INTRODUCTION

Suicide is a pervasive public health problem among adolescents in the in the United States, as it is the second leading cause of death for youth ages 10-24 (CDC, 2016). In the most recent national survey of high school students, 17.0% reported having seriously considered attempting suicide in the previous 12 months, 13.6% made a suicide plan, 8.0% attempting suicide at least once, and 2.7% made a suicide attempt that required medical attention (SAMHSA, 2014). Suicidal adolescents frequently present to acute care settings, such as an Emergency Department (ED) or inpatient psychiatric hospital, for psychiatric evaluation and/or clinical care. In fact, suicide-related thoughts and behaviors represent the primary presenting problem in the majority of ED visits for behavioral health among adolescents (Gabel, 2012) and the most common concern for adolescents admitted to an inpatient psychiatric unit (Wilson et al., 2012).

The time following discharge from an acute care setting represents a period of especially high risk for suicide among adolescents (Hunt et al., 2009; Knesper, 2010; Spirito & Esposito-Smythers, 2006). Safety planning interventions, which incorporate internal and external strategies and sources of support, have been developed for use with adults in this high risk period, and have been widely disseminated with a variety of populations (Stanley & Brown, 2012), including

planning process. Parents of adolescents who have attempted suicide frequently report that they lack knowledge in assessing suicide risk

suicidal adolescent (O'Brien et al., in review). Engaging individuals in an educational conversation about means restriction can

implementation of safety strategies (Britton, Bryan & Valentstein, 2014). Therefore, a stronger focus on means restriction within safety planning procedures may help parents of suicidal adolescents to more effectively restrict access to lethal means.

Evidence has increasingly elucidated the role that parents play in adolescent suicide attempts (Donath et al., 2014; Taliaferro & Muehlenkamp, 2014). Various parental variables such as marital

satisfaction with family (An, Ahn & Bhang, 2010; Randell, Wang, Herting & Eggert, 2006) poor relationship between parents, and low maternal/paternal care (Beautrais, Joyce & Mulder, 1996) have also been associated with higher rates of suicide behaviors. Increasingly, research has demonstrated that low parental connectedness has been associated with psychological and social distress among adolescents (Townsend & McWhirter, 2005) while the parent-child connection is a protective factor for adolescent suicide (Resnick, Ireland &

with a strong connection their caregivers are less likely to report suicidal thoughts (He, Fulginiti & Finno-Velasquez, 2015) and that family support is protective against self-injurious thoughts and behaviors (Tseng & Yang, 2015). Similarly, Rrelative to other domains of connectedness (i.e., peer and school), a negative parent-child connection is among the strongest predictors of suicide among adolescents (Resnick, Ireland & Borwsky, 2004; Kaminski et al., 2010).

As suicide research continues to unveil the importance of interpersonal relationships (Van Orden et al., 2010), belongingness (Joiner et al., 2009), connection, and communication (Whitlock, Wyman & Moore, 2014), parent roles become especially critical to adolescent suicide prevention. Focusing on the role of parents in maintaining the safety of their suicidal adolescent upon discharge

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