Who Gets Care? Mental Health Service Use Following a School-Based Suicide Prevention Program

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ABSTRACT

Objective: To examine symptomatology and mental health service use following students' contact with a large urban school district's suicide prevention program. **Method:** In 2001 school district staff conducted telephone interviews with 95 randomly selected parents approximately 5 months following their child's contact with the district's suicide prevention program, a School Gatekeeper Training model. Parents provided information regarding service use, their child's depressive symptoms (using the Diagnostic Interview Schedule for Children Predictive Scale, Depression module), and their perceptions of their child's need for services. Information about the crisis intervention was abstracted from a standardized assessment form. **Results:** More than two thirds of students received school or community mental health services following contact with the suicide prevention program. Depressive symptoms, but not past year suicide attempt, predicted community mental health service use. Latino students had lower rates of community mental health service use than non-Latinos. School-based service use did not differ by student characteristics including race/ethnicity. **Conclusions:** Most students identified by a school-based suicide prevention program received follow-up care, although Latinos were less likely to access services outside the school. School-based mental health services may be an important way in which underserved populations at risk of suicide can receive care. *J. Am. Acad. Child Adolesc. Psychiatry,* 2007;46(10):1341–1348. **Key Words:** suicide, prevention, school mental health, race, ethnicity.

In its recent report "Reducing Suicide: A National Imperative," the Institute of Medicine identifies suicide prevention as a national public health concern (Goldsmith et al., 2002), with suicide being the third leading cause of death in youths ages 10 to 19 years old (Centers for Disease Control and Prevention, 2004). It is estimated that 8.5% of youths in the United States have made at least one suicide attempt in the past 12 months (Kann et al., 1998), with the suicide rate among 10- to 14-year-olds doubling since 1980 (U.S. Public Health Service, 1999). To address the service needs of youths at risk for suicide, both the U.S. Surgeon General and the President's New Freedom Commission have highlighted the need for broad-scale suicide prevention programs in such settings as schools. Unlike the specialty mental health sector that often intervenes with youths only after problems have become chronic and persistent, schools provide an opportunity to provide prevention and early detection of mental health problems (Flaherty et al., 1996).

Suicide prevention programs are often developed with risk and protective factors in mind that are known to influence suicidal behavior and mental health in general. Characteristics such as strong social support

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networks, family connectedness, and participation in religious activities (Eccles et al., 1993; O'Donnell et al., 2002) have been identified as important protective factors for the emotional well-being of children and adolescents throughout development. Youths at risk for suicide include those with a previous suicide attempt, violence victimization, school problems, loss of a family member to suicide, and psychiatric disorders (Borowsky et al., 2001; Hollis, 1996; Shaffer et al., 1996). Strikingly, the vast majority (up to 90%) of youths who make a serious suicide attempt have a history of treatable psychiatric disorders such as depression, a disruptive behavior disorder, or substance use disorder (Brent et al., 1993; Costello et al., 1988; Marttunen et al., 1991; Shaffer and Pfeffer, 2001; Shafii et al., 1988).

As part of a community-wide suicide prevention strategy, schools are increasingly viewed as a promising way to identify at-risk youths and deliver suicide prevention services (Hogan, 2003; King, 1997). A substantial growth in school suicide prevention programs has occurred nationwide. Fifty-two percent of U.S. schools had a suicide prevention program in 1994; by 2000, this had increased to 77% of schools (Brener et al., 2001; Small et al., 1995). Given the high priority of suicide prevention in many communities (Garland and Zigler, 1993) and the pervasive safety concerns of schools regarding at-risk students, several states have passed laws mandating suicide prevention programs in public schools, and several more are in the process of creating such laws (Mazza, 1997).

Several models of school-based suicide prevention programs for youths have been described. Suicide awareness programs, educational curricula for youths that seek to increase the awareness of suicidal behavior among adolescents, have been shown to have detrimental effects, especially among students with a history of suicide attempts (Shaffer et al., 1988). More promising school-based suicide prevention programs include skills training, which focuses on providing youths with improved problem solving and social skills, and screening programs, which facilitate detection of suicidal behavior and psychiatric disorders (Shaffer et al., 2001). Another promising school suicide prevention program model, being implemented in a number of districts across the country, is the school gatekeeper training model. The Centers for Disease Control and Prevention's *Youth Suicide Prevention Programs: A Resource Guide* (Centers for Disease Control and Prevention, 1994) describes the school gatekeeper model as seeking to improve detection of students at high risk for suicide and enhancing their follow-up with appropriate services by engaging the student's social support networks and facilitating the student's referral for treatment and counseling. The gatekeeper model has two primary components: training school personnel (e.g., gatekeepers) to increase knowledge, change attitudes, and develop skills in intervening with a suicidal student, and crisis intervention, in which the trained school staff member uses his or her increased knowledge and skills to engage suicidal students' support networks and successfully refer them for counseling or treatment. The crisis intervention consists of three activities that occur when a suicidal student is identified: providing immediate support to the suicidal student, engaging the student's social support network (most commonly the family), and facilitating referral and engagement with treatment and counseling services. Gatekeeper training programs have been shown to effectively change school staff awareness of suicide warning signs, knowledge of resources to treat suicidal students, and attitudes toward referring students for services (Acevedo, 2000; Schneider et al., 1999; Shaffer et al., 1988). However, a recent review of suicide prevention strategies recommended further study of the impact that gatekeeper models have on subsequent referrals and treatment (Mann et al., 2005).

To enhance the knowledge of clinicians and policymakers, the present study examines the impact of a gatekeeper program on subsequent referrals and treatment of suicidal students. Specifically, of those students identified by a school-based suicide prevention program, we assess how many students subsequently receive mental health services and what characteristics predict who gets this care. We hypothesize that students with psychopathology such as depressive symptoms and past suicide attempts would be more likely to receive ongoing mental health services. In addition, given that parents' perceived need for services has been shown in other settings to be an important predictor of service use (Alegria et al., 2004), we hypothesize that this would also predict whether students identified by a school suicide prevention program would receive ongoing services.