



**HUDSON COUNTY
CHILDREN'S INTERAGENCY COORDINATING COUNCIL (CIACC)**

Student Crisis Assessment and Response

**Recommendations from CIACC and the Hudson County Special
Education Directors' Roundtable**

Hudson County Children's Interagency Coordinating Council (CIACC) plans and advises the county and New Jersey Department of Children and Families Children's System of Care regarding children, youth and young adults with serious emotional, behavioral, mental and intellectual developmental challenges. The mission of CIACC is to maintain Hudson County children at home, in school, and in the community. Council members represent families, service providers (including behavioral health agencies), the juvenile justice system, county and state government, and area school districts. Through this collaborative, CIACC works closely to identify needs across, and within, each child serving system and address these issues by providing trainings, technical assistance and other support.

In 2015, CIACC released a document of suggested practice for schools with regard to crisis policy response. In 2016 a joint subcommittee of CIACC and the Hudson County Special Education Director's Roundtable was formed to help adapt these principles into a workable blueprint for Hudson County School Districts.

The resulting guidelines set forth recommended steps for school personnel when addressing situations involving both immediate and potential danger. An accompanying toolkit includes supplementary documents to assist in implementation of an effective crisis response.

School districts within Hudson County are encouraged to review these suggestions and, where appropriate, integrate them into existing Board policies addressing school-based crisis assessment and management. Please note that this document is not intended to modify a school's obligation under N.J.S.A. 18A:6-111 et seq. (Instruction in Suicide Prevention) or N.J.A.C. 6A:16-5.1 (crisis management and response).

CRISIS

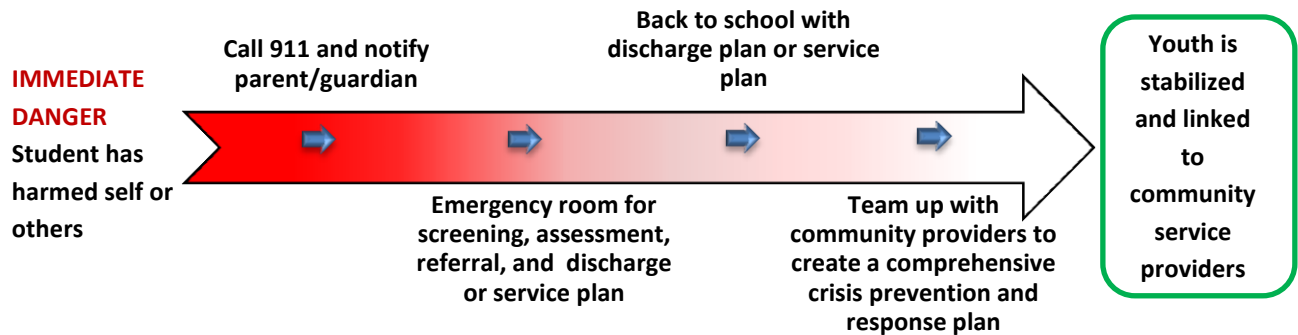
For the purpose of this document, "crisis" is defined as a scenario in which a child or youth's actions or verbalizations may:

- ▶ **Pose immediate danger to self or others**
- ▶ **Indicate the intent or plan to harm her/himself or others others (ex. suicidal or homicidal ideation); or**
- ▶ **Indicate that the student may be at risk of causing harm to her/himself or others.**



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IMMEDIATE DANGER
Student has harmed him/herself or others.



1. The designated school crisis response contact/team should call the parent/guardian and 911. This type of situation will require psychiatric assessment and in some cases, hospitalization.
2. The parent/guardian shall be notified to report to the school or hospital. If the parent is not available at the time the student is transported to the hospital, a staff member must accompany the student and remain until the parent arrives.
3. If possible, the parent accompanying the child to the hospital should be provided with a general consent form (Attachment A) to complete so that the hospital may collect relevant information from the school, if necessary and, conversely, information from the hospital may be shared with the school.
4. A discharge plan from the hospital should be presented to the school nurse for re-admittance to school.
5. Optimally, the school will partner with a community behavioral health provider to connect the student to needed services to prevent future crisis. Schools may choose to contract with providers to assist in assessing risk and recommending follow up services (Attachment B).

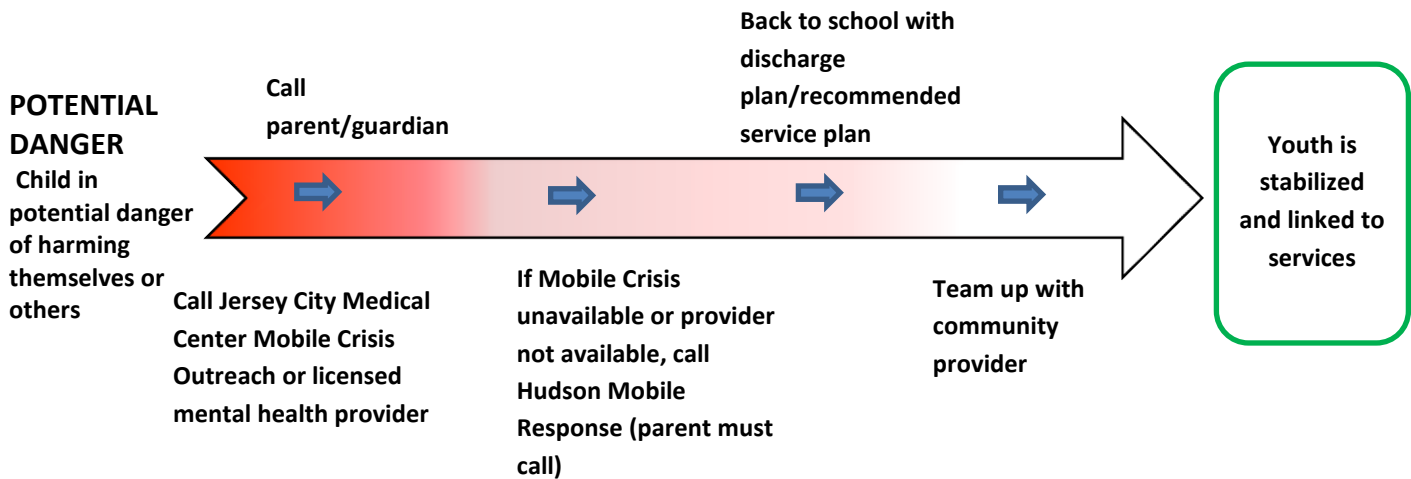
POTENTIAL DANGER
Student has voiced or written an intent to harm him/herself or others or is displaying signs of at-risk behavior.

1. In this scenario, the designated school crisis contact/team should assess level of risk by interviewing the student and referral source (s) and administering a risk assessment tool. The SAD PERSONS Assessment Tool (adapted for adolescents), and scoring system, is provided in the Toolkit section of this document for guidance (Attachment C). Prior to, or during the assessment, the student's parents or guardians should be notified.



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POTENTIAL RISK IDENTIFIED



1. If the school determines the student is suicidal or a threat to others the designated school crisis response contact/team should call the parent/guardian and **Jersey City Medical Center Mobile Crisis Outreach: (201) 915-2210**. Mobile Crisis can provide screening and assistance with any trauma or emergency, and a discharge plan. Alternately, schools may contact a licensed mental health provider in their community for similar services. Contracting with a licensed mental health provider can ensure ongoing access to risk assessment services and discharge planning (Attachment B).
2. A Parent Notification letter may also be sent to the student's parent/guardian to indicate the need for an assessment (Attachment D).
3. A copy of the risk assessment should be provided to the parent, Mobile Crisis or other mental health provider.
4. If it is determined that the student is in potential danger of harming themselves or others, and Crisis Response and/or a contracted mental health provider is not available, **Hudson Mobile Response and Stabilization may be contacted through PerformCare at (877) 652-7624**. **The youths' parents must make this call on behalf of the student**. Mobile Response can provide immediate assessment, de-escalation and safety planning. In addition, Mobile Response provides services for up to eight weeks to stabilize the crisis situation, offers transition planning after these services and links families to long-term services, if needed.



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5. If a psychiatric assessment is required or if a hospitalization has occurred, the psychiatrist and/or hospital will complete a discharge plan enabling the child to return to school. In other circumstances, an assessment and discharge plan should be completed by a licensed, professional mental health clinician.

NO IMMEDIATE DANGER

1. If the school determines that the youth is not at-risk of imminent self-harm or harm to others, the school may suggest resources to the parent such as a community-based mental health provider for linkage to services. In addition, the parent should be encouraged to contact the Children's System of Care through **Perform Care at (877) 652-7624**.
2. It is the goal of CIACC and the Children's System of Care to work closely with school districts and community providers with the goal of reducing incidents and crisis in the schools. CIACC encourages ongoing open communication and crisis planning with:
 - Jersey City Medical Center Mobile Crisis Outreach (201) 915-2210;
 - Family Partners of Hudson at (201) 915-5140;
 - The Hudson Partnership CMO at (201) 537-1460;
 - Mobile Response 201-798-7452 and
 - Perform Care 877-652-7624.



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**Student in Crisis @
School**



Student is brought to the attention of the school-based crisis response team. Team determines level of danger through observation and/or risk assessment tool.

IMMEDIATE DANGER
Student has harmed self or others.

CALL 911

Notify
Parent/Guardian

POTENTIAL IMMEDIATE DANGER
Child in potential danger of harming themselves or others.

Call *Jersey City Medical Center Mobile Crisis Outreach* or licensed community mental health provider for screening and recommended service plan.

Notify Parent/
Guardian.

NO IMMEDIATE DANGER -
Child has calmed and does not require immediate screening.

If necessary, notify private licensed, professional mental health provider partner for screening and recommended service plan.

Notify parent and recommend follow up (PerformCare, mental health providers).

Emergency Room for services, screening, assessment, referral, and discharge plan.

If Mobile Crisis or community provider not available, call *Hudson Mobile Response and Stabilization* for screening and service referral within 24 hours. Parents must call for student.



**BACK TO SCHOOL WITH
RECOMMENDED SERVICE
PLAN OR DISCHARGE PLAN.**

Team up with community providers to ensure the student's mental health needs are addressed.



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**CRISIS REPOSE TOOLKIT
DOCUMENTS**

Attachment A: General Consent Form

**Attachment B: Sample Contract with Community Mental
Health Provider**

Attachment C: SAD PERSONS Risk Assessment

Attachment D: Parent/Guardian Notification Letter



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DOCUMENT A: GENERAL CONSENT FORM

I _____

(Student [if over 14] or parent/guardian name)

authorize _____

(Name of person/school disclosing information)

to disclose to/receive from _____

(Name or title of person/organization to whom information is to be disclosed)

the following identifying information from my records (specify the extent or nature of information to be disclosed has already been taken in reliance thereon.

The purpose or need for such disclosure is:

The consent to disclose information may be revoked by me at any time except to the extent that action has already been taken in reliance thereon.

The consent, unless revoked earlier, expires upon:

(Specify date, event or condition upon which it will expire)

(Signature of Student, if over 14) (Date)

(Signature of Witness) (Date)

(Signature of Parent/Guardian/Legal Representative) (Date)



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DOCUMENT B: SAMPLE CONTRACT

This constitutes an Affiliation Agreement between the ***Board of Education and the Community Mental Health Provider.

INTRODUCTION:

The purpose of the Affiliation Agreement is to maintain a formal cooperative working relationship between the ***Board of Education and the Community Mental Health Provider. It is hereby understood that a mutual referral agreement exists between the above agencies.

RESPONSIBILITIES OF BOTH PARTIES

The ***Board of Education

The ***Board of Education personnel agree to refer students in need of a Mental Health Screening, or psychiatric evaluation or substance abuse evaluation to the Community Mental Health Provider.

They will do so by calling the Community Mental Health Provider at _____.

*** personnel will be responsible for:

1. The identification and referral of students in need of services at the cost of:
 - \$____ for a mental health screening (risk assessment)
 - \$____ for a full psychiatric evaluation
 - \$____ for a full substance abuse evaluation including SASSI and drug screen.to be paid to the Community Mental Health Provider by the *** Board of Education.
2. Notifying of the student's parents of their recommendation for mental health services.
3. Providing (by secure fax) to the Community Mental Health Provider the reasons for the referral and contact information as outlined on the referral form provided by the Community Mental Health Provider.
4. Soliciting from, and provide to, the Community Mental Health Provider follow up information on the student referred.

The Community Mental Health Provider will provide mental health services to the students of the _____ School District. The Community Mental Health Provider will be responsible for:

1. Providing mental health screenings to referred students from the *** Board of Education as soon as possible after the referral is made but within 24 hours.
2. Provide full psychiatric evaluations for referred students from the *** Board of Education as soon as possible after the referral is made
3. Provide substance abuse evaluations for referred students from the *** Board of Education as soon as possible after the referral is made.



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4. Provide to the referring personnel of the ***Board of Education documentation of the mental health screening, psychiatric evaluation or substance abuse evaluation and recommendations in a timely manner (usually within one week of the evaluation).
5. Assist referred students from the *** Board of Education with follow up treatment if necessary and provide to the referring personnel ongoing reports of their progress.
6. Bill the *** Board of Education only for services contracted for under this agreement.

ADDITIONAL RESPONSIBILITIES:

1. Both parties to this agreement will abide by all Federal and State laws especially those dealing with the confidentiality of information.
2. Both parties shall provide for an exchange of pertinent information about the referred student during the period when services are provided. The referred student's guardian will be asked by the Community Mental Health Provider to sign a release of information during the intake process for this purpose.
3. It is understood that students referred by the *** Board of Education shall not be denied treatment or be discriminated against on the basis of race, sex, creed, national origin or sexual orientation.
4. The Community Mental Health Provider agrees to indemnify and hold harmless the *** Board of Education from any and all liability arising out of any negligent act of omission or commission by any of the Community Mental Health Provider agents, and representatives.
5. The*** Board of Education agrees to indemnify and hold harmless the Community Mental Health Provider from any and all liability arising out of any negligent act or omission or commission by any of the *** Board of Education's agents, and representatives.

Signature

Name_____

Title_____

Date_____

*****Board of Education**

Signature

Name_____

Title_____

Date_____

Community Mental Health Provider



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ATTACHMENT C : RISK ASSESSMENT TOOL

“SAD PERSONS”

ITEM	YES	NO
Sex (male)		
Age (15 and older)		
Depression or affective disorder		
Previous suicide attempt or psychiatric care		
Ethanol or drug abuse		
Rational thinking loss (psychosis)		
Social support lacking		
Organized plan or attempt		
Negligent parenting, significant stressors, suicidal modeling by parents or siblings		
School problems (aggressive behaviors or experiencing humiliation)		

Scoring System

1 point for each positive answer on the above

Score Risk

- 0-2 NO IMMEDIATE DANGER**
- 3-4 POSSIBLE DANGER**
- 5-6 POTENTIAL DANGER**
- 7-10 DANGER**



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SAD PERSONS SUMMARY

Prediction of suicide is never easy. However, there are known risk factors, and cumulatively they may offer a better accuracy of prediction for suicidal risk. One method goes under the acronym SAD PERSONS. It was originally described by Patterson et al¹ and has been reviewed by Juhnke². Juhnke also adapted the scale for kids³.

S: Sex. Men are more likely to commit suicide than women. Males kill themselves about four times more often, although females make far more attempts.

A: Age. The ages which are most dangerous for suicide vary over time. You should consult current statistics. As this is being written in 2006, individuals 15-24 have an elevated risk. Suicide is the third leading cause of death in this age group. However, estimates exist which suggest that people this age making attempts outnumber actual suicides by a ratio of 100-400 times.

D: Depression. The suicide rate for those who are clinically depressed is about 20 times greater than for the general population. Hopelessness is one aspect of depression that has a close tie to suicide. These two issues, depression and hopelessness, are the strongest predictors of wishes for a hastened death.

P: Prior History. Roughly 80% of completed suicides were preceded by a prior attempt.

E: Ethanol Abuse. Alcohol and /or drug abuse increase risk.

R: Rational Thinking Loss. Psychosis ('I heard a voice saying I should kill myself') increases risk. Some estimates suggest that 20-40% of schizophrenics make an attempt at some point, and the risk is highest early on in the illness.

S: Social Support Lacking. Loss of support can vary tremendously. With kids and adolescents it can be the break-up of their first 'puppy love' which they can take very seriously even though others like parents may view it as a trivial event. Other lost relationships for adolescents can include parents divorcing and remarrying someone else. Even a parent who is divorced or separated and living with a new person can be a trigger for adolescent suicide. The death of a relative, such as grand-parents, can be another trigger for kids. Loss of a spouse can be devastating to some. Loss of a parent within the past 3-5 years increases risk of suicide. Among older individuals, men who are widowed, and women who are divorce or separated are at increased risk.

O: Organized Plan. This speaks for itself. Having a method in mind created more risk.

N: Negligent parenting, significant stressors, suicidal modeling by parents or siblings. Neglect, abuse, trauma, chaotic lifestyle, and a history of suicidal behaviors in the family increase the risk of suicide.

S: School Problems. Bullying in the schools and cyber-bullying have taken on epic proportions. Chronic conflict with peers and problems associated with school increases the risk.

1 Patterson, W, Dohn, H, Bird, J, Patterson, G. Psychosomatics, 1983, 24, 343-349

2 Juhnke, G.E. "SAD PERSONS Scale Review." Measurement & Evaluation in Counseling & Development, 1994, 27, 325-328

3 Juhnke, G.E. "The Adapted SAD PERSONS: An assessment scale designed for use with children" Elementary School Guidance & Counseling, 119, 252-258



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ATTACHMENT D: PARENT/GUARDIAN NOTIFICATION LETTER

Dear _____

The _____ School has concern for your son/daughter _____ because of the following: _____

_____.

The School requires the following plan of action for the well-being of your child:

1. A screening by a licensed mental health professional or certified screener within the following time frame:
 Twenty-four hours
 Seventy-two hours

If the school is contracting with a specific mental health provider for screening services the agency's contact information may be provided here.

2. Follow-up to recommendations of Mental Health screener.

*The _____ School District does not provide ongoing counseling. It is the responsibility of the parent/guardian to obtain counseling services recommended at the time of the mental health screening.

I acknowledge that _____ Public School personnel have expressed a concern for my son/daughter _____. I agree to comply with these instructions within the allotted timeframe.

Parent/Guardian

Date

School Administrator

Date