YOUTH SUICIDE PREVENTION
REFERRAL AND TRACKING TOOLKIT

Maine Youth Suicide Prevention Program

RELATED PUBLICATIONS

Madden, M., Haley, D., Hart, S, Kalafat, J., & Saliwanchek-Brown, C. (2007). An Evaluation of Maine's Comprehensive School-Based Youth Suicide Prevention Program. Orono, ME: Center for Research and Evaluation, University of Maine.

Madden, M., Haley, D., & Saliwanchek-Brown, C., (2009). Maine's SAMHSA Youth Suicide Prevention Project Evaluation. Orono, ME: Center for Research and Evaluation, University of Maine.

Kalafat, J., Madden, M., Haley, D., O'Halleron, S., & DiCara, C.M. (2009). Evaluation of Lifelines Classes: A Component of the School-Community Based Maine Youth Suicide Prevention Project. Submitted to National Registry for Evidenced-Based Programs.

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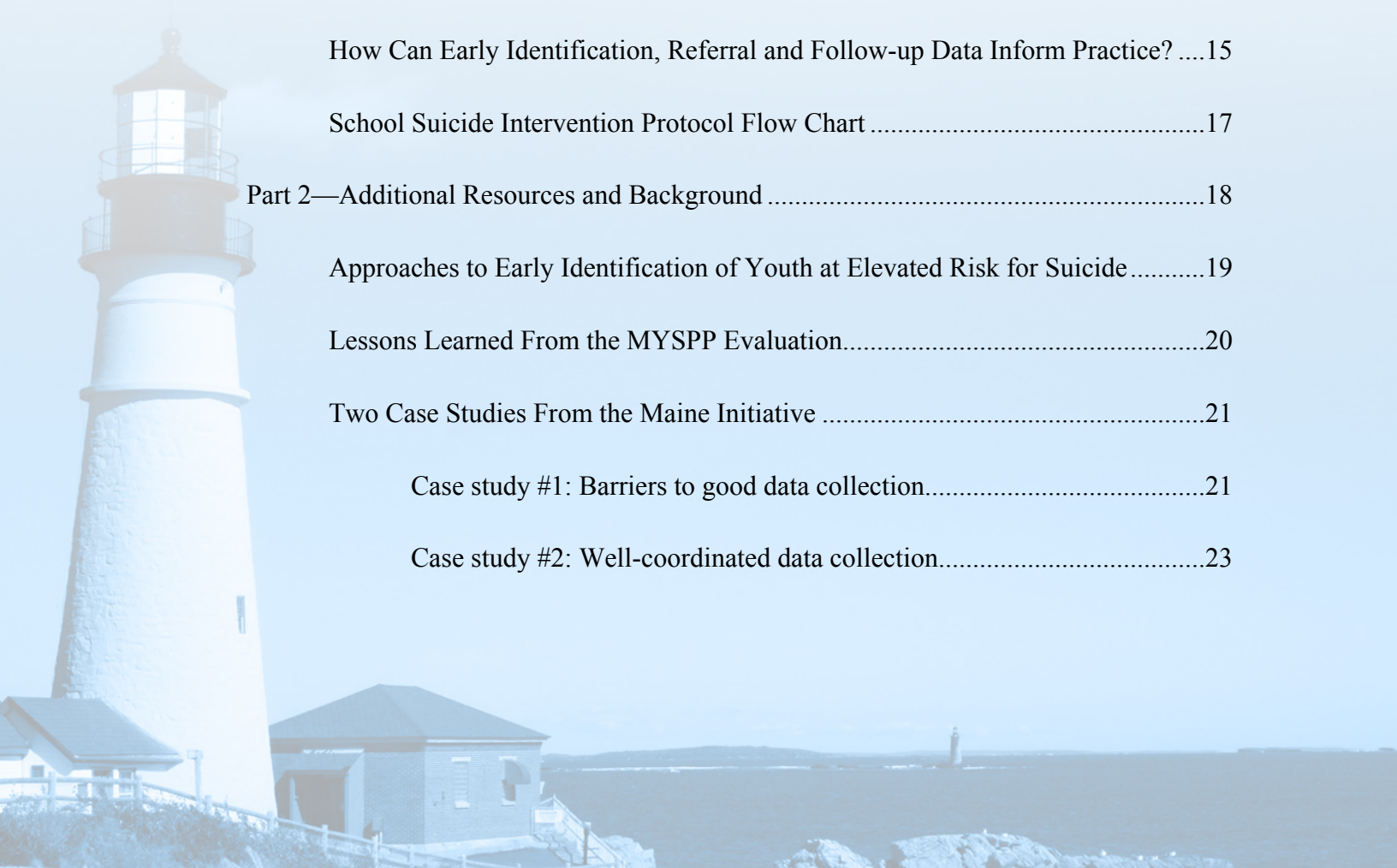College of Education and Human
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Introduction

This toolkit has been created to help school personnel involved in school-based suicide prevention and intervention to (1) track youth identified and referred for risk of suicide and (2) use that information to inform and evaluate suicide prevention practice. It is based on the lessons learned from the Maine Youth Suicide Prevention Program's (MYSPP) implementation of a comprehensive approach to suicide prevention.

The toolkit is organized into two parts:

Part 1—Facilitating Good Data Collection and Use

In this section, you'll find sample data collection forms, sample procedures for data collection, examples of analysis, and ideas about how data can be used to support suicide prevention initiatives and improve practices and protocols.

Part 2—Additional Resources and Background

In the section, you'll find data collection case studies, lessons learned from the MYSPP initiative, and information about approaches to youth suicide prevention.

Although Maine implemented the Lifelines* program, the information and resources in this toolkit are applicable regardless of what program you use.

*More information about Lifelines may be found at
http://www.hazelden.org/web/public/lifelines.page.

Part 1   Facilitating Good Data Collection and Use

MYSPP has worked with schools to collect early identification, referral, and follow-up (EIRF) data on youth identified as potentially at risk for suicide. This experience has provided many insights about what facilitates good data collection and the barriers that can impede data collection.

A key lesson to come out of our work with schools is that poorly coordinated data collection is often a signal that a school lacks clear guidelines and communication protocols for staff to follow if they are concerned about a student's risk for suicide.

Based on MYSPP's work, this section contains a variety of tools, resources, and recommendations to facilitate good data collection and use in order to inform practice:

■   **Making the Case.**

■   **Recommendations for Facilitating Good Data Collection.**

■   **Tip Sheet for Data Coordinators.**

■   **Sample Data Collection Forms:**

   1) For use when a student is identified as possibly at risk (early identification).

   2) For information about services a student received (referral).

■   **How Can EIRF Data Inform Practice?**

■   **School Suicide Intervention Protocol Flow Chart.**

> **SAMHSA's Garrett Lee Smith grantees who participate in the cross-site evaluation will be familiar with many of the questions on the data collection forms. Also included are additional questions that are specific to Maine's project and that have been very useful in guiding program decisions.**

Making the Case:
Why Collect Early Identification, Referral and Follow-up Data on Students Identified for Risk of Suicide?

The early identification, referral and follow-up (EIRF) process tracks information about a youth who has been identified as potentially at risk for suicide and referred for additional services. EIRF data include information on the youth; the person who first was concerned about the youth; the circumstances that caused concern; the referral made, if any; and the service received.

Benefits of Collecting EIRF Data

There is no doubt that collecting EIRF data takes extra effort, but collecting and analyzing these data provide important benefits. EIRF data can:

- Help a school improve its suicide prevention efforts.

- Help a school determine if its suicide prevention efforts lead to identifying and supporting youth at risk for suicide.

- Document the need for suicide prevention efforts in times when schools have fewer resources and need to prioritize how they are used.

- Reinforce the importance of staff in suicide prevention efforts and promote their continued attention to signs of risk in students.

- Be used to improve practice.

Challenges of Collecting EIRF Data

- Staff turnover. Changes in a key position, such as administrator, can alter commitment to the project and to data collection.

- Misunderstanding related to confidentiality. School personnel assume that the Health Insurance Portability and Accountability Act—HIPAA—prevents them from sharing information about a student's risk for suicide with those who need to know. In fact, with a parent's permission, the information can be shared with certain people.

- Licensing guidelines related to confidentiality. Staff, such as guidance counselors, social workers, and nurses, abide by ethics and licensing guidelines. These may restrict some personnel from sharing information about students with others.

- Time. School staff often juggle an increasing number of roles and responsibilities as funding in schools is cut by states and local communities.

- Lack of understanding. Incomplete knowledge about how data can inform prevention and intervention strategies hinders commitment to consistent collection of data.

Recommendations for Facilitating Good Data Collection

■ **Consider the regulations for confidentiality for different professionals in your school.** Some mental health professionals cannot share information about a student with others unless they have parental consent. However, these people can usually fill out EIRF data forms that do not have identifying information.

■ **Identify a champion.** Enlist the support of a person in the school who advocates for the issue of suicide prevention, has social capital, and is a trusted "go-to" person in the school.

■ **Secure administrative cooperation** to:

- Make time on staff meeting agendas for presentations.

- Allow staff to attend trainings.

- Ensure involvement in developing and obtaining approval for protocols.

- Endorse the integration of student lessons into existing curricula.

- Allow key staff to take time for data collection and entry.

- Keep the issue in the forefront.

■ **Consider providing a stipend** paid directly to the person coordinating data collection and entry.

■ **Build staff awareness.** Provide information at a staff training or meetings that makes staff aware of:

- Signs of risk in a student.

- Protocols and procedures for identification and referral.

- Key staff managing the flow of information and data.

■ **Build appreciation** for the utility of data by sharing an analysis of staff and discussing the implications of the data for practice.

■ **Choose the right data coordinator.** Ensure that the person who coordinates data collection and entry is someone whose role is linked to student wellness/mental health (i.e., school social worker or guidance counselor) and is a champion for suicide prevention in order to facilitate interaction with school staff. The data coordinator also should prompt, remind, support, and identify challenges and solutions to data collection issues.

Tip Sheet for Data Coordinators

- Have an initial face-to-face meeting and training with the person(s) responsible for collecting and entering data.

- Provide a written or online guide to data entry.

- Provide a user-friendly Web-based entry form. If you choose to use an online survey development and collection service, be sure to check that it is a secure system.

- Assign a unique and confidential identifier to each student, and use the identifier each time an EIRF report is filled out for the student. Maintain one central list of identifiers, with student names, and provide access to all those entering data.

- Set clear expectations about regular and timely data entry.

- Pilot the data entry form, and solicit feedback to improve it.

- Schedule regular monthly calls to review reports submitted and encourage data collection and submission.

- Track initial submissions by date, and send timely reminders for follow-up information to be submitted.

- Explore with school personnel factors that may be affecting the internal communication and referral system in the event that data are not submitted or fewer-than-expected reports are submitted.

- Review data and follow up quickly if you have questions or need to make corrections.

- Expect an increase in reports of students at risk after a suicide or other death of a student or staff member. Check in with the school after the initial crisis to support data gathering and entry.

- Deliver annual presentations of data and findings for staff to review and discuss.

Early Identification Data Collection Form

For use when a student is identified as possibly at risk.

Department of Health & Human Services
Maine Youth Suicide Prevention Program
State of Maine

School Event Report: Part 1

The intent of this log is to record each report of a concern about a youth suicide risk that is reported to you ("you*" is used to mean "you yourself or any other authorized school personnel") including when it occurred and the action taken by school staff. Please complete this form as soon after dealing with a youth that is identified as potentially at risk as you can. Prompt reporting will make it easier for you to remember the information.

Preservation of the youth's anonymity is absolutely essential in this report. Do NOT include any names, events, characterizations, descriptions, etc. that would identify or allow anyone else to think they might be able to identify the youth who prompted the actions described in this documentation of a report of a concern about a youth suicide risk.

Section I: Reporting Information:

1. School name: _____

2. Name of person submitting report: _____

3. Email of person submitting report (email address will be used to remind you to submit follow up information form if you haven't done so within 30 days): _____

4. Date of the initial report: Month _____ Day _____ Year _____

Section II: Student Information

5. Student ID: _____

6. Gender: ○ Male   ○ Female

7. Grade:

○ 7   ○ 8   ○ 9   ○ 10   ○ 11   ○ 12

8. Age:

- ○ 11　　○ 16
- ○ 12　　○ 17
- ○ 13　　○ 18
- ○ 14　　○ 19
- ○ 15　　○ 20

Section III: Suicide Attempt

9. Did the student come to your attention because of a hospitalization for suicide ideation or suicide attempt?

○ Yes　　○ No

9a. If you answered yes to the above question, how did you learn of this event?

- ○ Suicide attempt was on school grounds
- ○ Parent notified school personnel
- ○ Student self-reported after event
- ○ Notified by mental health provider
- ○ Other: Please explain._____

If this report is about a student who was hospitalized for suicide ideation or attempt, this is all the information you need to submit. You will not need to respond to the remaining questions or fill out follow-up form.

Section IV: Data Tickler System

10. Did this student come to the attention of school staff through the data monitoring (data tickler system)?

○ Yes　　○ No

10a. If yes, which of the following flagged this student? (Check all that apply)

- ☐ Drop in grades
- ☐ Absences
- ☐ Detentions
- ☐ Suspension
- ☐ Visits to nurse or guidance counselor
- ☐ Teacher concerns

Section V: Information about the person who FIRST expressed concern

11. How would you classify the role of the first person who expressed concern about this individual? If you were the first person to express concern, please identify your role.

- ○ Student who is the subject of this report
- ○ Teacher
- ○ Guidance Counselor
- ○ School social worker
- ○ Administrator
- ○ School nurse
- ○ School substance abuse counselor
- ○ School-based mental health provider
- ○ School resource officer
- ○ Ed tech or 1:1 aide
- ○ Peer
- ○ Parent of student who is subject of the report
- ○ Parent of a peer
- ○ Adult family member other than parent
- ○ Sibling
- ○ Other: _____

12. If this person is a school staff member, did they attend a gatekeeper training?

○ Yes   ○ No   ○ Don't know   ○ N/A

13. If this person is a school staff member, did he/she attend a suicide awareness session provided by school staff?

- ○ Yes
- ○ No, suicide awareness session was provided, but person did not attend
- ○ No, suicide awareness session was not provided.
- ○ Don't know

14. If this person is a student, did they participate in the Lifelines curriculum taught in health class?
- ○ Yes
- ○ No, Lifelines curriculum was provided, but person did not attend
- ○ No, Lifelines curriculum was not provided
- ○ Don't know
- ○ Not a student

15. Has this individual initiated any other reports about a youth suicide risk since Fall 2006?

      ○ Yes   ○ No

16. Did the person(s) who first expressed the concern speak directly with the youth about suicidal thoughts or behaviors?

      ○ Yes   ○ No   ○ Don't know   ○ N/A

17. What signs prompted their concern? Check all that apply.

- ☐ Anniversary of a death
- ☐ Breakup with a girlfriend/boyfriend
- ☐ Change in behavior
- ☐ Change in emotional stability/mood
- ☐ Death of family member or close friend
- ☐ Drop in academic performance
- ☐ Giving away personal belongings
- ☐ Kicked out of or left home
- ☐ Self-injury/cutting
- ☐ Significant problems/stress in their life
- ☐ Verbal statements about suicide or self-injury
- ☐ Written statements about suicide in school assignment
- ☐ Written statements about suicide NOT related to school assignment
- ☐ Recent or past suicide attempts
- ☐ Other: _____

Please add any clarifying information.

Section VI: Action Taken by You or Other Authorized School Personnel.

18. Did you* speak with the youth?   ○ Yes   ○ No   ○ If you checked "No", please tell us why

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19. Was there a referral for immediate evaluation to a

       Crisis service provider   ○ Yes   ○ No

       If yes, name of crisis service agency _____

       Emergency room   ○ Yes   ○ No

       Psychiatric Hospital   ○ Yes   ○ No

20. Did you refer to any of the following? (check all that apply):

       A crisis service provider   ○ Yes   ○ No

       If yes, name of provider _____

       A community mental health provider   ○ Yes   ○ No

       In-school guidance counselor   ○ Yes   ○ No

       In-school social worker   ○ Yes   ○ No

       In-school mental health provider   ○ Yes   ○ No

       The student's current provider   ○ Yes   ○ No

       Substance abuse counselor   ○ Yes   ○ No

21. If a mental health referral was not made did you: (Check all that apply)

       ☐ Determine the student was not in need of mental health service

       ☐ Determine that youth was already receiving services

       ☐ Inform the youth of the crisis hotline

       ☐ Discuss the availability of other supports – i.e., family members

       ☐ Refer for academic or tutoring services

       ☐ Refer for physical health services i.e., pregnancy test

       ☐ Other, please describe _____

22. Did you* speak with the youth's parent(s) or guardian?

       ○ Yes   ○ No

If you checked "No", please tell us why

Reminder: Please Complete the Follow-up Form on this Student within 30 days.

Referral Data Collection Form

For information about services received

Department of Health & Human Services
Maine Youth Suicide Prevention Program
State of Maine

School Event Report: P2

Follow-up on Referral

Directions: Please complete this form within 30 days after a student has been identified as potentially at risk for suicide.

Section I: Reporting Information:

1. School name: _____

2. Today's date: Month _____ Day _____ Year _____

3. Name of person submitting report: _____

4. Date of the initial report: Month _____ Day _____ Year _____

Section II: Student Information

5. Student ID: _____

6. Gender: ○ Male   ○ Female

7. Were you able to obtain follow-up information?

    ○ Yes   ○ No

If no, what barriers prevented you from obtaining the information?

Directions: If you were not able to obtain follow-up information STOP HERE. If you did obtain follow-up information please continue.

8. If yes, from whom did you obtain information? (Check all that apply)

☐ Parents or guardian
☐ Student
☐ Mental Health Provider based at the school
☐ Mental Health Provider based at a crisis agency or community agency
☐ School Social Worker
☐ Other, please describe _____

9. What happened as a result of the referral? (Check all that apply)

☐ Student received emergency services.
☐ Student received services from crisis agency
☐ Student saw a school-based mental health provider.
☐ Student saw a community-based mental health provider.
☐ Student has not seen a mental health provider but has an appointment.
☐ Student has not made an appointment with a mental health provider but intends to do so.
☐ No follow through on referral and no intention to follow through.
☐ Parents/guardian chose another course of action. Please describe. _____

10. If the student was seen by a school-based mental health provider (i.e., a school social worker, a contracted mental health provider based in school) how soon was the student seen for the assessment?

○ Did not see a school-based mental health provider
○ Same day
○ Within 1 week
○ More than a week but less than a month
○ A month or more later

11. If the student was seen by a crisis agency or community-based provider, how soon was the student seen for an assessment?

○ Same day
○ Within 1 week
○ More than a week but less than a month
○ A month or more later
○ Did not see a community based provider

12. What type of services did the student receive? (Check all that apply)

☐ Emergency services
☐ Mental health assessment
☐ Substance abuse assessment
☐ Individual therapy
☐ Family therapy
☐ Group therapy
☐ Substance abuse counseling
☐ Other

13. Was the assessment conducted by a: (Check all that apply)

☐ In-school provider (i.e., school social work; contracted mental health provider based at school)
☐ A community-based mental health provider not located at the school
☐ A crisis service provider

14. At the time of the assessment, it was determined that the student was:

○ At risk for suicide
○ Not at risk for suicide at this time but referred for further counseling or mental health services
○ Not at risk for suicide at that time and not in need of further services
○ Do not know the outcome of the assessment

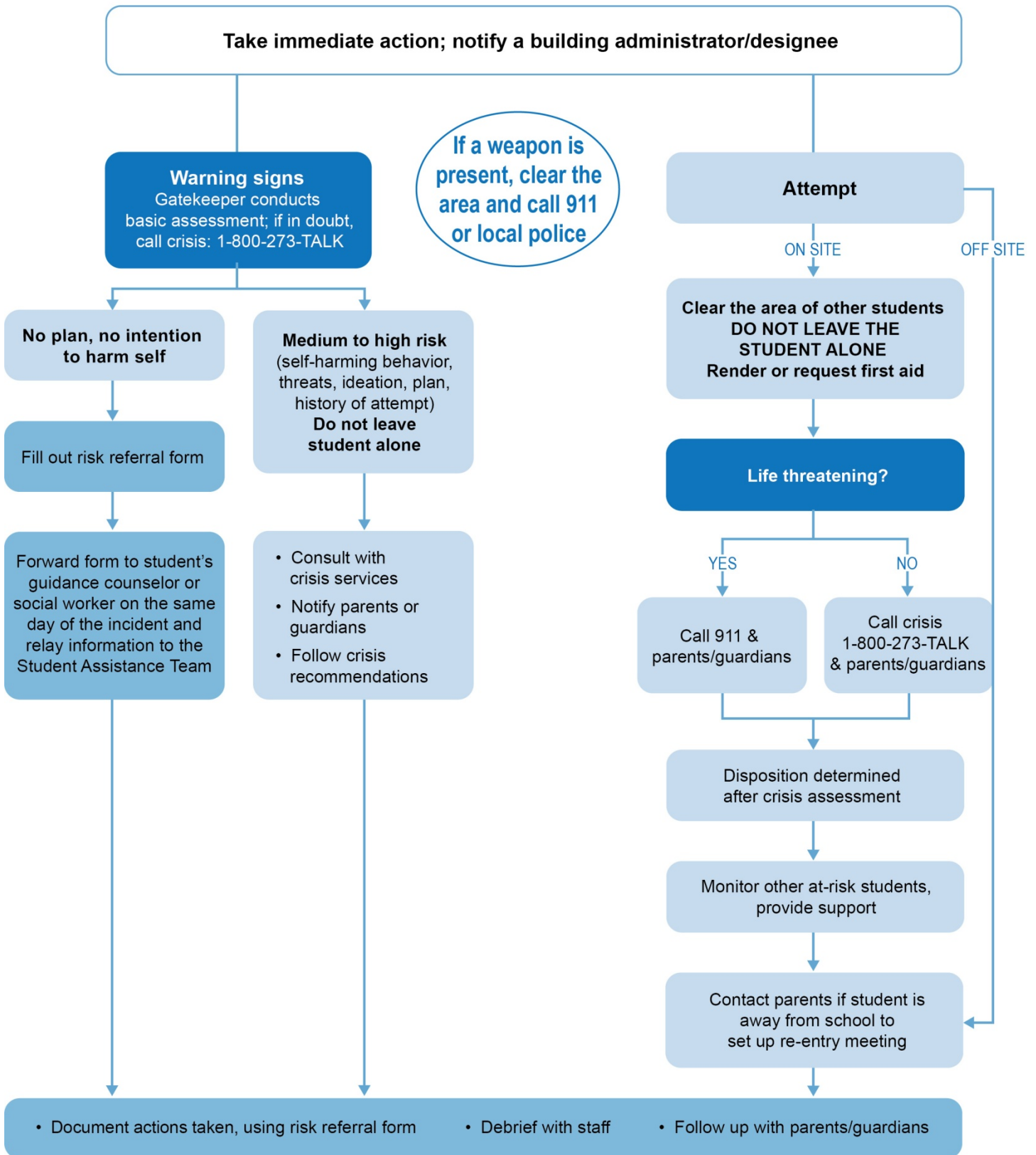## How Can Early Identification, Referral and Follow-up Data Inform Practice?

The data can help you explore many questions beyond "How many students are identified?" The information can help you to understand what is working as you intended and what needs to be revised or enhanced. For example, Maine school staff often identified students cutting as a sign of suicide risk. This finding prompted education for staff on cutting and how to respond to a student who they suspected was cutting.

Your data can supply many answers. These suggested questions may help get you started.

■ **What is the proportion of girls identified and boys identified? Does this proportion match the portion of each gender in your school?**

- In Maine schools, we noticed that twice as many girls as boys are identified as potentially at risk. This finding prompted discussions about how boys may express distress differently from girls because we live in a culture where boys are not encouraged to express emotions other than anger.

■ **What signs did the students show that alerted another person that they might be at risk for suicide? Or, what events were most frequently associated with a student showing signs of risk? What signs are most frequently noticed by staff?**

- Maine data showed that staff often noticed boys exhibiting signs of risk after a relationship breakup. Opportunities for boys to process their feelings after a breakup could be beneficial to them.

■ **What is the role of individuals identifying students who may be at risk?**

- Are people in a variety of roles taking responsibility for paying attention to signs of risk for suicide and reporting their concerns to a gatekeeper? If not, then this gap may signal a need for additional training and/or reminders about the signs of risk and to whom to report concerns.

■ **Have the individuals who are identifying students at risk had training? If so, did they attend a training offered by your school?**

- Tracking if persons who have expressed concern about students have attended training can provide evidence of the effectiveness of training efforts.

- **Are students self-identifying or expressing concern about their friends and peers?**

  - If students are reporting concerns about themselves or other students and they have participated in education offered by the school, this factor can provide evidence of the impact of lessons.

  - If students are not reporting concerns to adults, this gap may indicate a need for more education or a need to understand whether students see adults in the school setting as a resource. If they do not see adults as a helping resource, then what needs to be done differently to promote their help-seeking from adults?

- **Are students receiving timely assessments?**

  - If students are receiving timely assessments, can you report on who is completing these assessments? This information is important to know when decisions about budget reductions are being considered in your school.

  - If students are not receiving timely assessments, then what resources does the school need to reach out to in order to ensure the availability of timely resources?

- **What are the most common referral resources that are being recommended to students and their families?**

  - Do school personnel have a relationship with this resource? Is there an agreement with the referral resource to seek parental permission to share information with key school personnel in order to create a better safety net for students when they return to school?

- **Are students following through with referrals?**

  - If students and families are not following through with referrals, this gap may be caused by a variety of reasons, such as the availability of services, the distance to get to services, or the hours that services are available. Knowing the reason can help a school develop solutions to help families. For example, in one rural Maine community, distance and hours of operation were a problem for students and families. The solution was that the community health agency would offer services at the school several days a week.

SCHOOL SUICIDE INTERVENTION PROTOCOL FLOW CHART

Take immediate action; notify a building administrator/designee

If a weapon is present, clear the area and call 911 or local police

Warning signs
Gatekeeper conducts basic assessment; if in doubt, call crisis: 1-800-273-TALK

Attempt

ON SITE

OFF SITE

No plan, no intention to harm self

Medium to high risk
(self-harming behavior, threats, ideation, plan, history of attempt)
Do not leave student alone

Clear the area of other students
DO NOT LEAVE THE STUDENT ALONE
Render or request first aid

Fill out risk referral form

Life threatening?

YES

NO

Forward form to student's guidance counselor or social worker on the same day of the incident and relay information to the Student Assistance Team

- Consult with crisis services
- Notify parents or guardians
- Follow crisis recommendations

Call 911 & parents/guardians

Call crisis 1-800-273-TALK & parents/guardians

Disposition determined after crisis assessment

Monitor other at-risk students, provide support

Contact parents if student is away from school to set up re-entry meeting

- Document actions taken, using risk referral form
- Debrief with staff
- Follow up with parents/guardians

Part 2   Additional Resources and Background

In this part of the toolkit, you will find additional helpful information, including:

- **Approaches to Early Identification of Youth at Elevated Risk for Suicide.**

- **Lessons Learned From the MYSPP Evaluation.**

- **Two Case Studies From the Maine Initiative.**
  Each case study—one where data collection was poorly coordinated and one where data collection was well coordinated—is followed by a list of factors that either impeded or facilitated good data collection, as well as additional factors identified at other schools.

Approaches to Early Identification of Youth at Elevated Risk for Suicide

This toolkit may be useful for tracking information related to any early identification approach. Each school should identify the approach or combination of approaches that would work best in its community. Two primary approaches used by schools are screening and gatekeeper surveillance. While both approaches aim to identify youth with possible increased risk for suicide, the two approaches differ. Furthermore, these should not necessarily be seen as mutually exclusive strategies, and many programs effectively combine these approaches for a more robust student safety net.

Screening	Gatekeeper Surveillance
Usually involves administering a standard assessment that identifies students who may be at risk for suicide.	Involves training adults in a setting to recognize students demonstrating signs of suicide risk.
Takes place within a specified period of time, and is carried out by a limited number of people in the school setting.	Is ongoing throughout the academic year, and relies on the participation of a larger number of people.
Results in information about students with suicide risks that can be compiled and used in a school's prevention and intervention efforts.	Does not have a built-in way to capture information about students who are identified as at risk for suicide. This lack of information can leave school personnel questioning the impact of their efforts.

Extensive information and resources about approaches to youth suicide prevention are available through the Suicide Prevention Resource Center at http://www.sprc.org

Lessons Learned From the MYSPP Evaluation

The evaluation of the MYSPP's Lifelines program was designed to compare schools that participated in one of the funded projects to implement Lifelines and comparison schools that had not participated in one of the funded projects. Comparison schools were not restricted from participating in trainings offered by the MYSPP. The broad lessons learned in the evaluation included:

1) Schools that implement the Lifelines program do identify and refer more students for risk of suicide than schools that do not have the program in place.

2) While the schools identify and refer students at risk, they may struggle to document information about the youth who are identified and the circumstances that lead to the identification. Schools that struggle to capture the data often lack clear, consistent communication protocols related to youth at risk for suicide. Providing suicide prevention awareness training that includes a review of written protocols on the actions to take if personnel are concerned about a student is critical to enhancing early identification and referral and to establishing a clear chain of communication. The School Suicide Intervention Protocol Chart on page 19 provides a sample visual that schools can adapt and provide to teachers and other staff to remind them of the protocols and chain of communication.

3) When there is a clear chain of communication regarding concern about a student at risk for suicide, the person at the end of the chain is the best person to record information about the identification and referral.

These lessons learned highlight the importance of a systematic process for data collection in order to ensure the timely referral of at-risk youth.

More information about the guidelines for coordinating communication and referrals recommended to schools in Maine is available at http://www.maine.gov/suicide/.http://www.maine.gov/suicide/docs/Guidelines%2010-2009--w%20discl.pdf.

Two Case Studies From the Maine Initiative

Case study #1:
Barriers to good data collection

The project coordinator at this site was the health education teacher, who spearheaded efforts to become involved in the project, writing the grant along with the school nurse. Once the grant was awarded, these two also played a key role in writing and gaining approval of the suicide prevention protocols as well as implementing other aspects of the project. They delivered a suicide awareness presentation to staff at the beginning of the project, where they reviewed the suicide prevention, intervention, and postvention protocols, including procedures for referral of students showing warning signs for suicide risk. However, they were not able to get time on staff meeting agendas thereafter. These two individuals were the face of the suicide prevention project in their school; the health education teacher, in particular, was identified in this role by both staff and students.

Minimal early identification, referral and follow-up (EIRF) data were submitted by this site during the first year of the project. In the second year, the guidance counselor was pulled into a more active role, primarily to take responsibility for submission of EIRF data. Over the following months, a few reports were submitted, far fewer than other schools of similar size. Throughout the project, the coordinator (health education teacher) remained the primary liaison between evaluators and the school, channeling information between the two and taking responsibility for on-site project activities. Thus, reminders to submit data and efforts to troubleshoot problems were directed to the project coordinator, rather than the guidance counselor. Within the school, the health education teacher remained the person most associated with suicide prevention and the one to go to, initially, with concerns. He would, in turn, refer them to the guidance counselor.

During close-out interviews conducted by the evaluator, we discovered that the coordinator had given all responsibility for EIRF data collection and submission to the guidance counselor. The guidance counselor, having many other demands on her time, acknowledged that this task was low on her list of priorities and that she did not consider submitting data unless there was a confirmed risk for suicide. Additionally, she had not received any orientation in the use of the online form and confidential student log. She reported having difficulty with the forms, especially maintaining continuity between initial and follow-up reports. The log was not used properly, adding to the confusion.

What prevented good coordination of EIRF data entry?

- Inadequate follow-up by the evaluator with the site coordinator failed to identify communication problems between the staff early on. This gap was a missed opportunity for problem solving.

- Responsibility for EIRF data submission was transferred to another staff member at the school, and this person was not trained on how to use the tools provided for data collection and entry.

- The guidance counselor was overwhelmed with her caseload and unable to prioritize data entry.

- The person responsible for data entry was not part of the project from the beginning and had less buy-in than the coordinator.

- The person who was known as the suicide prevention expert in the school was not the same person collecting and submitting the data.

- The person responsible for coordinating data submission had low comfort level with data.

- The coordinator, a health education teacher, functioning in an atmosphere of constant change and insecurity, had minimal influence and was not able to get time on staff meeting agendas where staff could have been reminded about the project, the warning signs for suicide risk, and the need to make referrals to the guidance counselor.

Case study #2:
Well-coordinated data collection

At another participating school, coordination of the suicide prevention project was shared by the school's two social workers. They took responsibility for implementation of all aspects of the project, including collection and entry of early identification, referral, and follow-up (EIRF) data. To ensure that school staff and students would be aware of their roles on this initiative, they delivered all of the in-school trainings and student lessons themselves. Conducting a staff awareness presentation about suicide prevention in the early days of the project provided an opportunity for them to introduce suicide prevention, intervention, and postvention protocols, which included procedures for referral of students showing warning signs for suicide risk. Each semester, a brief review and reminder at staff meetings are given about the warning signs and to whom staff should go with concerns about suicide risk.

Prior to this initiative, these two individuals, in their capacity as social workers, were already known as the "go–to" people for concerns related to behavioral and mental health. As this project got underway, they also became known by the entire school community—staff, faculty, administration, and students—as the ones to go to with concerns about possible risk for suicide. As staff awareness about suicide risk signs increased among the school community, they said that referrals went up for concern related to suicide. Regarding the EIRF data, they found it easy to obtain the information needed to complete the forms, and since they split the alphabet (one saw students with last names in the first half of the alphabet, the other saw students whose names were in the second half), there was no confusion about repeat incidents. The stipends they received were considered a nice support, though not an adequate reflection of the effort put forth.

What were the facilitators of good EIRF data collection and submission?

■ Social workers were dedicated to the initiative: They gave constant reminders to staff, by doing trainings and classroom lessons for students, and brought attention to the issue and to their roles as referral sources.

■ Social workers could prioritize suicide prevention efforts as part of their regular roles and responsibilities.

■ Staff were made aware of suicide prevention protocols and procedures for internal referral on a regular basis.

■ A stipend was paid to the person(s) who coordinated the suicide prevention initiative at the school and assumed responsibility for data collection and entry.

■ There was administrative support for data collection and entry.

■ Data collection and submission lay with staff who were already viewed as the "go–to" people in the school.