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Early Identification, Referral, Follow up, and Treatment Form – Individual (EIRFT-I)

Directions: The following information should be completed by a professional for youth—ages 10–24—who are identified as at risk by a trained gatekeeper or screening tool as part of your GLS program. This form should be completed for every new identification of suicide risk that is made by a trained gatekeeper or screening tool, as a result of GLS activities. As you complete the form, please note that all entries and descriptions of other should not use acronyms or any local terms; please be sure that you only select other when none of the available response options apply and that your descriptions of other be sufficient for someone who is not familiar with your program or community to interpret

Section 1: Demographics

1. Participant ID (Assigned by site)	
2. Age (in years)	
3. Sex	<input type="radio"/> Female <input type="radio"/> Male <input type="radio"/> <input type="radio"/>
4. Race/Ethnicity <i>Select all that apply</i>	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Middle Eastern or North African <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other, please specify: <input type="checkbox"/> Information Missing
5. Please select the primary reason this youth is in your continuity of care and follow up process?	<input type="radio"/> Identified via a GLS funded screening or by a trained gatekeeper <i>[Continue to Section 2]</i> <input type="radio"/> Discharged from an emergency department for suicidal ideation or after a suicide attempt <i>[Go to Section 3]</i>

	<input type="radio"/> Discharged from an inpatient psychiatric unit for suicidal ideation or after a suicide attempt [Go to Section 4]
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Section 2: Identification Information

6. Date of identification	MM/DD/YYYY
7. Did this identification occur virtually or in person?	<input type="radio"/> Virtual <input type="radio"/> In person
8. ZIP code where the youth was identified	
9. How was this youth identified as being at risk?	<input type="radio"/> Gatekeeper <input type="radio"/> Screening <input type="radio"/> Other, please specify
10. Where was the youth first identified? <i>location/setting of first identification</i>	
<input type="radio"/> School or School Based Health Center <input type="radio"/> Social Service Agency (child welfare, supportive housing) <input type="radio"/> Juvenile Justice Agency (pre-trial services, mental health court) <input type="radio"/> Law Enforcement Agency (police, jail or detention center) <input type="radio"/> Community based organization, recreation or after school activity (Boys & Girls club, faith-based organization, AA, job training programs) <input type="radio"/> Physical Health Agency (pediatrician, primary care, hospital)	<input type="radio"/> Mental Health Setting (private MH provider, psychiatric hospital, outpatient clinic) <input type="radio"/> Home <input type="radio"/> Emergency Response Unit or Emergency Department <input type="radio"/> College or University (campus health center, classroom) <input type="radio"/> Digital or social media (Snapchat, TikTok, Instagram, text message to a friend) <input type="radio"/> Don't Know <input type="radio"/> Other: Please specify
11. Was this a tribal setting?	<input type="radio"/> Yes <input type="radio"/> No
12. Who first identified the youth as being at risk for suicide? <i>Who first noticed that the youth was in need of assessment, or who conducted the screening that identified the youth?</i>	
<input type="radio"/> School-based mental health service provider (including college or university providers) school counselor, social worker, guidance counselor, nurse) <input type="radio"/> Family member/foster family member/caregiver <input type="radio"/> Mental health service provider except school-based providers (clinician, private counselor) <input type="radio"/> Teacher or other non-mental health school staff (including college or university staff) (principal, sports coach, resident staff) <input type="radio"/> Community based organization, recreation,	<input type="radio"/> Child welfare or social service staff <input type="radio"/> Probation officer or other juvenile justice staff <input type="radio"/> Pediatrician or primary care provider <input type="radio"/> Emergency Responder or other emergency room staff <input type="radio"/> Police officer, security guard, or other law enforcement staff <input type="radio"/> Peer <input type="radio"/> Self (the youth themselves) <input type="radio"/> Don't Know <input type="radio"/> Other: Please specify

religious or after school program staff		
13. Was this individual trained as a gatekeeper		<input type="radio"/> Yes <input type="radio"/> No [Go to 15] <input type="radio"/> Don't know [Go to 15]
a. Please select the type of training the gatekeeper received. Select all that apply		
<input type="checkbox"/> American Indian Life Skills Development <input type="checkbox"/> Applied Suicide Prevention Intervention Skills Training (ASIST) <input type="checkbox"/> Assessing and Managing Suicide Risk (AMSR) <input type="checkbox"/> Campus Connect Suicide Prevention Training for Gatekeepers <input type="checkbox"/> Connect Suicide Postvention Training <input type="checkbox"/> Counseling on Access to Lethal Means (CALM) <input type="checkbox"/> Kognito At-Risk <input type="checkbox"/> Lifelines	<input type="checkbox"/> QPR (Question, Persuade, Refer) <input type="checkbox"/> Recognizing and Responding to Suicide Risk (RRSR) <input type="checkbox"/> Response (A Comprehensive High School-based Suicide Awareness Program) <input type="checkbox"/> SafeTALK <input type="checkbox"/> Signs of Suicide (SOS) <input type="checkbox"/> Sources of Strength <input type="checkbox"/> Yellow Ribbon <input type="checkbox"/> Youth Depression Suicide: Let's Talk <input type="checkbox"/> Locally Developed, please specify: <input type="checkbox"/> Other, please specify: <input type="checkbox"/> Don't Know	
14. Please enter the approximate month and year the gatekeeper was most recently trained. If the gatekeeper received more than one training, please indicate the date of their most recent training.		MM/YYYY
15. At the time of identification, was the youth screened for suicide risk (was a screening tool administered to determine whether the youth is at risk for suicide)?		<input type="radio"/> Yes [Continue to 16a] <input type="radio"/> No [Skip to 17] <input type="radio"/> Don't know [Skip to 17]
a. What screening tool was used? Select all that apply.		
<input type="radio"/> Patient Health Questionnaire (PHQ-9) <input type="radio"/> Columbia Suicide Severity Rating Scale (CSSR-S) <input type="radio"/> Behavioral Health Screen (BHS) <input type="radio"/> Ask Suicide Screening Questions (asQ) <input type="radio"/> Beck Depression Inventory (BDI) <input type="radio"/> Suicide Behaviors Questionnaire (SBQ-R)	<input type="radio"/> Screening Tool in Signs of Suicide (SOS) <input type="radio"/> SAFE-T <input type="radio"/> Patient Safety Screener (PSS-3) <input type="radio"/> Locally developed screening tool <input type="radio"/> Other, please specify:	
16. What the youth determined to be in need of a referral?		<input type="radio"/> Yes [Continue to Section 5] <input type="radio"/> No [Complete 17 a and then end form]
a. Please indicate why the youth was determined not to be in need of a referral.		

Section 3: Emergency Department Services

[This section if you selected, “Discharged from an emergency department after a suicide attempt” for question 7.

17. What was the date of Emergency Department admission?	<input type="radio"/> MM/DD/YYYY
18. What was the date of Emergency Department discharge?	<input type="radio"/> MM/DD/YYYY
19. While in the emergency department what services did the youth receive? <i>Select all that apply</i>	<input type="checkbox"/> Mental health assessment <input type="checkbox"/> Substance use assessment <input type="checkbox"/> Mental health Counseling <input type="checkbox"/> Substance abuse counseling <input type="checkbox"/> Medication <input type="checkbox"/> Tribal or cultural services <input type="checkbox"/> Don't Know <input type="checkbox"/> Other, please specify
20. While in the emergency department, did the youth receive any of the following services? <i>Select all that apply</i>	<input type="checkbox"/> Means restriction counseling <input type="checkbox"/> Safety planning <input type="checkbox"/> Suicide risk assessment
21. Prior to the visit to the Emergency Department, was this youth receiving MH services?	<input type="radio"/> Yes [Continue to 22a] <input type="radio"/> No [Skip to question 23] <input type="radio"/> Don't know [Skip to question 23]
a. What MH services was the youth receiving prior to the visit to the ED?	
<input type="checkbox"/> Mental health assessment <input type="checkbox"/> Substance use assessment <input type="checkbox"/> Mental health counseling <input type="checkbox"/> Substance abuse counseling <input type="checkbox"/> Inpatient or residential psychological services	<input type="checkbox"/> Medication <input type="checkbox"/> Tribal or cultural services <input type="checkbox"/> Case Management <input type="checkbox"/> Stabilization <input type="checkbox"/> Don't Know <input type="checkbox"/> Other, please specify
22. Did the youth receive any of the following services prior to the visit to the Emergency Department?	<input type="checkbox"/> Means restriction counseling <input type="checkbox"/> Safety planning <input type="checkbox"/> Suicide risk assessment
CONTINUE TO SECTION 5	

Section 4: Inpatient Psychiatric Unit Services

[This section if you selected, “Discharged from an Inpatient Psychiatric Unit after a suicide attempt” for question 7.

23. What was the date of Inpatient Psychiatric Unit admission?	<input type="radio"/> MM/DD/YYYY
24. What was the date of Inpatient Psychiatric Unit discharge?	<input type="radio"/> MM/DD/YYYY
25. While in the Inpatient Psychiatric Unit what services did the youth receive? <i>Select all that apply</i>	<input type="checkbox"/> Mental health assessment <input type="checkbox"/> Substance use assessment <input type="checkbox"/> Mental health counseling <input type="checkbox"/> Substance abuse counseling

	<input type="checkbox"/> Medication <input type="checkbox"/> Tribal or cultural services <input type="checkbox"/> Don't Know <input type="checkbox"/> Other, please specify
26. While in the Inpatient Psychiatric Unit, did the youth receive any of the following services? <i>Select all that apply</i>	<input type="checkbox"/> Means restriction counseling <input type="checkbox"/> Safety planning <input type="checkbox"/> Suicide risk assessment
27. Prior to the stay in the Inpatient Psychiatric Unit, due to suicidal ideation or an attempt, was this youth receiving MH services?	<input type="radio"/> Yes [Continue to 28a] <input type="radio"/> No [Skip to Section XX] <input type="radio"/> Don't know [Skip to Section XX]
a. What MH services was the youth receiving prior to the stay in the Inpatient Psychiatric Unit?	
<input type="checkbox"/> Mental health assessment <input type="checkbox"/> Substance use assessment <input type="checkbox"/> Mental health counseling <input type="checkbox"/> Substance abuse counseling <input type="checkbox"/> Medication	<input type="checkbox"/> Tribal or cultural services <input type="checkbox"/> Case management <input type="checkbox"/> Stabilization <input type="checkbox"/> Don't Know <input type="checkbox"/> Other, please specify
28. Did the youth receive any of the following services prior to the stay in the Inpatient Psychiatric Unit?	<input type="checkbox"/> Means restriction counseling <input type="checkbox"/> Safety planning <input type="checkbox"/> Suicide risk assessment
CONTINUE TO SECTION 5	

Section 5: Referral Information

29. [Question based on pathway] Upon discharge from the [inpatient psychiatric unit/Emergency Department], did the youth receive referrals for additional mental health services? Was the youth referred to mental health services and/or other supports as a result of having been identified as being at risk for suicide?	<input type="radio"/> Yes [inpatient/ER path continue to 31a; other continue to 31b] <input type="radio"/> No [SKIP to 31e, then end form] <input type="radio"/> I don't know [SKIP to 31f, then end form]
a. How were referrals made?	<input type="checkbox"/> Appointment(s) set up before discharge <input type="checkbox"/> Youth/parent given referral information, but must schedule their own appointment <input type="checkbox"/> Both <input type="checkbox"/> Other, please specify <input type="checkbox"/> Don't know
b. What was the date of referral?	MM/DD/YYYY
c. To which of the following mental health services was the youth referred? Select all that apply	
<input type="checkbox"/> Public Mental Health Agency or Provider (tribal or state sponsored mental health agency) <input type="checkbox"/> Private Mental Health Agency/Provider <input type="checkbox"/> Psychiatric Hospital/unit	<input type="checkbox"/> Mobile crisis unit <input type="checkbox"/> School based health clinic <input type="checkbox"/> Tribal or cultural services (traditional healing practices, talking circles, sweat lodge) <input type="checkbox"/> Non-hospital crisis stabilization unit

	<input type="checkbox"/> Emergency department <input type="checkbox"/> Substance abuse treatment center <input type="checkbox"/> School counselor (K-12 or college or university staff)	<input type="checkbox"/> Youth was not referred to mental health services <input type="checkbox"/> Don't Know <input type="checkbox"/> Other, please specify
d. To which of the following other supports was the youth referred? Select all that apply.		
	<input type="checkbox"/> School or academic organization (school club, academic counseling, tutoring) <input type="checkbox"/> Family or extended family (parent, foster parent, grandparent, aunt, uncle) <input type="checkbox"/> Community based organization, recreation religious, afterschool program (Boys & Girls club, faith-based organization, AA, job training programs) <input type="checkbox"/> Physical health provider (pediatrician, primary care provider)	<input type="checkbox"/> Law enforcement/ Juvenile justice agency (pre-trial services, mental health court, police) <input type="checkbox"/> Social service agency (child welfare, supportive housing) <input type="checkbox"/> Crisis hotline (988, local crisis hotline, text msg hotline) <input type="checkbox"/> Youth was not referred to other supports <input type="checkbox"/> Don't Know <input type="checkbox"/> Other, please specify
e. Why not? Select one primary reason		
	<input type="checkbox"/> Youth was already receiving services or supports <input type="checkbox"/> No capacity at provider agencies to receive a referral <input type="checkbox"/> Youth or parent refused services	<input type="checkbox"/> Unable to contact youth <input type="checkbox"/> Don't know <input type="checkbox"/> Other, please specify
f. Why don't you know? Select one primary reason.		
	<input type="checkbox"/> Parent permission for tracking required but not granted <input type="checkbox"/> No tracking system in place <input type="checkbox"/> Tracking system requires an agreement to share data, but the agreement is not in place	<input type="checkbox"/> Tracking system prohibits data sharing <input type="checkbox"/> Parent or youth could not be contracted <input type="checkbox"/> Don't know <input type="checkbox"/> Other, please specify

Section 6: Follow up and Treatment Receipt

This set for questions repeats for each of the 6 months post referral/discharge

30. In the [first/second/third/fourth/fifth/sixth] month following discharge from the [emergency department/inpatient psychiatric unit] did someone reach out to provide a supportive or caring contact for the purpose of expressing care or concern for the youth?	<input type="radio"/> Yes [Continue to 31a] <input type="radio"/> No [Skip to question 32] <input type="radio"/> Don't know [Skip to question 32]
a. Please describe the caring contact(s) with this youth?	
31. In the [first/second/third/fourth/fifth/sixth]	<input type="radio"/> Yes [Continue to 32a]

<p>month following discharge from the [emergency department/inpatient psychiatric unit] did someone contact the youth for the purpose of checking in on the status of the youth, for care coordination, or to check in on service receipt?</p>	<p><input type="radio"/> No [Skip to question 33] <input type="radio"/> Don't know [Skip to question 33]</p>
<p>a. Please describe the follow up contact(s) with this youth?</p>	
<p>32. In the [first/second/third/fourth/fifth/sixth] month following the [date of referral/date of discharge], did the youth receive a mental health service(s) as a result of the mental health referral?</p>	<p><input type="radio"/> Yes [Continue to 33a] <input type="radio"/> No [Skip to question 33g] <input type="radio"/> Don't know [Skip to question 33h]</p>
<p>a. As a result of the referral, which of the following services did the youth receive in the [first] month since referral? Select all that apply.</p>	
<p><input type="checkbox"/> Mental health assessment (assessment of psychosocial needs and conditions) <input type="checkbox"/> Substance use assessment <input type="checkbox"/> Mental health counseling (outpatient group or individual counseling) <input type="checkbox"/> Substance abuse counseling (inpatient or outpatient, group or individual) <input type="checkbox"/> Inpatient or residential psychological services <input type="checkbox"/> Medication</p>	<p><input type="checkbox"/> Tribal or cultural services <input type="checkbox"/> Case management <input type="checkbox"/> Stabilization <input type="checkbox"/> Don't Know <input type="checkbox"/> Other, please specify</p>
<p>b. As a result of the referral, did the youth receive any of the following services in the [first/second/third/fourth/fifth/sixth] month since referral? Select all that apply.</p>	<p><input type="checkbox"/> Means restriction counseling <input type="checkbox"/> Safety planning <input type="checkbox"/> Suicide risk assessment</p>
<p>c. Which of these services was received first after the referral? <i>[FIRST TIME YES IS SELECTED CONTINUE TO 33 Complete 33 c and d]. ALL OTHER TIMES SKIP TO 33e]</i></p>	
<p><input type="checkbox"/> Mental health assessment (assessment of psychosocial needs and conditions) <input type="checkbox"/> Substance use assessment <input type="checkbox"/> Mental health counseling (outpatient group or individual counseling) <input type="checkbox"/> Substance abuse counseling (inpatient or outpatient, group or individual) <input type="checkbox"/> Inpatient or residential psychological services <input type="checkbox"/> Medication</p>	<p><input type="checkbox"/> Tribal or cultural services <input type="checkbox"/> Case management <input type="checkbox"/> Stabilization <input type="checkbox"/> Means restriction counseling <input type="checkbox"/> Safety planning <input type="checkbox"/> Suicide risk assessment <input type="checkbox"/> Don't Know <input type="checkbox"/> Other, please specify</p>
<p>d. What is the zip code for where this first service occurred?</p>	
<p>e. Were any of these services provided via telehealth or virtual appointments?</p>	<p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know</p>
<p>f. Which of the services were provided via telehealth? <i>[Continue to 34]</i></p>	
<p><input type="checkbox"/> Mental health assessment (assessment of psychosocial needs and conditions)</p>	<p><input type="checkbox"/> Tribal or cultural services <input type="checkbox"/> Case management</p>

<input type="checkbox"/> Substance use assessment <input type="checkbox"/> Mental health counseling (outpatient group or individual counseling) <input type="checkbox"/> Substance abuse counseling (inpatient or outpatient, group or individual) <input type="checkbox"/> Inpatient or residential psychological services Medication	<input type="checkbox"/> Stabilization <input type="checkbox"/> Means restriction counseling <input type="checkbox"/> Safety planning <input type="checkbox"/> Suicide risk assessment <input type="checkbox"/> Don't Know Other, please specify
g. Why not? Select one primary reason [then 32]	
<input type="radio"/> Made an appointment for youth, but youth did not attend <input type="radio"/> Youth was waitlisted <input type="radio"/> Parent or youth refused service for non-financial reasons <input type="radio"/> Youth did not have insurance or could not afford services	<input type="radio"/> Youth did not have transportation to the appointment <input type="radio"/> Appointment made, but in the future <input type="radio"/> Don't Know <input type="radio"/> Other, please specify:
h. Why don't you know? Select one primary reason [then 34]	
<input type="radio"/> Parent permission for tracking required but not granted <input type="radio"/> No tracking system in place <input type="radio"/> Tracking system requires an agreement to share data but the data agreement is not in place	<input type="radio"/> Tracking system prohibits data sharing <input type="radio"/> Parent or youth could not be contacted (parent or youth moved) <input type="radio"/> Don't Know <input type="radio"/> Other, please specify:
33. Did the youth receive any services beyond those to which they were referred? (this may include services <i>in addition</i> to those to which they were initially referred or services they had already started prior to identification and referral)	<input type="radio"/> Yes [Continue to 34a] <input type="radio"/> No [SKIP to 35] <input type="radio"/> Don't know [SKIP to 35]
a. What additional services were received? Select all that apply	
<input type="checkbox"/> Mental health assessment (assessment of psychosocial needs and conditions) <input type="checkbox"/> Substance use assessment <input type="checkbox"/> Mental health Counseling (outpatient group or individual counseling) <input type="checkbox"/> Substance abuse counseling (inpatient or outpatient, group or individual) <input type="checkbox"/> Inpatient or residential psychological services <input type="checkbox"/> Medication	<input type="checkbox"/> Tribal or cultural services <input type="checkbox"/> Case management <input type="checkbox"/> Stabilization <input type="checkbox"/> Don't Know <input type="checkbox"/> Other, please specify
b. Did the youth also receive any of these services?	<input type="radio"/> Means restriction counseling <input type="radio"/> Safety planning <input type="radio"/> Suicide risk assessment
34. Was it determined that they youth needed additional referrals?	<input type="radio"/> Yes [Continue to 35a] <input type="radio"/> No [END MONTHLY REPORT] <input type="radio"/> Don't know [END MONTHLY REPORT]
a. What additional referrals did the youth receive during [MONTH]? Select all that apply	
<input type="checkbox"/> Public Mental Health Agency or Provider (tribal or state sponsored mental health	<input type="checkbox"/> School Based Health Clinic <input type="checkbox"/> Tribal or cultural services (traditional

<p>agency)</p> <ul style="list-style-type: none"><input type="checkbox"/> Private Mental Health Agency or Provider<input type="checkbox"/> Psychiatric Hospital/ Unit<input type="checkbox"/> Emergency department<input type="checkbox"/> Substance abuse treatment center<input type="checkbox"/> School counselor (K-12 or college or university staff)<input type="checkbox"/> Mobile crisis unit	<p>healing practices, talking circles, sweat lodge)</p> <ul style="list-style-type: none"><input type="checkbox"/> Youth was not referred to mental health services<input type="checkbox"/> Non-hospital Crisis stabilization unit<input type="checkbox"/> Don't Know<input type="checkbox"/> Other, please specify
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