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School personnel experiences in notifying parents about their child's risk for suicide: lessons learned

Erum Nadeem,
Assistant Professor, Department of Child and Adolescent Psychiatry, New York University, One Park Ave, 7th Floor, NYU Child Study Center, New York, NY 10016

Catherine DeCarlo Santiago,
Assistant Professor, Loyola University Chicago, Department of Psychology, 1032 W. Sheridan Road, Chicago, IL 60660

Sheryl H. Kataoka,
Associate Professor, Center for Health Services and Society, Semel Institute for Neuroscience and Human Behavior, University of California, Los Angeles, 10920 Wilshire Boulevard, Los Angeles, CA 90024

Vickie Y. Chang, and
1220 University Drive, Menlo Park, CA 94025

Bradley D. Stein
RAND Corporation, University of Pittsburgh School of Medicine, 4570 Fifth Ave., Pittsburgh, PA 15213

Erum Nadeem: erum.nadeem@nyumc.org; Catherine DeCarlo Santiago: csantiago4@luc.edu; Sheryl H. Kataoka: SKataoka@mednet.ucla.edu; Vickie Y. Chang: vickieychang@gmail.com; Bradley D. Stein: stein@rand.org

Abstract

BACKGROUND—Schools across the nation are increasingly implementing suicide prevention programs that involve training school staff and connecting students and their families to appropriate services. However, little is known about how parents are engaged in such efforts.

METHODS—This qualitative study examined school staff perspectives on parent involvement in the implementation of a district-wide suicide prevention program by analyzing focus group and interview data gathered on the program implementation processes. Participants included middle school teachers, administrators, and other school personnel.

RESULTS—Study results revealed that in the immediate wake of a crisis or concern about suicide, school staff routinely contacted parents. However, substantial barriers prevent some students from receiving needed follow-up care (eg, lack of consistent follow-up, financial strain, parental stress, availability of appropriate services). Despite these challenges, school staff identified strategies that could better support parents before, during, and after the crisis. In particular, school-based services increased the success of mental health referrals.

Human Subjects Approval Statement
The RAND and UCLA Institutional Review Boards and the school district research review committee approved the study.

CONCLUSIONS—Our study suggests that systematic post-crisis follow-up procedures are needed to improve the likelihood that students and families receive ongoing support. In particular, school-based services and home visits, training and outreach for parents, and formal training for school mental health staff on parent engagement may be beneficial in this context.

Keywords

suicide prevention; schools mental health; parent involvement; implementation

Designing and implementing effective suicide prevention programs is critical, given suicide's role as the third leading cause of death in individuals 10–24 years old.[1] According to the national Youth Risk Behavior Survey, 17% of students have seriously considered attempting suicide, 13.6% have planned a suicide attempt, and 8% have made a suicide attempt.[2] These rates have generally remained consistent over the past two decades.[2] School-based suicide prevention programs and mental health services have the potential to reach many suicidal adolescents, who otherwise would be unlikely to receive supportive services.[3] There are various approaches to school suicide prevention, including curriculum-based programs,[4] universal screening programs,[5] and staff in-service and training programs.[6] Staff in-service and training, which occurs in the "gatekeeper model,"[7] has been found to be feasible and acceptable to principals, with little staff or parent resistance and few barriers with respect to time commitment.[8] The gatekeeper model relies on staff training to identify distressed students and connect them with needed services, improve awareness of suicide warning signs and referrals for services.[9–11] Still, the success of such programs requires school professionals to effectively involve caregivers.[7]

Although family involvement can be a key part of a successful school intervention, schools commonly have difficulty engaging parents in education and mental health services.[12] Potential barriers to parental involvement include language barriers, negative attitudes from school personnel toward partnering with parents, lack of knowledge and skills among school personnel for engaging parents, and lack of outreach from teachers and administrators.[13–15] These factors (eg, attitudes, experiences, local norms, and knowledge and skills), consistent with key predictors delineated in well-established theories of behavior change,[16,17] are critical to understanding school staff behavior as it relates to engaging parents of students at risk for suicide. Yet, overcoming these barriers becomes even more critical when a suicidal student has been identified.

There are few investigations of parent engagement with school-based mental health services and personnel. [15,18] However, qualitative research points to the potential value of on-site mental health resources in fostering favorable attitudes among school staff towards parents and engaging families in services. A study of teacher perspectives on mental health service needs in two urban schools with differing levels of mental health staffing (ie, the number of hours and type of support available from mental health staff, presence of on-site mental health services and referral structures), found that teachers at the school with limited resources portrayed parents as uncooperative and disengaged.[19] At the better-resourced school, teachers described the majority of the parents as very supportive, which they attributed to the presence of mental health services, parent outreach personnel, and strong

school and parent leadership.[19] Moreover, teachers' perceptions of parental involvement affected whether they would make referrals for mental health services.[19] Additional research suggests that school-based mental health programs are generally perceived as helpful by both parents and school personnel, though parent engagement in programs may still vary.[18] For example, consistent outreach (contacting parents multiple times through various methods), school culture that values parent involvement, and clinician views that parent involvement is important were linked to better parent engagement, whereas lack of consistent outreach and time on the part of school-based clinicians in addition to logistical barriers faced by parents were linked to lack of parent involvement.[15]

Better understanding of school personnel experiences with engaging parents in suicide prevention efforts may point to critical training and support needs, and help to inform improvements in school suicide prevention program implementation. This study uses qualitative methods to explore school personnel perspectives on working with parents in a school-based suicide prevention program serving primarily low-income and ethnic minority students—Youth Suicide Prevention Program (YSPP). YSPP is consistent with the School Gatekeeper Training Model[7] with two primary goals: (1) improving at-risk student detection through increased staff knowledge, skills, and use of specific criteria—sudden worsening of mood, suicidal ideation, and behavior; and (2) engaging suicidal students' support networks and making appropriate referrals in the crisis intervention phase. When a student is referred to the YSPP, the trained school staff member conducts a risk assessment and determines if crisis intervention is needed. The crisis intervention includes immediate support to the student, contacting parents, and facilitating referral and access to specialty mental healthcare. Following an incident, school personnel complete a mandatory district suicidal risk assessment form documenting reason for referral, referral source, and actions taken. The YSPP also suggests steps for post-intervention, including developing school supports for students, following-up with parents and community agencies, and facilitating school re-entry, as appropriate. Examining qualitative data gathered to understand general YSPP program implementation processes, the specific goal of the study is to identify facilitating factors and barriers to connecting with and engaging parents after their child has been identified as at risk for suicide.

METHODS

Participants

This study is part of a broader examination of the implementation of YSPP[20–23] in one of the nation's largest school districts serving approximately 688,000 students, predominantly low-income (77% qualify for free/reduced cost lunch) and from racial/ethnic minority backgrounds (about 73% Latino, 11% Black, 6% Asian/Pacific Islander). We categorized district middle schools (N = 80) as having high, middle, or low YSPP implementation, by the number of suicide risk assessment forms completed per enrolled student per year, and 6 schools were randomly sampled from the high and low categories (3 in each category). Of the 6 schools randomly chosen, five schools participated. These schools reflected the school district's diversity with respect to school size, attendance, and test performance. Each school had a majority minority population, primarily Latino, with 33%–56% of students being

English language learners and an average class size of 28 to 32 students. Additional school characteristics are reported elsewhere.[21]

At each of the 5 schools, one focus group with 6–8 school staff members and 2 key informant interviews with administrators were conducted. Participants were identified via referral from a school point person (school social worker or administrator), or through flyers in faculty mailboxes and faculty meeting announcements. There were 45 participants across the focus groups and interviews (35 focus group participants, 10 interview participants). Specifically, there were 7 counselors or mental health staff (16%), 2 nurses (4%), and 26 teachers (58%), and 10 administrators (22%). At least one counselor or mental health staff person was a participant in each focus group. Nineteen of the participants were male (42%), 25 were Whites (56%), 10 (22%) were Latinos, 3 (7%) were African Americans, and the remaining 7 (15%) were Native Americans, Asian Americans, or persons of another or mixed ethnicity. Participants had been employed at their current schools for an average of 6.4 years (SD=5.5) and worked in education for 14 years (SD =11.32). Twelve (27%) participants had bachelor's degrees, 30 (67%) had master's degrees, and 3 (7%) had doctorates.

Procedures

Focus groups were held on school sites, while administrator interviews were conducted by phone or in person (9 phone interviews, 1 in-person interview). Two research team members conducted the focus groups (one facilitator, one note-taker). Interview and focus group protocols were semi-structured, asking staff about their experiences with suicide-prevention strategy implementation, crisis intervention follow-up, improving the YSPP specific to middle school needs, and parents' role in the crisis intervention phase. Interviews and focus groups were audio-recorded and transcribed. Participants received $40 for study participation.

The semi-structured interview and focus group protocols were organized around the key facets of YSPP implementation: (1) detection of students at-risk for suicide, (2) crisis intervention, (3) post-crisis response, (4) prior school staff training experiences and current training needs related to suicide prevention, and (5) quality improvements targeting each phase of the program. Within each of the broad topic areas, questions were designed to elicit case examples, specific protocols/procedures, descriptions of the school's communication processes, and suggested improvements. The questions were written to capture the broad processes for the entire YSPP program. Specific prompts with the respect to parent contact and involvement at the different phases were embedded within these categories. Additional details on the interview protocol is available in previous research.[21]

Data Analysis

Transcripts were coded using techniques described by Morgan and Krueger.[24] First, 2 primary coders openly coded participants' responses guided by the semi-structured interview. The full research team then jointly generated a working code list. The coders then independently coded half of the transcripts and met with the research team to discuss expanding, collapsing, or eliminating codes until there was a refined list of mutually agreed

upon codes. Once the final code list was agreed upon, coding of all transcripts was conducted using Atlas.ti.[25] Any coding issues were reviewed by the research team and resolved through consensus. The initial primary coding focused on overall implementation processes for the YSPP program;[21] however, themes emerged about the respondents' interactions with parents. Subsequent coding focused on capturing school personnel perspectives on parent involvement across the YSPP phases (eg, detection of students risk, referral and support, post-crisis follow-up). An independent coder reviewed all transcripts related to parent involvement and confirmed original coding.

RESULTS

Four key themes emerged regarding YSPP parent involvement: (1) parent involvement during the crisis phase; (2) parent engagement post-crisis; (3) challenges to parent involvement in mental health supports at school (family stressors); and (4) strategies for enhancing parent engagement and involvement. The themes are presented below in order of their salience in the focus groups and interviews. Results are presented across all schools, as themes did not differ across high and low implementation schools.

Parent Involvement during the Crisis Phase

Across all schools, school social workers participating in the focus groups described "always" contacting parents when a student reported having suicidal ideation or intent. Depending on the crisis severity or the immediate needs, parents were telephoned and asked to come to the school or be involved in hospitalizing the student. A social worker described: "*It is district protocol when you are calling in a [involuntary psychiatric hold], that you make every effort possible to get the parent to come to the school. We are trained extensively on the importance, because there are liability issues when we don't alert the parent. Plus, we want them to be on our team.*" Another commented, "*You always call the parent. Even if the child says, "I'm not, I'm not, I'm not.*" Unlike the school social workers, few teachers reported that it was their role to contact the parent during the crisis phase.

School mental health staff provided additional detail on specific ways they engage parents in the wake of a crisis. A social worker noted, "*We do an assessment to see how [the child] is feeling, what their mood is, to find out if there's something that [is] triggering their desire to die or to hurt themselves, to find out if they have a plan, if they have a method, who lives in their home, and if there are any weapons in the home. I call the parents to come in, I have a conference with the child and the parents, and I give the parents referrals in the community to get services for the child.*"

Parent involvement Post-crisis

In the post-crisis phase, participants reported often finding parents responsive, with one social worker relating, "*Most of the time parents are quite agreeable to participate in counseling.*" However, the majority of participants did not report on any a district-wide or systematic protocol for following up with parents. The intensity of school staff efforts to involve parents post-crisis depended on the approach of individual clinicians and schools. In the majority of cases, the specific approach and responsibility for follow-up appeared to be

left to individual clinicians. One counselor described, *"If they were going to an outside agency, I would follow-up with the parent and get permission to follow-up with the agency, so that I know what services they're getting, and we can share information. "*An administrator in one school described a more formal, centralized school process, "*Every two weeks we'll [review] the students who have been referred. There will be a follow-up as to whether or not the parents followed through with the intakes, if the child's attending, or if the parent indicated that they didn't want the services."*

Challenges to Parent Involvement in Mental Health Supports at School

Despite reports from school personnel that many parents were responsive to outreach from the school, a number of challenges in working with parents of students at risk for suicide were identified. These included communication, parent perceptions of the issues, and parental stressors. Participants were empathetic about parents' stressors and frustration with the engagement process.

Communication—Despite indicating that it was possible to reach parents in most cases, school staff described challenges in contacting some parents during a crisis. One teacher described, *"The child needed to be transported [to the hospital] and we could not get in touch with a parent, no emergency numbers, nothing. We ended up having to stick a note on their door. Can you imagine coming home at the end of the workday to find out that your child is hospitalized?"* An administrator in another school observed, *"We have a high transiency rate in this community and low socio-economic backgrounds. They consistently change phone numbers. A lot of times we just have to ask the kid."* A teacher noted that language barriers compound communication challenges, *"Many times we can't reach the mom until 11:00 at night and somebody has to speak Spanish."*

Parental perceptions of the incident—Another challenge with parent involvement was the perception that parents felt that they were the "last to know" and often did not understand the seriousness of the incident. A social worker explained, *"Most parents don't take it as seriously as the staff do. They say, "Oh they say this all the time at home."* Similarly, a social worker in another school reported, "*Sometimes we have a student who is suicidal that needs to be evaluated, and a parent takes eight hours to show up. That's hard because the parent doesn't see the importance of what we see."*

Parental stressors—Participants recognized the significant life stressors many parents faced, which they saw as contributing to parents' difficulty in being involved in school and mental health services. Several participants mentioned that parents often have long work hours that impede their involvement with their child's school. A social worker reported, *"Because of the community that we live in, the parents work 6 to 8, all day long, so it's pretty much impossible for them to get to an agency for counseling."* A teacher related, *"A lot of them live under the poverty level, a lot of them are in homes that are missing one or the other parent, and a lot of our kids' parents came earlier and [the child] stayed in Guatemala or El Salvador with relatives and came later to a new family."*

Parents also had limited access to community services, as one social worker described, *"Most of the services in this area are not very close. Most of the parents have to work and they don't have the time or the energy to take kids [to an outside agency]."* Another respondent reported, "*It's very difficult to get parents to take their child for outside service, unless you [the clinician are] going to drive them there and pick them up."* Another respondent described addressing the challenge of long waitlists at community mental health clinics by referring some families to the emergency room, "*If anything's going to happen, I'll tell them to go to [the county hospital], because then [suicidal ideation] can be addressed there."*

Strategies for Enhancing Parent Engagement and Involvement

Despite these challenges, school staff creatively engaged families through school-based resources for families, informal outreach efforts, and formal educational trainings for parents.

Resources—Participants from schools with onsite mental health services felt more confident that parents and students would get needed follow-up services. An administrator described their value, "*If simple counseling doesn't help, then we refer them to Family Center. (The Center) has many resources depending on whether the student has insurance or doesn't have insurance. They do house visits and they are very involved with the parents."* Another valuable resource described by a teacher was the school's Parent Center (a space at the school designed to provide parents with support and resources, led by the schools' Parent Coordinator and volunteers), "*Most parents feel very comfortable to go and share their concerns with the parent volunteers,"* who can then connect parents to resources. One teacher reported the benefits of having a Healthy Start program, designed to help address the achievement gap by providing an array of learning supports (eg, services addressing physical, emotional, and academic needs) to students on campus, stating, "*When it comes to emotional problems, we can only do so much in the classroom. Having a Healthy Start program in school, they can channel it better than we could.*" The social worker involved in this program described their pre-crisis, general outreach strategies which included a family community learning fair that offered workshops to parents and students about a variety of topics [including mental health], targeted outreach through grade-level parent meetings, and incorporation of family involvement strategies from the school district's coordinated school health program.

Some participants also reported engaging families informally by providing a safe place for parents to receive guidance regarding non-academic concerns, as a social worker described, *"Even problems that are not necessarily school-related, [parents] will come to the school and ask for help. It is more family issues. I've gone out with the principal to homes, you know, when crises have happened, just to help connect them with services because they look at the school like the safe place for them to go."* A teacher described making home visits, *"I went to a couple parents' homes with another teacher just to get to the parent to let them know what is happening with the child."*

Parent support—Despite success with school-based mental health services for students on school campuses, many school staff noted the need for parent services, such as training, education, and support. One administrator stated, "*Parent training needs to be in there as well to identify what's wrong with their child or to get parenting skills.*" Many felt focusing on parenting was particularly important as children transition to middle and high school, while others felt that schools had too much responsibility to support this transition. Participants also identified parents' need for information about on and off campus resources.

Participants also identified ways in which school staff might be better trained to support and educate parents. One social worker felt that parent education usually occurs after an incident, "*What we do is after the fact, at a parent meeting, we will go over situations. But we haven't been as proactive as we should be,*" and went on to suggest training in ongoing involvement of parents, "*How should we address parents, how can we make them aware without scaring them, aside from providing facts and statistics. Everyone thinks it's not ever going to happen to them. We have to continuously keep them aware. I think that's what we're lacking.*"

DISCUSSION

This study highlights school staff perspectives on parent involvement and the challenges and successes in engaging parents in a school-based suicide prevention program. Results suggest that parents are routinely contacted in the immediate wake of a concern about suicide, but that parent engagement post-crisis varied and outreach was less formalized and systematic. Results highlighted communication barriers, parental perceptions of the incident, and parental stressors as key challenges in engaging parents in efforts to ensure follow-up care for students. However, school-based resources and informal and formal ongoing parent support services were identified as strategies for overcoming these challenges and facilitating follow-up care. Our results are suggestive of 3 stages when school staff members have the opportunity to involve parents: during the immediate crisis, during post-crisis follow-up, and preventively prior to a crisis.

The Immediate Crisis

Consistent with research on barriers to accessing mental health care,[26–29] our study highlighted the burden of stress, including long work hours, single parent homes, and lack of community resources, that could prevent parents from being available for suicide prevention efforts during the crisis. The study also highlighted instances where parents' attitudes about their children's mental health needs and lack of concern about suicide risk could be a barrier. Given these challenges, school staff may benefit from training in parent engagement strategies that incorporate motivational interviewing,[30,31] cultural competency, as well as problem-solving logistical barriers and exploring parental concerns.[32] For example, the Family Intervention for Suicide Prevention, developed for use in emergency departments, includes techniques in mobilizing family support and problem-solving as well, reframing a suicide attempt as a critical event that requires treatment, and addressing the motivation of families to initiate and follow up with treatment recommendations.[33] Empirically-supported parent engagement strategies in the community mental health context involve working with

parents to identify and predict potential barriers to participation, and jointly generating strategies to address these issues when they arise.[32] For instance, if communication or logistical challenges are anticipated by schools, schools could proactively set up school-family communication protocols that are updated routinely. Future work could apply and evaluate these specific techniques in school settings during the crisis phase of a suicide prevention program.

The Post-crisis Phase

In the current study, mental health and counseling resources on the school campus were perceived to make a tremendous difference in providing mental health access and increasing acceptability of services. This finding is consistent with previous research of school staff and parent perceptions about the value of mental health services.[18,19] School-based mental health services can dramatically increase the number of children that receive needed mental health care.[34] However, our findings suggested that when such services are unavailable, successful referrals to mental health agencies were uncommon due to parental stressors, long wait-lists, and distance to community clinics. These findings underscore the importance of school based mental health services in under-resourced communities. School mental health programs can be feasibly designed according to the resources available in the school and community. Possible configurations include school supported models (eg, staff employed by the school district), community connected models (eg, co-location from community mental health agencies, contracted providers), and comprehensive, integrated models (eg, spectrum of services from prevention, screening and referral, to onsite mental health services).[35] Funding sources may include federal, state, and local grants or contracts, and Medicaid billing for mental health services.

Of note, our results indicated that referrals to emergency rooms or teacher home visits were necessary at times for working with parents to ensure students received support post-crisis. However, many students may not need emergency room evaluations, and there is limited research addressing whether referrals to emergency rooms translate to ongoing service use by families. Though potentially difficult for schools to sustain, home visits from school personnel are often effective in both reaching underserved families and in improving child mental health functioning.[36] Partnerships between school staff, school mental health providers, and community agencies could bolster home-school connections and may be particularly important for schools that do not have on-site mental health resources. Related, our results highlight the need for ongoing parent supports, such as parent training or services connecting parents and children to other resources (eg, extracurricular activities, tutoring, etc.). Such programs may also foster better home-school connections.

This study highlighted a lack of such systematic follow-up with parents, which although concerning, is consistent with prior studies finding reduced school-parent contact in secondary schools and challenges in engaging families in educational and mental health programs.[12,37,38] Though connecting students to resources is a key goal of the gatekeeper model,[7] the majority of schools did not appear to have a systematic and coordinated strategy for following up with students and their families after a suicide crisis intervention. Both

students and school staff may benefit from a district-wide structured follow-up system that allows ongoing school and parents communication.

Consistent with findings in other studies,[39] participants noted numerous obstacles to parent involvement in services specific to the low-income, urban, and primarily ethnic minority population they served, such as immigration stressors, language barriers, cultural beliefs, client-therapist match, and education level. We found notable empathy for highly stressed parents, though staff were also concerned that some parents did not seem to take the issue of suicidality seriously. Educating parents about suicide may help reduce stigma and deepen parents' understanding. To effectively engage parents, future studies must explore parents' perspectives about working with their child's school around student suicidality in addition to parental cultural beliefs about mental health and suicide or perceived meaning of services.[31,40] Community-participatory partnerships with immigrant families have been found to not only engage family members around mental health concerns but also improve parental-school involvement.[41]

Prior to a Crisis: Preventive Strategies

As noted in our results, parent outreach through programs that provide information about mental health or proactively raise awareness about suicide prior to crises may help make parent involvement easier when crises do occur. Research suggests that pre-implementation engagement is key for raising awareness about the need for mental health programs and gaining parental support for such programs.[42] Psychoeducational outreach with parents through existing school programs, school mental health service providers, school fairs, and parent nights may also foster communication and sharing of information with parents proactively. In addition, results indicate that some parents see the school as a safe place, underscoring schools' potential role as a key access point and source of support for at-risk students and their families. Increasing parents' comfort in communicating with the school more broadly may also promote mental health service use. Strategies for fostering collaborative relationships with parents prior to a crisis should be incorporated into school staff suicide prevention training.[43–45]

Limitations

Our findings must be considered within the context of the study limitations. The focus groups and interviews were not designed to focus exclusively on parent involvement in suicide prevention or school mental health, so we likely did not fully capture all aspects of the topic. However, the spontaneous discussion of parental involvement within the context of conversation about program implementation provides important insights into how school staff experience their work with parents. Importantly, we conducted no parent focus groups, and information from parents is a critical next step in understanding parental perspectives of school suicide prevention programs. Finally, participants were from a large urban school district serving primarily low-income, ethnic minority students, and our findings may not apply to schools in other communities.

IMPLICATIONS FOR SCHOOL HEALTH

Despite limitations, our study provides important insights into ways of improving parent involvement in school suicide prevention efforts. Parent involvement is critical to ensuring that students identified by school suicide prevention programs as being at risk for suicide receive appropriate evaluations and care. Our study suggests that coordination of follow-up and post crisis response is sorely needed. If contact with parents is challenging, school-based mental health providers should be encouraged reach out to parents post-crisis through home visits, meeting and parent work-sites, or through engaging another family member or friend. In addition, proactive education and community awareness for parents and school and community stakeholders about school-based suicide prevention, intervention, and follow-up could ensure that crises are managed in more streamlined way. This education must be available in Spanish or other native languages for non-English speaking parents. Specific training for school mental health staff on parent engagement may also be beneficial. Finally, school districts should establish a crisis intervention plan that includes on-going training for school-based mental health providers, teachers and administrators; referral mechanisms and available community resources; and on-going follow-up and support for students, parents, and involved school staff members. Developing community partnerships that engage school staff and parents around parent involvement challenges could lead to successful intervention or program strategies that are supported by both parents and school staff.

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References

1. Centers for Disease Control and Prevention. [Accessed November 20, 2009] Suicide prevention: Youth Suicide. 2009. Available at: http://www.cdc.gov/violenceprevention/pub/youth_suicide.html
2. Centers for Disease Control and Prevention. [Accessed August 14, 2014] Trends in the Prevalence of Suicide–Related Behavior National YRBS: 1991—2013. 2013. Available at: http://www.cdc.gov/yrbss
3. Pirkis JE, Irwin CD, Sawyer MG, Friestad C, Biehl M, Patton GC. Receipt of psychological or emotional counseling by suicidal adolescents. Pediatrics. 2003; 111(4):387–394.
4. Aseltine RH, James A, Schilling EA, Glanovsky J. Evaluating the SOS suicide prevention program: a replication and extension. BMC Public Health. 2007; 7:161–167. [PubMed: 17640366]
5. Brown MM, Grumet JG. School-based suicide prevention with African American youth in an urban setting. Professional Psychology: Research and Practice. 2009; 40(2):111–117.
6. Gibbons MM, Studer JR. Suicide awareness training for faculty and staff: A training model for school counselors. Professional School Counseling. 2008; 11(4):272–276.
7. Centers for Disease Control and Prevention. Programs for the prevention of suicide among adolescents and young adults. MMWR Morb Mortal Wkly Rep. 1994; 43:1–7.
8. Whitney SD, Renner LM, Pate CM, Jacobs KA. Principals' perceptions of benefits and barriers to school-based suicide prevention programs. Child Youth Serv Rev. 2011; 33:869–877.
9. Eckert TL, Miller DN, DuPaul GJ, Riley-Tillman TC. Adolescent suicide prevention: school psychologists' acceptability of school-based programs. School Psychol Rev. 2003; 32:57–77.

10. Miller DN, Eckert TL, DuPaul GJ, White GP. Adolescent suicide prevention: acceptability of school-based programs among secondary school principals. Suicide Life Threat Behav. 1999; 29:72–85. [PubMed: 10322622]
11. Scherff AR, Eckert TL, Miller DN. Youth suicide prevention: a survey of pubilc school superintendents' acceptability of school-based programs. Suicide Life Threat Behav. 2005; 35:154–169. [PubMed: 15843333]
12. Gopalan, G.; Burton, G.; McKay, MM.; Rosenzweig, JM. Achieving school-family collaboration for children with emotional or behavioral disorders. In: Rosenzweig, JM.; Brennan, EM., editors. Work, Life, and the Mental Health System of Care: A Guide for Professionals Supporting Families of Children with Emotional or Behavioral Disorders. Baltimore, MD: Paul H. Brookes; 2008. p. 201-237.
13. Broussard CA. Facilitating home-school partnerships for multiethnic families: school social workers collaborating for success. Children & Schools. 2003; 25(4):211–222.
14. Patrikakou EN, Weissberg RP. Parents' perceptions of teacher outreach and parent involvement in children's education. Journal of Prevention & Intervention in the Community. 2000; 20(1–2):103–119.
15. Santiago CD, Pears G, Baweja S, Vona P, Tang J, Kataoka SH. Engaging parents in evidence-based treatments in schools: community perspectives from implementing CBITS. School Mental Health. 2013; 5:209–220.
16. Ajzen, I.; Fishbein, M. Understanding Attitudes and Predicting Social Behavior. Englewood Cliffs, NJ: Prentice-Hall; 1980.
17. Jaccard, J.; Litardo, H.; Wan, C. Subjective culture and social behavior. In: Adamopoulos, J.; Kashima, Y., editors. Social Psychology and Cultural Context. Thousand Oaks, CA: Sage; 1999. p. 95-106.
18. Wegmann KM, Powers JD, Blackman K. Supporting vulnerable families through school-based mental health services: results of caregiver and teacher focus groups. J Fam Soc Work. 2013; 16(4):297–313.
19. Williams JH, Horvath VE, Wei H-S, Van Dorn RA, Jonson-Reid M. Teachers' perspectives of children's mental health service needs in urban elementary schools. Children & Schools. 2007; 29(2):95–107.
20. Stein BD, Kataoka SH, Hamilton AB, Schultz D, Ryan G, Vona P, et al. School personnel perspectives of thier school's implementation of a school-based suicide prevention program. J Behav Health Ser Res. 2010; 37:338–349.
21. Nadeem E, Kataoka SH, Chang VY, Vona P, Wong M, Stein BD. The role of teachers in school-based suicide prevention: a qualitative study of school staff perspectives. School Mental Health. 2011; 3(4):209–221.
22. Kataoka SH, Stein BD, Lieberman R, Wong M. Datapoints: suicide prevention in schools: are we reaching minority youths? Psychiatr Serv. 2003; 54(11):1444. [PubMed: 14600297]
23. Kataoka S, Stein BD, Nadeem E, Wong M. Who gets care? Mental health service use following a school-based suicide prevention program. J Am Acad Child Adolesc Psychiatry. 2007; 46(10): 1341–1348. [PubMed: 17885576]
24. Morgan, D.; Kreuger, R. The Focus Group Kit. Thousand Oaks, CA: Sage Publications; 1997. p. 1-6.
25. Muhr, T. ATLAS.ti. Scientific Software Development. Berlin, Germany: ATLAS.ti; 1998.
26. Santiago CD, Kaltman S, Miranda J. Poverty and mental health: how do low-income adults and children fare in psychotherapy? J Clin Psychol. 2013; 69(2):115–126. [PubMed: 23280880]
27. Larson J, Stewart M, Kushner R, Frosch E, Solomon B. Barriers to mental health care for urban, lower income families referred from pediatric primary care. Adm Policy Ment Health. 2013; 40(3):159–167. [PubMed: 22113729]
28. Nadeem E, Lange JM, Edge D, Fongwa M, Belin T, Miranda J. Does stigma keep poor young immigrant and U.S-born Black and Latina women from seeking mental health care? Psychiatr Serv. Dec; 2007 58(12):1547–1554. [PubMed: 18048555]

29. Owens PL, Hoagwood K, Horwitz SM, Leaf PJ, Poduska JM, Kellam SG, et al. Barriers to children's mental health services. J Am Acad Child Adolesc Psychiatry. 2002; 41(6):731–738. [PubMed: 12049448]
30. Burke BL, Arkowitz H, Menchola M. The efficacy of motivational interviewing: a meta-analysis of controlled clinical trials. J Consult Clin Psychol. 2003; 71(5):843–861. [PubMed: 14516234]
31. Erickson SJ, Gerstle M, Feldstein SW. Brief interventions and motivational interviewing with children, adolescents, and their parents in pediatric health care settings: a review. Arch Pediat Adol Med. 2005; 159(12):1173–1180.
32. McKay MM, Nudelman R, McCadam K, Gonzales J. Evaluating a social work engagement approach to involving inner-city children and their families in mental health care. Res Social Work Prac. 1996; 6(4):462–472.
33. Asarnow JR, Berk MS, Baraff LJ. Family intervention for suicide prevention: a specialized emergency department intervention for suicidal youths. Professional Psychology: Research & Practice. 2009; 40(2):118–125.
34. Jaycox LH, Cohen JA, Mannarino AP, Walker DW, Langley AK, Gegenheimer KL, et al. Children's mental health care following Hurricane Katrina: a field trial of trauma-focused psychotherapies. J Trauma Stress. 2010; 23(2):223–231. [PubMed: 20419730]
35. American Academy of Pediatrics. Policy statement: school-based mental health services. Pediatrics. 2009; 113(6):1839–1845.
36. Snell-Johns J, Mendez JL, Smith BH. Evidence-based solutions for overcoming access barriers, decreasing attrition, and promoting change with underserved families. J Fam Psychol. 2004; 18(1): 19–35. [PubMed: 14992607]
37. Epstein JL. School and family connections. Marriage Fam Rev. 1990; 15(1–2):99–126.
38. Grolnick WS, Kurowski CO, Dunlap KG, Hevey C. Parental resources and the transition to junior high. J Res Adolescence. 2000; 10(4):465–488.
39. McCabe KM. Factors that predict premature termination among Mexican-American children in outpatient psychotherapy. J Child Fam Stud. 2002; 11(3):347–359.
40. McKay MM, Bannon WM Jr. Engaging families in child mental health services. Child Adolesc Psychiatr Clinic N Am. 2004; 13(4):905–921.
41. Santiago CD, Kataoka SH, Hu-Cordova M, Alvardo-Goldberg K, Maher LM, Escudero P. Preliminary evaluation of a family treatment component to augment a school-based intervention serving low income families. J Emot Behav Disord. 2015; 23(1):28–39.
42. Langley AK, Santiago CD, Rodriguez A, Zelaya J. Improving implementation of mental health services for trauma in multicultural elementary schools: stakeholder perspectives on parent and educator engagement. J Behav Health Serv Res. 2013; 40:147–162.
43. Korfmacher J, Green B, Staerkel F, Peterson C, Cook G, Roggman L, et al. Parent involvement in early childhood home visiting. Child Youth Care Forum. 2008; 37(4):171–196.
44. McKay MM, Hibbert R, Hoagwood KE, Rodriguez J, Murray L, Legerski J, et al. Integrating evidence-based engagement interventions into "real world" child mental health settings. Brief Treatment and Crisis Intervention. 2004; 4(2):177–186.
45. Staudt MM. Helping children access and use services: a review. J Child Fam Stud. 2003; 12(1):49–60.