HHS Public Access

Author manuscript

J Sch Health. Author manuscript; available in PMC 2018 May 22.

Published in final edited form as:

J Sch Health. 2017 February ; 87(2): 114–120. doi:10.1111/josh.12473.

Evaluating Active Parental Consent Procedures for School Programming Addressing the Sensitive Topic of Suicide Prevention

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Abstract

BACKGROUND—Suicide is the second leading cause of death for adolescents. While school-based prevention programs are effective, obtaining active consent for youth participation in public health programming concerning sensitive topics is challenging. This study explored several active consent procedures for improving participation rates.

METHODS—Five active consent methods (in-person, students taking forms home, mailing, mailing preceded by primers, mailing followed by reminder calls) were compared against passive consent procedures to evaluate recruitment success, as determined by *participation* (proportion who responded yes) and *response* (proportion who returned any response) rates.

RESULTS—Participation acceptance rates ranged from 38%-100% depending on consent method implemented. Compared to passive consent, active consent procedures were more variable in response and participation rates. In-person methods provided higher rates than less interpersonal methods, such as mailing or students taking consents home. Mailed primers before or reminder calls after consent forms were mailed increased response but not participation rates. Students taking consents home resulted in the lowest rates.

CONCLUSIONS—While passive consent produces the highest student participation, these methods are not always appropriate for programs addressing sensitive topics in schools. In-person active consent procedures may be the best option when prioritizing balance between parental awareness and successful student recruitment.

HUMAN SUBJECTS APPROVAL STATEMENT

All recruitment, consent, and study procedures were approved by the Institutional Review Board of the University of South Florida, IRB# CR4_104100.

Keywords

school-based research; response rates; consent; suicide prevention

Suicide is the second leading cause of death for adolescents, accounting for more deaths each year than all natural causes combined.[1,2] The need to address this public health crisis via prevention has been repeatedly affirmed.[3,4] Given the challenges inherent in identifying those most at-risk,[5,6] school-based suicide prevention training and screening programs have been developed and found to be effective in identifying at-risk youth and referring them for services.[7-9] However, obtaining active parental consent for adolescents to participate in these programs remains incredibly challenging, and limits the extent of their dissemination and implementation.

Oftentimes, when implementing prevention programming such as general health promotion curricula, schools use waiver of written informed consent (ie, passive consent) procedures due to their convenience.[10] However, when covering sensitive topics such as suicide prevention, parents and school administrators may not find passive consent an acceptable option. Passive consent for programs discussing sensitive topics may raise concerns, as these procedures do not actively gauge parents' understanding of programming and may not adequately respect parental rights to determine the content to which their children are exposed, given that they usually only allow "opting out" of participation.[11]

Active consent procedures ensure that parents are able to make informed decisions about activities in which their children are invited to take part.[12] However, the nature of these procedures can be a barrier to youth receiving essential prevention programming. Active consent requires prevention programmers and school staff to work collaboratively and commit significant resources to develop, distribute, and collect consent forms.[13-15] Unfortunately, staff are often overburdened and not able to commit the time necessary, resulting in lower consent rates and subsequently lower levels of youth participation in programs.[14,16] Even more troubling, the students most likely to benefit most from participation tend to be those least likely to return consent forms, thereby limiting access to those most at-risk and reducing generalizable conclusions about programmatic impact.[15,17-19]

Nevertheless, despite these challenges, high consent rates have been documented when techniques facilitating the active consent process are utilized. Successful prevention partners engage parents and school personnel from the earliest stages to increase buy-in, focusing on clear communication and meaningful interactions about the purpose, procedures, and benefits of youth participation.[12,14,20] Methods of consent form distribution in which prevention/school staff interact directly with parents, such as face-to-face and phone contact, have yielded greater response rates than more indirect methods, such as mailing forms or sending forms home with students.[15,21] The most successful mechanisms include providing parents with consent forms at school functions,[22] attaching consent forms to other required school paperwork,[14,22] or reminding parents by phone or mail to return consent forms once they have been distributed.[14,22,24] Furthermore, programs with active participation by school personnel and high levels of teacher and administrator support have significantly better

consent response rates,[12,14,22] especially when demonstrations of support, such as principal cover letters, accompany consent forms or staff and administration contribute resources and effort to the consent process.[14,24-26]

Utilizing techniques to capture parental attention and capitalize on the influence of staff and administrators may be particularly critical when programs target sensitive issues. Notably, consent procedures described in previous research were derived from studies that did not involve topics as sensitive as suicide prevention.[12,14,26] Although not as stigmatizing as suicide, research on substance use prevention programs indicated that connecting consent procedures with existing school operations, such as attaching consent forms to other required school forms, results in better response rates.[14] Despite their importance, programs that include topics of high stigma such as suicide prevention may face even greater challenges in the active consent process,[27-29] as parents may be more cautious to allow involvement of their children due to the complex nature of the topic.[30] Considering the importance of addressing such public health issues, determining the best method for obtaining high participation is vital.

In this study, active consent was obtained via different methods to determine which procedures most strongly augmented response and participation rates in school-based suicide prevention gatekeeper training programming for students in comparison to frequently-utilized passive consent. Based on findings from previous studies of personal, yet less sensitive, topics, we hypothesized that obtaining active consent for such a sensitive topic would prove challenging, but that methods utilizing direct contact with parents or integrated into existing school structures, such as parent-teacher conferences, would result in higher response rates than more indirect procedures, such as mailing or sending forms home with students.

METHODS

Participants

Four high schools in the Southwest were recruited for participation, with two schools participating in all three years of the study (CHS, WMHS), one school participating for the first two years (LCHS), and one school (SHS) participating in the second year only. All four schools cover grades 9-12 and have large student populations (>2,000 students; see Table 1). Three schools had substantial numbers of students from low socioeconomic households, with 62%, 21%, and 18% of students qualifying for free/reduced lunch. Two schools had White majority (LCHS, SHS), one had a Hispanic majority (WMHS), and the final school had equal numbers of Hispanic and White students (CHS). Approximately 67% of the sample was in the 9^{th} grade, while 10^{th}, 11^{th}, and 12^{th} graders comprised 16.3%, 10.4%, and 6.4% of the sample, respectively.

Consent Forms

In years 1 and 2, active informed consent forms were used, requiring parents to respond affirmatively if they wanted their child to participate in suicide prevention programming. In year 3, passive consent procedures were implemented, where parents were instructed to

return forms only if they prohibited the participation of their children in suicide prevention programming.

Procedure

All schools agreed to implement a multiple-component suicide prevention program utilizing the Jason Foundation gatekeeper training curriculum between 2005 and 2008, with the intent of educating students on the warning signs of suicide among their peers and identifying students who were at-risk for assessment and treatment referral. Suicide prevention was offered as supplemental, standalone health programming during the first 2 years of the study. During the 3rd year of the study, suicide prevention became a required part of school health curriculum due to a district-wide policy change. As standard curriculum, active consent was no longer required for student participation.

In year 1, three schools (CHS, WMHS, LCHS) participated in the Jason Foundation gatekeeper training evaluation; one school (CHS) had utilized the Jason Foundation curriculum previously and administered only booster sessions to students in grades 10th to 12th, while all three schools administered the curriculum in its entirety to 9th grade health classes. Active consent forms were given to students to take home for their parents to review, sign, and return. Teachers distributed consent forms in health classes in February through April for suicide prevention efforts later in spring.

In year 2, the full Jason Foundation gatekeeper training curriculum and associated evaluation were conducted at all four schools with incoming 9th grade students. Distribution and collection of active consent forms were also modified in order to bolster return rates. At one school (WMHS), consent forms were mailed directly to parents to review, sign, and return. At a second school (LCHS), a primer was mailed to parents one month prior to direct mailing of consent forms. A third school (SHS) received mailed consent forms followed by reminder phone calls to parents. Finally, at a fourth school (CHS), consent forms were integrated into packets of school-related paperwork and handed directly to parents by school or research staff during required, in-person parent-teacher meetings. Staff were asked to discuss the study and consent form and provide parents the opportunity to ask questions. All consent forms were distributed in October through November for suicide prevention activities in either late fall or early spring.

In Year 3, as part of a district-wide policy change, the remaining participating schools (CHS, WMHS) integrated suicide prevention programming into their regular 9th grade educational curricula; thus, active consent was discontinued. Passive consent procedures were implemented, wherein parents were instructed to return forms if they opted to prohibit the participation of their children in suicide prevention programming (see Table 2 for summary).

Variable Definition & Statistical Analysis

Response rate refers to the percentage of active consent forms or “opt out” passive consent forms returned out of the total number distributed. *Acceptance rate* refers to the percentage of returned consent forms permitting youth participation; acceptance rates are presented for active consent procedures only in order to distinguish those parents who provided active permission from those who provided implied permission as part of the passive consent

process. This distinction better sets apart the utility of active consent procedures from passive consent. *Participation rate* refers to the percentage of participating youth out of the total number of youth. These areyouth whose parents returned consent forms permitting participation under active consent procedures along with youth who did not have returned "opt out" forms under passive consent procedures. Significant differences in participation rates by consent method were determined using two-proportion Z-tests with modified Bonferroni corrections for multiple testing.

RESULTS

Response rates, acceptance rates, and participation rates across different consent methods are presented in Table 3. Across the two years of the study that utilized active consent, 13,548 consent forms were distributed and 1917 forms were returned, a response rate of 14.1% and participation rate of 11.0%. However, different methods of obtaining consent showed substantially varying response and participation rates, indicating that certain methods of delivery may improve the likelihood of consent forms being returned and permission for participation being granted. Providing consent forms to parents in-person at school events resulted in the greatest participation rates (22.9%), whereas steep drops in participation were seen for less interpersonal methods such as giving consent forms to students to deliver to their parents (8.3%), mailing preceded by a primer (4.8%) or followed by reminder phone calls (2.9%), and stand-alone mailing (1.5%). Due to the differences in sample characteristics across schools and consenting methodology, Z-tests were conducted to test the significance of differences between these independent response-rate proportions.

In-person delivery to parents at school events showed statistically significant improvement in participation rates over stand-alone mailing to parents (21.4% improvement, $Z=3.90$, $p < .0001$), mailing to parents followed by reminder phone calls (20.0%, $Z=2.90$, $p < .01$), mailing to parents preceded by a primer (18.1%, $Z=2.33$, $p < .01$), and student delivery of forms to their parents (14.6%, $Z=2.13$, $p < .01$). If in-person distribution to parents was not possible, giving forms to students to deliver to their parents produced the next highest participation rate, with small but statistically significant improvement over stand-alone mailing (6.8% improvement, $Z=2.04$, $p < .05$), but no improvement over mailing to parents preceded by a primer ($Z=0.43$, $p=.66$) or followed by reminder phone calls ($Z=1.14$, $p=.25$).

Without question, passive consent procedures were found to have statistically superior response rates to all active consent procedures, with 98.5% improvement over stand-alone mailing to parents ($Z=7.90$, $p < .0001$), 97.1% improvement over mailing to parents followed by reminder phone calls ($Z=6.51$, $p < .0001$), 95.2% improvement over mailing to parents preceded by a primer ($Z=6.17$, $p < .0001$), 91.7% improvement over student delivery of forms to their parents ($Z=6.59$, $p < .0001$), and 77.1% improvement over in-person delivery to parents at school events ($Z=5.49$, $p < .0001$). Taken together, these results affirm that passive consent produces the highest response rates, but that more dynamic, in-person, or personalized methods of active consent may improve consent rates even for sensitive topics.

DISCUSSION

This study assessed various methods for improving participation in school-based suicide prevention programming. Given that suicide prevention is a sensitive topic, it was anticipated that participation rates would vary by active consent methods. Active consent methods where consent forms were distributed in-person at school events resulted in greater participation than more indirect methods, such as mailing or student delivery home. These findings indicate that the endorsement of school administration through drafting of a cover letter or substantively involving school personnel in consent distribution increase the likelihood that parents will respond.[14,15,24-26]

The stand-alone mailing to parents resulted in the lowest response and participation rates of all active consent methods. Likewise, mailing consent forms to parents followed by reminder phone calls or preceded by a mailed primer resulted in negligible improvements in participation over stand-alone mailing procedures. Giving consent forms to students to deliver to their parents produced small but significant improvements over stand-alone mailing, but this method still resulted in unacceptably low participation rates. Perhaps indirect correspondences may not adequately address parent questions and concerns; rather, in-person distribution, during which there is greater opportunity to discuss the study with trusted school personnel, was the method most likely to result in participation. Given these findings, it may be particularly important for suicide prevention planners to better facilitate opportunities for addressing parent concerns and questions when using active consent procedures.

In the present study, active consent response rates were lower than in other prevention studies (e.g., 35%[15]; 75%[32]). A possible reason for lower consent rates may be stigma, such that participation in suicide prevention can be perceived as participants having mental health problems;[33] illustratively, participation is higher in prevention studies addressing school violence and substance use, issues that may be less stigmatizing than suicide.[15,32] Also, some cultures may not favor discussing mental health outside of the family. Given the diversity of our sample, parents may have been hesitant to allow their children to participate in school programming focused on mental health.[34] Notably, active consent resulted in greater participation rates when school personnel obtained consent in face-to-face interactions. Perhaps parents experience hesitation or barriers to processing consent requests on their own, and may prefer to give consent after having the opportunity to obtain information about the importance of suicide prevention programming in-person from trusted teachers, counselors, and administrators during regularly scheduled school events.

This study's results have important implications for mental health programming. Certain youth may be underrepresented in prevention program studies due to lack of consent,[18,32,35] particularly those at greatest behavioral health risk.[36] Active consent procedures can thus contribute to sampling bias in studies, subsequently impacting design and implementation of interventions for those intended to benefit most.[18] Improving active consent response rates can reduce bias and increase generalizability of prevention outcomes to all intended beneficiaries. Furthermore, acceptance or reluctance to participate in school-based suicide prevention programming has been a relatively unexplored area of public health research. To

our knowledge, this is the first study to examine multiple methods in active consent procedures for school-based suicide prevention programming within a large and diverse sample from a high-risk region.

Limitations

Several limitations must be considered. Notably, each school implemented different consent strategies, making direct comparison across consent methodologies within each unique school environment difficult. Therefore, factors such as student demographics, attitudes toward prevention, or pre-study levels of parent engagement in school programs, could have contributed to consent rates. Likewise, it is not clear whether school personnel at each site equally encouraged returning both participation acceptances and refusals, nor was there available data on the nature of discussions they may have had with parents regarding the study and consent procedures. Consequently, it was assumed that unreturned forms represented refusals to participate. Lastly, some consent procedures occurred at different times of the school year. Mailings and in-person methods were administered in the fall, whereas student delivery occurred in the spring. These variations may have contributed to differences in consent rates.

Conclusion

This study provides guidance on how to encourage participation in school-based public health programs regarding sensitive topics such as suicide prevention, especially for those at greatest risk of health disparities. The active support of school administrators and staff, particularly through integration of consent procedures into existing school functions and operations, increases the likelihood that parents will agree for their children to participate.[14] Active consent is traditionally seen as the quintessential informed research process; however, it requires a substantial investment of time and resources to produce relatively small response rates. While many schools may advocate for passive consent procedures to maximize access to programming, this approach potentially sacrifices adequate parental awareness.[12] It is important for educators and prevention planners to balance engaging parents and enhancing the reach of beneficial public health programs addressing sensitive issues such as suicide prevention when implementing active consent procedures. Future research should explore methods for accomplishing this optimal balance.

IMPLICATIONS FOR SCHOOL HEALTH

Schools are increasingly stretched to meet multiple and sometimes disparate academic, institutional, and student health-related demands. However, school personnel are very much devoted to implementing programming that will support student well-being and concordant academic success. Unfortunately, this programming cannot be utilized to its highest potential if there are low levels of student participation. Understanding methods for improving response and participation rates for school-based programs that utilize active consent procedures has significant implications for enhancing youth access to critical public health prevention efforts addressing sensitive issues that have great potential for impacting academic outcomes.

Therefore, several recommendations can be made based on the results of this study:

- School-based suicide prevention programming should include the substantial involvement in consent procedures of those school staff who have an active role in implementing the programming. These school personnel may be better attuned to the challenges of obtaining consent and can problem-solve methods for significantly improving parental response and acceptance to youth participation.
- School personnel often face limited time and resources to take on additional health promotion activities. Therefore, they should integrate consent procedures into typical activities that are part of their role in the school, such as holding parent-teacher conferences or providing programming as standard curricula. The findings from this study suggest that this is a pivotal way to ensure that staff can better implement new programs.
- Schools seeking to reach as many parents as possible, especially those who are typically underrepresented in public health programming, should work to form a personal connection with families through multiple consent approaches. In-person consent distribution practices, in particular, may provide a crucial context for parents to process information about programming, discuss questions and concerns first hand with school personnel, and potentially make more informed decisions about their child's participation.

While these recommendations hold promise, more research is needed to evaluate which consent process facilitates better communication with parents. Further research is also needed to determine which methods for parental outreach to underrepresented families in particular can foster increases in youth participation in sensitive public health programs. This would require greater assessment of the barriers and facilitators to parent engagement.

Acknowledgments

This research was supported by Substance Abuse and Mental Health Services Administration grants (#SM57442-01, 02-3) to Drs. Karver, Kutash, and Totura.

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Table 1

Student Demographics.

				Race & Culture			
School	**Grades**	**Number of Students**	**% Free and Reduce lunch status**	**Hispanic**	**White**	**African American**	**Other**
CHS	9-12	2197	18.4%	40.8%	46.4%	5.3%	7.4%
WMHS	9-12	2292	62.0%	81.6%	8.1%	2.7%	7.6%
LCHS	9-12	2149	7.0%	20.4%	68.9%	2.3%	8.3%
SHS	9-12	2071	21.4%	32.5%	55.8%	4.1%	7.6%

Source: http://www.rda.aps.edu/RDA/ReportCard/index.cfm; CHS, WMHS, LCHS, and SHS represent participating schools.

Table 2

Summary of Consent Methods Utilized Across Schools and Years of the Project.

Year	Schools Participating	Type of Consent	Method of Distributing and Collecting Consent Forms
1	CHS WMHS LCHS	Active	Consent forms given to students by teachers in health class to be brought home (All schools)
2	CHS WMHS LCHS SHS	Active	The following consent methods were utilized at select schools: •Mailed to parents (WMHS) •Mailed to parents, preceded by a primer one month prior (LCHS) •Mailed to parents, followed by reminder phone calls (SHS) •Given to parents directly at Parent-Teacher conferences (CHS)
3	CHS WMHS	Passive	Opt-out procedures only

Note: JFGT=Jason Foundation gatekeeper training and evaluation; CHS, WMHS, LCHS, and SHS represent participating schools.

Table 3

Consent Form Response and Participation Rates for Consent Procedures by School and Method.

		Response Rate		Acceptance Rate		Participation Rate
Consent Procedure	**Type**	**% of Total**	**N**	**% of Responding**	**N**	**% of Total**
Given to students to deliver to parents (N=2754)	Active	8.3%	228	100%	228	8.3%
All mailing (N=7394)	Active	6.6%	490	55%	270	3.7%
Stand-alone mailing to parents (N=3000)	Active	2.5%	76	58%	44	1.5%
Mailing preceded by primer (N=2200)	Active	12.5%	275	38%	105	4.8%
Mailing followed by reminder phone calls (N=2194)	Active	6.4%	140	45%	63	2.9%
Given in-person to parent at school event (N=3400)	Active	35%	1199	65%	779	22.9%
Mailed “opt out” forms (N=4500)	Passive	0%	0	N/A		100%

Note: *Response rate* refers to the percentage of consent forms (active) or “opt out” forms (passive) returned out of the total number distributed. *Acceptance rate* refers to the percentage of returned consent forms permitting youth participation in suicide prevention activities. Acceptance rates are not presented for passive consent procedures, as all persons who did not respond are considered to have accepted; therefore (Acceptance Rate) = (100% – Response Rate). *Participation rate* refers to the percentage of youth participating in the suicide prevention program out of the total number of youth (i.e., youth whose parents returned consent forms permitting participation under active consent procedures or youth with a lack of returned “opt out” forms under passive consent procedures).