

**MCAS: Student Propensity Toward Violence Risk Analysis**

Student Name: \_\_\_\_\_ I.D. #: \_\_\_\_\_ School: \_\_\_\_\_ Grade: \_\_\_\_\_ D.O.B: \_\_\_\_\_  
 Staff Name/Evaluator: \_\_\_\_\_ Date of Incident: \_\_\_\_\_ Date of Screening: \_\_\_\_\_  
 Location of Incident: \_\_\_\_\_ Name of Staff Reporting Incident: \_\_\_\_\_

Assessment Area	Low	Medium	High
<b>Violence Toward Self/Others</b>			
Details of Plan	<input type="checkbox"/> Vague	<input type="checkbox"/> Some Specifics	<input type="checkbox"/> Knows, when, where, how
Availability to Means	<input type="checkbox"/> Not available, would have to get	<input type="checkbox"/> Available, close by	<input type="checkbox"/> Has in possession
Time	<input type="checkbox"/> No specific time or in distant future	<input type="checkbox"/> Within a Few Hours	<input type="checkbox"/> Immediately
Lethality of Method	<input type="checkbox"/> Non-lethal: bodily cuts, drug dosage	<input type="checkbox"/> Drugs/Alcohol - accident	<input type="checkbox"/> Gun, violent action, severe bodily cuts
Chance of Intervention	<input type="checkbox"/> In company of others, typically	<input type="checkbox"/> Others available if called upon	<input type="checkbox"/> No one nearby, isolated
History of Previous Violence	<input type="checkbox"/> None, one of low lethality	<input type="checkbox"/> 1 non-lethal previous attempt	<input type="checkbox"/> 1 high lethality/several moderate attempts
<b>Stress Factors</b>	<input type="checkbox"/> No significant stress	<input type="checkbox"/> History of repeated threats	<input type="checkbox"/> Severe reaction to loss, change
<b>Coping Behavior</b>	<input type="checkbox"/> Little change in daily activities	<input type="checkbox"/> Moderate reaction to loss, change	<input type="checkbox"/> Gross disturbances in daily activities
<b>Depression</b>	<input type="checkbox"/> Mild, feeling slightly "down"	<input type="checkbox"/> Some disruption on daily activities	<input type="checkbox"/> Overwhelmed, hopelessness, extreme sadness, worthlessness
<b>Resource Support</b>	<input type="checkbox"/> Access to significant others who are consistently available to help	<input type="checkbox"/> Some moodiness, sadness, irritability	<input type="checkbox"/> Family/friends not available to help or who may be hostile
<b>Communication Skills</b>	<input type="checkbox"/> Direct expression of feelings/thoughts	<input type="checkbox"/> Loneliness decreased energy	<input type="checkbox"/> Indirect/non-verbal expression, internalized goal of violence
<b>Stability of Relationships</b>	<input type="checkbox"/> Stable relationships, personality and school performance	<input type="checkbox"/> Available family and friends, but unwilling to be a consistent help	<input type="checkbox"/> Unstable personality, Hx of repeated personal/family/school turmoil
<b>Medical Status</b>	<input type="checkbox"/> No significant medical problems	<input type="checkbox"/> They'll be sorry)	<input type="checkbox"/> Chronic medical problems, catastrophic illness
<b>TOTAL CHECKS</b>	<b>LOW</b>	<b>MEDIUM</b>	<b>HIGH</b>

(Instructions: Use as a check list and average for final assessment. Each item carries the same weight.)

This Screening Shared With: \_\_\_\_\_  Other: \_\_\_\_\_  
 Building Principal  Parent/Guardian  Mental Health Agency: \_\_\_\_\_

**Follow Up Notation from Screening:**  
 Strongly suggest student follow up with physician  
 Strongly suggest student follow up with mental health agency for further assessment  
 Strongly suggest family follow up with mental health agency for further assessment  
 School / family meeting MUST occur prior to student's return to school  
 Other: \_\_\_\_\_

Building Principal/Administrative Designee Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 As the Parent/Guardian of \_\_\_\_\_ I understand the seriousness of my son/daughter's health needs and agree to initiate outside professional help for my child and give consent for chosen health care provider & MCAS to exchange information on my child's health status/needs.  
 Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Form to be completed by: School Counselor / Social Worker  
 Copies to: School, Parent, Director of Special Education

MCAS: Student Risk Analysis Follow-up Form

Student Name: \_\_\_\_\_ I.D. #: \_\_\_\_\_ School: \_\_\_\_\_ Grade: \_\_\_\_\_ D.O.B: \_\_\_\_\_

Health Care Agency Providing Assessment of Student: \_\_\_\_\_

Address: \_\_\_\_\_ Evaluator's Name: \_\_\_\_\_

Evaluator's Title/Position: \_\_\_\_\_ Evaluator's Phone Number: \_\_\_\_\_

Assessment(s) performed: \_\_\_\_\_ Date(s) of Assessment: \_\_\_\_\_

Assessment Results:

Potential to Harm Self (low) 1 2 3 4 5 (high) Comments: \_\_\_\_\_

Potential to Harm Others (low) 1 2 3 4 5 (high) Comments: \_\_\_\_\_

Insufficient information for assessment of student's potential toward violence, explain: \_\_\_\_\_

*The above named child has been screened for his/her risk for serious violence toward him/herself or others in the immediate future. The conclusion reached is based on the information available to the evaluator at this time. Student's risk level may change as his/her circumstances change.*

**Evaluator's Recommendations:**

Inpatient Hospitalization  Outpatient Services  School Counselor/Social Worker Monitoring

Report to Law Enforcement  Report to Child Protective Services  On-site School-based health services: \_\_\_\_\_

Student Return to School  Student out of school until further health assessment(s) are completed \_\_\_\_\_

School/Family/Provider Meeting Prior to Student's Return to School

Suggested further educational intervention assessment via RTI model.  Other: \_\_\_\_\_

Intensity of Services Needed: \_\_\_\_\_

**School Staff Follow-up Plan:**

Service Description: \_\_\_\_\_ Party Responsible: \_\_\_\_\_

Service Description: \_\_\_\_\_ Party Responsible: \_\_\_\_\_

Service Description: \_\_\_\_\_ Party Responsible: \_\_\_\_\_

Service Description: \_\_\_\_\_ Party Responsible: \_\_\_\_\_

**Parent/Guardian Follow-up Plan:**

**Signatures of Involved Parties:**

Parent/Guardian Signature: \_\_\_\_\_ Relationship: \_\_\_\_\_ Date: \_\_\_\_\_

Building Principal Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Michigan City Area Schools**  
**STUDENT CRISIS SCREENING REFERRAL**

Date: \_\_\_\_\_

Principal Requesting Screening: \_\_\_\_\_ School: \_\_\_\_\_ Phone: \_\_\_\_\_

**Student Information**

Student Name: \_\_\_\_\_ Grade: \_\_\_\_\_ D.O.B. \_\_\_\_\_ Age: \_\_\_\_\_

Gender: Male \_\_\_\_\_ Female \_\_\_\_\_

Is student currently on medication? No \_\_\_\_\_ Do Not Know \_\_\_\_\_ Yes (List): \_\_\_\_\_

Is student currently a client of a Mental Health Provider? No \_\_\_\_\_ Do Not Know \_\_\_\_\_ Yes (Where): \_\_\_\_\_

**Family Information**

Parent/Guardian Name: \_\_\_\_\_ Phone(s): \_\_\_\_\_

Address: \_\_\_\_\_ Parent Notified By: \_\_\_\_\_ When: \_\_\_\_\_

**Other Party Involvement**

If other parties have been threatened by student, who are they? \_\_\_\_\_

Have threatened parties/students' parents been notified? No \_\_\_\_\_ Yes (when?) \_\_\_\_\_

If appropriate, has Child Protective Services been notified? No \_\_\_\_\_ Yes (when and who?) \_\_\_\_\_

If appropriate, has Law Enforcement been notified? No \_\_\_\_\_ Yes (when and who?) \_\_\_\_\_

**Incident Information**

Reason for Referral (check all that apply and explain):

\_\_\_ Student attacked another student/staff \_\_\_\_\_

\_\_\_ Student threatened physical harm to another student/staff \_\_\_\_\_

\_\_\_ Student threatened harm to family member \_\_\_\_\_

\_\_\_ Student threatened harm to self \_\_\_\_\_

\_\_\_ Student was in possession of a dangerous object \_\_\_\_\_

Other: \_\_\_\_\_

When did the incident occur? Date: \_\_\_\_\_ Time: \_\_\_\_\_

Where did the incident occur? \_\_\_\_\_

What was the school's response? \_\_\_\_\_

Has student exhibited other recent behaviors that are atypical to the situation or circumstances? (If yes, explain):

Was student secluded? (Explain/attach report.) \_\_\_\_\_

Was student restrained (Explain/attach report.) \_\_\_\_\_

School Contact person (for additional information/communication of screening results):

Name: \_\_\_\_\_ Position: \_\_\_\_\_ Phone: \_\_\_\_\_

Additional Comments: \_\_\_\_\_

Building Administrator Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Follow Up Notification from Screening:**

\_\_\_ Strongly suggest student follow up with physician.

\_\_\_ Strongly suggest student follow up with mental health agency for further assessment.

\_\_\_ Strongly suggest family follow up with mental health agency for further assessment.

\_\_\_ School/family meeting **MUST** occur prior to student's return to school.

Other: \_\_\_\_\_



### Mental Health Screening Referral

To:

From:

Re:

Date:

\_\_\_\_\_ is being referred to you for a Crisis Screening.  
Student's name

\_\_\_\_\_ is requesting the following from you:  
Student's school

- Review the attached **Student Crisis Screening Referral** form and the **Student Propensity Toward Violence Risk Analysis** form;
- Determine whether this student is safe to return to school.

Recommendation:

\_\_\_\_\_ the student is safe to return to school as of \_\_\_\_\_  
Date

\_\_\_\_\_ the student needs a comprehensive evaluation from a psychiatric facility

Comments:

---



---



---



---



---

Mental Health Representative: \_\_\_\_\_ Date: \_\_\_\_\_

Please forward this document to the Director of Special Education via facsimile at: 219-877-3548

#### Office Notes

Date received by the Director of Special Education: \_\_\_\_\_

Meeting conducted with the building Principal and/or Counselor: \_\_\_\_\_

Action Required:

---



---

**Michigan City Area Schools  
Student Crisis Screening  
PARENT NOTIFICATION SHEET**

Your child: \_\_\_\_\_ has been referred by his or her school to the local Mental Health Facility: \_\_\_\_\_ for a Student Crisis Screening. This screening referral is due to behavior(s) to/from or at school that has led school personnel to be concerned that your child may be at risk for serious violence toward himself/herself or others.

The specific purpose of this screening is to determine whether or to what extent such a risk is present and if present, what can be done to lower the risk to harm self/others. It is noted that should your child convey intent to harm others, it is the responsibility of the school building Principal to notify parties identified of your child's potential intent to cause him/her/them harm. The evaluator's role is to provide an objective screening of the information provided. The conclusions reached in the screening are based on the information available to the evaluator at this time. It should be noted that the student's risk level may change as his/her circumstances change.

The screening process involves an immediate screening conducted at the Mental Health Facility of: \_\_\_\_\_ by professional mental health staff, at the following address: \_\_\_\_\_ or the screening may take place at your child's school site by the Mental Health Facility's professional mental health staff. This screening enables mental health and school professionals to respond immediately to concerns about your child. In order to ensure safety and provide for clear communication among all parties, the Student Crisis Screening is NOT a confidential process. The results of the screening will be shared with your child's school, so that they may assist in supporting your child's success within the school environment. Within one day of the screening appointment, a verbal report will be sent to the school building Principal with recommendations for responding to the needs of your child.

Should your child's initial Student Crisis Screening Referral reveal your child is at risk for violence toward self/others, then a more thorough assessment of your child's needs will be discussed. Obviously, it is important for all concerned to complete additional mental health testing of your child as quickly and thoroughly as possible. Should further assessment of your child's mental health status be needed, a more in-depth evaluation will be scheduled within two business days of your child's initial screening. The Mental Health Facility will try to accommodate your schedule as much as possible, but your assistance and flexibility will be required in completing the evaluation process. Additional mental health testing will be the financial responsibility of the parent(s)/guardian(s) and determined between Mental Health Facility and the parent(s)/guardian(s).

**The Mental Health Facility of: \_\_\_\_\_ has already been notified by the school of the need for your child to have a Student Crisis Screening. Your next step is to contact the Mental Health Facility as soon as possible regarding your child's status.**

**Bring your copy of this information sheet to the mental health facility: \_\_\_\_\_**

**Address: \_\_\_\_\_**

**Phone: \_\_\_\_\_ Contact Department: \_\_\_\_\_**

\_\_\_\_\_  
(Parent)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(School Building Administrator)

\_\_\_\_\_  
(Date)

The Michigan City Area Schools has a policy of providing equal opportunity. All courses/activities are open to all students regardless of race, color, sex, handicapping conditions, or national origin including limited English proficiency. Educational services, programs, instruction, and facilities will not be denied to anyone in the Michigan City Area Schools as the result of his or her race, color, sex, handicapping conditions, or national origin including limited English proficiency. For further information, clarification, or complaint, please contact the following persons: Associate Superintendent, 408 S. Carroll Avenue, Michigan City, Indiana 46360 at (219) 873-2000 for Title IX (gender equity related issues); or Director of Special Education, 408 S. Carroll Avenue, Michigan City, Indiana 46360 at (219) 873-2000 for Section 504 (non-discrimination/disability issues and Americans With Disabilities). Any other information concerning the above policies may be obtained by contacting the Superintendent, 408 S. Carroll Ave, Michigan City, Indiana 46360 at (219) 873-2000.

Michigan City Area Schools

STUDENT CRISIS SCREENING REFERRAL: MENTAL HEALTH FEEDBACK FORM

Date: \_\_\_\_\_

Mental Health Organization Designee Completing Form: \_\_\_\_\_

Student Name: \_\_\_\_\_ School: \_\_\_\_\_

D.O.B. \_\_\_\_\_ Age: \_\_\_\_\_ Parent Name: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Presenting Problem:

School Summary: \_\_\_\_\_

Student/Family Summary: \_\_\_\_\_

Information Reviewed:

1) \_\_\_\_\_ 2) \_\_\_\_\_

3) \_\_\_\_\_ 4) \_\_\_\_\_

Current Risk Level:

Violence Potential: (low) 1 2 3 4 5 (high)

Potential to Harm Others: (low) 1 2 3 4 5 (high)

Potential to Harm Self: (low) 1 2 3 4 5 (high)

\_\_\_ Insufficient evidence for screening violence potential or infliction of emotional distress (explain):

Recommendations:

\_\_\_ In-patient hospitalization \_\_\_ Report to Law enforcement

\_\_\_ Report to CPS \_\_\_ Return to school

\_\_\_ On-site therapy at school \_\_\_ School/Family Conference

\_\_\_ School counselor/social work intervention \_\_\_ Outpatient therapy

\_\_\_ Mental Health meeting with parent to discuss child's mental health needs

\_\_\_ Psychological testing to gain additional information pertaining to student risk involvement relating to imminent danger

\_\_\_ Referral for full school educational evaluation (RTI)

\_\_\_ Extended monitoring & assessment in day treatment/partial hospitalization

\_\_\_ Other: \_\_\_\_\_

Plan:

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Evaluator Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Agency Supervisor Signature: \_\_\_\_\_ Date: \_\_\_\_\_

The above child has been screened for his/her risk for serious violence toward him/herself or others in the immediate future. The conclusions reached are based on the information available to the evaluator at this time. His or her risk level may change as his/her circumstances change.

The Michigan City Area Schools has a policy of providing equal opportunity. All courses/activities are open to all students regardless of race, color, sex, handicapping conditions, or national origin including limited English proficiency. Educational services, programs, instruction, and facilities will not be denied to anyone in the Michigan City Area Schools as the result of his or her race, color, sex, handicapping conditions, or national origin including limited English proficiency. For further information, clarification, or complaint, please contact the following persons: Associate Superintendent, 408 S. Carroll Avenue, Michigan City, Indiana 46360 at (219) 873-2000 for Title IX (gender equity related issues); or Director of Special Education, 408 S. Carroll Avenue, Michigan City, Indiana 46360 at (219) 873-2000 for Section 504 (non-discrimination/disability issues and Americans With Disabilities). Any other information concerning the above policies may be obtained by contacting the office of the Superintendent, 408 S. Carroll Ave, Michigan City, Indiana 46360 at (219) 873-2000.