



Predictors of Parent Behavioral Engagement in Youth Suicide Discharge Recommendations: Implications for Family-Centered Crisis Interventions

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Abstract

The number of youth presenting to Emergency Departments (EDs) with psychiatric chief complaints has almost doubled in the last decade. With pediatric patients, ED brief interventions and discharge recommendations necessitate meaningful parental engagement to optimize youth safety and support. This study examined parent-level factors (stigmatizing attitudes, self-efficacy beliefs, distress symptoms, and illness-related stressors) in relation to parents' behavioral engagement (i.e., participation in and follow-through with best practice discharge recommendations). In this short-term prospective study, participants were 118 parent-youth (aged 11–18) dyads (57% female) recruited from a psychiatric ED. Parents' behavioral engagement was measured with parent- and youth-self report at 2-week follow-up. Parents' self-reported anxious and depressive symptoms, insomnia, stress, and stigmatizing attitudes were not related to engagement 2 weeks later. Higher parental self-efficacy beliefs were significantly associated with greater engagement in standard discharge recommendations. Implications for maximizing parent implementation of clinical recommendations during a youth suicide crisis are discussed.

Keywords Youth suicide prevention · Family-centered care · Brief interventions · Emergency department

Introduction

Suicide is the second leading cause of death among youth in the United States [1], and the number of youth presenting to Emergency Departments (EDs) for psychiatric reasons has almost doubled in the last decade [2]. The National Strategy for Suicide Prevention [3] recommends improvements in our health care system that “promote continuity of care and the safety and well-being of all patients treated for suicide risk in emergency departments or hospital inpatient units”. Brief interventions such as safety planning, means restriction, outpatient treatment linkage, and caring follow-up

contacts are recommended across the lifespan [4, 5] yet for youth, these crisis interventions often rely on parents for successful implementation [6]. A meta-analysis of promising preventive interventions for youth with suicide risk [7] points to family involvement as a key factor in efficacious interventions [8–10]. Despite the critical role of parents in caring for youth post-suicide crisis, there is limited information available about how to engage parents during a youth suicide crisis or how to maximize their implementation of ED discharge recommendations. Understanding the factors that contribute to parent implementation of these recommendations is a critical component to designing effective, scalable youth and family-centered brief interventions to prevent youth suicide after an ED visit.

EDs are increasingly relied on to provide safety net mental health care to youth at risk for suicide [11, 12]. Youth who present to psychiatric EDs or who experience a psychiatric admission for suicide risk are at greatest risk in the subsequent weeks and months [13, 14], with elevated rates of repeat attempts in this post discharge period [15]. ED staff struggle to develop feasible discharge plans given the limited numbers of inpatient psychiatric beds serving youth as well

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as limited access to outpatient treatment [12]; as a result, the burden of enhancing safety and support for suicidal youth during this high-risk time falls increasingly on the family.

Parent Engagement in Youth Discharge Recommendations

In her conceptual model of caregiver engagement in youth mental health treatment, Staudt [16] describes engagement as a complex process, influenced by practitioner behaviors, the therapeutic alliance, and parent-factors, described below. *Behavioral engagement* (e.g., attending appointments, actively participating in therapeutic activities) is defined as caregiver behaviors that are necessary to implement treatment and that support positive outcomes. The *attitudinal* component (e.g., denial of the problem vs. expectation that treatment will be helpful) of caregiver engagement is postulated to be a necessary precursor to behavioral engagement.

Practitioner strategies that promote parent behavioral engagement [11, 17] may be a particularly critical tool in the ED, in order to maximize implementation of clinician recommendations. Such strategies are challenging for ED clinicians, however, given limited time and opportunity to establish close and trusting relationships with youth and parents. With respect to youth in a suicide crisis, parent behavioral engagement would entail implementation of standard, best practice ED clinician recommendations, including (1) supporting youth utilization of safety plan, (2) providing emotional support, (3) monitoring mood and suicidal ideation, (4) restricting access to lethal means, and (5) linking to an outpatient treatment team [4, 6].

Factors Associated with Parent Behavioral Engagement

Factors associated with parents' engagement in implementing behavioral health and medical recommendations include parental attitudes and beliefs about treatment effectiveness and acceptability [16, 18], parents' own psychopathology symptoms, parent stressors, and external barriers to accessing care. In a review of 44 studies examining parents' perceptions of barriers to accessing mental health care for their children [19], stigma (concerns about what others might think, a desire to keep problems within the family, discomfort with their child's mental health problems, etc.) was identified as a critical factor related to help-seeking. Self-efficacy [20, 21], the belief in one's capacity to manage a particular situation with success, has also been associated with a variety of health behaviors [22]. Parental self-efficacy, by extension, has also been linked to youth outcomes [23]. In a study of parents of ED treatment-seeking adolescents, low parental self-efficacy, or sense of confidence, in being able to engage in suicide prevention activities (e.g., identifying

suicide warning signs, encouraging coping skills use), as well lower confidence in being able to keep their adolescent safe, differentiated adolescents who did and did not experience a suicidal crisis during the following 4 months [24]. This study suggests that parental self-efficacy beliefs may influence the extent to which parents initiate or sustain supportive suicide prevention activities, further pointing to the need of directly assessing its link with parent behaviors post ED discharge.

Across a range of presenting concerns and types of interventions, parental psychopathology (e.g., anxiety, depression) has been negatively associated with parents' ability to participate effectively in their child's treatment and with youth outcomes [25, 26]. Parental stress has also been shown to be negatively related to parental treatment engagement behaviors [16]. Although we have limited empirical evidence regarding the impact of youth suicide risk on caregivers nor about how caregiver stress/distress may influence engagement in suicide-related ED discharge recommendations, it stands to reason that parents of youth at risk for suicide would be experiencing elevated levels of stress/distress and these factors may influence their ability to implement prevention strategies at home. Qualitative data collected from parents following their child's suicide-related ED visit demonstrates that many parents are feeling overwhelmed and unsure about how to support their child [27]. Drawing a comparison between life-threatening youth psychiatric and medical illnesses provides some additional insights. Estimates suggest that 27–63% of parents whose children are treated for a life-threatening medical illness meet criteria for an acute stress disorder at the time of treatment [28]. Parents of critically ill children are also at elevated risk for anxiety, depression, sleep disorders, and post-traumatic stress disorder [29]. Moreover, parent distress has been demonstrated to negatively impact parents' comprehension of medical information and their medical decision-making in samples of youth with medical illness [29]. More research is needed to explore parents' experiences during and following their child's suicide crisis and to identify factors that impact parents' behavioral and attitudinal engagement in standard ED discharge recommendations in order to maximize youth safety and support.

Study Aims

The purpose of this study is to improve our understanding of the factors that may contribute to, or interfere with, parent engagement in and implementation of standard ED discharge recommendations following their child's suicide crisis. We focus on improving our understanding of proximal markers of parent well-being (current symptoms, current illness-related family stressors) as well as beliefs and attitudinal components (e.g., self-efficacy, stigma) that may influence

parent engagement. Moreover, in addition to describing the extent of parental implementation of standard, best practice discharge recommendations, we examine the relationships between these parent factors and implementation behaviors 2 weeks following the child's ED visit. The long-term goal of this line of research is to identify parent- and family-level factors that are related to implementation of brief safety and support interventions in order to enhance the ability of clinicians to engage parents in safety and support measures during high risk times. Our study objectives are as follows:

Objective 1: To describe the extent of parental distress (anxiety and depressive symptoms, insomnia, and negative affect), current stressors, as well as parent attitudes and beliefs (stigma, self-efficacy) at the time of their child's psychiatric ED visit.

Objective 2: To describe the extent to which parents are engaged in implementing best-practice standard discharge recommendations in the two weeks following the youth's ED visit.

Objective 3: To examine the relationship between parent factors at index visit and implementation of these standard recommendations. We hypothesize that parents experiencing higher levels of distress and stressors, and who report higher levels of stigma and lower levels of self-efficacy, will demonstrate lower levels of behavioral engagement in discharge recommendations 2 weeks post ED discharge as reported by both parents and youth.

Method

Participants

Participants included 118 youth, ages 10–17 years (mean age = 14.6, SD = 1.88) and 118 parents/legal guardians (mean age = 45.15, SD = 7.97) presenting for care at a Psychiatric ED. Table 1 summarizes parents' demographic characteristics. Of the youth participants, 57.3% identified as female, 37.6% male, 2.6% transgender (female to male), and 2.6% gender nonconforming.

Youth ages 10–17 years, 11 months who presented to the ED with suicide-related concerns (ideation, attempt, depressive symptoms, non-suicidal self-injury) and who were accompanied by a parent or legal guardian were eligible to participate. Participants were ineligible if they were non-English speakers, experiencing psychosis, intoxicated,

Table 1 Parent demographics

Characteristic	<i>n</i>	%
Relationship to child		
Biological mother	87	73.7
Biological father	16	13.6
Stepmother	1	0.8
Stepfather	2	1.7
Legal guardian/other	12	10.2
Gender		
Female	97	82.2
Male	21	17.8
Race/ethnicity		
White	103	87.3
Black/African American	7	5.9
Hispanic	4	3.4
American Indian/Alaskan Native	6	5.1
Asian	3	2.5
Pacific Islander	1	0.8
Educational background		
Some high school	7	5.9
High school degree	9	7.6
Some college	37	31.4
College degree	37	31.4
Post-graduate degree	28	23.7
Income		
\$0 to \$50,000	23	19.5
\$50,000 to \$100,000	23	19.5
\$100,000 to \$200,000	39	33.1
\$200,000 and up	7	5.9

cognitively impaired, not accompanied by a legal guardian, or experiencing severe aggression or agitation.

Of the 118 dyads, 40 parents (33.9%) and 47 youth (39.8%) were not retained in the 2-week follow-up survey. Retention analyses indicated that neither parent gender nor parents' symptom severity (i.e., self-reported anxiety and depressive symptoms, insomnia, or negative affect) were related to participation in the follow-up. Parents with higher educational attainment and higher income, parents with lower levels of self-efficacy at baseline, and parents of youth with higher levels of depression and suicidal ideation at baseline were more likely to participate in the follow-up. There were no differences between youth who did and did not participate in the follow-up in terms of baseline depressive symptoms and suicidal ideation. Severity of parent symptoms was not associated with youth retention.

Procedures

Research staff recruited participants between September 2018 and March 2020 in accordance with Institutional

Review Board regulations and approvals. All participants received standard care in the ED provided by licensed social workers and psychiatrists, which included risk assessment, safety planning, lethal means counseling, and recommendations for treatment linkage. RA's were trained to ensure that recruitment did not interfere with clinical care; most families were recruited in the interim between their visit with the social worker and prior to their visit with the psychiatrist. Following consent, families completed a battery of measures detailed below. Youth were given \$10 and adults \$5 as incentives for completing the baseline assessment. Two weeks after discharge, parents and youth were asked to complete an online Qualtrics survey. Youth and parents received another \$10 and \$5, respectively for completion of follow-up surveys. Per ED protocol, youth discharged to an inpatient facility are not required to receive a safety plan in the ED because this is likely to occur during hospitalization.

Measures

Baseline Parent Measures

Parents provided demographic information (e.g., age, race, gender, educational background, income, etc.) and their reasons for seeking ED services for their child, and responded to a checklist specifying their desired outcomes following the ED visit [30]. Parents also reported on the presence of firearms in the home at baseline [31], recent symptoms and stressors, as well as relevant attitudes and beliefs.

Parent Stigma The 5-item Stigma Scale for Receiving Psychological Help (SSRPH) was completed by parents to measure attitudes about the acceptability of seeking mental health treatment. Each question is rated on a 4-point Likert scale, ranging from 0 (strongly disagree) to 3 (strongly agree). Factor analysis supports the existence of a unitary scale. Internal consistency in this sample was 0.79. The SSRPH was slightly modified for this study by changing the exclusive focus on “psychological treatment”. The word “psychologist” was replaced by “mental health professional” [32]. Scores range from 0 to 15, with higher scores reflecting more stigmatizing attitudes.

Parental Self-efficacy Parental level of confidence in their ability to engage in supportive and suicide prevention activities was assessed with Parental Self-Efficacy Scale [24]. The 10-item scale includes response options ranging from 0 (not at all confident) to 10 (completely confident), with items reflecting standard, best practice recommendations for caring for high-risk adolescents (e.g., lethal means restriction, inquiring about suicidal ideation, identifying suicide warning signs, encouraging use of coping skills, offering emotional support, etc.). The scale was developed using a

sample of parents of ED treatment-seeking youth. In the current sample, internal consistency was 0.86.

Parent Distress Symptoms Parent symptoms of anxiety, depression, insomnia, and negative affect at the time of the ED visit were assessed using the PHQ-4, Insomnia Severity Index, and the negative subscale of the PANAS. The 4-item Patient Health Questionnaire [33] assesses symptoms of depression and anxiety in the last 2 weeks. The measure includes an overall score (0–12; alpha in this sample = 0.89) and two 2-item subscales for anxiety (alpha in this sample = 0.87) and depression (alpha in this sample = 0.86). The Insomnia Severity Index [34] is a 7-item measure used to assess the severity of insomnia experienced by parents within the last 2 weeks (alpha in this sample = 0.93). The 10-item Negative Affect subscale of the PANAS [35] was also administered (alpha in this sample = 0.89). Questions referred to the past week and were rated from 1 (very slightly or not at all) to 5 (extremely). A summary scale of parental distress symptoms (anxiety, depression, sleep problems, negative affect) was constructed by calculating z-scores for the total score of each measure and then summing these scores to create a composite variable, referred to below as Parental Distress.

Parent Stressors The Pediatric Inventory for Parents (PIP) [36] was developed to measure the parenting stress of caring for a medically ill child and initially validated in a pediatric oncology sample. Illness-related stress is assessed by asking parents to rate both the frequency (never to very often) and subjective difficulty (not at all to extremely) associated with 34 different stressors using a 5-point Likert scale. The PIP yields 4 subscales: (1) communication (e.g., ‘speaking with my child about his/her illness’), (2) emotional functioning (e.g., ‘feeling numb inside’), (3) medical care (e.g., ‘disagreeing with a member of the healthcare team’), and (4) role function (e.g., ‘trying to attend to the needs of other family members’) as well as overall composite scores calculated as sums on both the frequency (PIP-F; alpha in this sample = 0.93) and difficulty (PIP-D alpha in this sample = 0.94) of stressors. The measure was adapted for this study by eliminating medical items that were not relevant for caring for youth with a psychiatric condition. Due to a high level of collinearity between the frequency and difficulty summary scales in this sample, only the frequency summary scale is used in analyses.

Baseline Youth Measures

In addition to the self-report measures described below, youth also provided demographic information about their age, race, gender, and grade level.

Youth Clinical Characteristics Youth's present level of depressive symptoms was measured using the Reynolds Adolescent Depression Scale-2 (RADS-2) [37, 38], a 30-item measure which includes assessment of dysphoric mood, anhedonia and negative affect, negative self-evaluation, and somatic complaints [37]. The measure had good internal consistency ($\alpha=0.88$) in this sample. The Suicidal Ideation Questionnaire-Junior (SIQ-Jr), a 15-item measure designed specifically for youth, was used to assess current suicidal ideation [37]. The SIQ-Jr uses a 7-point Likert scale (almost every day to I never had this thought) to indicate ideation frequency; α in this sample was 0.93. In previous research, the total score of the SIQ-Jr has been found to be a significant predictor of both ideation and attempts in psychiatrically hospitalized youth in the 6 months following hospitalization [39].

Parent and Youth Follow-Up: Implementation of Standard Discharge Recommendations

Two weeks post-ED discharge, both parents and youth completed online Qualtrics follow-up surveys. Portions of each survey were developed for this study to evaluate the extent of parents' behavioral engagement in discharge recommendations. Items were based on standard, best practice clinical recommendations [4] post ED discharge and expert guidelines for how parents can support youth during this period [6, 40]. Items also reflected the parent behaviors assessed in the parent self-efficacy questionnaire described above. Parents were asked to report (yes/no) on (1) their use of recommended safety/support behaviors (e.g., asking their child about their mood/suicidal ideation, encouraging child's use of coping skills), (2) participation in or encouragement of the child's use of the safety plan, (3) restriction of access to lethal means (removing firearms if present, medications, sharps), and (4) establishing next steps in care (e.g., outpatient psychotherapy, psychiatry services). Parental means restriction behaviors were assessed with items derived from previous studies [41]. Treatment utilization was assessed with items from the Services for Children and Adolescents Parent Interview [42]. Youth were asked similar questions to assess their perception of parents' implementation of recommendations, with the exception of the means restriction items. Youth report of parents' use of recommended safety/support behaviors, including encouragement of safety plan use, was assessed using Likert scales of the frequency with which they perceived their parents implementing each behavior. Composite variables (parent report and youth report) of parents' behavioral engagement across all standard recommendations were created. Parents received 1 point for each of the recommendations they reportedly implemented at home, which were then summed and divided by the total number of follow-up recommendations. Scores reflect the

percentage of possible actions that a parent could take. For example, if a family did not have a firearm, the denominator of possible actions would be adjusted. For the Likert scale items in the youth follow-up survey, response categories were collapsed to create dichotomous variables.

Data Analysis

For the first and second study objectives, we provide descriptive statistics—including means, standard deviations, and frequencies—to, respectively, describe parent factors measured at initial ED visit (attitudes and beliefs, symptoms, and stressors) hypothesized to be related to subsequent parent behavioral engagement as well as to characterize (by parent and youth report) the extent to which parents implemented standard best practice suicide prevention actions within two weeks of their child's psychiatric ED visit. Two-tailed Pearson correlations were also used to examine the relationship between parents' attitudes, beliefs, symptoms, and stressors.

In terms of the third study objective, we fitted two multiple linear regression models to examine the association between four predictors assessed at ED visit (parent stigmatizing attitudes about mental health treatment; parental self-efficacy beliefs, parental distress symptoms, as indexed by a composite variable; and parental stressors indexed by the PIP frequency subscale) that were hypothesized to influence parental implementation of recommendations after ED discharge. The two dependent variables, measured two weeks after the index ED visit, were composite variables reflecting the extent to which parents implemented the recommended safety and supportive behaviors, based on parent report and youth report. For both regression models, we controlled for baseline covariates that were associated with follow-up attrition (youth suicidal ideation severity, family income). Analyses were conducted using SPSS Version 26 [43].

Results

Characteristics of the Sample

At baseline, 76% of youth met the clinical threshold for depressive symptoms (RADS-2 $M = 89.64$, $SD = 13.85$) and suicidal ideation (SIQ $M = 49.56$, $SD = 22.52$). Per parent report, 50% of youth were previously seen in an ED for mental health concerns and a third (33.3%) had been previously admitted for an inpatient psychiatric hospitalization.

Reasons for Seeking ED Services and Preferred Outcomes

When asked to indicate their reasons for seeking emergency care, of which participants could select more than one, 30.5% of parents reported being referred to the ED

by their child's school, 28% by an outpatient mental health professional, 21.2% due to the child's request, and 60.2% due to parent concerns for the child's safety. Parents were also asked to share their preferred outcomes of the ED visit: 41.5% reported wanting a referral to an outpatient provider; 41.5% were hoping to receive a medication prescription/adjustment; 58.5% desired inpatient hospitalization; and 56% wanted educational resources (focused on mental health, risk management, etc.). Based on both youth and parent report at the 2-week follow-up, 18 youth (15%) were admitted to an inpatient unit following their visit to the ED and 37.1% were discharged to a partial hospitalization program. The remainder were discharged home with a recommendation for outpatient treatment.

Parental Attitudes, Beliefs, Distress, and Stressors at Index ED Visit

Descriptive statistics and bivariate correlations between all four parent-level factors (stigma, self-efficacy, distress symptoms, stressors) are found in Table 2. Parents reported a fairly accepting attitude about psychological treatment (range 0–15, lower scores indicate more accepting attitudes). Parents' self-efficacy or confidence in their ability to engage in suicide prevention activities (range 0–100) was moderately high. With respect to parents' symptoms of depression and anxiety at the time of their child's visit to the ED, scores on the PHQ-4 (range 0–12) suggest that 51.3% of participating parents reported some level of current distress. Although most were experiencing mild symptoms, 23.2% of the sample reported scores in the moderate to severe range. In addition, parents reported significantly more anxiety than depression on the PHQ-4 ($t(1, 111) = 5.86, p \leq 0.001$). Mean scores on the Insomnia Severity Index (range 0–28) suggest that most parents were reporting only mild sleep disruption, although 16.8% of participating parents reported moderate to severe insomnia. On the 10-item negative affect scale of

the PANAS (possible range 1–50), scores suggest that most parents were reporting negative affect consistent with a rating of "a little" ($M = 20.74, SD = 8.18$; range 10–48).

Lastly, parents were asked to report on a number of stressors related to their child's illness. When asked to document the frequency of each event (1 = never to 5 = very often), parents indicated that they experienced the following stressors most: (1) seeing my child sad or scared ($M = 3.82, SD = 1.1$); (2) knowing my child is hurting or in pain ($M = 3.79, SD = 1.08$); (3) feeling helpless over my child's condition ($M = 3.74, SD = 1.33$); (4) seeing my child's mood change quickly ($M = 3.56, SD = 1.13$); and (5) trying to attend to the needs of other family members ($M = 3.56, SD = 1.28$). Four out of the top five most frequently occurring stressors loaded on the emotional distress subscale of the measure. Parents also rated the perceived difficulty associated with each stressor separately (1 = not at all difficult to 5 = extremely difficult). Difficulty ratings were as follows: (1) knowing my child is hurting or in pain ($M = 4.25, SD = 1.06$); (2) seeing my child sad or scared ($M = 4.23, SD = 1.06$); (3) feeling helpless over my child's condition ($M = 3.73, SD = 1.34$); (4) seeing my child's mood change quickly ($M = 3.35, SD = 1.35$); and (5) trying to attend to the needs of other family members ($M = 3.1, SD = 1.28$). Subscale total scores are reported in Table 2.

Examination of bivariate relationships between measures of parents' stigmatizing attitudes about psychological services, self-efficacy beliefs, parent symptoms, and the frequency/difficulty of parent stressors (Table 2) suggests that higher parent self-efficacy was significantly correlated with more accepting attitudes of psychological treatment ($r(111) = -0.19, p = 0.05$) and lower ratings of negative affect ($r(111) = -0.22, p = 0.022$). Parents' endorsement of anxiety and depressive symptoms was significantly correlated with the other measures of parent symptoms—increased insomnia severity ($r(109) = 0.66, p < 0.001$ and $r(109) = 0.67, p < 0.001$, respectively), frequency of stressors

Table 2 Parent attitudes, beliefs, symptoms, and illness-related stressors: descriptive data and bivariate relationships

Variables	<i>n</i>	<i>M</i>	<i>SD</i>	1	2	3	4	5	6	7	8	9	10
1. Stigma of psychological services	112	4.37	2.85	–									
2. Self-efficacy	113	75.24	16.54	–0.19*	–								
3. PHQ-4 total score	112	3.38	3.4	0.05	–0.12	–							
4. PHQ-4 anxiety	112	2.09	2.02	0.03	–0.14	0.94**	–						
5. PHQ-4 depression	112	1.29	1.65	0.06	–0.08	0.91**	0.71**	–					
6. Insomnia	109	7.89	6.6	0.09	–0.17	0.71**	0.66*	0.67**	–				
7. Negative affect	110	20.74	8.18	0.11	–0.22*	0.68**	0.65**	0.61**	0.56**	–			
8. PIP frequency	113	88.28	24.48	0.16	–0.15	0.53**	0.53**	0.45**	0.47**	0.49**	–		
9. PIP difficulty	112	85.89	26.34	–0.26**	–0.21**	0.52**	0.54**	0.41**	0.40**	0.48**	0.91**	–	
10. Parental distress composite	115	0.00	2.58	0.09	–0.19*	0.91**	0.85**	0.83**	0.86**	0.85**	0.56**	0.52**	–

* $p < 0.05$, 2-tailed. ** $p < 0.01$, 2-tailed

($r(108) = 0.53, p < 0.001$ and $r(108) = 0.45, p < 0.001$, respectively), and negative affect ($r(108) = 0.65, p < 0.001$ and $r(108) = 0.61, p < 0.001$, respectively). The frequency of stressors was also significantly correlated with increased insomnia severity ($r(108) = 0.47, p < 0.001$) and higher ratings of negative affect ($r(109) = 0.48, p < 0.001$). The Parent Distress composite score was significantly correlated with all measures of parent symptoms as well as their self-efficacy but not their attitudes about psychological services.

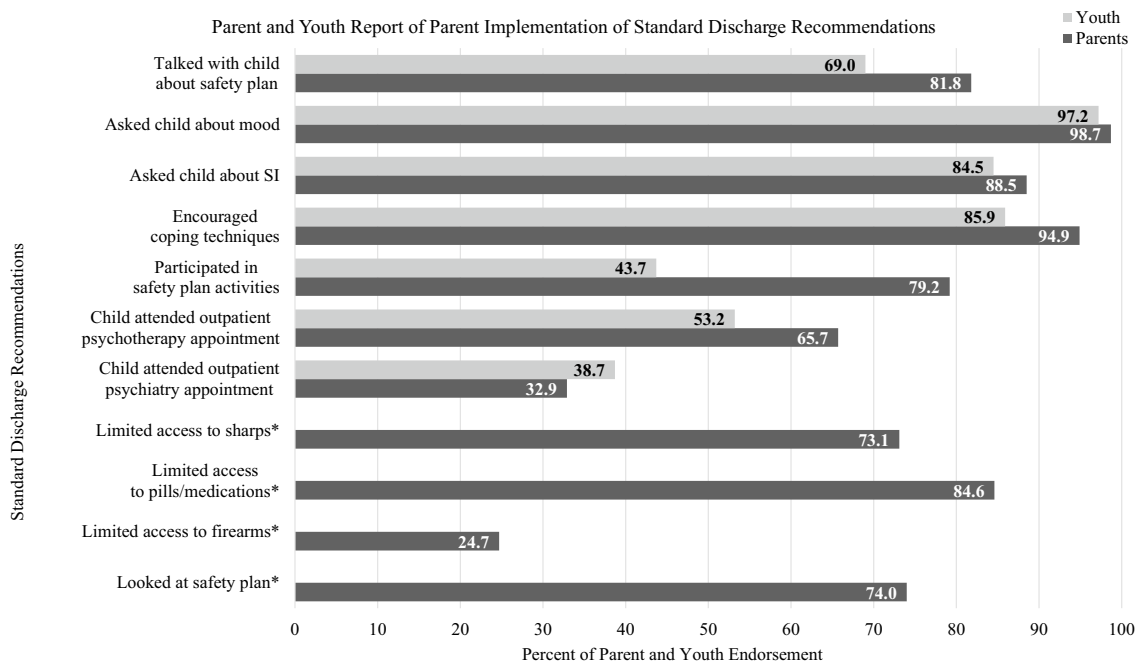
Parent Behavioral Engagement in Discharge Recommendations

Figure 1 displays parent and youth report of parent implementation of standard, best practices ED discharge recommendations at 2-weeks post-ED visit, reflected as the percentage of the sample who positively endorsed that parents had engaged in the listed behavior. Consistently, parents rated themselves as more behaviorally engaged than youth rated their parents. The highest level of engagement occurred in asking youth about their mood, with 97.8% of parents reporting they had done this in the past 2 weeks and 97.2% of youth also reporting that parents had asked about their mood. The lowest rate of implementation occurred with respect to youth attendance at an outpatient appointment, with 65% of parents and 53% of youth endorsing. This finding may reflect systems issues with timely access to care.

The item with the greatest discordance between parents and youth was parent participation in safety plan activities, with 43.7% of youth and 79.2% of parents reporting that parents had participated in safety plan activities with their child in the 2 weeks after the ED visit.

Means Restriction

At the time of the index visit, 28.8% of the sample ($n = 32$) reported owning a firearm. Of the parents who reported firearm ownership, 3 parents (9.8%) reported that the firearm was kept loaded; 7 (21.9%) reported that the firearm was unlocked; and 7 (21.9%) reported that their child either had possible access, easy access, or unknown access to the firearm, with 71.1% of parents reporting that the child did not have access to the weapon. Of the 20 families who reported owning a firearm at baseline and participated in the 2-week follow-up, 14 (70%) reported taking steps to restrict their child's access to the firearm. In addition, 84.4% of families who participated in the 2-week survey reported taking steps to restrict access to prescription medications and 73.1% restricted access to sharp objects. In sum, 91% of families participating in the 2-week follow-up survey reported that they had engaged in some type of lethal means restriction (sharps, medications, or firearms).



*Note. These items were only asked in the Parent 2-Week Follow-Up survey.

Fig. 1 Percent of sample endorsing parent implementation of standard discharge recommendations

Treatment Linkage

In order to assess the engagement behavior of linking with additional treatment, parents were asked to report on appointments that had been either scheduled or attended. At the 2-week follow-up, 88.5% of participating families reported that their child had either attended or scheduled some type of follow-up mental health service. Of those, 65.7% had attended or scheduled a therapy appointment, 35% had attended or scheduled a partial hospitalization program, and 33% had attended or scheduled a psychiatry appointment.

Relationship Between Parent Factors and Parent Behavioral Engagement

As shown in Table 3, there were no associations between parent stigmatizing attitudes and parents' implementation of/engagement with standard discharge recommendations at 2 weeks as reported by parents or by youth. Higher parent-reported self-efficacy at baseline was significantly related to parent report of greater implementation ($\beta=0.341$, $t=2.77$, $p=0.007$, R^2 change=0.12; $p=0.007$) but not to youth report. There was no relation between parent distress (composite of anxious/depressive symptoms, sleep problems, and negative affect) at the time of ED visit and implementation of recommendations 2 weeks later as reported by parents and as reported by youth. The frequency of illness related stressors was also not significantly related to parent report of implementation, although there was a trend suggesting that higher frequency of parent stressors ($\beta = -0.24$, $p=0.06$, R^2 change=0.06; $p=0.06$) may be related to lower levels of implementation behaviors. Parent stress was not related to implementation by youth report.

Discussion

We examined parent-level factors hypothesized to be related to parental engagement with and implementation of standard best practice ED recommendations for youth suicide risk. We hypothesized that parents with more stigmatizing attitudes about mental health treatment, lower self-efficacy

beliefs in their own abilities to keep their children safe, higher levels of recent distress, and higher levels of illness-related stressors would be less likely to demonstrate behavioral engagement/implementation of discharge recommendations in the critical 2-week period post ED visit for suicide risk. Higher parental self-efficacy beliefs were significantly related to parent report of implementation behaviors based on parent, but not youth, report. Contrary to hypotheses, neither stigmatizing attitudes nor parents' distress symptoms (composite of anxiety, depression, insomnia, negative affect) were related to extent of parental behavioral engagement/implementation of discharge recommendations. This is one of the first studies to empirically examine, with both youth and parent report, parental behaviors during the critical period of time following an ED visit for suicide risk.

Given many of the gaps in our youth mental health system, the burden of caring for youth at risk for suicide often falls on families; and the literature is clear that family involvement in youth treatment is beneficial [7, 8, 10]. Yet there is a paucity of information available about how the experience of parenting a child at risk for suicide impacts parents and, by extension, how brief crisis interventions might take parent and family factors into account in order to improve care and outcomes for high risk youth. One of the main findings of this study is the high level of distress being experienced by parents during the child's ED visit. Over half of parents reported some level of distress on the PHQ-4, with almost a quarter of parents (23.2%) reporting scores in the moderate to severe range, and 16.8% of participating parents reporting moderate to severe insomnia. Parent sleep problems could reflect depression or anxiety, but also could result from parents feeling the need to monitor their child overnight for safety reasons. Certainly, any level of insomnia would further reduce the ability of a parent to adequately support their child [44]. Moreover, half of the youth in this sample had been to an emergency setting for a suicide related issue in the past, which highlights the parental exhaustion and stress that may occur when their child's suicidal crises are recurrent and chronic. While not surprising, given the familial and genetic links between parent and child mental health problems [45], data describing the extent of parent distress underscores the emotional strain for the

Table 3 Parent and youth report of implementation of standard discharge recommendations

Variables	Parent report					Youth report				
	B	SE(B)	Beta	t	P value	B	SE(B)	Beta	t	P value
Stigma	-0.008	0.007	-0.154	-1.188	0.24	-0.034	0.054	-0.086	-0.629	0.532
Self-efficacy	0.003	0.001	0.341	2.774	0.007	0.006	0.009	0.094	0.686	0.496
Parental distress composite	-0.006	0.008	-0.098	-0.748	0.457	0.037	0.061	0.084	0.609	0.545
Illness-related stress	-0.002	0.001	-0.243	-1.918	0.06	0.003	0.006	0.055	0.404	0.688

family during these times of crisis and points to the need for clinicians to attend to parental well-being.

Studies of children with life threatening medical illness suggest that parent distress symptoms can interfere with comprehension of medical recommendations or adherence to treatment [29]. In this study, parent symptoms measured at the time of the child's ED visit were not related to parent implementation behaviors measured 2 weeks later; however, it is important to further study these relationships, as factors such as chronicity of parent distress, the extent to which symptoms reflect an acute crisis versus long-standing parental psychopathology, and the interplay between parent and youth symptoms, may be moderating factors in the relationship between parental distress, parents' behavioral engagement, and youth outcomes. Further research may elucidate subgroups of parents in need of specialized support during a youth's suicide crisis.

This study is the first, to our knowledge, to examine the types of illness-related stressors reported by parents whose children are struggling with life-threatening medical illness in a sample of parents whose children are at risk for suicide. Within the pediatric medical literature, the impact of a child's life-threatening illness on parents and families has been well-described [36, 46]), yet this information is lacking for families struggling to care for a child with a psychiatric life-threatening illness. Given the limitations in crisis services for children, parents caring for youth with psychiatric life-threatening illnesses are likely to experience high levels of illness-related stress which should be considered by clinicians when creating a discharge plan. Focus groups and qualitative data obtained from parents post youth ED discharge [27, 31] suggest that parents report the common experience of being told to take their child home and "keep an eye on him/her," while feeling unprepared and overwhelmed with the responsibility of keeping their child safe. In our sample, parents report that the most difficult aspect of their child's illness is seeing their child sad or in pain and feeling helpless about it. Although not reaching statistical significance, regression analyses suggested that parental stressors were negatively associated with implementation behaviors at trend level, warranting further study.

Potentially contributing to parents' stress and distress is the mismatch that this study has identified between parents' hopes for the outcome of their ED visit and the likely result, with over half of parents in this sample (57%) desiring inpatient hospitalization for their child and over 40% desiring a medication prescription/change. In this sample, only 15% of youth were hospitalized. Nationally, estimates suggest that approximately a third of youth presenting to EDs are admitted to an inpatient facility [47]. The potential disappointment upon learning that a parent will need to continue to bear the burden of monitoring their child's safety should not be overlooked. Similarly, the majority of visits to a psychiatric

or medical ED will not result in a new psychiatric medication prescription or a significant change in the medication regimen [48]. Our data suggest the need to better educate parents and referring providers/gatekeepers about what to expect during an ED visit, the most likely outcomes of that visit, as well as pros and cons of inpatient hospitalization. Further research should examine whether providing parents with more accurate expectations about what will happen during and after the ED visit would reduce distress and result in more appropriate referrals to the ED. Nationally, crisis care advocates [49] are calling for investment in a care continuum that would provide supports beyond the ED and inpatient hospitalization, which could include greater access to hotlines, mobile crisis services, peer to peer support, and home-like stabilization or respite environments.

Parents in this study reported a high level of behavioral engagement in standard, best practices discharge recommendations. This may be a result of a dedicated effort in the specialized academic medical center psychiatric study site to implement evidence-based risk reduction interventions, such as lethal means counseling, involving parents in safety planning, and providing support for timely mental health follow-up (e.g., bridging clinics in the affiliated ambulatory care setting). Such specialized mental health expertise is often not available in general medical EDs. Most parents in our study reported implementing some measure of means restriction and some type of mental health follow-up for their child. These data support the impact of providing specialized mental health care and brief interventions in the ED.

Despite the high parent-reported rate of participation in safety/support activities post-discharge, youth reported lower parent participation, including parents offering emotional support, engaging in safety plan activities, and talking with the youth about the safety plan. While these discrepancies could be partially explained by recall bias or social desirability reporting on the part of parents, it highlights the need for engagement in safety plan follow-up and emotional support that is meaningful and impactful for the youth themselves. Future research should focus on better understanding what youth most want from parents during and after a crisis, and the extent to which possible moderating variables such as parent-child conflict, family environment (e.g., child custody), or parent psychopathology might influence concordance ratings and/or youth satisfaction with parent supervision and support. Further research should also assess parent engagement in recommendations that are individualized for their family.

Parent attitudes and beliefs were also investigated as potential contributing factors to parent behavioral engagement/implementation of discharge recommendations. While stigmatizing attitudes were not related to parent behavioral engagement in safety and support behaviors, parents' ratings of their own self-efficacy to engage in those behaviors were related

to implementation in the 2 weeks post-ED visit. A previous study of ED service-seeking adolescents at risk for suicide and their parents reported that parental self-efficacy to engage in recommended suicide prevention strategies at index ED visit differentiated adolescents with and without suicide-related outcomes four months later [24]. Findings from the current study provide additional support that parental self-efficacy is an important target of assessment and possibly intervention prior to ED discharge when providing services to adolescents at risk for suicide.

Limitations

There are a number of limitations to the current study. This study was conducted at a single site, with a sample of parents that was largely female and White. Services were provided in an academic medical center psychiatric ED, in which all clinicians are highly trained in the use of best practices in risk assessment and brief interventions. Thus, results may not generalize to other community settings or diverse populations, but do highlight the benefits of specialty care during high risk times. Differential attrition may have influenced our study results. Parents with a higher income and level of education and those whose children were experiencing more severe illness were more likely to answer the 2-week follow-up questions. Despite controlling for these variables in analyses, this pattern may have influenced findings regarding the extent of parental engagement, given that parents with more psychosocial barriers may not have continued in the study. It is also important to underscore that parental self-efficacy, a hypothesized independent variable, was related to study attrition, such that parents with less self-efficacy were more likely to participate in the 2-week follow-up. Although a strength of our study was the multi-informant assessment strategy with parent and youth, our measure of engagement in discharge recommendations was limited to a focus on standard, best practices recommendations [5, 6]) and were not individualized to particular youth. We also cannot confirm that every family in the sample received every recommendation during their ED visit, although clinicians are expected to provide this level of care. It is also possible that being involved in the study or completing study measures may have “primed” parents in some way or resulted in social desirability reporting at follow-up. Finally, parents also had different levels of opportunity to provide support and participate in safety plan activities, depending on the youth’s discharge plan (inpatient, partial, vs outpatient care). Six families in our sample indicated that they did not receive a safety plan, which is likely explained by study site protocols that do not require youth transferring to inpatient to create a safety plan in the ED. Additional research is needed to study linkages between clinician behaviors and parent engagement as well as ideal methods of measuring parental behavioral engagement in individualized discharge plans [50].

Summary

In sum, this study was designed to both describe and examine relationships between parent-level factors (stigmatizing attitudes, self-efficacy beliefs, distress symptoms, and illness-related stressors) and parents’ behavioral engagement in the implementation of standard, best practice discharge recommendations for youth following an ED visit for suicide risk. Our findings suggest that many parents are experiencing both stress and emotional distress during their ED visit, with a small but notable subgroup experiencing clinically significant symptoms. Parent self-efficacy beliefs were related to greater engagement in discharge recommendations, pointing to the importance of helping parents to grow in their confidence to implement recommendations that can promote safety and support of their children following an ED visit. This study informs our understanding of clinicians’ use of brief interventions with parents and youth who present to EDs with suicidal crises, with the ultimate goal of maximizing safety and support following a suicide crisis.

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Declarations

Conflict of interest The authors declare that they have no conflict of interest.

Research Involving Human Rights All procedures performed were in accordance with the ethical standards of the University of Michigan Institutional Review Board and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards. This study was approved by the Michigan Medicine IRB.

Informed Consent Informed consent was obtained from all individual participants included in the study.

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