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Development of guidelines for hospital care of suicide attempts in adolescence

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Abstract *This article aims to describe a qualitative and quantitative study of the construction and validation of guidelines for hospital care of adolescents with suicide attempts. The methodological approach involved an integrative literature review with thematic content analysis of 27 articles, which generated 3 categories: assessment of suicidal behavior in the context of the emergency department; intervention in suicidal behavior, and hospital multidisciplinary team. The content of these categories was the basis for the construction of an instrument with 15 statements about the performance of adolescents in suicidal crisis assisted in the hospital setting. This instrument was applied with 20 healthcare professionals selected from two hospital institutions in southern Brazil, who acted as judges/evaluators of the proposed statements. The content of the 15 statements was validated as guidelines through the Percentage of Concordance Calculation and the Score Calculation. The constructed guidelines may help multidisciplinary hospital teams when facing adolescents with suicide attempts, to base their conduct on criteria that guide actions of reception, assessment, intervention, and referral.*
Key words *Suicide attempt, Adolescence, Emergency department*

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Introduction

Suicide is a phenomenon that accompanies the history of humanity, with various meanings according to the cultural and historical context in which it occurs[1]. It is characterized as a multifactorial phenomenon resulting from a complex interaction of biological, psychological, sociological, cultural, and environmental factors[2,3]. It is not limited to a single field of knowledge, which means that disciplines such as philosophy, anthropology, sociology, medicine, and psychology contribute to the analysis of the theme. Shneidman, an American psychologist, considered the father of suicidology, defined suicide as "[...] a conscious act of self-induced annihilation, best understood as a multidimensional malaise in a needful individual who defines an issue for which the suicide is perceived as the best solution"[4](p.203). The same author emphasizes that suicide is an attempt to stop the flow of unbearable psychological pain[4]. Nowadays, suicide is circumscribed to a broader phenomenon called "suicidal behavior"[2,3,5], which is considered a non-adaptive behavior with multiple determinants that presents itself on a scale of severity that includes at least three types of phenomena associated with suicide: suicidal ideation, attempted suicide, and suicide itself[3,6].

Suicidal ideation encompasses ideas, wishes, and manifestations of the intention to die. It can also include planning how, when, and where to do the act: Suicide attempt, as clarified by Bertolote *et al.*[5], has the same phenomenological characteristics as suicide, differing only in the outcome, which is not fatal, and they propose that suicidal behavior should be differentiated from other self-destructive behaviors, in which there is no intention of ending one's life.

According to the World Health Organization (WHO), adolescence is circumscribed to the period between 10 and 19 years[7] and is characterized by an accelerated rate of growth and body, biological, social, psychological, and cognitive changes, in which the social context has a primary influence on the development of potentialities and vulnerabilities[7,8]. It is important to emphasize that there is no universal standard for adolescence so this stage should be understood as a social construction[8], historical-dialectical[9], the result of the subject's appropriation of their experiences, social relations, living conditions, and values present in his culture[9,10]. In this process, the teenager may experience impasses and weaknesses, developing complications in the mental health sphere. These complications are related to the constitutional path of their singularity, which is dialectically processed in their lives of relationships on the one hand, and with the social and historical context on the other[9,10]. Suicide attempts in adolescence are associated with the search for relief from intense psychological suffering[11]. The WHO[2] considers factors such as dysfunctional family life, neglect and lack of social support, inability to cope with academic challenges, poor problem-solving skills, low self-esteem, conflicts over gender identity, loss of love relationships, situations of mistreatment, physical and sexual abuse, family psychiatric disorder, and substance abuse or dependence associated with depression may increase the risk of suicide among adolescents. The suicide of prominent and reference figures or someone the adolescent knows personally is pointed out as an additional risk factor at this stage.

Adolescent suicidal behavior is characterized as a growing public health problem in Brazil. According to data released in the latest epidemiological bulletin from the Ministry of Health in September 2021[12], there has been a significant increase in mortality rates for adolescents and a sustained increase in deaths by suicide in those under 14 years of age. It is estimated that for every death by suicide there are more than 20 attempts[3]. In turn, Rigo[13] warns that half of those who commit suicide have made a previous attempt, making previous suicide attempts an important risk factor for self-extermination. It is important to emphasize that the analysis period of the epidemiological bulletin data is before the new coronavirus COVID-19 pandemic, which was a potentiating variable in the aggravation of mental health for everyone[14].

Given the data found, the epidemiological bulletin emphasized the need for healthcare networks to be trained in the reception and care of child and adolescent mental health. There is a lack of national research to formulate an effective approach for users in suicidal crisis, highlighting the lack of development of specific intervention strategies for people who have attempted suicide and arrive at the emergency services[5,15].

The WHO has been articulating a series of actions, since 1999, aimed at the global prevention of suicide[3]. In line with this policy, the Brazilian Ministry of Health has also been articulating a strategic suicide prevention agenda with states and municipalities, which has translated into the definition of national[16], state, and municipal prevention guidelines. Despite these initiatives

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around suicide prevention and the publication of guidance content, there is still little material directed to the specifics of the adolescent public, especially regarding the intervention of health professionals who work at emergency hospital entrances.

In this context, the adequate assessment and management of adolescents who have attempted suicide that arrives at emergency rooms, aiming at the prevention of new attempts, becomes more urgent. This paper aims to describe a qualitative and quantitative study of the construction and validation of guidelines for multidisciplinary hospital care of adolescents who have attempted suicide.

Method

This research was planned and carried out in line with the ethical procedures of resolution No. 466, December 12, 2012, and was submitted to the Ethics Committee on Research with Human Beings.

Regarding the methodological path, the study was conducted in seven (7) stages, four related to the construction of the guidelines and three related to their validation. The first step was the bibliographic research through an integrative literature review, which allows the synthesis of multiple published studies and the development of conclusions about a specific study area[17]. The review's starting point was the following guiding question: "How to assess and manage suicidal behavior in adolescents seen in the context of hospital urgency and emergency?". This directed the definition of the search terms, which were chosen based on the descriptors standardized by the Descriptors in Health Sciences (Decs) and the Medical Subject Headings Terms (MeSHTerms). To search the databases, the terms "adolescence", "adolescent", "suicidal behavior", "suicide attempt", "suicidal ideation", "suicide", "emergency hospital service", "emergency medical services", "emergency room" were used, with their synonyms, in Portuguese, English, and Spanish, using the Boolean operators "OR" and "AND". Inclusion criteria were: articles available in full; in Portuguese, English, and Spanish languages; with a period of five years (2014-2018); contributing to answering the research question; preferably covering the adolescent audience; having the context of hospital urgency and emergency as locus. The integrative review took place from March to May 2019, and the following databases were consulted: BVS/Bireme, Scopus, Web of Science, PsycINFO, Medline/Pubmed, CINAHL, Pepsic, Index Psi, SciELO. A total of 1,595 articles were identified, and after reading the titles, 463 articles remained. The abstracts of these articles were read, and 27 articles were included.

The second stage of the study was defined by the content analysis of the 27 articles selected according to Bardin's thematic categorization[18]. From this analysis, 3 categories emerged (Assessment of suicidal behavior in the context of hospital urgency and emergency; Intervention in suicidal behavior in the context of hospital urgency and emergency; Hospital multidisciplinary team), which were the basis for the identification of the contents for the preparation of the statements that later comprised the guidelines. Fifteen statements were prepared in the third stage of the study, based on the mentioned categories. A Likert-type scale was built with the 15 statements in the fourth stage. The instrument with the Likert scale presented 5 (five) options: totally disagree; partially disagree; neither agree nor disagree; partially agree; totally agree; reserving an optional space at the end for comments and suggestions.

Next, the fifth stage consisted of selecting the judges/evaluators to validate the content of the statements contained in the instrument. We adopted the definition of 20 (twenty) participants and this number was determined based on the criteria presented by Alexandre and Coluci[19], who refer to the number of six to twenty experts for participation in content validity processes. The judges/evaluators were recruited based on the criterion of working in the hospital urgency and emergency context in the care of adolescents with suicide attempts. Twenty judges/evaluators were selected from two hospital institutions in southern Brazil, which are references as hospital urgency and emergency gateways in the care of adolescents in suicidal crisis. All judges/evaluators had from 4 to 35 years of professional training. The distribution among the professional categories was: 7 psychologists, 5 physicians (being 3 psychiatrists and 2 pediatricians), 5 nurses, and 3 social workers, totaling 20 (twenty) participants.

The sixth stage was characterized by the quantitative analysis of the answers to the Likert scale through the Percentage Agreement Calculation[19] and by Score Calculation[20]. The percentage of agreement is the simplest measure of interobserver agreement, and when using this method, a significant agreement rate must be considered 90%[19]. The calculation of the Score[20] makes it

possible to identify the direction of the answers of all the judges/assessors for the agreement or disagreement concerning each proposed statement. For this, different weight is determined for each of the alternatives contained in the Likert scale based on the values 1, 2, 3, 4, and 5. Then, the Score Calculation[20] formula is applied to each statement. The final score of each statement is reached from the sum of the values found for each of the five response options on the Likert scale. To interpret the results, a statement is considered to have a "high" agreement score when the value is equal to or higher than 4 (four), and when the value is equal to or lower than 3 (three), it has a "low" agreement score.

The results obtained regarding the agreement rates of the statements from the Percentage Agreement Calculation (12 statements with 100% agreement, 2 with 90%, and 1 statement with 85%) and the Score Calculation (all statements with scores between 4.5 and 5) allowed us to consider that the content of the 15 statements was validated regarding the assessment and management of suicidal behavior in adolescents in hospital emergency setting. Methodological details and results are available for access in SciELO data (https://doi.org/10.48331/scielodata.V2JW9R). Thus, we reached the seventh and last stage of the study, which was the final presentation of the validated guidelines' content for in-hospital care of adolescent suicide attempts. Next, the guidelines are presented in their qualitative and content aspects, as well as the discussion of these guidelines based on the literature.

Results and discussion

According to Chart 1, guidelines 1 to 7 were built from the first category of analysis, with their respective subcategories and thematic units, and refer to the relevant aspects that need to be included in the scope of the evaluation of the adolescent who attempted suicide and is in the hospital setting.

In the first guideline, the execution of emergency actions in the hospital context was pointed out based on the thematic units; first aid and physical and laboratory exams. In this sense, the clinical exam (physical and laboratory) of the patient at the moment of admission is highlighted as decisive in defining the emergency procedures that need to be taken to ensure the patient's clinical stabilization, ruling out possible complications[21,22].

As a second guideline, the promotion of ambiance was highlighted, based on the thematic units; safe physical space and privacy conditions. Ambiance is one of the National Humanization Policy's (PNH, or *Política Nacional de Humanização* in Portuguese) guidelines and comprises not only the physical space, but also the social space, the interpersonal relationships that are aligned with a welcoming, caring, and humane care[23]. Gutierrez[24] emphasizes that welcoming the person who has attempted suicide to hospital care must be done safely, promptly, and with quality to promote patient acceptance and adherence to treatment. Chun *et al.*[21], Margret and Hilt[22], and Kuczynski[25], also point out the safety and privacy conditions of where the adolescent will be evaluated and kept under observation, as well as an approach that includes comprehensiveness and care.

The topic related to the welcoming/communicational approach with the adolescent and their parents/caregivers was highlighted as a third guideline, based on the thematic units of empathy, listening, and absence of judgment. According to Gutierrez[24], reception represents the most important technology in an emergency service, as it enables integral care through active and empathetic listening. In this context, it is essential to avoid judgment and censorship, but to adopt a continent approach based on tranquility, empathy, and resoluteness[25,26]. Botega and Rapeli[6] have also pointed out the importance of trying to establish a bond that allows the patient's trust, especially at this moment when he is fragile and not always willing to collaborate with the interview.

The fourth guideline refers to the conduct of the clinical interview for the assessment of suicidal behavior and points to crucial aspects to be observed as described below.

The first aspect is the lethality of the suicide attempt, which is usually an indication of the intentionality of the act. However, it is necessary to be alert, because children and adolescents can misjudge the lethality of their actions. An adolescent whose suicide attempt had a low lethality may conceal a significant desire for self-injury or suicide[25,27,28]. Suicide planning, according to the stages of suicidality[29], is one of the factors considered when defining a high risk of suicide. The frequency and intensity of suicidal ideation show the degree to which the adolescent is suicidal[21,22,25,28,30].

The history of suicidal/self-mutilation behaviors delimits whether the risk of suicide is

Chart 1. List of guidelines validated with category 1 and subcategories.

Category	Subcategories	Validated guidelines
1. Suicidal behavior assessment in a hospital urgency and emergency context	1.1. Execution of emergency actions	1. It is essential to evaluate the need to implement emergency actions aimed at clinical stabilization in the face of suicidal behavior of adolescents who seek care at emergency hospital admission entrances.
	1.2. Ambience promotion	2. The promotion of the ambiance regarding the guarantee of privacy and safety conditions in the physical space where the adolescent in a suicidal crisis is seen, are aspects to be observed in hospital emergency care in the context of suicide risk assessment.
	1.3. Welcoming/communicational approach with the adolescent and their parents/caregivers	3. Communication skills based on empathy, active listening, and absence of judgment in the relationship with the adolescent and their parents/caregivers, are fundamental conditions for the assessment of suicide attempt and risk.
	1.4. Conducting the clinical interview	4. Assessing suicidal behavior involves conducting a clinical interview with the adolescent and other family members and aims to identify risk factors (current and past suicidal behaviors, awareness of the lethality of the means used, the degree of intentionality and planning of the act, precipitating events, among others) and protective factors (family and peer support, social support, access to mental health treatment, restricted access to lethal means, and others). 5. The classification of the adolescent's suicide risk – low, medium, or high risk – is a key point of the assessment to be carried out in the clinical interview and aims to indicate which intervention plan should be conducted with the adolescent and their parents/caregivers. 7. In the clinical interview, the occurrence of self-mutilation, with or without suicidal intent, must be verified, since this behavior is a suicide attempt predictor, especially in the adolescent population.
	1.5. Application of standardized instruments	6. Suicide risk assessment of adolescents in the context of emergency departments and hospital admissions may include standardized instruments, such as scales and questionnaires, used as auxiliary elements in making this assessment.

Source: Authors (2022).

chronic or more current. Regarding the history of self-harm, the research of Pettit *et al.*[28], Asarnow *et al.*[31] found the importance of assessing and monitoring self-harm regardless of suicidal intent in adolescents, as it is an important predictor of suicide attempts, especially in girls. Chun *et al.*[27] indicate that the existence of signs of self-mutilation should be verified in the clinical examination of the patient, since these signs may be hidden under the patient's clothing. Another important item to be listed in the clinical interview refers to the identification of precipitating events associated with the suicidal crisis. Chun *et al.*[21], Kuczynski[25], Chun *et al.*[27,] and Ginnis *et al.*[32] define precipitating factors as triggers for the suicidal crisis. Bertolote *et al.*[5] define precipitating events as proximal factors that trigger the suicidal crisis and are also called stressors associated with the risk of suicidal behavior.

Obtaining information from family members and people close to them about the life situation of the adolescent who attempted suicide was shown to be an important aspect of measuring the suicide risk, considering that the adolescent frequently minimizes the severity of their symptoms or the intention behind their acts[21,22,26,33]. This fact may be related to the adolescent's fear that reporting suicide risk and self-harm may lead to hospitalization. Identifying risk and protective factors is a key aspect in evaluating suicide attempts and indicates the adolescent's degree of vulnerability. But it is necessary to em-

phasize that none of the isolated factors has the power to provoke or prevent suicidal behavior[5]. Pesce[34] emphasizes that the protective factors can modify the subject's response to risk factors, and they must be analyzed interconnectedly since they are not static entities and change according to the person and their life context. The studies included in the research described many risk factors and few protective factors, as described in Chart 2.

The fifth guideline addresses the need for conducting the clinical interview also with a focus on the risk classification of adolescents in a suicidal crisis. However, Ambrose and Prager[35] consider this classification an imprecise task since suicide risk is not static. Pettit *et al.*[28] emphasize that even when the risk level is considered low, a suicidal crisis can arise and the risk of suicide in some situations can be high. They also advise that healthcare professionals need to be vigilant in monitoring suicide risk during the year following an attempt and consider that the first 3 to 6 months represent the highest risk for a new attempt.

The sixth guideline refers to assessing suicide risk using auxiliary means during the clinical interview by applying standardized instruments. Margret and Hilt[22], Kuczynski[25], Berk and Asarnow[33], King *et al.*[36], and Ambrose and Prager[35] suggest the inclusion of screening instruments to assess suicide risk and support the decision to hospitalize or discharge for outpatient follow-up. There are many internationally validated instruments, but Silva *et al.*[37] point out the need for investment in cross-cultural adaptation and validation of these instruments for use in Brazil, since there is a limitation of psychological assessment instruments in our country specifically directed to suicidal behavior in children and adolescents.

The seventh guideline concerns another aspect to be observed in the clinical interview, which is the presence of self-injury as a risk factor for a suicidal crisis that was advocated by some authors of the included studies[27,28,31,35,38].

According to Chart 3, guidelines 8 to 13 were built on the second analysis category, which was intervention in the face of suicidal behavior in an urgent and emergency hospital setting. This category is comprised of 3 subcategories: preventive approach, use of criteria for hospital admission, and use of criteria for hospital discharge.

The eighth guideline addresses the need to consider care related to suicidal behavior in the hospital emergency setting as an opportunity to implement effective strategies for suicide prevention for those who are at risk of committing it. Several studies have emphasized the importance and possibility of a preventive approach that begins in the emergency setting, offering brief therapeutic interventions that will positively impact treatment adherence and, consequently, suicide prevention[22,26,28,30,32,35,36,38-44]. Among these interventions, the safety plan, family counseling, and co-responsible counter-referral to outpatient mental health services[21,22,26,28,30,32,36,38,39,41-43] stand out.

A relevant aspect of the eighth guideline that will be addressed in more depth in the tenth guideline is the issue of developing a "safety plan" with the adolescent and their parents/caregivers. This type of intervention is highlighted in the eighth guideline, as is the welcoming and guidance of parents/caregivers. Parents and caregivers need individual attention during care because they are often in shock and find it difficult to deal with their adolescent's suicidal crisis; in addition to being part of the context in which the young person lives, they are the people that the adolescent will turn to in other moments of crisis. The articulation of the adolescent's mental health follow-up is another crucial point of the preventive approach, and it is present in the eighth guideline. Health professionals have an ethical commitment to articulate the continuity of care, especially in suicidal crises. This topic is corroborated by other authors, such as Ferreira and Gabarra[45], who reinforce the need for communication with the psychosocial care network and describe ongoing telephone contact with the network points as a means to articulate the outpatient follow-up.

Regarding the ninth guideline, the studies highlighted some options that are applied used in the emergency context of American hospitals as brief therapeutic interventions, such as Counseling Access to Lethal Means (CALM)[39], Family Intervention for Suicide Prevention (FISP) [41], Family-Based Crisis Intervention[32], Teen Option for Change (TOC)[36], Coping, Problem-solving, Enhancing life, and Safety planning (COPES)[46] and several coping strategies that can compose the safety plans[21,22,26,28,30,32]. An Irish study that proposes a specific approach to self-harm behaviors was also found: National Clinical Programme for Assessment and Management of patients presenting to the emergency departments after self-harm[38].

The ninth guideline aims to bring attention to the importance of the multidisciplinary teams' conducts in the management of adolescents in suicidal crisis and their families/caregivers in the

Chart 2. Risk and protection factors according to the studies included.

Risk Factors	Protective Factors
- Previous suicide attempt(s). - Suicide plan in the past 12 months. - Cognitive: hopelessness, impulsivity, dysfunctional style, lack of coping strategies; rigidity of thoughts. - Self-harm practices. - Depressed mood, irritable mood, impulsivity. - Disruptive behavior disorders. - Sleep disorders (especially insomnia). - Substance abuse. - Recent psychiatric hospitalization. - Family history of suicide. - Physical or sexual abuse. - Bullying. - Conflicts with family, peers, and school. - Problems in love relationships. - Antisocial behavior. - Self-identification as lesbian, gay, bisexual, or transgender, for the psychosocial stress. - Religious beliefs. - Recent loss of a patient or family member. - Chronic and/or physical illness. - Access to lethal methods. - Social isolation. - Barriers or unwillingness to seek mental health care. - Little social support.	- Restricted access to lethal means. - Family support. - Peer support. - Social support. - Access to mental health treatment. - Short- and long-term future desires. - Ability to identify triggers for suicidal crisis and adopt coping strategies.

Source: Authors (2022).

context of hospital urgency and emergency. The preventive approach implies an overview of the subject's situation in line with the logic of psychosocial care, in which the expanded clinic (*clínica ampliada* in Portuguese), the welcoming, the incentive to the leading role of patients, and social inclusion are some of the aspects involved[47].

The tenth guideline specifically addresses the issue of developing a safety plan with the adolescent in a suicidal crisis treated in a hospital setting. Chun *et al.*[21] clarify that "safety plans" typically include: a) Identification of warning signs and possible triggers for recurrence of suicidal ideation; b) Coping strategies that the patient can use; c) Healthy activities that can distract from or suppress suicidal thoughts; d) Supports that the patient can seek if the suicidal impulse return; e) Contact information for professional support, including instructions on how and when to call for emergency services; f) Restriction of access to lethal means. This plan is usually first made with the adolescent, who writes the plan on a standard sheet of paper, retaining a copy. Afterward, the plan is worked on with the parents/caregivers, especially regarding the aspects that involve them, such as when they are people that the teenager will signal to ask for help when faced with triggers for the suicidal crisis.

In turn, the eleventh guideline emphasizes the importance of an approach with the parents/caregivers of the adolescent in a suicidal crisis. Gutierrez[24] emphasizes that health professionals should offer support, care, and clarification to family members at this time since they are people who can collaborate in suicide prevention. Babeva *et al.*[41] stress that family involvement aims to increase family support, emphasizing the importance of restricting access to lethal means in the home environment and the need for protective monitoring, empowering parents to support adolescents in using their safety plans, and obtaining a parental commitment to engage in follow-up treatment after discharge.

Regarding the twelfth guideline, the studies pointed to the use of previously established criteria for hospital discharge. Chun *et al.*[27] point out that the decision for "inpatient" vs. "outpatient follow-up" depends on many factors, including

Chart 3. List of guidelines validated with category 2 and subcategories.

Category	Subcategory	Validated guidelines
2. Intervention in the face of suicidal behavior in a hospital urgency and emergency context	2.1. Preventative Approach	8. The assessment and management of suicidal behavior in adolescents in the emergency setting should involve, in addition to clinical stabilization, a preventive approach that implies the implementation of brief therapeutic interventions, such as a safety plan, welcoming and guidance of family members, and articulation of mental health follow-up. 9. Brief therapeutic interventions conducted by a multidisciplinary team with adolescents and their families aim to promote comprehensive care, prevent new suicidal crises, and ensure adherence to mental health treatment. 10. The development of a "safety plan" with the adolescent in a suicidal crisis and their parents/caregivers is one of the interventions to be executed before hospital discharge from the emergency room or in the inpatient unit. This plan implements strategic actions organized in steps to prevent and manage other suicidal crises. 11. Parent/caregiver guidance is an intervention aimed at counseling on restricting access to lethal means, identifying warning signs, protective monitoring, and reducing mental health stigma.
	2.2. Using criteria for hospital admission	14 Admission for hospitalization involves criteria such as the presence of clinical aggravations requiring medical monitoring and treatment; the presence of severe psychiatric condition; high lethality suicide attempt with the clear intent of dying; continued intent to die; severe hopelessness; fragile family and social support network; the inability of the patient and/or family members to engage in the "safety plan"; continued psychomotor agitation, non-adherence to outpatient psychiatric and psychological treatment, need to change psychiatric medication regimen.
	2.3. Use of criteria for hospital discharge	12. The use of criteria for hospital discharge in the emergency room or inpatient setting is necessary for suicide risk management, such as the adolescent's clinical stability; a low suicide risk classification; the presence of protective factors; the patient and family being guided on the mental health treatment proposal and the safety plan. 13. Regarding hospital discharge, health professionals should articulate the follow-up of mental health care provided by a multidisciplinary team, preferably at the Child Psychosocial Care Center (CAPSi, or Centro de Atenção Psicossocial Infantil in Portuguese) and, in its absence, at the Basic Health Unit (UBS, or Unidade Básica de Saúde in Portuguese).

Source: Authors (2022).

a careful assessment of suicide risk and should include consultation with a mental health professional. Betz *et al.*[30] describe the 5 steps for the discharge plan and follow-up in the network that are associated with the execution of the safety plan, psychoeducation for family members, and provision of emergency telephones. The 5 steps are: identify risk factors, identify protective factors, conduct suicide inquiry, determine risk level, perform brief intervention and guidance.

Regarding the thirteenth guideline, it establishes the need to articulate follow-up care after patient discharge. Rothes and Henriques[42] point out that health professionals should promote a chain of care provided by a multidisciplinary team, allowing the integration of pharmacological and psychological therapy. In Brazil, according to the logic of network care advocated by SUS (Unified Health System or *Sistema Único de Saúde* in Portuguese), all points of care are

bound to the principles of the Unified Health System, such as the guarantee of universality, equity, and comprehensiveness of care, humanization of care, and guarantee of implementation of the multidisciplinary care model. Thus, suicidal behavior assessment and management in adolescents seen at hospital urgent care or emergency rooms should be guided by this logic of care. This guideline is also aligned with what is recommended in the National Policy of Child and Youth Mental Health[48], which, among other principles, provides for implicated and co-responsible referral. This principle requires that the referring professional included themself in the referral and take responsibility for the demand, following the case until its new destination. The Psychosocial Care Network (RAPS)[49] exists since 2011 and has been changing over the years but establishes an articulation and integration flow between the network points.

The fourteenth guideline emphasizes the issue of hospitalization criteria, which can be a necessary strategy for the moment of crisis aiming at patient safety. Wolff *et al.*[46] proposed that hospitalization can be an opportunity for interventions focused on improving adolescent coping skills and problem-solving around the factors that led to their hospitalization. It also allows professionals to better evaluate the family's protective capacity and conduct psychoeducation with family members to help them better manage the situation with the adolescent.

The ninth and fifteenth guidelines, according to Chart 4, include the theme of the multidisciplinary hospital team under different aspects, but at the core of these guidelines are the contents related to the promotion of comprehensive care and continuing education. Chart 4 reveals the following results.

The ninth guideline addresses the promotion of integrality of care so that the actions that align with suicide prevention for adolescents seen in the hospital setting must be comprehensive and conducted by a multidisciplinary team. Gutierrez[24] emphasizes that integrality is offered through a network and that professionals need to consider the biopsychosocial aspects of the patient and their families. The National Policy of Child and Youth Mental Health[48] also emphasizes the relevance of permanently building the network and of intersectionality. As previously highlighted, suicidal behavior is multifaceted and a result of a complex interaction of factors[2,3], and cannot be solely understood as an individual issue. In this sense, the approach of a multidisciplinary hospital team articulated with the psychosocial care network and with other social, justice, and child and adolescent protection agencies are compliant with the complexity of the phenomenon.

The fifteenth guideline addresses the need for hospital health team training and qualification based on technical and scientific criteria in their conduct. The studies emphasized that there are scientifically proven interventions for adolescents seeking emergency services who are at risk for suicide. Gutierrez[24] reminds us that permanent education is a strategy for the consolidation of SUS (Unified Health Care, or *Sistema Único de Saúde* in Portuguese), recommending that an in-service education project be carried out in the area of mental health.

Final considerations

The guidelines that were constructed and validated aim to help the emergency hospital teams based on criteria in their conduct, guiding ac-

Chart 4. List of guidelines validated with category 3 and subcategories.

Category	Subcategory	Validated guidelines
3. Multidisciplinary hospital team	3.1. Promotion of care integrality with the patient and family	9. Brief therapeutic interventions conducted by a multidisciplinary team with adolescents and their families aim to promote comprehensive care, prevent new suicidal crises, and ensure adherence to mental health treatment.
	3.2. Continued training	15 Health teams at hospital emergency department and inpatient units should receive training regarding the prevention of suicidal crises in adolescence to avoid ineffective and fragmented actions in the care of the adolescent and their parents/family members.

Source: Authors (2022).

tions of welcoming, assessment, intervention, and referral. In this sense, the proposed guidelines aim to guide and build effective practices when facing an adolescent in a suicidal crisis, since weaknesses were highlighted regarding the assessment and management of suicidality in urgent and emergency hospital settings.

Among the aspects that fragilize the care of these adolescents is the lack of training among teams, generating insecurity and a certain discomfort for health professionals since they are trained to deal with life rather than with people in intense psychic suffering who are placing their existence at risk.

The adolescent and their family need welcoming and qualified action in mental health.

In addition to the role of guiding, the validated guidelines contribute to the prevention of suicide risk in adolescents, because as was revealed in the studies selected in the integrative review, the conduct of the multidisciplinary team in hospital services can be preventative if based on scientifically supported interventions and criteria. Therefore, urgency and emergency services can offer suicide prevention care that effectively saves lives. It is understood that, in this way, the multidisciplinary team at hospital emergencies can perform one of the "indicated" suicide prevention actions recommended by the World Health Organization[50], which is directed to the person who presents a high risk of suicide.

Considering the above, the guidelines developed and validated in this study are considered not only as possible guidelines for the care of adolescents in suicidal crisis seen in the context of hospital urgency and emergency but as guidelines that can promote the prevention of new suicide attempts.

Collaborations

The authors participated in the preparation of the paper from its conception and design, in the analysis and data interpretation, in the writing of the paper and in its critical review, as well as in the approval of the version to be submitted to the journal.

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