Behavioral Threat Assessment and Management Institute

Documentation and Case Notes

Why documentation matters for the BIT/CARE or threat team. Good note-taking:

- 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.
- Is useful in reducing the "silo" experience among team members.
- Provides an opportunity for a review of cases once they are completed to identify areas of improvements or best practices.

There are several approaches to documenting case notes for BIT/CARE and threat teams. 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.

Know your audience when writing notes. BIT/CARE and threat team notes are governed by FERPA. As such, they may be read by the student, other staff, counselors/psychologists, teachers, attorneys, newspapers, family members and the courts. Document with an awareness that the note may be reviewed groups you may not be thinking about in the moment of writing.

When documenting a case note for a BIT/CARE or threat case, be sure to 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 timeline summary of what happened in each note. Prioritize the summary of events over including multiple details for each incident or note. When additional details are available in other documents, such as an incident report or case management note, make reference to that location for further details.

Where the event occurred. Note clearly where the event(s) occurred in relationship to the timeline established.

When the events occurred. Include times relevant to the case at hand. If the times are estimated, be sure to note that. 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 the creating a hypothesis rather than assuming how an incident occurred. Hypotheses should be educated guesses supported by the facts.

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 elements of the incident related to each other?

Here are a few general concepts around documentation:

- 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 to convey a deeper meaning.
- Avoid the use of jargon or clinical diagnosis—documentation should be easily read and understood by each member of the team. Items such police codes or psychological diagnoses are not in the scope of each team member should be avoided.