons, or suicide attempts. The practice of this concept is certainly more complicated depending on the size of the institution, the type of police (sworn officers, local department, security, private armed security), and the relationship between the school and the community law enforcement agency.

Cautions Against Expanded Informed Consent

One of the main arguments against the use of an EIC suggests it erodes client autonomy and confidentiality, the cornerstone of the therapeutic relationship. There is a concern that the EIC is used to make the client aware of whom the counselor should/must/may legally inform in the case of an emergency or duty to warn situation. This should/must/may language shifts from state to state and is an essential element for clinical staff to understand related to sharing. An ROI would be the sole document that gives the counselor permission to share specific information in

non-emergency situations. Another concern is the potential for coercion on the part of the licensed provider requiring the client to sign an EIC as a condition of treatment, which also reduces client autonomy. There is another issue with BITs pressuring counselors to use EICs, as well. It is also possible that an ethics board might take the position that offering an EIC is an ethical breach by the counselor, or that overuse of an EIC, or an overly broad interpretation of what can be released under an EIC, would also risk an ethics inquiry.

While there may be arguments that medical settings use a single release to share information with the entire department, a BIT is a closed system of professionals who also have an obligation to maintain privacy. Records of the BIT are governed by FERPA, and those records are only permeable to those who have a legitimate educational interest, internally, or those who meet a FERPA exception, externally. Clinical treatment information shared with a BIT, with or without the EIC, becomes part of the educational record and protected by FERPA. The information is effectively removed from the protection of state mental health laws and moving forward the BIT can use that information at its discretion without the counselor’s input. While some may argue it is the counseling center’s right to set the limits of confidentiality for the clients they serve, others would suggest this is an overreach and that boundaries of confidentiality should be limited to those mandated by state law.

Clinical staff have long struggled with the ethics and ambiguity of when to share information in the interest of protecting the client and the community. Some argue the aspirational use of an ROI is the most appropriate path, as staff already have disclosure laws in place that allow for sharing in emergency situations to create safety. Clinical staff would see the EIC as chipping away at confidentiality by expanding minimal disclosure, threatening autonomy, and diluting transparency. Trust between the client and therapist is paramount in the relationship, and the EIC shakes the foundation of the therapeutic alliance by starting the relationship with a heightened potential of a breach of trust. This could also limit what a student will share in therapy, making the treatment less effective.

Counselors, as with all members of the BIT, should have access to the BIT recordkeeping system. Similar to information sharing and interactions in a BIT meeting, counselors need to determine the appropriate level of recordkeeping in the BIT database. Information included in BIT records is protected by FERPA. Thus, if privileged clinical information is shared with the BIT, it is no longer protected by privilege. To this end, counselors should be cautious of the level of detail of the notes they record for the BIT.

Ways to use an Expanded Informed Consent (EIC) document well:

- Empower offices such as student conduct, BIT, disability services, and the Dean of Students office to discuss the limited need for ROI and EIC documents.

Table 1. *The Expanded Informed Consent*

Reasons to Use an Expanded Informed Consent (EIC)	Reasons Not to Use an Expanded Informed Consent
Allows clinical staff the choice to share sub-imminent risk with the BIT, to allow for collaborative intervention.	May erode the privacy of information sharing between client and therapist, a cornerstone of the relationship. Might cause the client to withhold their most candid thoughts or fears.
It is a common practice in other medical settings where a single release creates the ability to share with a multi-disciplinary staff (e.g., hospital E.R. or residential care).	Schools differ greatly from medical settings and the EIC could cause a slippery slope between client and therapist relationship that erodes the privacy of the relationship.
It is reasonable for the clinical staff to set some limitations on confidentiality and services such as: abuse to an elder or child, insurance billing, session limits, scope of practices, psychological testing, and information sharing with the BIT.	Lack of clarity and understanding about what it means to sign the “informed consent” could lead the student to sign on for something they do not completely agree with. Student could also feel coerced to sign.
Offers legal protection for clinical staff who may otherwise have to hold onto sub-clinical threatening information (e.g., a student who has fantasies about killing others, but no plan to act upon this).	Even when the EIC is limited to a single person in student affairs, it will likely be shared with the entire team (re-disclosure concern). Once information leaves the confidentiality of the clinical relationship, it may become protected only by FERPA, a weaker standard of disclosure.
Gives the counseling center an opportunity to be seen as solution-focused and working toward a common, collaborative goal with student affairs.	Could create a stigma around the counseling center sharing information that may lead to disciplinary responses, and thus create a hesitation for others seeking services.

- Clearly explain the EIC so the client understands what the expectations are around information sharing, and review expectations as needed throughout treatment.
- Define the role and purpose of the BIT and how the multidisciplinary team approach can be helpful to the client.
- Consider limiting release to a specific person, position, or department, rather than the entire CARE team or BIT. This could create a challenge if the person is out sick or away and would necessitate the identification of an alternate designee that the student understands would serve in this role during these times.
- Allow a client to “opt out” when it comes to this section of the EIC. The EIC can be amended if the student is particularly concerned about this provision.
- Have a time frame associated with the EIC so that it must be renewed and is not durable. It is reasonable to ask a student to sign a new EIC at the start of each academic year.

Instead of using an Expanded Informed Consent (EIC) document for all clients, the clinical staff could:

- Speak in hypotheticals all the time for all cases, which allows the clinician to give guiding insight without specifics. By speaking in hypotheticals for all cases, the counselor avoids the risk of only sharing information when the student is a client and essentially confirming services without explicitly saying so.
- Use the EIC document only for higher-risk cases identified during the intake or those involving referrals from inpatient units or other higher-risk scenarios (e.g., transfer from another school with chronic, high-risk psychological history). Caution should be applied to ensure the rubric is created and applied in a manner that does not discriminate or inaccurately imply the presence of a diagnosis equated with a higher risk for violence.
- Automatically request an ROI to the BIT for all higher-risk cases that come in on intake or those involving referrals from inpatient units or other higher-risk scenarios (such as a transfer from another school with a chronic, high-risk psychological history).
- Use an ROI when there is a need to share information with a third party.

There is an inherent tension between the rights of the client and the rights of the community to be kept safe when a client shares a risk. This tension never dissipates, and a good counselor learns how to practice with this tension, doing their best to keep their client's information privileged and the trust of the relationship paramount, while keeping an eye toward the greater community and working collaboratively with the BIT.

Conclusion

Counseling staff are critical to the successful development, application, and intervention approaches of a BIT. They are useful in providing consultation, assessment, and ongoing intervention. Given their special status related to information protection and the limits associated with this, it is equally critical that schools understand the boundaries that accompany clinical staff as they participate on the team. It is essential to separate personal feelings or preferences from ethical and state law decisions on how licensed clinical staff may assist with the BIT process, such as the assumption that involvement of counseling staff lends itself to a therapy-based solution, rather than a predominantly conduct-related approach.

Counseling staff should clarify their role on the BIT by engaging BIT members immediately in conversations about the function of the team and how a partnership would be helpful. Not all BIT members are fully versed in what constraints or opportunities mental health providers have when sharing information. This conversation can be based on topics gleaned from this paper and used as a way to provide clarity to all team members. In the end, the BIT is most effective when counseling staff have well-defined roles on the BIT and are collaborative and fully engaged members of the team.

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Appendix A

Authorization for Limited Release of Information

[Office of the Dean of Students and/or Director of Student Care Services/Title IX Coordinator] for Students is requesting authorization for a limited release of information. By signing this document, I am authorizing the following information to be released:

- That I have scheduled a counseling appointment for the future
- The name of my counselor
- Dates and times of past appointments
- Whether I have attended or missed appointments
- Disclosure of referrals to other offices or services on and/or off campus

I authorize Counseling Services to provide attendance information to the Dean of Students and/or Director of Student Care Services/Title IX Coordinator as requested. My authorization will automatically expire within one year of the date signed unless otherwise specified by me below.

- When the information is no longer requested by the [Dean of Students and/or Director of Student Care Services/Title IX Coordinator]
- Other: _____

I understand that:

- I do not have to sign this authorization and my refusal to sign will not affect my abilities to obtain treatment at Counseling Services.
- I may cancel this authorization at any time by submitting a written request to Counseling Services, except where a disclosure has already been made in reliance on my prior authorization.
- The [Dean of Students/Director of Student Care Services/Title IX Coordinator], as requested representatives receiving this information, are not health care or medical providers covered by HIPAA privacy regulations, thus the information stated above could be re-disclosed, only as permitted by FERPA.

Department or person requesting authorization: (e.g., Dean of Students or Director of Student Care Services/Title IX Coordinator)

Printed Name of Student and ID#: _____

Signature of Student: _____ Date: _____

Request Reviewed by: _____ Date: _____