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Challenges in hospital care for adolescents in suicidal crisis

Os desafios no cuidado hospitalar ao adolescente em crise suicida

Los retos de la atención hospitalaria a adolescentes en crisis suicida

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Abstract:
Objective: to report the case of an adolescent hospitalized due to a serious suicide attempt and the challenges of psychological care. **Methods:** case report, with a descriptive design, narrative and reflective character, based on the practice of a multidisciplinary resident with a degree in psychology. The records of care in the patient's medical records were analyzed considering the second quarter of 2023, and discussed based on the production on the subject. **Results:** 60 consultations were carried out between the family and the patient, who was 11 years old, hospitalized for three months, after setting himself on fire. The challenges in the care and performance of psychology were structured into four categories: *Assessment of the intentionality and motivation of the act*; *Physical pain vs. psychological pain*; *Assessment of suicide risk*; and *Hospital discharge and articulation with the health network*. **Conclusion:** the adolescent in suicidal crisis requires complex care. It is necessary to assist the family members to welcome, guide and collect information to understand the case and plan care. The coordination with the Psychosocial Care Network for responsible discharge and the training of professionals to address the specificities of suicide in adolescence are essential.
Keywords: Adolescent; Suicide, Attempted; Mental health.

Resumo:
Objetivo: relatar o caso de um adolescente hospitalizado devido a grave tentativa de suicídio e os desafios do atendimento psicológico. **Método:** relato de caso, de delineamento descritivo, caráter narrativo e reflexivo, a partir da prática de uma residente multiprofissional com formação em psicologia. Os registros dos atendimentos no prontuário do paciente foram analisados considerando o segundo trimestre de 2023, e discutidos com base na produção sobre o tema. **Resultados:** foram realizados 60 atendimentos entre família e paciente, que tinha 11 anos, hospitalizado por três meses, após ter ateado fogo ao próprio corpo. Os desafios no cuidado e atuação da psicologia foram estruturados em quatro categorias: Avaliação da intencionalidade e da motivação do ato; Dor física x dor psíquica; Avaliação de risco de suicídio; e Alta hospitalar e articulação com a rede de saúde. **Conclusão:** o adolescente em crise suicida demanda cuidados complexos. É necessário atender os familiares para acolher, orientar e coletar informações para entender o caso e planejar o cuidado. A articulação com a Rede de Atenção Psicossocial para a alta responsável e a capacitação dos profissionais para atender às especificidades do suicídio na adolescência são imprescindíveis.
Palavras-chave: Adolescente; Tentativa de suicídio; Saúde mental.

Resumen:
Objetivo: relatar el caso de un adolescente hospitalizado debido a un grave intento de suicidio y los retos de la atención psicológica. **Método**: relato de un caso, de diseño descriptivo, carácter narrativo y reflexivo, a partir de la práctica de una residente multiprofesional con formación en psicología. Se analizaron los registros de las consultas en el historial del paciente correspondientes al segundo trimestre de 2023 y se discutieron a partir de la bibliografía sobre el tema. **Resultados**: se realizaron 60 consultas entre la familia y el paciente, de 11 años, hospitalizado durante tres meses tras prenderse fuego. Los retos en la atención y la actuación de la psicología se estructuraron en cuatro categorías: *Evaluación de la intencionalidad y la motivación del acto*; *Dolor físico frente a dolor psíquico*; *Evaluación del riesgo de suicidio*; y *Alta hospitalaria y coordinación con la red de salud*. **Conclusión**: el adolescente en crisis suicida requiere cuidados complejos. Es necesario atender a los familiares para acogerlo, orientarlo y recabar información para comprender el caso y planificar los cuidados. Es imprescindible la coordinación con la Red de Atención Psicosocial para el alta responsable y la formación de los profesionales para atender las especificidades del suicidio en la adolescencia.
Palabras clave: Adolescente; Intento de suicidio; Salud mental.

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INTRODUCTION

Suicide is a major public health problem, a complex and multi-causal phenomenon, with individual and collective impact, which can affect individuals of different ages. In Brazil, from 2010 to 2021, suicide represented the 11th leading cause of death among children and adolescents aged 5 to 14, and the third leading cause among adolescents aged 15 to 19[1]. Therefore, there is an increase in the risk of suicide throughout adolescence.

According to the World Health Organization, adolescence comprises the period between 10 and 19 years of age, and is divided into pre-adolescence (10 to 14 years) and adolescence (15 to 19 years). It is a phase of human development that involves several physical, psychological and social changes that can generate developmental stressors[2]. Situations of acute stress can contribute to impulsive attitudes appearing more frequently, which favors the increase in suicidal thoughts and behaviors[3].

Suicidal behavior includes ideation, planning, and attempted suicide. Suicidal ideation includes thoughts about taking one's own life or about being dead. Planning is when a plan is made to carry out suicide. A suicide attempt (SA) is any non-fatal suicidal act. Suicide is an intentional act, initiated and completed by someone who wants to cause their own death by choosing a method that they consider lethal. It is a multifactorial phenomenon in which it is necessary to consider, in addition to biopsychosocial factors, the historical, socio-environmental, cultural, and economic dimension of the subject[4].

In the Mortality Information System (*Sistema de Informação sobre Mortalidade* - SIM) of Brazil, between 2012 and 2021, 6.90% of deaths recorded in the 15 to 19 age group and 3.41% in the 10 to 14 age group were caused by intentional self-harm[1]. The real numbers of suicidal behavior are underestimated. Underreporting involves the difficulty in distinguishing suicides from accidents and incorrect reporting, either due to family denial or vague description of the occurrence[4].

The methods chosen show a predominance of exogenous poisoning (67.1%), followed by sharp objects (17.9%) and hanging (6.6%). Among males, suicide rates are higher and the methods used are potentially more lethal, such as hanging and firearms. Among females, there are more reports of self-inflicted injuries[1].

After SA, the adolescent is usually referred to an emergency service. These places provide care for clinical/surgical needs and support for emotional needs. A suicide risk assessment should also be carried out, an action that will guide the definition of the most appropriate referral for care in the case[5]. The care of a psychologist is essential when dealing with a patient who has attempted suicide. This professional can work in Emergency Care Units

(*Unidade de Pronto Atendimento* - UPA), Emergency Rooms (ERs), Intensive Care Units (ICUs), general wards, among other places.

In a hospital setting, the psychologist is responsible for assessing and monitoring the psychological complications of admitted patients regarding the risk of SA and being aware of the need to request a psychiatric evaluation from the responsible medical team. In general, the psychologist's role involves welcoming, listening, providing care and guidance, and referring patients to mental health services. The psychologist's care also extends to the family, especially when the patient is in a serious health condition and is unable to be initially approached[6].

Although adolescents with suicidal behavior are often admitted to emergency care units, and some of them are referred to general hospitals, there are few publications discussing the management of care in these cases[7], especially when the attempt occurs at an early age.

The relevance of this study is justified by the understanding of the uniqueness of the suicidal act, considering the age at which the attempt occurs and the choice of a suicide method with greater lethality and lower prevalence among adolescents. This study aims to report the case of a teenager hospitalized due to a serious suicide attempt and the challenges of psychological care.

METHODS

Case report, with a descriptive design, narrative and reflective character, resulting from the practice of a resident psychologist in a Multidisciplinary Health Residency Program at a public university. For this study, information was retrieved from the records of psychological and multidisciplinary care contained in the patient's medical records during his hospitalization at a university hospital in the state of Minas Gerais, Brazil. The information obtained was analyzed and organized into categories and discussed based on productions on the theme.

The psychological care was conducted by the resident under the supervision of a preceptor psychologist and involved the following activities: interview and psychological care using playful resources and verbal communication; active and welcoming listening aimed at obtaining information, addressing anxieties and encouraging expression; continuous assessment of suicide risk and mental/emotional state; reception, interview and guidance to accompanying family members; communication with the health team; and implementation of conducts oriented towards responsible discharge.

The treatments were carried out between April 2023 and July 2023. The information was treated so that the patient was not identified, maintaining secrecy and confidentiality. Since this is a case report, consent was obtained from the participant and their guardian, through the

signing of a Free and Informed Consent Form (FICF) by the guardian, accompanied by the signing of a Consent Form by the adolescent.

It was also necessary to obtain written authorization from the heads of the sectors of the hospital where the research was conducted. This case report was assessed by the Research Ethics Committee of the Universidade Federal do Triângulo Mineiro/MG/Brazil and approved under opinion no. 7,357,615 and CAAE 85649124.1.0000.8667.

RESULTS

The 11-year-old patient, originally from a town in the interior of Minas Gerais, was admitted to the Children's Emergency Room (*Pronto Socorro Infantil* - PSI) with severe burns and suspected attempted suicide after setting himself on fire using a flammable substance. He was admitted in serious condition, in anasarca, with significant lip edema, drowsy but somewhat responsive and able to breathe on his own in ambient air. The body surface area burned (BSA) was 27.1%, and he had burned airways. He was placed on orotracheal intubation (OTI) with mechanical ventilation and transferred to the Pediatric Intensive Care Unit (PICU). He remained intubated for twenty-one days, and three days after extubation, a psychological evaluation was requested.

Sixty psychological consultations were carried out, initially with the family and then with the adolescent, after his state of consciousness had improved. During most of the care, the patient was unconscious and the psychological intervention was carried out with the family member who was accompanying him at the time, always in an isolation bed. During the psychological monitoring during his hospitalization, a significant clouding of consciousness was observed due to the sedative and analgesia required for medical treatment.

The family reported that the teenager was playing as usual in the backyard when they heard his screams and realized that he had set himself on fire. At first, the family and the health team were unable to determine whether the act was accidental or intentional, due to the difficulty in communicating with the patient and the ambiguous information that emerged regarding the case.

The patient's family nucleus consisted of his mother, a widow, and his seven siblings. His father had died about two years previously and was elderly, with a significant age gap between the parents. During the consultations with the family, it was reported that the patient had started psychiatric treatment prior to his hospitalization due to the grieving process over the death of his father, after experiencing crying spells, shortness of breath, chest pain, irritability, and reporting visual and auditory hallucinations with content related to his father.

In addition, he presented self-harming behaviors, such as allowing his pet cats to scratch him and hindering the healing of wounds; changes in behavior when upset, such as aggressive speech and a tendency to isolate himself until he calmed down; and a significant increase in food intake, with weight gain. He attended school regularly and had already reported, on more than one occasion, situations of conflict with peers, with the presence of verbal and physical aggression. There was a change in behavior at school, with the presence of behaviors classified as “distracted” and “attention-seeking”. He sought psychological care prior to hospitalization, but, up to the date of the SA, the care had not been provided.

The patient's care was provided based on several variables that permeate the hospital context, including the occurrence of procedures by other professional categories at the time of the visit; the patient's state of consciousness; their objective and subjective availability for psychological care; the occurrence of interruptions in care due to the need for organic health care, among other conditions that interfered with the quantity and quality of psychological care.

When awake and willing, the adolescent described the relationship with his father as permeated by feelings of care, affection, complicity, joy and consideration, expressing how the death of this beloved parental figure was a determining factor in his intense psychological suffering. He reported dreams that he experienced as pleasant, in which he sometimes saw his father's figure.

He spontaneously reported that, after his father's death, he exhibited several risky behaviors, with suicidal intent, including: jumping from a high place, running in front of a moving vehicle, causing self-harm with suicidal intent with a sharp object and, later, intentionally setting himself on fire using a flammable substance. It also expressed content that was symbolically understood as referring to psychological suffering related to feelings of guilt, the traumatic circumstances of the act, and the stressors intrinsic to the treatment context, especially pain during dressing changes and baths.

During his stay in the PICU, the patient presented several complications in his physical health, requiring monitoring, mechanical ventilation, drug therapy, and procedures and surgeries that were experienced as invasive and painful.

When his physical condition no longer required intensive care, he was transferred to the pediatric ward. During some consultations, despite being awake, he appeared unwell. It was also noted that, as the patient became more conscious, when issues related to the expression of feelings and thoughts were addressed, he adopted a change in posture, becoming less receptive and less communicative. Affective blunting, hypothymic mood, and apathy were also observed during hospitalization.

During the consultations, it was possible to identify, based on the discursive elements, distorted perceptions of reality, with persecutory content, which it is not clear whether they can be better explained by the effect of post-traumatic symptoms or by delusional ideas due to a previous mental disorder. He reported the content of a visual hallucination with the presence of his father's figure and a figure he named "Splinter". He reported that he had been seeing these figures since his father's death, and mentioned that they had ordered him to set himself on fire so that he could die and be with his father again. He reported that, in other attempts at self-extermination, prior to the episode with fire, he had also heard commands received through hallucinations.

After his physical condition improved, the medical team decided to transfer him to his hometown, to a hospital, given the complexity of the dressings that were still needed. Case discussions were held as a team; family conferences were held during hospitalization; and contact was made with the health network that would receive the adolescent after discharge from the university hospital. The patient had scars with a tendency to hypertrophy and scar retraction on the neck.

In the discharge instructions regarding the conduct of the Psychology specialty, the need for continuous monitoring of the adolescent and his psycho-emotional state was reinforced; as well as to maintain frequent psychological and psychiatric follow-ups; and the importance of attending medical outpatient follow-ups. In addition, family members were asked to contact the patient by phone to monitor the patient.

The patient's clinical psychological follow-up was being carried out in his hometown. Considering the specificity of the demand, the comprehensive care for his health within the scope of hospital follow-up, the need for adequate counter-referral and the possibility of readmission to the high-complexity hospital institution due to possible complications and the need to perform future procedures, it was decided to maintain the therapeutic bond with the patient and his family after hospital discharge. Therefore, the family was asked to inform the resident psychologist when the patient was present at the outpatient clinic, so that an approach could be carried out by the psychology specialty prior to the medical appointment.

During the psychological follow-up, during telephone calls and meetings while waiting for outpatient medical appointments, it was possible to follow the following chronology related to mental health care after discharge from the high-complexity hospital: hospitalization in the city of origin and beginning of psychological and psychiatric care, but without adequate connection; discharge from the hospital in the city of origin; return to hospitalization in the city of origin after a suspicion of suicide planning; consideration of the possibility of psychiatric

hospitalization in a specialized mental health institution in a distant city, which was rejected by the family; coordination with the network and implementation of care at the Psychosocial Care Center (*Centro de Atenção Psicossocial* - CAPS) in the reference city for mental health in the city of origin, which is closest to the family's residence.

Challenges were identified in the psychologist's intervention path, which were categorized as: *Assessment of the intentionality and motivation of the act*; *Physical pain vs. psychological pain*; *Assessment of suicide risk*; and *Hospital discharge and coordination with the health network*.

DISCUSSION

Assessment of the intentionality and motivation of the act

When a person is admitted to the hospital or emergency room due to trauma, injury or poisoning, the physician must be able to indicate whether the injury was self-inflicted, intentional or accidental[8]. Self-injurious behavior refers to the intentional aggression of one's own body with non-fatal results, without suicidal intent and without social validation[4]. It is a way of demonstrating suffering and relieving it momentarily.

Self-injury without suicidal intent (SWSI) can result in death, making it difficult to distinguish it from suicidal behavior. It is a risk factor for suicide, but does not necessarily indicate suicidal ideation[9]. Suicidal intentionality is related to the desire and determination to end one's life. Its severity is determined according to the intensity of the suicidal motivation and how much this motivation is balanced by the ambivalent desire to continue living. In determining intentionality, the belief that the chosen method will achieve suicide is more relevant than objective lethality[3].

The more detailed and frequent the suicidal ideation, the greater the risks. The more detailed the suicide plan, the greater the severity of the ideation. Verifying whether the attempt was planned or impulsive, understanding the lethality of the methods and their complexity is essential to assess the risk of a new attempt and to understand the reasons that led the subject to the act[4].

The intention to kill involved in self-harm can be difficult to assess in some situations, such as when the person is unable to communicate or refuses to talk about it, as was the case with the adolescent referred to in this study, initially. In this situation, the assessment of intentionality took into account the reports of family members.

Initially, both family members and the health team had difficulty determining whether the suicidal act was intentional. There was doubt as to whether the adolescent had attempted

suicide and whether he had resorted to a method that was so lethal and so rarely used among adolescents. Furthermore, while he was being taken to the hospital, he gave different versions of the motivation for the act, sometimes saying it was an accident, sometimes it was intentional. The suspicion that it was an intentional act, however, always existed.

During the consultations, he confirmed, through verbal reports, the intention of the act, revealing that he had made previous suicide attempts and that, since his father's death, he had seen (hallucinatory) figures who ordered such actions. In addition, the family reported situations of conflicts with peers at school, including suspected physical violence, one of these episodes a few days before the SA that hospitalized him. These psychosocial factors refer to a life context permeated by aggression, which may be related to this attempt with an impulsive characteristic and a potentially lethal method.

Physical pain vs. psychological pain

During hospitalization, the patient was sometimes unconscious or unwell, and psychological intervention was performed with the family member who accompanied him. The more conscious he became, the greater the emotional dullness and the less receptive he was to care. If, on the one hand, sedation was necessary to maintain his life, alleviating the physical pain resulting from the after-effects of the treatment attempt and procedures, on the other hand, everyone knew that, in addition to physical pain, there was also a subject with intense psychological suffering.

At times when the patient was awake and unwilling to receive care, the perspective was that the hospital psychologist also had to witness the patient's pain, which facilitated the process of processing the suffering and producing meaning related to situations that are generally traumatic. The person who suffers uses the psychologist as a witness to their physical and psychological pain, and this testimony helps to ensure that the illness, often unexpected, does not become a simply passive situation that makes it difficult to process it[10].

Pain is considered a human defense process that indicates that something is not right. Although this alert situation is positive, its effect is sometimes negative, as it implies physical and psychological suffering. Physically, pain is localized in the body and attributed to some injury. Normally, it is a symptom of another problem that can lead to a diagnosis and treatment. Even if the injury is the same, the pain threshold is different from one individual to another. Pain is perceived differently depending on the severity of the injury and cultural, social, environmental and, mainly, emotional factors[11].

Psychological pain was differentiated from physical pain, and was named psychache by Shneidman[12]. It is an emotional state of intolerable pain associated with feelings experienced

as unpleasant, such as sadness, guilt, anguish, fear, anger, despair, loneliness, shame and loss. Those who suffer from psychological pain may be distant or incommunicable from the pleasures of life. Such suffering generates a state of psychological precariousness that threatens the constitution of identity and imposes the fragmentation of oneself, which can lead the subject to rupture, experiencing the end of his/her existence[12].

Suicidal behavior demonstrates psychological suffering in which the individual finds no alternatives to overcome the pain. The presence of this phenomenon indicates that basic psychological needs have not been met, such as: comfort, security, autonomy, affiliation and tendency to avoid shame. It can also arise from the rupture of important interpersonal relationships and be related to difficulties in dealing with suffering, anger and hostility. In their treatment, people who exhibit suicidal behavior should be cared for with an emphasis on identifying unmet needs, aiming to reduce psychological pain and, therefore, prevent suicide. The psychologist should collaborate with the patient to find ways to deal with psychological pain[12].

Over the course of the treatments, it became evident that the patient was and remained in intense psychological suffering. Suicidal crises are the most acute moment in which there is greater risk and lethality, generally occurring in short intervals, such as hours or days. In terms of management, at the time of the crisis it is important that the subject has access to services and health professionals trained to act in such a way, with a view to carrying out the appropriate interventions, considering the complexity of each case, reducing the chances of the attempt being carried out[3].

Crisis intervention, aiming to achieve greater benefits in the therapeutic process, is aimed at protecting life, reducing risks/sequelae and helping the subject to return to balance. Although there is the possibility of using different approaches and techniques, the multidisciplinary approach should preferably be chosen, making it possible to share responsibilities and knowledge.

Depending on the assessed risk, the conduct may vary, from calling emergency services; involving the family; sharing confidentiality in an ethical manner and justified by the best interests of the person being treated; to carrying out classic outpatient monitoring[3]. During the psychological monitoring of the patient, crisis intervention was carried out using a multidisciplinary approach, family involvement and coordination with the network.

Assessment of suicide risk

Suicidal behaviors are complex and multi-determined and result from a balance between risk factors and protective factors. In order to make a clinical decision, the risk factors

associated with suicidal behavior must be identified, as well as possible diagnoses of underlying mental disorders and the risk of death. There are often several risk factors that act cumulatively and increase a person's vulnerability to suicidal behavior[4].

The need to assess and formulate suicide risk is provided for in the Multidisciplinary Protocol for Suicide Risk Prevention of the hospital where the patient was admitted, which directs the actions of the professionals involved. It indicates that formulating suicide risk is the physician's responsibility. The psychologist should assess and monitor patients regarding the risk of suicide, especially when the team signals the suspicion of this risk[13]. From the beginning of the care until the moment of discharge, the psychologists responsible for the case were concerned about assessing the intentionality of the act and the risk of suicide before, during and after hospitalization.

Suicide risk assessment involves a careful, sincere and respectful clinical interview through direct questions. How the professional feels about the subject influences the way they will interact with the person and even the understanding of clinical reasoning. Therefore, personal and technical preparation is important for an adequate assessment, which will guide the clinical management of the case. This assessment involves technical knowledge about suicidal behavior (risk and protective factors), psychological assessment techniques, crisis intervention techniques and personal preparation through supervision[3].

The risk factors for suicide are: gender (more frequent in males); life history (loss, trauma, physical/sexual/psychological abuse, neglect), severe psychological distress or history in the family; low tolerance to frustration and ambivalence; alcohol and/or substance abuse; job loss and financial problems; loneliness and hopelessness; access to lethal means[6].

A history of SA and a family history of suicide are considered important risk factors, in addition to the presence of some mental or personality disorder. Protective factors are: individual characteristics such as social skills, self-esteem and spirituality; family support (secure bonds, appropriate parenting practices - limits, communication, protection) and social support from friends and school[6].

Based on the criteria presented, it is assessed that the adolescent being treated is male, his life story includes mourning for a much-loved father, he has a brother diagnosed with schizophrenia and, after the loss of his father, he began to present mental, behavioral, affective-emotional and psychosomatic manifestations that were understood as signs and symptoms of intense psychological distress: crying fits, shortness of breath, chest pain, irritable mood, self-harming behavior, isolation, visual and auditory hallucinations, and weight gain, among others.

The patient had little social, academic and peer support. There was a change in behavior at school, with aggressive speech and increased distraction. Despite the great grief felt by all, the family tried to support him and do what they felt was necessary: they sought health care (psychiatry and psychology, the latter not provided), and contacted the school to inform them about the violence the adolescent suffered from his peers and to try to reduce its occurrence, however the aggressions persisted.

It is essential to recognize the warning signs that correspond to the risk of suicide in adolescence: distancing from friends and family, decreased or loss of interest in activities previously enjoyed, changes in personality or habits, change in sleep patterns, interest in death, hopelessness and self-deprecating comments[3].

Before, during and after hospitalization, the risk of suicide was considered high. Surveillance, difficulty moving and limited access to potentially lethal means were interpreted as making it difficult to carry out other attempts during hospitalization, since he was accompanied by a family member or a member of the team almost all the time, and the medications were always administered by a professional.

Psychiatric consultation was requested several times and psychological care was provided on an ongoing basis. In discussions with the team, the patient's severe psychological distress was evident to everyone, although most professionals knew little about what to do with this distress. The patient's distress was reflected in the professionals' subjectivity, generating psychological distress that triggered coping mechanisms and defensive processes in different ways for each person, which in turn influenced the conduct they took.

In general hospitals, the work process often takes place on a shift basis. It is common for a patient to be seen by a different professional from the same category (nursing technician, physical therapist, doctor, psychiatrist, and others) each day. Thus, the service delivery model imposes challenges related to possible divergences in conduct due to the individual assessment of each professional, and in the process of bonding with the patient and their family members. Regarding the psychology team, the same professionals were always responsible for the follow-up, with the care provided by the resident and supervised by the supervising psychologist.

Due to the particularities of the case, regarding the limited supply of specialized health services in the city of origin, the family's lack of objective and subjective resources to support the patient's physical and psychological care needs, and the unfavorable assessment regarding the risk of suicide, among other factors, the team was very concerned about how post-discharge care would be provided.

At this point, the need for continuous monitoring of the adolescent and his psycho-emotional state was reinforced, the need for frequent psychological and psychiatric follow-ups, and the need to attend medical outpatient follow-ups. In addition, the family members were asked to contact the patient by phone until confirmation that the demand for mental health care was met by the health network in the city of origin.

Hospital discharge and coordination with the health network

The Clinical Protocol for Responsible Discharge of Pediatric Patients of the hospital where the patient was hospitalized provides that the organization of hospital discharge in a responsible manner involves planning and transferring care from one health unit to another, or to the patient's home, in order to provide continuity of care through coordination with other service delivery points of the Health Care Networks. Another principle of responsible discharge concerns providing guidance to the patient and their family members with a view to promoting self-care[13].

In the team discussions, it was possible to perceive the difficulty in defining, in the context of the conduct inherent to each professional category, effective strategies to ensure a safe discharge. On the one hand, discharge was already considered possible, and even necessary, considering that at that time the patient no longer presented organic health needs corresponding to the level of complexity of the hospital. On the other hand, the psychological, social and emotional needs of the patient and his family group at that time could not be disregarded in defining discharge. It was clear that, although the organic state was stable, the psychological state was not.

The suicide risk assessment indicated that the risk of a new attempt was high. There was also concern that the patient's comprehensive care needs, which involved treatments from various specialties, such as physical therapy, psychology, occupational therapy and psychiatry, in addition to coordination with primary care, might not be met by the health care network in the city where he lived. The proposed alternative was to maintain psychological care in his hometown while, at the same time, the patient would remain hospitalized in a hospital in his city for dressings and management of the risk of suicide, given the monitoring he would be subject to, and would also attend follow-up appointments for medical care at the university hospital's outpatient clinic with the specialties of psychiatry and plastic surgery.

Despite the fact that the patient was referred for care at the Child and Adolescent Psychosocial Care Center (*Centro de Atenção Psicossocial Infanto-Juvenil* - CAPSi), the question remained: *How could this be done, since the patient did not live in the city where he received the most complex care, and there was no CAPSi facility in his hometown?*

Although contact had been made with the health network that would receive the adolescent, the arrangement for him to be treated in the most appropriate model, in which the specialties of psychology, psychiatry and other mental health services would be integrated in the same service, as is the case with the CAPSi, could only occur if this institution were available in the area, since, given the simultaneous need for organic care, it was not possible, at that time, for the patient to travel frequently for care in another location.

Networking should be based on the broader concept of health that guides the mental health care network, so that attention to the psychological distress of all users is important, regardless of the existence of a formal nosological diagnosis[5].

The integration of the various sectors of the territory plays a central role in care, since community health promotion actions require intersectoral coordination to be effective. Care strategies focused on suicide can function as mechanisms to integrate the actions of mental health professionals, allowing them to share responsibility for monitoring individuals with suicidal ideation[5]. It is therefore important that the various services in the network communicate throughout the process of constructing the patient's health care.

CONCLUSION

Adolescents hospitalized for suicide in a general university hospital require complex care from the team and their families, and family members need to be supported to provide help, strength, guide, and gather important information to understand the case and plan care.

To address the specificity of suicide in childhood and adolescence, the work of trained professionals is essential, as well as coordination with the Psychosocial Care Network.

The limitations of this study were related to the difficulty in finding up-to-date productions, especially regarding the assessment of suicide risk in the age group corresponding to childhood and adolescence in the context of the Brazilian reality. In addition, given the complexity of the phenomenon and the intersection of the subjectivity of the people treated, the trends observed in the case discussed cannot be generalized to other contexts.

Considering the limitations and contributions of the study, it is concluded that further research on the topic is necessary to broaden the debate on the topic of suicide in childhood and adolescence.

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