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Discourses about mental health demands of young offenders serving detention measure in juvenile correctional centers in Rio de Janeiro, Brazil

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Abstract *This paper aims to analyze the discursive conceptions of what is considered mental health demand of young offenders serving detention measure in juvenile correctional centers in Rio de Janeiro. Nine interviews were conducted with the mental health professionals of these centers, and the results were discussed with the support of Fairclough's critical discourse analysis. Four discursive groups were identified: the first shows intertextuality with the psychiatric discourse; the second, with the Psychiatric Reform; the third, with the discourse of social determinants; and the fourth, with institutional discourses about adolescents' misbehavior. It is concluded that the conceptions are different among the professionals, but there is no single predominant discourse. The statements are related and especially linked through the discussion of social determinants. Health professionals and social workers as demand vocalizers are overvalued. Adolescents are barely given the opportunity of directly exposing their needs, and demands are mediated by technicians. We identified conflicts between staff members working in the care flow concerning the misbehavior-associated demands because some referrals are unrelated to mental health issues.*

Key words *Mental health, Adolescent, Institutionalized, Health of institutionalized adolescents*

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Introduction

Mental health problems affect 12% to 24.6% of Brazilian children and adolescents[1], thus are not a rare phenomenon. Recurrent diagnoses of disorders are found among adolescents in conflict with the law – in some studies, reaching almost 100% among inmates[2].

The Child and Adolescent Statute provides for the application of socio-educational measures to adolescent offenders, including confinement in an educational establishment[3]. The General Department of Socio-Educational Actions (Degase) manages the socio-educational system of Rio de Janeiro and is responsible for all inpatient units in the state.

The National Policy for Comprehensive Health Care for Adolescents in Conflict with the Law on Detention and Provisional Detention (PNAISARI) focuses on adolescents serving detention measures. It proposes that the primary care team of the territory that is a reference for the socio-educational unit make the articulation with the network services[4].

In Degase, the Coordination of Comprehensive Health and Social Reintegration (CSIRS) coordinates the implementation of PNAISARI in socio-educational units. In this arrangement, mental health teams are planned for all hospitalization units, and they should develop disease prevention, subjective listening, and articulation actions with the mental health network[5]. However, hospitalization units face several difficulties, especially related to overcrowding. Such inadequate operating conditions have been denounced by the press[6] and rights advocacy entities[7].

This paper aims to analyze the perspective of mental health professionals working in the Rio de Janeiro socio-educational system on the mental health demands of adolescents. Thus, demands are distinguished from needs, which are individual and vary by social class and territory, among other aspects[8]. Demands exist for specific health "offerings". Health needs may not always be solved through the provision of services or reflected in what is provided[9].

We seek to understand how the recognition of what is a mental health demand of these adolescents that can be identified, directed, and met by the teams of hospitalization units is discursively built.

Methods

Rio de Janeiro's socio-educational system has six hospitalization units. The research subjects were professionals from the mental health teams of two units (one male and one female) and the CSIRS team. Nine semi-structured interviews were conducted[10] between July and August 2016, all individually and thoroughly, gathering four psychologists, two social workers, one psychiatrist, one music therapist and one occupational therapist. The research was approved by the Ethics Committee of the National School of Public Health under Opinion 1.630.187.

The interview script covered topics such as organization and attributions of mental health teams, main demands, and the way they are met, articulation with health care networks, difficulties, and proposals for improvement. The interviews varied widely, lasting 16 minutes (shortest) to 150 minutes (longest). Mean duration was 47 minutes, but most lasted up to 50 minutes.

Critical Discourse Analysis (CDA) was the method employed in this study. Fairclough[11] believes that discourse is a way of acting and representing the world. The discourse has three effects, as follows: it contributes to the construction of social identities, influences the construction of social relationships between people, and affects the construction of "knowledge and belief systems".

Fairclough[11] proposes a three-dimensional framework as a reference for this analysis. The first dimension is the textual analysis of discourse, considering four items: vocabulary, grammar, cohesion, and textual structure. In the second dimension, called discursive practice, the relationship between discourse and social structure is identified. In this aspect, an analysis of how texts (as discursive productions) are produced, interpreted, distributed, and consumed is proposed. This dimension includes a reflection on the coherence of discourse and the social action performed. Intertextualities (dialogues with other texts) and interdiscursivities are also analyzed. The third and last dimension provides for the discourse analysis as social practice, which considers the identification of power relations and ideologies.

The results were analyzed by themes, and textual elements of cohesion and grammar, as well as methods of constructing social reality by the respondents and the social groups they represent, were discussed and highlighted in each.

We analyzed the use of resources as modality (terms that indicate the degree of implica-

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tion with the statements made), interdiscursivity, word lexicalization (multiple meanings of a word), word creation, nominalization (textual resources of transformation of a temporary condition into a property; processes in objects or things), metaphors, use of negations and presuppositions, irony and terms with a meaning of politeness[11].

Results and discussion

The illustrative context: the mental health and measure teams

During the interviews, it was possible to understand the presence of internal flow in the units for the referrals of adolescents to care by mental health teams, which denotes some power imbalances to identify and prioritize the demands.

Each unit has a measure team, with a psychologist, a pedagogue and a social worker, responsible for monitoring the court proceedings and preparing reports for the hearings. This team contacts all adolescents and is primarily responsible for referring them to mental health teams.

The mental health teams are responsible for the care of individuals and families, for the realization of groups and articulation with the health care network of the territory. They are staffed with professionals such as psychologists, occupational therapists, social workers, and music therapists. Psychiatrists are also available, but they are not part of a team.

Conception of mental health demands

"So this is biochemistry": intertextuality manifests with psychiatric discourse

The first discursive block evidenced strong intertextuality with psychiatric discourse and is characterized by associating the demands of mental health to brain biochemical changes during adolescence.

The construction of the arguments of this discourse begins with an explanation of what adolescence means from the "physical and the biological viewpoint".

In adolescence, we have another phenomenon, which is neuronal pruning [...]. *This phenomenon of neuronal pruning causes neurotransmitters to* float*, just float*. (Interview 2)

Although full of technical lexicons, the meaning of the wording is completed with expressions of the daily world ("floating"), as found in other studies on scientific discourses for didactic purposes[12].

Reiterating the pedagogical tone, in a scheme of questions and answers, the relationship between biological explanation and mental health demands is shown, reinforcing its cohesion (the use of the adverb "so", affirming the idea of conclusion):

So *what is this floating of neurotransmitters? It's mood swings.* So *it is common in adolescents.* [...]. So *what is the main problem? Mood swings.* (Interview 2)

Mood swings are therefore defined as biological, natural to the brain development process. Such changes cause adolescents to seek balance to stabilize the mood, and so they look for ways to produce "endorphins and adrenaline". Despite some criticism of its pillars, the neurotransmission theory is often adopted as a causal explanation for mental health issues identified in children and adolescents[13].

So that's why they say, he doesn't reason: biological vulnerability. (Interview 2)

In this short excerpt, we observe the invocation of the perception of common sense (the adolescent is not able to reason, because he acts moved by emotions), with the use of the undetermined subject in the verb "to speak". Then, the term "biological vulnerability" is introduced, reviving this circulating concept in the field of collective health to understand health-disease phenomena. This moment witnesses a rapprochement between the discourse of psychiatry, common sense, and the discourse of collective health.

Besides mood swings, attention deficit, hyperactivity, post-hospitalization depressive conditions, and post-traumatic stress disorder are also highlighted. However, for this second group of demands, there is not the same concern in contextualizing the origin of the issues at hand. The statements are instructive. Biological psychiatry is characterized as a powerful control device because it is comprehensive and global. Interventions, especially pharmacological ones, are no longer focused on people with mental disorders, but especially those "normal" with problems such as insomnia, sadness, pain[14,15].

While, on the one hand, the explanation of psychiatric anchoring does not distinguish the social origin, includes all adolescents under the same pattern of "biological vulnerability", and understands that such conditions are exacerbated by the lack of social opportunities and family "supervision".

Situations of vulnerability are relational rather than static, and their understanding requires that the perspective overcome the individual aspect of suffering and reach the associated social reality[16]. In a survey conducted with CAPSi teams, the understanding of the disorder as transient was considered representative and may evidence ups and downs, which hinders a static classification of a demand as severe or non-severe, as well as the definition of decontextualized and definitive diagnoses[17].

The "demands of suffering": intertextuality with the psychiatric reform discourse

References to the psychiatric reform discourse were identified at various times, even stated among those with no education in mental health (social workers). The demands of mental health are conceived in two ways: either by denying the diagnosis of the disorder, but acknowledging intense mental suffering or by the set of complaints. Care is taken not to label adolescents, nor define them from a pathology, overcoming the stigmas of mental illness. The statements echo the principles of the psychiatric reform movement in Brazil[18,19].

Some grammatical features are common in this discourse model, such as the use of modalizations.

When she is referred by the measuring team because they observe a certain psychic suffering*, a* situation *of anguish* [...] (Interview 4)

[...] *Another common* complaint *they have is insomnia. Insomnia, for several reasons, one because one is in an* adverse *situation, right* [...] (Interview 4)

In the first passage, the words "a certain" and "situation" attenuate the meaning of what is introduced shortly thereafter, as well as the term "adverse" in the second passage. We highlight the use of the words "complaint" and "suffering", which replace the use of other terms such as pathology and disease[18,19].

Psychic suffering is one of the criteria for the team to structure care and interventions. Suffering is a counterpoint to the delimited proposals of diagnosis, which tend to the reductionism of the disease that "speaks for itself" without contextualizing the demands of each adolescent. Another research with CAPSi professionals points out that they favor the issue of suffering, considering that young people with no delimited clinical condition but with fragile family and social situations can be seen as more severe cases compared to others[17].

Elsewhere, it is expressly stated that adolescents should not be diagnosed:

I don't work with pathology, you see, because I no longer believed it [...]*; I started to reject any kind of 'ah, he's bipolar', that doesn't matter to me* [...] (Interview 7)

But we cannot diagnose some disorders [...], *right, they are adolescent, they are still developing* [...] (Interview 3)

In the first citation, the subject "I" indicates authorship. The way the respondent stands shows confidence in the personal decision not to make diagnoses. In the second, there is a distinct sense of order, as if there were an orientation that no diagnosis be made. In the latter, the subject is "us", collective, indicating a possible common and consensual practice.

In the representative statements of this group of discourses, demands related to insomnia, drug use, suffering, anguish, anxiety are highlighted. This perception is consistent with a research in the Federal District in 35 medical records of adolescent psychotropic drug users of an inpatient unit that pointed insomnia, drug abuse, suicidal ideation, self-mutilation, and depression, in this order[2], as the primary mental health demands.

The broader conception of what would be mental health demand is shown below:

So it would be the boys who are in a time of crisis. What ... are we talking about a crisis? Very broad indeed [...]*, so, there is no* super *specific criterion, right* [...] (Interview 8)

It is often one of these issues - the boy *is at a very high level of distress for some reason, and among these reasons, the most common are first-time inpatient boys; it is widespread for them to be very mobilized, and that is good, right,* [...] *because this is not a nice little place where you will be happy, ok, no adolescent whatsoever*. (Interview 8)

The first passage draws attention to the opposition between having and not having a criterion to define what mental health crisis means. The word "super" gives an idea of irony when referring to the specificity of the crisis classification criterion.

In the second citation, there is a difference in the use of the term "boys", referring to adolescents who are serving socio-educational measures, and the term "adolescent" to refer to the general population. This last statement introduces a new element, in which the respondent recognizes that the suffering of adolescents when they go to the hospitalization units, is a sign of health since apathy would be viewed with strangeness. This new element represents a discontinuity in discourse.

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"These boys live without supervision", "they have no condition to live the world they live in": intertextuality with the discourse of social determinants

It is possible to identify explanations of the mental health demands associated with the socioeconomic conditions in which the adolescents lived before arriving at the unit. This statement appears related to the previous ones.

The "natural" issues of mental health in adolescence highlighted by the discursive reference of psychiatry are related to the poverty situation of adolescents, as well as the lack of family supervision and the absence of social protection through public policies. This association is not new in the literature. Lugon[13] argues that the diagnosis as a process includes, besides the biological dimension, a perspective on the adolescent's context, considering that other subjective and micro/macro-political aspects are interrelated with brain development at this stage of life.

Underlined terms are used to characterize the social condition of poor adolescents: "abandonment", "unsupervised", "poor" supervision. In the construction of the argument, these elements of instability point to the conclusion that "adolescent alone will not survive" - an expression repeatedly emphasized in the third passage.

So that is why our concern is with abandonment*, abandonment of* both health and public policies [...]*, of institutions*. (Interview 2)

But these boys live unsupervised*. Or with inadequate supervision of unaware grandparents* [...] (Interview 2)

Adolescent alone will not survive*, will not survive; he cannot survive. There is no way one can survive*. (Interview 2)

It is interesting to highlight the critical content emphasis given to the state's "abandonment" (of "health" and "public policies"), embodied in the lack of public policies. Wacquant[20] also notes this disparity in the United States with the reduction of Welfare State social protection policies and increased penal policies. The state broadens its capacity also to punish and imprison poor adolescents, the primary target audience for detention measures, reaffirming the criminalization of poverty.

Highlighted sentences have several verbs in the present tense and are categorical, characterizing a determinism in the associations made between poverty, lack of supervision, abandonment, and the adolescent's entry into the socio-educational system. The use of connectives such as "so" also reinforces the idea of conclusion and causality. In this way, the adolescents experience, on the one hand, the changes in the brain that are characteristic of the adolescent phase, and, if exposed to abandonment, in many ways, as a logical consequence, they end up going to the socio-educational system because they do not have the ideal apparatus required to cope with mood swings and "emotions".

This type of discourse may bring to light the idea that there is only one possible path for a specific group of adolescents with predetermined characteristics, which involves introduction into the socio-educational system as a very likely destination.

Among statements in which discourse with strong intertextuality predominates over the ideals of psychiatric reform, the vulnerability of the families of adolescents assisted by mental health teams is mentioned:

It's something, or, for absolutely complicated family stories*, which is almost one ...* that's something that everyone has*. I would say* that the absolute minority *will have an organized family and stuff, right, a* linear *family history*. (Interview 8)

We also do family care. It is not just a physical issue, sometimes it's about distance, the economic issue, sometimes it's about having a hard time coming, sometimes because of the distance, or because of the poor economic situation, but also of the relationship, yes, from families. (Interview 4)

The families of adolescents are described as fragile and unstructured, contributing to the aggravation of their suffering when they enter the hospitalization units. In the first quote, the term "absolutely" emphasizes and gives certainty to the phrase "complicated family stories". The term "absolute minority" is also used for the same purpose. The sentence "which is something everyone has" also reinforces certainty about "complicated" families. The expression "linear history" has a moral connotation and is the idealization of a type of family.

In the second highlighted passage, the respondent argues that the relationship of families is the main difficulty, more critical than the "economic issue". Denials are used to reaffirm that the relationship is the big issue – "it's not just a physical issue", "it's not just (...) an economic issue".

Respondents' reports are based on a large number of cases treated over time. The association between poverty, broken families, and the existence of mental health demands appears in the statements. This type of discourse is anchored in the empirical knowledge of the young people assisted; however, it seems that the determinism

of such associations leads to the blaming of families and the acquittal of the State of protection responsibilities.

This pre-deterministic view about socioeconomic conditions is analyzed by a study that points to the risk of a prejudiced attitude towards suburban populations, which would be "doomed" to an immutable and static situation[16].

Wacquant[20] demonstrates the selectivity of the justice system, which directs mass containment and imprisonment to the "problematic" poor. Thus, low-income families become the focus while being increasingly affected by the reduction of public social security policies. Based on Wacquant's concepts, Birman[21] points out that low-income families feel responsible for their suffering, making the state not responsible for their living conditions.

Bad behavior, troubled adolescents

A discursive block that associates disciplinary problems with mental health demands was identified in two interviews. Adolescents are referred to the teams for misbehaving.

This type of demand is disciplinary, and the team eventually responds to try to find a way to help with the internal conflicts generated at the unit.

[...] *the crisis is not necessarily the boy's; sometimes it is the* team that has many difficulties *servicing that adolescent* (Interview 8)

I think there are cases of first hospitalization, or of back and forth, back and forth, back and forth cases*, even institutionalization, boy who exits and enters in all the time, that* the team no longer knows what to do*; so it is a bet that perhaps an in-depth, closer listening can have some effect*. (Interview 8)

Well... Anyway, I think what comes up most *is boys who give trouble. Then you will see, according to whom do they give trouble?* (Interview 7)

In a full house, it's easy for a boy to give trouble, you see. What is giving trouble? What is giving trouble in an overcrowded unit? It is taking peace away from *employees* [...] (Interview 7)

In these excerpts, what can be noticed is that the demand directed to the mental health team portrays the need of other employees of the socio-educational unit to find some solution for adolescents with whom they have difficulty dealing or controlling.

Some textual elements are used for different emphases. In the first and second passages, we perceived the use of terms such as "necessarily" (preceded by a denial), "sometimes", "maybe", "some", in order to soften the presuppositions that point the internal teams of the units as responsible for defining the troublesome adolescents and should, therefore, be referred.

In the second and third passages, the respondents make explicit that the statements are personal, that is, the subject "I" and the use of the verb "believe" show that their analysis is not necessarily a shared opinion.

In the second citation, the repetition expression "go back and forth" emphasizes that the respondent refers to adolescents who have already fulfilled other measures. In the third citation, terms such as "what comes up most" are used, also to emphasize and show the relevance of referring "boys who give trouble".

Noteworthy is the expression "taking peace away" from employees in the last section. In this case, a lexicalization feature is used with the creation of new uses for the words most commonly used in other meanings[11].

Part of the identity construction of "problematic", which transcends undisciplined behavior, is shown in a statement that points to cases in which adolescents themselves get injured in order to be assisted by mental health teams.

[...] *Well, now the thing is setting oneself on fire to be treated, right* [...]. *You know, so ...* this is a public health problem*, it's* a mental health problem*, in a very different meaning from what people can imagine, you see*. (Interview 7)

[...] *Now there are* some *suicide demands, suicide attempts. So you see the story, a boy attempted it, then he was attended and referred somewhere. Then you see a flood of suicide attempts*. (Interview 7)

In the first fragment, we observe the adoption of nominalization through the word "thing", to reduce the complexity of the fact that adolescents set their bodies on fire. The use of the term "thing" gives the idea that the phenomenon is not so serious because it is transient and due to the imitation of behavior.

The second fragment highlights the ambiguity of the discourse, since at the beginning the respondent speaks of "some" demands, as if they were few, and then introduce the "flood" metaphor giving the opposite idea, that the number of suicide attempt cases is too large. The respondent seems to have a conflict in dealing with such situations.

These reports point to the urgent need to review the strategies of access of adolescents to teams, and also to reflect on the mission of these teams, which audience to serve and what needs

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to be prioritized. To what extent are mental health demands triggered by the institutionalization process itself? What does the attitude of adolescents to hurt themselves to ensure access to care?

Nardi et al.[22] show studies that point to an increasing rate of suicide among adolescents. The results found in one socio-educational unit evidence a high percentage of adolescents with suicidal thoughts or attempts. These and other reflections also already exist in research in the adult prison system[23].

Also, different strategies for "regulating" access to health care are identified in these institutions. Those professionals who mediate between the adult prisoner and the health teams, usually the workers, select the cases that should be prioritized. Among these priorities, physical injuries are usually seen as deserving greater attention[24].

Studies point to the relevance of ideations and suicide attempts among adolescents. However, the strength of the demands established by professionals of the measure teams is evident to the detriment of what is expressed by the adolescents as necessities.

Drug abuse and resulting mental health demands

In all interviews, drug use appears as a frequent mental health demand, but discourses on the subject vary. The drug is sometimes seen as a solution found by adolescents to deal with the "physiological mood changes", other times chemical dependence is not recognized, or abuse is seen as the primary demand. Also mentioned is the "moralism" of the measure team professionals when they make some referrals from reports of potential drug use. It is noteworthy that all respondents report that any legal or illegal drug use is prohibited in the unit. It is implied that the big issue is abuse before the measure. The statement concerning psychiatry points out that the drug is the primary mood stabilizer.

So I think it's mood swings [...] *because they are precursors to problems related to alcohol and drug use*. (Interview 2)

The hallmark of this discourse is the use of presuppositions with a high degree of certainty, verbs in the present tense, determined subjects - "facts". Statements about this discourse reveal that poor adolescents have no other means to stabilize their mood (school, cultural, sports activities) and use the drug to address such changes. The same set of arguments is used to explain the quarrels caused by adolescents who are serving a detention measure:

So that's what we say, no activity performed will result for sure in a mess and fight at night, they will have to produce adrenaline somehow. (Interview 2)

Thus, these adolescents would need to be offered activities that would function as drug alternatives for "adrenaline production" and mood stabilization. Other interviews show that drug use is very relevant in the set of mental health demands. In the second passage, the respondent introduces into his speech a statistical data to give objectivity in his statement about the use of cannabis.

[...] *what catches my attention the most, right, of the Center, is drug abuse, right*. (Interview 5)

99% of the system are marijuana users, both boys, and girls. (Interview 6)

The mode of discourse with intertextuality to psychiatric reform argues that it is not appropriate to say that adolescents have chemical dependence, and are considered only as users. Its arguments are carefully introduced, with terms such as "most", "one cannot say", giving an attenuating meaning.

Although most *cases are not;* one cannot say *that it is chemical dependence. They are users* [...] (Interview 3)

The referral of adolescents is discussed in this type of discourse that identifies moral prejudgments given that a report of eventual drug use can be considered a priority demand. In the excerpt below, the use of the diminutive "just a little beer" counteracts an employee's previous statement about an adolescent's alcoholism.

[...] *referral already happened before; there's a lot of morality, a lot of moralization, you see, which accompanies the history of the course of institutionalization. 'The boy has a problem with alcoholism', mind you, 'alcoholism'. So then I called the boy for treatment; he had* just a little beer *with his father over the weekend*. (Interview 7)

The discussion of chemical dependence diagnosis in each case is pointed as a necessity by studies of the field in order not to label adolescents and avoid any consumption being considered pathological[25,26].

A survey of nationwide schoolchildren found that 27.3% regularly used alcohol, 8.6% illicit drugs, and 6.3% tobacco[27]. Nardi et al.[22] identified that 70% of adolescents in a hospitalization unit used drugs. Harmful use of drugs is found, albeit disproportionately, among adolescents serving or not socio-educational measures, and, while prioritized in some public policies, CAPSi resists to address cases and discuss them[28].

Final considerations

Mental health studies point to the complexity in establishing consensus on the concept of mental health and related demands. Differing conceptions coexist. The challenge for professionals is to approach the phenomenon of suffering without limiting it to predetermined categories so that there are flexibility and diversity in the understanding and definition of intervention strategies.

Different discourses about what is a demand in mental health are present and are conjured up by professionals at different times, pointing to the coexistence between multiple conceptions and orientations, without there being a hegemonic discourse.

Differences between mental health conceptions draw care profiles and suffer interference from particular scientific values and backgrounds. Moreover, what teams "get" to treat varies with the perceptions of professionals. There are also external influences on the mental health team in the establishment of some demands.

We highlight the absence of other professionals in the identification of demands, such as socio-educational workers, relevant potential interlocutors for mental health teams, especially regarding "invisible" adolescents in the current referral flow.

Drug use by adolescents is recognized as a relevant demand, sometimes more deterministically (one of the few ways to deal with poor adolescent mood swings), sometimes attenuated as a transient condition during this stage of life. Comparing the different conceptions of drug use, we can realize that such discourses evidence elements that could be considered in the team's reflections: drug use frequency, circumstances, and objectives of use, existence or not of abuse and evaluation of drug use parameters used to identify priority cases.

The discursive blocks appear interrelated. The divisions made in this paper have a didactic purpose and identify the discussion of the demands, considering elements of the socioeconomic and family context. However, we identified a greater emphasis on family breakdown than on the state's mismatch concerning these adolescents and their families.

The discourse of "biological psychiatry" does not appear single-handedly in this research. Traditional psychiatric knowledge is relativized in such a way that elements of the social context are incorporated to analyze the demands.

There are conflicts in the relationship between measure teams and mental health teams. Especially in the discourse on misbehavior, there is an indication of inadequate prioritization made by measure teams when they do not know how to deal with "problematic" adolescents and direct them to mental health teams. In these cases, the demands are of those that forward and not the adolescents themselves.

Again on this discursive block, such statements, including suicidal ideations and self-mutilation, appear with greater emphasis among male unit respondents, but one female unit respondent mentions that it is common for adolescents to cut themselves. He considered that this is a frequent behavior; however, there is no prominence in the statements of this demand as a priority issue.

Attention is drawn to the reports about the poor direct access of adolescents to mental health teams to submit their demands and the way this is attenuated in the discourses, especially among male respondents. One of the respondents of the female unit mentions that, lately, the team has not met self-referrals and that the circulation of the team in the unit allows the identification of needs. Self-referrals end up not being prioritized in the internal flow of the units. Voicing adolescents' needs almost always occurs through the intermediation of institutional agents, as per their rationale and power capitals.

Reflecting on the limitations of this study, one of them is precisely the absence of adolescents and their reports. Another possibility to complement the research presented here would be the inclusion of other professionals of the socio-educational system who are also in direct contact with adolescents in their routine; as well as teams of network professionals who work in the regions where the socio-educational units are located. These other perspectives would significantly contribute to understanding the theme in future works.

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Collaborations

DS Ribeiro, FML Ribeiro and SF Deslandes participated equally in the elaboration of the paper.

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