CONCERN, ASSESSMENT, RESPONSE AND ENGAGEMENT (CARE) PROCEDURE

PROCEDURE			
Effective Date	December 12, 2024	**Procedure Type**	Academic
Responsibility	Dean, School of Students	**Related Policies**	CARE Policy Student Rights and Responsibilities Policy Residence Handbook Academic Accommodations for Students with Disabilities Records Management Policy Campus Security Policy Violence Prevention Policy Sexual Violence Policy Violence Prevention Procedure Fit to Work/Fit to Learn Policy Risk Rubric (Appendix A) Intervention Rubric (Appendix B)
Approver	Deans' Council	**Review Schedule**	Annually

1. Purpose:

1.1. The CARE procedure outlines how Northwestern Polytechnic (NWP) will provide Screening, Intervention, and referral to resources to support the mental health of students and the campus community.

2. CARE Team Mission:

2.1. The CARE team serves as a resource for concerns of distress, disruptive, and/or threatening behaviour by providing screening, intervention, and referrals to appropriate supports to promote the overall safety and well-being of the NWP community.

3. Scope:

3.1. This procedure applies to registered students and non-registered community members.

3.1.1. Non-registered community members may be referred to the CARE Team for risk assessment and to determine the appropriate interim Intervention and resource referrals based on the context of the situation.

4. CARE Team Membership

CARE Team Chair:	Dean, School of Students
Core Team Members:	Associate Dean, Student Life Psychologist, Mental Health Services Representative Leader, Accessibility Services Representative Leader, Registrar's Office Representative Leader, Campus Security Operations Representative Leader, Residence Life Faculty Member
Resources Members:	CARE Team Administrative Support Advisory Member(s)
	*Consideration should be made for campus representation when choosing CARE Team Members.

4.1. CARE Team Chair:

4.1.1. Provides CARE team continuity by leading standing meetings. Facilitates discussions so they remain productive and focused. Promotes team cohesion and collaboration.

4.1.2. Maintains a long-term view of team development and education. Identifies training needs and plans professional development. Ensures the CARE team is equipped to perform CARE team functions including risk assessments, case management, and knowledge related to common presenting concerns.

4.1.3. Leads risk analysis efforts and the deployment of Interventions through case management oversight.

4.1.4. Responsible for an annual report to the Provost and Vice-President Academic and review of CARE ream operations, assessing CARE team success and adjusting CARE team processes to continuously improve CARE functions.

4.2. Core Members:

4.2.1. Review cases on the agenda before CARE team meetings to come prepared to report and share appropriate information on current cases.

4.2.2. Are assigned as case managers for cases requiring Intervention as recommended by the CARE team.

4.3. Resource Members:

4.3.1. Advisory members provide input, information, and context regarding situations and students of concern. Advisory members are invited by the chair. Resource members are non-decision-making members.

4.3.2. CARE team administrative support is responsible for the administrative function of the CARE team including preparing and distributing meeting packages. CARE team administrative support is a non-decision-making member.

5. CARE Team Meetings

5.1. The CARE team shall have standing bi-weekly meetings. Ad-hoc meetings will be called by the CARE team chair as needed. The CARE team chair and core team members will prioritize ad hoc meetings when called.

5.1.1. If team meetings are not required for the purpose of case review, they are used for education, building team effectiveness, and determining how to support the campus community in their efforts to support student mental health.

5.2. The CARE team chair and core members will attend every meeting as reasonable.

5.2.1. The CARE team chair will designate a core member to serve as their proxy when they are unable to fulfill CARE team chair duties.

5.2.2. Core members will have a designated proxy who attends meetings when they are unable to.

6. Gathering Information

6.1. Campus community members provide information to the CARE team about individuals who are displaying signs of distress or when they believe a campus-wide response and approach is necessary to support an individual's well-being and/or campus safety. CARE referrals do not replace emergency responses. Campus community members will refer to emergency services such as 9-1-1 and campus security as appropriate.

6.2. Campus community members may have direct conversations with a student of concern. Responding with interest and concern to behaviours indicating distress is a critical factor in providing support and preventing violence. Responding requires gathering more information, actively listening, and expressing care. Responding also includes referral to relevant campus resources, including the CARE team. Responding can also mean connecting with emergency services.

6.2.1. When a Campus community member is not comfortable responding directly, they shall actively seek support from someone comfortable in such situations to respond to the concern.

6.3. When a referral is received, the Associate Dean, Student Life will review the referral and respond to the referral source, so they are aware their concern has been received and reviewed.

6.4. The Associate Dean, Student Life (or designate) will assess the referral and assign an initial risk rating based on the Risk Rubric (Appendix A) to determine if information or action is necessary before the next CARE team meeting. The Associate Dean, Student Life will consult with the CARE team chair as needed. Immediate actions may include:

Reasonable Indication of:	Immediate Actions
- Imminent acute risk of harm - A welfare check is needed - A need for acute risk of harm to be assessed by emergency responders (police, EMS, fire) or Campus Security	Call 911 or Campus Security
- An urgent need for a coordinated response - An urgent need to compile more information	Connect with the chair of the CARE team to activate the CARE team meeting ad hoc
- Referral information is vague but concerning, more information to accurately assess the level of Risk - An identified need to set up an interim safety plan with the student	Contact the student of concern to gather information directly and assess risk
- Referral is vague but concerning, need more information to accurately assess the level of risk	Contact the referral source and/or other community members to gather information

6.5. At CARE team meetings and/or when requested, core team members provide relevant background information from their respective areas to inform the ongoing assessment and to collaboratively determine the risk level and appropriate Interventions.

6.6. Information is gathered, shared, and maintained in accordance with the Freedom of Information and Protection of Privacy Act. Team members with privileged relationships, such as psychologists, share information only as allowed by professional ethical standards and applicable law.

7. Assessment

7.1. All referrals are assessed and assigned a risk rating of mild, moderate, elevated, or critical using the Risk Rubric (Appendix A).

7.2. Risk assessment shall occur at the following points:

7.2.1. CARE referral. Completed by Associate Dean, Student Life (or designate).

7.2.2. CARE team meetings (active cases), completed by CARE team.

7.2.3. When actioning Interventions, completed by case manager.

7.3. The CARE team will collaboratively determine risk at CARE team meetings, final decision authority will rest with the chair when necessary.

8. Intervention

8.1. A case manager is appointed by the chair for each case that requires intervention. Case managers act as the point person for communication with students of concern and the referral source.

8.1.1. Due to the privileged relationship, the institutional psychologist should not serve as case manager.

8.2. Case managers hold the accountability for completing Interventions, assessing new information as it comes in, monitoring risk, and reporting updates on the case to the CARE team for continuous collaborative assessment.

8.3. The CARE team will collaboratively discuss an appropriate Intervention plan informed by the Intervention Rubric (Appendix B); final decision authority will rest with the CARE team chair when necessary.

8.4. The intervention rubric is a guide, and Interventions may include strategies and resources not listed as determined by the CARE team and case manager. Interventions align with risk level and respond to the concerns exhibited.

8.5. Interventions may range from recommended to mandated. Mandated interventions will only be required in limited circumstances. Interventions for risk ratings that are elevated or critical may include a mandated meeting with a case manager to assess risk.

8.6. Failure of a student of concern to attend or cooperate with mandated Interventions including mandated meetings may result in the activation of Student Rights and Responsibilities or Residence Handbook process, or additional Interventions.

9. Authority

9.1. CARE team members, collectively, have a level of authority to make decisions on behalf of NWP to mitigate risk and provide brief intervention and referral when individuals display signs of distress, disruptive, or threatening behaviour.

9.2. In response to risk, case managers have the authority to make independent decisions and take action when necessary.

9.3. There may be situations that create significant and imminent risks and/or that require a level of support that exceeds what would be considered a reasonable accommodation or support for NWP to provide. When current medical documentation and/or the best available objective information indicates that there is a significant risk to the safety, health, or well-being of the student of concern or the NWP campus community, the CARE team has the authority to initiate a required to withdraw process.

10. Case Status

10.1. The CARE team is responsible for determining case status: active, monitoring, or closed. The CARE team works collaboratively to close a file.

10.2. The CARE team may opt to close a file with "mild" and "moderate" risk ratings, when:

10.2.1. The risk level was never at "critical" or "elevated" and,

10.2.2. Interventions are complete, and

10.2.3. The student's risk level has decreased or stabilized, or

10.2.4. The student no longer falls within the scope of services, or

10.2.5. The student did not respond to multiple outreach attempts over a period of time and there are no additional referrals or indicators of risk.

10.3. The CARE team may opt to move an active file to monitoring for a period of time, when:

10.3.1. The rating was "critical" or "elevated", and

10.3.2. Interventions are now complete, and

10.3.3. The risk rating has reduced.

10.4. A monitoring plan may include:

10.4.1. Periodic check-ins (email, phone, meeting) with the student.

10.4.2. Consultation with instructors or staff (coach, advisor, residence life staff) who regularly interact with the student.

10.4.3. Academic checks, grades, assessment, attendance.

10.5. If at any point during monitoring, the CARE team or case manager learns of information indicating that the student's risk level may be increasing, the case manager and/or CARE team may designate the case as active again.

11. Concurrent Processes

11.1. Other necessary processes like academic accommodation for students with disabilities, Student Rights and Responsibilities processes, and Residence Handbook processes, can occur concurrently with the CARE process.

11.2. It is the responsibility of students with disabilities to follow the academic accommodations for students with disabilities process and fulfill their responsibilities in seeking accommodation.

12. Records

12.1. The CARE team chair and core members have access to records, including case notes, risk ratings, intervention, and documentation notes.

12.2. Case managers maintain secure records and documentation regarding new information, observations, on-going risk assessment, and Intervention actions.

12.3. All CARE team referrals and records are created and stored in a confidential and secure electronic portal. The records will be stored/destroyed as per the Records Management Policy.

Appendix A: Risk Rubric

Scale A: Life Stress and Emotional Health Scale

1. Is the person actively suicidal with an expressed lethal plan or suicidal actions?

2. Is the individual engaging in extreme self-injurious behaviors such as cutting, burning, or eating behaviors (binge/purge) that put them at life-threatening Risk?

3. Does the person engage in impulsive violence or make serious threats of violence? This violence is due to an individual's emotional health and/or impulsive, reactionary behavior.

   Examples include:
   a. repeated severe attacks while intoxicated or brandishing a weapon;
   b. making threats that are concrete, consistent, and plausible in reaction to an emotionally-driven event;
   c. or impulsive stalking that presents a physical danger.

4. Has the individual lost touch with reality (hearing or seeing things that are not there)? Are they reacting to dangerous delusions or paranoid beliefs which create risk of grievous injury or death? For example, a belief that the CIA is spying on them, resulting in them taking life-threatening actions (cutting through all of the electrical wires in the home, running into traffic) to prevent them from spying.

5. Is the person engaging in life-threatening substance use (repeated acute alcohol intoxication with medical or law enforcement Intervention, multiple DUIs, chronic risky substance use)?

If 'YES' to any of these questions (1-5). Risk rating is CRITICAL on Scale A. Jump to question 14 to assess Scale B.

If the answers to questions 1-5 are all 'NO', continue to question 6.

6. As a result of life stress or emotional health, is the person's behavior destructive, increasingly disruptive (multiple incidents), or bizarre in a way that significantly impacts those around them?

7. Is the individual engaging in high-risk substance abuse or non-lethal, disordered eating or self-injury (e.g. cutting or burning self with no risk of death or serious harm)?

8. Is the person communicating direct thoughts of suicide that lack lethality or immediacy?

9. Is the person making threats of affective, impulsive, or poorly planned violence which are driven by their emotional health or life stressors? Examples include comments like "why don't we just take this outside?" or "I'm going to make their life a living hell."

If 'YES' to any of these questions (6-9), Risk rating is ELEVATED on Scale A. Jump to question 14.
If 'NO' to all, continue to question 10.

10. Does the person make threats that are vague, indirect, implausible, and lack detail or focus?

11. Is the individual demonstrating difficulty managing their emotions or experiencing stress and challenges in their behavior stemming from chronic mental illness, mild substance abuse, or

disordered eating? The resulting behaviors do not overly disturb others, present a significant medical concern, but they are noticed and cause for concern?

12. Is the individual demonstrating poor coping skills related to an event such as failing an assignment, stress from home or family, a relationship loss, etc.? Typically, the negative behavior or stress would dissipate when the stressor is removed or the person is connected to resources.

If 'YES' to any of these questions (10-12), Risk rating is MODERATE on Scale A. Jump to question 14.

If 'NO' to all, proceed down.

13. Is the person experiencing situational stressors and demonstrating appropriate coping skills?

If 'YES', Risk rating is MILD on Scale A, continue through the following questions to determine Scale B Risk rating.
If 'NO', there is no rating on Scale A, move on to Scale B by continuing to question 14.

Scale B: Hostility and Violence to Others Scale

14. Does the individual have a fixed way of seeing the world or an issue that could be described as hardened or crystalized?
These are typically related to politics, religion, social justice, academic standing, relationship status, or money/power.

If 'YES', continue to next question.
If 'NO', there no rating on Scale B. Stop and refer to the rating from Scale A to determine Overall Rating.

15. Does the person reject beliefs that don't agree with their own or filter out material that doesn't line up with their beliefs? Do they limit their exposure to alternative perspectives? And/or do they move from a deadlocked debate to non-verbal gestures to communicate their growing frustration?

If 'YES', continue to the next set of questions.
If 'NO', Risk rating is MILD for Scale B.

16. Does the person express their hardened point of view to others, filtering out opposing ideas or detracting viewpoints leading to a polarizing tendency? AND/OR Does the person storm off when frustrated or argue with others with the intent to embarrass or shame them?

17. Is there brief, impulsive, reactive and/or poorly planned physical violence that is driven by the individual's hardened perspective?

18. Has the individual narrowed down their frustrations with a fixation and/or focus on a particular target? Are they enlisting others in their frustration toward the target to support their point ofview? Does the individual now create an outcast of their target in an effort to unmask or embarrass them in the community?

If 'YES' to 16, 17, or 18, continue to the next question.
If 'NO' to all (16-18), MODERATE Risk for Scale B.

19. Have threats or ultimatums been made, typically around what will happen if perceived injustices and grievances are not addressed? (e.g. "If you don't change my grade, I will make your life a living hell.") The threats may be vague but direct or specific but indirect. They are becoming more targeted and repeated.

If 'YES', proceed to the next question.
If 'NO', ELEVATED Risk for Scale B.

20. Does the person have any of the following:
    a. Issued a threat which is credible, repeated, and specific?
    b. Leakage of an attack plan through a list, video, or social media post?
    c. Their behavior indicates that they are moving toward violence by using increasingly militaristic or tactical language, and/or increasingly driven toward a singular outcome with hopelessness and desperation?
    d. They have a clear fixation on a target or demonstrate increased research of an attack plan with access to lethal means?

If 'YES' to 20, CRITICAL Risk for Scale B.
If 'NO' to 20, ELEVATED Risk for Scale B.

Scoring

Scale A: Mild, Moderate, Elevated, Critical Life Stress and Emotional Health Scale	**Scale B: Mild, Moderate, Elevated, Critical Hostility and Violence to Others Scale**
Overall Risk: To calculate overall risk, choose whichever rating is highest level from the Scale A and Scale B to determine the overall risk rating and the appropriate intervention level.	

CRITICAL:

Scale A: Life Stress and Emotional Health

- Behavior is severely disruptive, directly impacts others, and is actively dangerous. This may include life-threatening, self-injurious behaviors such as:
- Suicidal ideations or attempts, an expressed lethal plan, and/or hospitalization
- Extreme self-injury, life-threatening disordered eating, repeated DUIs
- Repeated acute alcohol intoxication with medical or law enforcement involvement, chronic substance abuse
- Profoundly disturbed, detached view of reality and at risk of grievous injury or death and/or inability to care for themselves (self-care/protection/judgment)
- Actual affective, impulsive violence or serious threats of violence such as:
    - Repeated, severe attacks while intoxicated; brandishing a weapon
    - Making threats that are concrete, consistent, and plausible
    - Impulsive stalking behaviors that present a physical danger

Scale B: Hostility and Violence to Others

- Behavior is moving towards a plan of targeted violence, sense of hopelessness, and/or desperation in the attack plan; locked into an all or nothing mentality
- Increasing use of military and tactical language; acquisition of costume for attack
- Clear fixation and focus on an individual target or group; feels justified in actions
- Attack plan is credible, repeated, and specific; may be shared, may be hidden
- Increased research on target and attack plan, employing counter-surveillance measures, access to lethal means; there is a sense of imminence to the plan
- Leakage of attack plan on social media or telling friends and others to avoid locations

In this stage, there is a serious Risk of suicide, life-threatening self-injury, dangerous risk taking (e.g. driving a motorcycle at top speed at night with the lights off) and/or inability to care for oneself. They may display racing thoughts, high risk substance dependence, intense anger, and/or perceived unfair treatment or grievance that has a major impact on the students' academic, social, and peer interactions. The individual has a clear target for their threats and ultimatums, access to lethal means, and an attack plan to punish those they see as responsible for perceived wrongs. Without immediate Intervention (such as law enforcement or psychiatric hospitalization), it is likely violence will occur. There may be leakage about the attack plan (social media posts that say "I'm going to be the next school shooter" or telling a friend to avoid coming to campus on a particular day). There may be stalking behaviour and escalating predatory actions prior to violence such as intimidation, telegraphing, and "test-runs" such as causing a disruption to better understand reaction time of emergency response.

ELEVATED:

Scale A: Life Stress and Emotional Health

- Destructive actions, screaming or aggressive/harassing communications, rapid/odd speech, extreme isolation, stark decrease in self-care
- Responding to voices, extremely odd dress, high risk substance abuse; troubling thoughts with paranoid/delusional themes; increasingly medically dangerous binging/purging suicidal thoughts that are not lethal/imminent or non-life threatening self-injury
- Threats of affective, impulsive, poorly planned, and/or economically driven violence
- Vague but direct threats or specific but indirect threat; explosive language
- Stalking behaviors that do not cause physical harm, but are disruptive and concerning

Scale B: Hostility and Violence to Others

- Fixation and focus on a singular individual, group, or department; depersonalization of target, intimidating target to lessen their ability to advocate for safety
- Seeking others to support and empower future threatening action; may find extremists looking to exploit vulnerability; encouraging violence
- Threats and ultimatums may be vague or direct and are motivated by a hardened viewpoint; potential leakage around what should happen to fix grievances and injustices
- There is rarely physical violence here, but rather an escalation in the dangerousness and lethality in the threats; they are more specific, targeted, and repeated

Behavior at the elevated stage is increasingly disruptive (with multiple incidents) and involves multiple offices such as student conduct, law enforcement, and counseling. The individual may engage in

suicidal talk, self-injury, substance intoxication. Threats of violence and ultimatums may be vague but direct or specific but indirect. A fixation and focus on a target often emerges (person, place, or system) and the individual continues to attack the target's self-esteem, public image, and/or access to safety and support. Others may feel threatened around this individual, but any threat lacks depth, follow-through, or a narrowing against an individual, office, or community. More serious social, mental health, academic, and adjustment concerns occur, and the individual is in need of more timely support and resources to avoid further escalation. Conditional ultimatums such as "do this or else" may be made to instructors, peers, faculty, and staff.

MODERATE :

Scale A: Life Stress and Emotional Health

- Distressed individuals engage in behavior that concerns others, and have an impaired ability to manage their emotions and actions. Possible presence of stressors such as:
    - Managing chronic mental illness, mild substance abuse/misuse, disordered eating
    - Situational stressors that cause disruption in mood, social, or academic areas
    - Difficulty coping/adapting to stressors/trauma; behavior may subside when stressor is removed, or trauma is addressed/processed
- If a threat is present, the threat is vague, indirect, implausible, and lacks detail or focus

Scale B: Hostility and Violence to Others

- Driven by hardened thoughts or a grievance concerning past wrongs or perceived past wrongs; increasingly adopts a singular, limited perspective
- When frustrated, storms off, disengaged, may create signs or troll on social media
- Argues with others with intent to embarrass, shame, or shut down
- Physical violence, if present, is impulsive, non-lethal, and brief; may seem similar to affective violence, but driven here by a hardened perspective rather than mental health and/or environmental stress

Prior to this stage, conflict with others has been fairly limited. The hallmark of moderate is an increase in conflict with others through aggressive speech, actions, and mannerisms. They may become frustrated and engage in non-verbal behaviors or begin to post things on social media, put up posters around campus, or storm away from conversations. Stress, illness, lack of friends, and support are now becoming an increasing concern. The individual may be tearful, sad, hopeless, anxious, or frustrated. This may be caused by difficulty adjusting, dating stress, failure in class assignments, and/or increasing social isolation. If there is a threat or physical violence such as carelessly pushing someone out of their way while storming off, the violence is typically limited and driven by adrenaline and impulsiveness, rather than any deeper plan to hurt others.

MILD:

Scale A: Life Stress and Emotional Health

- Experiencing situational stressors but demonstrating appropriate coping skills
- Often first contact or referral to the BIT/CARE Team, etc.
- Behaviour is appropriate given the circumstances and context
- No threat made or present

Scale B: Hostility and Violence to Others

- Passionate and hardened thoughts; typically related to religion, politics, academic status, money/power, social justice, or relationships
- Rejection of alternative perspectives, critical thinking, empathy, or perspective- taking
- Narrowing on consumption of news, social media, or friendships; seeking only those who share the same perspective
- No Threats of violence

The individual here may be struggling and not doing well. The impact of their difficulty is limited around others, with the occasional report being made to the CARE team out of an abundance of caution and concern rather than any direct behavior or threats. They may be having trouble fitting in, adjusting to college, making friends, or may rub people the wrong way. They alienate others with their thoughts or mannerisms, and there may be minor bullying and conflict. With support and resources, it is likely the individual will be successful adapting and overcoming obstacles. Without support, it is possible they will continue to escalate on the rubric.

Appendix B: Intervention Rubric

Risk Level	Intervention Tools
CRITICAL	• Police and first responder response • Wellness check/evaluation for involuntary hold or police response • Possible emergency notification to campus community for safety measures • Emergency contact notification • Coordination with on- and/or off-campus teams to create a plan for safety, suspension, or interim measures • Evaluate need for involuntary/voluntary withdrawal • Provide guidance, support, or information to inform safety planning to referral source
ELEVATED	• Consider welfare/safety check • Mandated meeting with a case manager to assess risk further (Recommended Structured Professional Judgment tools include Sivra-35, N-CAS, ERIS, HCR-20) • Residence check-in (for on-campus residents) • Provide guidance, support, and safety plan to referral source or relevant stakeholders • Deliver follow up and ongoing case management or support services • Evaluate parental/guardian emergency notification • Coordinate referrals to appropriate resources • Likely referral to conduct or disability support services • Coordinate with campus security, student conduct, residence life (if resident), and other areas as necessary to mitigate Risk. • Determine who will monitor ongoing risk and report on signs of escalation. • Safety planning with the student
MODERATE	• Call or email from case manager to student to encourage connection with resources, and/or a meeting with the case manager • Develop and implement case management plan or support services • Provide guidance and education to the referral source • Connect with campus service providers who interact with the student to enlist as support or to gather more information • Possible referral to conduct or disability support services • Access social media and other sources to gather information • Skills building in social interactions, emotional balance, and empathy; reinforcement of protective factors (social support, opportunities for positive involvement)
MILD	• No Intervention needed; document and monitor over time • Provide guidance and education to the referral source • Reach out to student to offer a meeting and/or resources • Connect with offices, support resources, instructors, who interact with the individual to offer support or gather more information