saúde
EM DEBATE

ORIGINAL ARTICLE

Understanding and management of psychological suffering in institutional care units for adolescents

Compreensão e manejo do sofrimento psíquico em Unidades de Acolhimento Institucional para adolescentes

Raphaela Carvalho[1], Sabrina Stefanello[1], Acácia Mayra Pereira de Lima[1], Deivisson Vianna Dantas dos Santos[1]

DOI: 10.1590/2358-28982026E110384I

ABSTRACT Brazilian youth centers are intended for adolescents whose rights are threatened or violated, but it can exacerbate vulnerabilities, including manifestations of psychological distress. This qualitative and hermeneutical research, based on interviews with 14 workers from Brazilian Unified Social Assistance System (SUAS) and aimed to investigate the management of crises and psychological distress of adolescents in institutional care. The workers expressed a desire to separate adolescents with mental health problems – an understanding linked to diagnosis – and substance users to services other than the care units of SUAS. The results indicated difficulties in crisis management, medicalization of care, dependence on specialized services, and tension between rules and the needs of young people as generators of suffering. The findings contrast with the SUAS guidelines for institutional care, which provide comprehensive care and integral attention to mental health within the SUAS units themselves.

KEYWORDS Adolescent. Mental health. Institutional care.

RESUMO *O acolhimento institucional destina-se a adolescentes com direitos ameaçados ou violados, mas pode acentuar vulnerabilidades, incluindo manifestações de sofrimento psíquico, aqui compreendido em sentido amplo, não restrito a diagnósticos. Esta pesquisa, de cunho qualitativo e hermenêutico, baseou-se em entrevistas com 14 trabalhadores do Sistema Único de Assistência Social (Suas) e visou investigar o manejo das crises e do sofrimento psíquico de adolescentes em acolhimento institucional. Os trabalhadores expressaram o desejo de separar adolescentes em sofrimento psíquico – compreensão atrelada ao diagnóstico – e os usuários de substâncias para outros serviços que não fossem as unidades de acolhimento do Suas. Os resultados indicaram dificuldades no manejo das crises, compreensão medicalizada do cuidado, dependência de serviços especializados e tensionamento entre as regras e as necessidades dos jovens como geradores de sofrimento. Os achados contrastam com as diretrizes do acolhimento, que preveem cuidado integral e atenção à saúde mental nas próprias unidades do Suas.*

PALAVRAS-CHAVE *Adolescente. Saúde mental. Acolhimento.*

[1] Universidade Federal do Paraná (UFPR) – Curitiba (PR), Brasil.
deivianna@gmail.com

This article is published in Open Access under the Creative Commons Attribution license, which allows use, distribution, and reproduction in any medium, without restrictions, as long as the original work is correctly cited.

Introduction

There are several definitions of the period encompassing adolescence. The United Nations Children's Fund (UNICEF) defines it as between 10 and 19 years of age[1], while the Statute of Children and Adolescents (ECA) establishes it as 12 to 18 years of age[2]. However, this phase should be approached beyond the definition of age, as it is a complex phenomenon involving the transition from childhood to adulthood[3], marked by biological, psychological, and social transformations. This requires an approach that considers factors such as race, economic status, experiences, territory, education, and gender[4,5].

From a legal standpoint, the 1988 Federal Constitution and the ECA[2] transformed the conception of adolescence by recognizing adolescents as subjects of rights, with guaranteed protection and full development. However, despite legal guarantees, violations of these rights still occur on the part of society, the State or the family itself. In these situations, the ECA provides for protective measures, including institutional care, to guarantee care and protection for those unable to remain with their families[2].

Institutional care, part of the Unified Social Assistance System (SUAS), coordinates services and resources to assist young people in situations of vulnerability and serious violation of rights. Based on brevity and exceptionality, it is adopted only when alternatives for family and community permanence are exhausted, prioritizing reintegration and the strengthening of existing bonds[2,6,7]. Separation only occurs in cases of serious risk to physical or mental health, as removal from the family environment can negatively impact their biopsychosocial development[8].

In this context, it becomes essential to engage in dialogue with the Social Assistance Policy and the regulations that structure the SUAS, which are responsible for guiding the organization and responsibilities of the institutional care units. These guidelines define reception as a special social protection service, aimed at guaranteeing rights, strengthening bonds, and providing qualified care by multidisciplinary teams[8,9]. In these spaces, the social educator plays a fundamental role in mediating daily life, promoting rights, and supporting processes of development and social reintegration, coordinating with the teams and regulations of the SUAS for care that encompasses the psychosocial and individual dimensions of young people[8,9].

It is estimated that approximately 30,000 children and adolescents are in institutional care[10], with neglect, family conflicts, abandonment, and substance abuse contributing factors to this reality[11]. Social and economic vulnerability should not be a reason for institutional care, as expressed in law, which establishes that lack of resources does not justify removing young people from their families, and that in such cases, redistributive and state protection policies are necessary[2,12]. However, the line between inequality and neglect is thin, with neglect being directly related to the violation of fundamental rights[12]. Many situations are classified as neglect without adequate assessment of the families' conditions, who frequently face extreme poverty, substance use, underemployment, violence, and weakened community ties. In this context, it is essential to reflect on poverty and the State's actions to guarantee comprehensive protection[11,13].

In Brazil, there is a scarcity of studies on the impacts of institutional care on the psychological distress of adolescents and its risk factors, a scenario similar to that of countries such as Germany, Spain, and the United Kingdom. While there is a diversity of terms related to the mental suffering of this population, the term 'psychic suffering' has a broader scope than traditional psychiatric diagnoses and is less medicalizing, since it recognizes human

suffering in its complexity, without reducing it to a mere diagnosis[14]. In this sense, some research shows a high rate of psychic suffering among young people in institutional care, as well as the need to improve the mental health network, in conjunction with social assistance[15-19]. Traumatic events increase the risk of psychic suffering in children and adolescents[12,20,21], with a significant prevalence of suicidal ideation among institutionalized adolescents[22].

It is evident, therefore, that further research is needed to understand how organizational elements and care practices are established within institutional care units, aiming to provide input for public policies that recognize adolescents as subjects of rights with specific needs. The objective of this study was to investigate how mental health care for adolescents in institutional care is organized by the workers in these units.

Material and methods

This is a qualitative research study, originating from a master's thesis in public health, conducted in four state-run Institutional Shelters in Curitiba, linked to the Social Action Foundation (FAS) – the municipal agency responsible for managing the Unified Social Assistance System (SUAS) – and part of the social assistance network, offering a representative view of local practices. The decision was made to recruit all state-run shelters because they are managed by the municipality and, due to their public service teams, would have more stable practices and work processes. Of the five initially eligible institutions, one did not respond to contact attempts and was excluded, resulting in the final composition of the field.

The study included workers from these units, among them managers, social educators, and technical staff (social worker and psychologist), all over 18 years of age and with at least six months of experience. The results are based on 14 in-depth interviews with workers, conducted with trigger questions about identification data, professional routine, identification of mental health problems, crisis management, medication use, and referrals to the health network.

This research adopts Gadamerian hermeneutics to analyze narratives about mental health management in care units. The interpretation seeks to understand how these experiences reveal ways of living and contribute to the collective construction of subjectivity[23]. The interviews were analyzed through successive readings, with systematic thematic coding in an Excel® spreadsheet, enabling the construction of analytical categories. Data triangulation occurred through validation with another researcher from the group, involving everything from joint interpretation to the construction of a shared understanding of the information[24]. The meaning of the statements was maintained as originally transcribed from the participants' voices, taking care not to incur interpretive excesses, thus following the hermeneutical precept of seeking meaning through the phenomena emanating from the discourses.

For Gadamer, understanding is a historical and non-linear process, marked by the hermeneutic circle and interaction between interpreter and text, in which the researcher's experience contributes to the expansion of meanings. The fusion of horizons occurred from the recognition of the researchers' pre-understandings with the workers' narratives, allowing the construction of meanings emerging from the confrontation between initial expectations and discourses, without any claim to neutrality[24]. Finally, the subsequent interpretive process was carried out by the research collective, relating how the data articulate with the principles and concepts inherent to psychosocial care, understanding it as a process that presents different modalities of care, centered on the person, and not essentially on diagnosis[25].

The research was approved by the Research Ethics Committee of the Federal University of

Paraná (Certificate of Presentation for Ethical Review – CAAE No. 53139821.7.0000.0102 and Opinion No. 5.920.474). The study complied with the ethical principles established by Resolution No. 466/2012 of the National Health Council, which provides guidelines and regulations for research involving human beings[26].

Results

The 14 workers interviewed were all employees of the Unified Social Assistance System (SUAS) in the city and had, on average, been in their current workplaces for more than 4 years (*table 1*).

Table 1. Characterization of the workers interviewed in the reception units of the municipality of Curitiba, Paraná (n = 14)

Worker	Color	Occupation	Gender
Interviewee 1	White	Psychologist	F
Interviewee 2	Brown	Social Educator	F
Interviewee 3	White	Coordination	F
Interviewee 4	White	Psychologist	F
Interviewee 5	Black	Coordination	F
Interviewee 6	White	Social Educator	F
Interviewee 7	Black	Social Educator	M
Interviewee 8	White	Coordination	M
Interviewee 9	Brown	Social Educator	F
Interviewee 10	White	Social Educator	M
Interviewee 11	White	Coordination	F
Interviewee 12	Brown	Social Educator	F
Interviewee 13	Brown	Social Educator	M
Interviewee 14	White	Social Educator	M

Source: Author's own elaboration, 2025.

F – feminine; M – masculine.

From these interviews, two major categories emerged, grouped by similarity:

1. Conceptions and the place of mental health in care units;

2. The identification and management of psychic suffering.

Conceptions and the place of mental health in care facilities

This category addresses participants' conceptions of work, reception, and how the mental health of adolescents in institutional care units is understood. Workers report that institutional care units are not the ideal place for adolescents with mental health problems,

highlighting the need for the development of a new SUA facility specifically designed to serve adolescents who use alcohol or other substances and those with mental disorders. According to the participants, the units are not suitable for this profile of adolescents, as this population requires a specialized approach and an environment with healthcare professionals, such as nurses and psychologists.

> *Look, I believe that services should be separated* (I1).

> *I think that if there was at least a small space for them* [teenagers with some mental health issue]*, I think it would alleviate things a lot for us, you know* (I2).

> *The issue of the anti-asylum policy is good, I agree and I think it's wonderful, but there are people who need a more suitable space, which isn't here* (I8).

Another point highlighted is the understanding that managing 'mental health cases' is not the responsibility of social services, nor is it included in the job descriptions and functions to be performed there. Therefore, many believe that this type of demand should not be addressed in these units. The accounts emphasized that, upon starting work in the unit and throughout their time there, there is no institutional support, training, or capacity building related to mental health issues. This includes, for example, the absence of guidance on how to handle crisis situations. Thus, each professional develops their own individual management approach through learning and practice acquired during their work in the units.

> *In fact, that's not even our job description, according to the terms of the job posting. We don't have the training, it's not our job to deal with mental health. It's not our job to manage or administer medication to adolescents. So I think it's necessary to have a healthcare professional within the care units to support this profile* (I3).

> *And then we have to deal with demands that aren't ours. There was a case of a girl who was hospitalized because of a breakdown, and the staff there called us. They wanted us to solve it! I said: - My God, if she's hospitalized, it's for that! And you're calling us? Is this serious?* (I10).

It has also been reported that, in some situations, adolescents use their diagnoses as a form of manipulation and bargaining with the staff. For example, in one case, a young woman was in crisis, but the symptoms ceased soon after they threatened to take away her cell phone. The workers share the same understanding regarding the manifestation of self-harm by adolescents, which is understood as an attempt to get attention.

They acknowledge, however, that the very process of institutional care generates suffering and is considered inherently traumatic. They state that all cases arriving at the units are related to some violation of the basic rights of children and adolescents, and that the follow-up by psychologists, psychiatrists, and other mental health professionals is insufficient in many situations. They report, however, that the trauma is not limited to the external elements that led the adolescent to be institutionalized, but also to the process of adapting to the rules of the units. The interviewees report that adolescents have difficulty adhering to the rules and activities, such as school attendance and the need for permission to leave the units. Some workers believe that the difficulty in 'following rules' is one of the main problems for these adolescents, seeing them as incapable of following family rules, and this as one of the reasons that led to their institutional placement.

> *The vast majority end up here because they didn't know how to deal with rules, with limits at home. Then when you come to the institutional care units there are even more rules and limits. Here it's very different from a home where you live with your parents. Here we have to deal with a group of young people, so there are many more rules and many more limits than in a home* (I4).

The issue frequently generates clashes between teenagers and staff, as the numerous escapes that occur in the units are attributed to the inability of this group to follow the established rules. They report that, in some units, this set of rules is drawn up exclusively by the staff and passed on to the young people, but, in other units, there are times, usually annually, when the teenagers are called upon to participate in their creation.

Identifying and managing psychic suffering

The workers reported that, upon arrival at the institutional care units, most adolescents already had a diagnosis of mental disorder and were using medication. In cases where the diagnosis was uncertain, the identification of a possible disorder occurred through the adolescents' prior history. When there was no formal diagnosis from a health service, the team observed behaviors such as self-harm, substance abuse, aggressiveness, and suicidal ideation, which may indicate the presence of a mental disorder during the period of institutional care.

> *Most have a disorder, but not all have a confirmed diagnosis. Because in adolescence it's still very open, the ICD isn't always finalized, right? Some don't have an ICD code. But it's very rare to find someone who doesn't use medication. There are very few who don't use medication* (I1).

According to them, one element that aided in this identification was establishing a bond with the adolescents. Through establishing a relationship of connection and dialogue with the young people, the professionals reported that they are able to develop greater contact and closeness with the adolescents. In crisis situations, escape attempts, or outbursts, the workers establish dialogue with the adolescents in an attempt to calm them down and keep them in the unit. Generally, the dialogue is conducted by the social educator or another professional with a closer bond, with the educator's role being highlighted here due to their greater interaction with the adolescents. However, in more serious cases, for example, when the adolescent is at personal risk – such as self-harm or posing a risk to others – the Mobile Emergency Care Service (SAMU) is called.

> *We try, together with the social educators who have a closer relationship, to calm the situation, and if that's not possible, we request support from Samu* (I8).

The use of psychoactive substances is frequently mentioned as one of the main problems they have to manage. According to those interviewed, most of the adolescents in care use or have used some substance; and precisely for this reason, this issue becomes one of the biggest challenges encountered in the units. Furthermore, they attribute the difficulty in establishing bonds with their population to psychoactive substances, as they say that the substance becomes central to the dynamics of the adolescents, who find it very difficult to replace. They relate the phenomenon of 'chemical dependency' to difficulties in the reception process, adherence to treatment, and the high number of dropouts.

> *These are the most complicated boys* [those with psychoactive substance use]. *They have a lot of difficulty adhering to the care program, even though the whole team works on guidance, referrals, showing what would be most appropriate. These are very withdrawn boys, they have difficulty staying in the unit, even when they are given guidance. So they leave without authorization, sometimes remaining for several days in an uncertain and undisclosed location. So these are very complicated cases where we have a lot of difficulty getting them to adhere to the institutional care program* (I8).

They say they are very strict on this point, as the use of substances is not allowed inside

the units, and they frequently call on the Municipal Guard to deal with these situations. The Municipal Guard is frequently called upon in critical moments, such as disrespect, threats, aggression, or violence. Furthermore, another situation in which the guard is called is during escapes from the units, when inmates frequently jump over the wall.

> *We made it clear that we have the support of the Municipal Guard. That's what the Constitution says: children don't smoke, teenagers don't drink! No type of drug. We refer these cases to the juvenile police station and issue a citation if we deem it necessary. Not with the intention of punishing, but with the intention of preserving life* (I14).

In situations where adolescents are diagnosed with a mental disorder, the teams offer care at the Psychosocial Care Center (CAPS), and a universal measure for all these adolescents is the prescription of medication. However, they report that these young people are the ones who most tend to distance themselves from the service. They inform that the teams at the care units try to talk to them and explain the importance of follow-up in health services. They also report that, even with the slightest suspicion of a mental disorder, they refer the adolescent to CAPS, even to protect themselves legally.

> *We receive the girl and, independently, we have been sending all of them to the CAPS. Because I prefer to be discharged from CAPS, or CAPS to tell me that the girl doesn't need psychological care, than to have the court pressure me later about why the girl wasn't referred* (I3).

Some accounts expressed disagreement regarding the procedures adopted by the CAPS, noting that the service frequently downplays the issues raised by the units, since they are not within their purview. This disagreement arises in situations where workers consider cases requiring hospitalization, but the CAPS does not refer the adolescent to such a service. In all interviews, the CAPS, the Hospital, and the SAMU appear as the primary resources to be involved with these adolescents, while primary care teams are almost never mentioned or contacted.

Discussion

The place of young people experiencing mental distress in institutional care

The care of vulnerable adolescents, especially those who have lost ties upon entering institutional care, presents challenges similar to those faced by those experiencing psychic suffering. Institutional Care and Mental Health Policies converge in the pursuit of overcoming the institutionalizing model, promoting actions coordinated with the community, focusing on autonomy, citizenship, and comprehensive protection[7,27,28].

The evolution of children's and adolescents' rights has driven changes in shelters, prioritizing new forms of care aligned with comprehensive protection. Shelters should house few adolescents to consider their individual needs, strengthen emotional bonds, and reduce negative impacts. They should resemble a residence in the territory, both in physical structure and operation, maintaining ties with the community and minimizing institutionalization. Shelter should be a last resort, and the team should prepare for the return to the family whenever possible[2,8,29].

The results show, however, that the intention expressed in the participants' narratives, to create a new device that would separate adolescents based on diagnosis, refers to a logic close to that of the asylum, by segregating adolescents based on psychopathology and symptomatology. The proposal to separate adolescents based on diagnoses moves away from an inclusive logic and approaches segregating practices, in contrast to the Brazilian

Psychiatric Reform, which shifts care from the biomedical hospital model to community-based psychosocial care[28]. In line with this expectation of creating a new facility, the workers reported that mental health would not be the responsibility of social assistance. However, thinking from the perspectives of psychosocial and institutional care, mental health care is not limited to specific spaces or devices, being transversal, capillary in territories, facilities and relationships, and not confined to institutional walls[30]. Comprehensive and territorial care is aligned with institutional care policies, which prioritize comprehensive care for adolescents. Thus, in cases of mental suffering or substance use, care must be guaranteed within the care units, in conjunction with the Psychosocial Care Network (RAPS) and promoting continuous training of workers[8].

The SUAS and the ECA share precepts of the Reform, seeking to break with institutionalization, historically represented by orphanages and shelters, which were characterized by rigorous control, isolation, and weakening of community ties[7]. The progress came from the successive achievements that care can be carried out in freedom, incorporating concepts that transcend cure and symptom suppression, strengthening the autonomy of young people through opportunities in the territory and intersectorality[30]. In this way, the policies of institutional and psychosocial care share strategies and territorial potentialities for integrated care[27].

The workers highlighted the lack of a diagnosis as a challenge; however, according to Amarante and Torre[31], the search for a classification within a diagnosis reflects an attempt to explain the phenomena. Amarante[27] emphasizes that mental health involves multiple meanings that go beyond diagnostic categorization. Therefore, when workers expect a categorization and a fitting into diagnoses, they reduce the possibilities of existence and subjectivity that these young people may present[27,30,32]. In psychosocial care, the approach prioritizes considering perspectives beyond the diagnosis, taking into account living conditions, deprivation of rights, and trajectories that led them to institutionalization – in addition to understanding the impact of institutionalization and the causes of psychological suffering associated with these processes[27,30,32].

The centrality of diagnosis accompanies the growth of psychiatric diagnoses for children and adolescents. Learning difficulties, distinct school experiences, and behaviors considered undesirable have begun to result in diagnoses[33]. Furthermore, predominant clinical practices assign labels that do not consider other explanations for suffering[34]. This reflection is also reinforced by the practice of workers always referring adolescents to CAPS, often regardless of any expressed symptomatology, in order to protect themselves legally. The excessive attribution of diagnoses can compromise the advances of deinstitutionalization and the Brazilian Psychiatric Reform, especially by pathologizing typical adolescent experiences[34]. This bias tends to hold young people responsible for structural problems resulting from deprivation, in addition to contributing to the increase in psychiatric hospitalizations, often treated as the main strategy for mental health care[35].

One important point is the existing gap in the debate about the principles of psychosocial care within social assistance, especially in institutional care units. The psychiatric reform is still seen by this public as a movement that withdrew services, instead of expanding rights strategies. This distorted understanding is reinforced by the notion that it is necessary to 'separate to treat', that hospitalization is a resource that should be used frequently, and that it is the individuals who need to be corrected, not the society around them. The arbitrary separation of policies – the SUAS and the Unified Health System (SUS) – hinders the understanding that adolescents and territories are not subject to this demarcation and that, in reality, the citizen is a full subject of rights[31].

And what do we do with suffering in institutional care?

During the interviews, workers indicated that they frequently relied on rigid institutional rules for managing crises and inadequacies in the units. In parallel, the support of health teams (SAMU and CAPS), medication administration, and the building of bonds and dialogue emerged as successful strategies for this management. Participants also pointed to difficulties in building bonds, associated with a lack of preparation and the structural insufficiency of the teams. Studies in Institutional Care Units highlight the importance of bonding in development during care[36] and point to the social educator as the professional who most builds bonds and is most sought after by young people, especially in situations of conflict and crisis[37]. These studies corroborate the interviewees' statement that it is precisely the social educators who maintain the most contact and, therefore, the strongest bond with the adolescents.

The use of institutional rules as a control mechanism disguised as a therapeutic approach is not recent. Goffman[38] introduced the concept of the Total Institution, in which standardization, through rules and discipline, is essential to maintain control and institutional functioning. Shelters thus assume a multifaceted role, functioning as housing, educational spaces, and control mechanisms, sheltering adolescents under state guardianship and separated from family and territorial life. Various forms of coexistence are concentrated in one place. Reports indicate difficulties for young people in following institutional guidelines, resulting in recurring confrontations. Although workers emphasize dialogue, the rules are established in a standardized way, hindering adaptation to individual needs[38]. Drawing a parallel with Goffman, in these units, young people are separated from their homes and territories, breaking routines, ties, and previous connections.

This research found that workers formulate rules without the participation of adolescents and that their application is general, without considering criteria of individuality. This finding is similar to another study carried out in institutional care units, in which the rules, defined exclusively by the teams, generated conflicts and difficulties in adherence, precisely because of the absence of adolescents in their construction[39]. In contrast, the Technical Standard for Institutional Care emphasizes the collective elaboration of rules as a strategy to promote a more welcoming environment[8]. A literature review indicates that, although these units still present traits of Total Institutions, they also have potential as a support network, highlighting the importance of training professionals and strengthening the autonomy and knowledge of rights on the part of those being fostered, showing the relative historical accumulation of gains in rights, since these units are also identified as a protective element for these young people[40].

The difficulty in territorializing care is also expressed in the understanding that mental health care should be provided in specialized facilities, such as CAPS and hospitals. However, the RAPS proposes expanding care points beyond specialized services, strengthening primary care, the territory, and intersectoral articulation[41,42]. From this perspective, care goes beyond specialized devices and is built in community spaces. Taño and Matsukura[42] advocate practices that overcome the psychiatric and pathologizing model, highlighting territorial support and intersectoral actions as essential to meet the complex needs of adolescents, promoting health, rights, and citizenship. Despite these premises, Basic Health Units are not understood as possible spaces for mental health care by these workers.

Another point highlighted by the workers was that most adolescents in these units were using psychotropic medication. The literature corroborates this result by pointing to a growing process of medicalization, in which subjectivities are reduced to diagnoses within

a biomedical logic, resulting in the reductionism of psychic suffering[32]. This model prioritizes medication, disregarding the nuances of illness and the influence of life contexts. Furthermore, it excludes the historical dimension of the subject, ignoring social, cultural, and psychological factors. With the expansion of diagnoses, there is a tendency towards the medicalization of human suffering, transforming experiences into symptoms of disorders[32,43].

Medication is seen as the primary resource for treating mental disorders and helps validate the diagnosis, so the two are interconnected. Adolescence is pathologized when its behaviors are dissociated from its life contexts, resulting in medicalization and the framing of deviations as mental disorders. This approach ignores contextual factors, the complexity of the youth experience, disregarding factors that go beyond the field of health, the subjective dimension of suffering, of vulnerability-causing processes, and of adolescence[32,34].

Final considerations

The analysis of the practices and management of this research highlights the complexity of mental health care for adolescents in institutional care, marked by multiple vulnerabilities. When reflecting on the place of psychic suffering within institutional care, the desire to separate adolescents from the perspective of diagnosis by the institutional care teams overrides the desire for acceptance and inclusion. Therefore, despite the advances enshrined in the Statute of the Child and Adolescent, in the current policy of institutional care and psychosocial attention, further progress is needed so that the letter of the regulations is reflected in the real practices of care.

Understanding the suffering of these young people requires considering aspects beyond diagnosis, such as their living conditions, social bonds, and the rights violations that permeate their histories. The management of these young people in institutional care reflects the current contradictions of our own society, where we identify advancements in territorial units that prioritize care through bonding, and in smaller units that coexist with desires for separation, rapid behavior correction, and a low threshold for breaking rules. Such movements can reduce suffering to diagnoses, without considering the broader contexts that affect adolescents.

The absence of strategies for continuous training and discussion of these topics is reflected in a certain mismatch between the prevailing principles and the type of care practiced. Behavioral rules and medication are frequently used as crisis management tools in the absence of other possibilities and due to structural deficiencies. Thus, traits of a total, medicalizing institution that relies on security forces appear in the same scenario as facilities that attempt rehabilitation and the articulation of care with other services. These elements alert all public policy makers that the concepts of comprehensive care, in freedom, person-centered care, and psychosocial attention are still under debate. Strategies aimed at democratizing and updating these discussions are necessary, respecting the social and personal realities of the work process in these units.

Finally, psychosocial care, by recognizing adolescents as subjects of rights and social actors, values their knowledge and experiences. The practices of institutional and psychosocial care share common objectives, aimed at guaranteeing the rights, autonomy, and citizenship of adolescents. However, expectations of institutional care still reflect a desire for institutionalization and a medicalized view of care and specialized services.

Authorship contributions

Carvalho R (0009-0000-4692-0687)*, Stefanello S (0000-0002-9299-0405)*, Lima AMP (0000-0003-4015-3768)* and Santos DVD (0000-0002-1198-1890)* also contributed to the preparation of the manuscript. ■

*Orcid (Open Researcher and Contributor ID).

References

1. Fundo das Nações Unidas para a Infância. 30 anos da Convenção sobre os Direitos da Criança: avanços e desafios para meninas e meninos no Brasil [Internet]. São Paulo: Unicef; 2019 [acesso em 2025 dez 17]. Disponível em: https://www.unicef.org/brazil/media/6276/file/30-anos-da-convencao-sobre-os-direitos-da-crianca.pdf

2. Presidência da República (BR). Lei nº 8.069, de 13 de julho de 1990. Dispõe sobre o Estatuto da Criança e do Adolescente e dá outras providências. Diário Oficial [da] República Federativa do Brasil, Brasília, DF. 1990 jul 16; Edição 135; Seção I:13563.

3. Coutinho LGA. A adolescência na contemporaneidade: ideal cultural ou sintoma social. Pulsional Rev Psicanálise [Internet]. 2005 [acesso em 2025 dez 17];17(181):13-9. Disponível em: https://pesquisa.bvsalud.org/portal/resource/pt/lil-477071

4. Ayres JRCM, Carvalho YM, Nasser MA, et al. Caminhos da integralidade na atenção primária à saúde: recursos conceituais e instrumentos práticos para a educação permanente da equipe [Internet]. São Paulo: Universidade de São Paulo, Departamento de Medicina Preventiva; 2012 [acesso em 2025 dez 17]. Disponível em: https://fm.usp.br/cseb/conteudo/cseb_152_Caminhos%20da%20Integralidade%20-%20adolesc%C3%AAncia%20e%20juventude.pdf

5. São Paulo (Estado). Linha de Cuidado para a Saúde na Adolescência e Juventude para o Sistema Único de Saúde no Estado de São Paulo [Internet]. São Paulo: LCA&J; 2021 [acesso em 2025 dez 17]. Disponível em: http://www.saudeadolescentesejovens.net.br/

6. Presidência da República (BR). [Constituição 1988]. Constituição da República Federativa do Brasil de 1988 [Internet]. Diário Oficial [da] República Federativa do Brasil, Brasília, DF. 1988 out 5; Seção 1:1.

7. Assis SGSS, Farias LOP, organizadores. Levantamento nacional das crianças e adolescentes em serviço de acolhimento. São Paulo: Hucitec; 2013. 368 p.

8. Ministério do Desenvolvimento Social e Combate à Fome (BR); Conselho Nacional de Assistência Social. Resolução Conjunta nº 1, de 18 de junho de 2009. Aprova o documento Orientações Técnicas: Serviços de Acolhimento para Crianças e Adolescentes. Diário Oficial da União, Brasília, DF. 2009 jul 2; Edição 124; Seção I:93.

9. Ministério do Desenvolvimento Social e Combate à Fome (BR). Política Nacional de Assistência Social – PNAS/2004. Brasília, DF: Secretaria de Desenvolvimento Social; 2005. 178 p.

10. Conselho Nacional de Justiça (BR) [Internet]. [local desconhecido]: CNJ; 2026. Sistema Nacional de Adoção e Acolhimento – Painel de acompanhamento; 2025 [atualizado em 2026 fev 13; acesso em 2025 dez 17]. Disponível em: https://paineisanalytics.cnj.jus.br/single/?appid=ccd72056-8999-4434-b913-f74b5b5b31a2&sheet=4f1d9435-00b1-4c8c-beb7-8ed9dba4e45a&opt=currsel&select=clearall.

11. Conselho Nacional de Justiça (BR). Destituição do poder familiar e adoção de crianças [internet]. Brasília, DF: CNJ; 2022 [acesso em 2025 dez 17]. Disponível em: https://www.cnj.jus.br/wp-content/uploads/2022/04/eixo3-primeira-infancia-sumario-executivo-final.pdf

12. Calcing J, Benetti SPCC. Caracterização da saúde mental em crianças e adolescentes em acolhimento institucional. Psico. 2014;45(4):559. DOI: https://doi.org/10.15448/1980-8623.2014.4.13629

13. Berberian TP. Serviço Social e avaliações de negligência: debates no campo da ética profissional. Serv Soc Soc. 2015;121:48-65. DOI: https://doi.org/10.1590/0101-6628.013

14. Guarido R. A medicalização do sofrimento psíquico: considerações sobre o discurso psiquiátrico e seus efeitos na Educação. Educ Pesqui. 2007;33(1):151-61. DOI: https://doi.org/10.1590/S1517-97022007000100010

15. Ford T, Vostanis P, Meltzer H, et al. Psychiatric disorder among British children looked after by local authorities: Comparison with children living in private households. Br J Psychiatry. 2007;190(4):319-25. DOI: https://doi.org/10.1192/bjp.bp.106.025023

16. Fernandes ADSA, Matsukura TS. Adolescentes inseridos em um CAPSi: alcances e limites deste dispositivo na saúde mental infantojuvenil. Temas Psicol. 2016;24(3):977-90. DOI: https://doi.org/10.9788/TP2016.3-11

17. Galhardi CC, Matsukura TS. O cotidiano de adolescentes em um Centro de Atenção Psicossocial de Álcool e outras Drogas: realidades e desafios. Cad Saúde Pública. 2018;34(3):e00150816. DOI: https://doi.org/10.1590/0102-311X00150816

18. Silva JF, Matsukura TS, Ferigato SH, et al. Adolescência e saúde mental: a perspectiva de profissionais da Atenção Básica em Saúde. Interface (Botucatu). 2019;23:e18063. DOI: https://doi.org/10.1590/Interface.180630

19. González-García C, Vassiliadis E, Moreno-Manso JM, et al. Changes in mental health of children and young people in residential care: outcomes and associated factors. Psychosoc Interv. 2023;32(1):11-9. DOI: https://doi.org/10.5093/pi2022a16

20. Parreira SMC, Justo JS. A criança abrigada: considerações acerca do sentido da filiação. Rev Psicologia Estudo. 2005;10:175-80. DOI: https://doi.org/10.1590/S1413-73722005000200003

21. Cavalcante LIC, Magalhães CMC, Pontes FAR. Institucionalização precoce e prolongada de crianças: discutindo aspectos decisivos para o desenvolvimento. Aletheia [Internet]. 2007 [acesso em 2025 dez 17];25:20-34. Disponível em: http://pepsic.bvsalud.org/scielo.php?script=sci_arttext&pid=S1413-03942007000100003&lng=pt

22. Ferreira AP, Santos DS, Wermelinger ED. Perspectivas e desafios do cuidado em saúde mental de adolescentes em regime socioeducativo: um estudo de caso. Saúde Debate. 2024;48(143):e8949. DOI: https://doi.org/10.1590/2358-289820241438949P

23. Vieira AM, Rivera DPB. A Hermenêutica no campo organizacional: duas possibilidades interpretativistas de pesquisa. Rev Bras Gest Neg. 2012;14(44):261-73. DOI: https://doi.org/10.7819/rbgn.v14i44.906

24. Gadamer H-G. Verdade e método: Traços fundamentais de uma hermenêutica filosófica 3ª ed. Petrópolis: Editora Vozes; 1997.

25. Oliveira E, Szapiro A. Porque a Reforma Psiquiátrica é possível. Saude Debate. 2020;44(Esp 3):15-20. DOI: https://doi.org/10.1590/0103-11042020E302

26. Conselho Nacional de Saúde (BR). Resolução nº 466, de 12 dezembro de 2012. Aprova as diretrizes e normas regulamentadoras de pesquisas envolvendo seres humanos e revoga as Resoluções CNS nºs. 196/96, 303/2000 e 404/2008. Diário Oficial da União, Brasília, DF. 2013 jun 13; Edição 112, Seção I:59-62.

27. Conceição MJ, Nunes MMCA. Transtornos mentais e o acolhimento institucional de adolescentes: desafios e reflexões sobre esta prática. In: Almeida F, organizador. Políticas públicas, educação e diversidade: uma compreensão científica do real. Guarujá, SP: Científica Digital; 2020. p. 1060-1071.

28. Amarante P. Saúde mental e atenção psicossocial. Rio de Janeiro: Editora Fiocruz; 2007.

29. Siqueira AC, Dell'Aglio DD. O impacto da institucionalização na infância e na adolescência: uma revisão de literatura. Psicol Soc. 2006;18(1):71-80. DOI: https://doi.org/10.1590/S0102-71822006000100010

30. Yasui S, Luzio CA, Amarante P. Atenção psicossocial e atenção básica: a vida como ela é no território. Rev Polis Psique. 2018;8(1):173-90. DOI: https://doi.org/10.22456/2238-152X.80426

31. Amarante P, Torre EHG. "Back to the city, Mr. citizen!" — psychiatric reform and social participation: from institutional isolation to the anti-asylum movement. Rev Adm Pública. 2018;52(6):1217-37. DOI: https://doi.org/10.1590/0034-761220170130

32. Sanchez VNL, Amarante PDC. Estudo sobre o processo de medicalização de crianças no campo da saúde mental. Saúde Debate. 2014;38(102):506-14. DOI: https://doi.org/10.5935/0103-1104.20140047

33. Chaves FAM, Caliman LV. Entre saúde mental e a escola: a gestão autônoma da medicação. Rev Polis Psique. 2017;7(3):136-60. DOI: https://doi.org/10.22456/2238-152X.75328

34. Pavani FM, Wetzel C, Olschowsky A. Clinics at Psychosocial Care Center for Children and Adolescents: diagnoses on adolescence is written in pencil. Saúde Debate. 2021;45(128):118-29. DOI: https://doi.org/10.1590/0103-1104202112809

35. Martins RWA, Silveira L. Internações de crianças e adolescentes usuárias de drogas: um desafio para o campo da saúde mental infantojuvenil. Rev Epistem Transversalis [Internet]. 2019 [acesso em 2025 dez 17];10(1):213-27. Disponível em: http://revista.ugb.edu.br/ojs302/index.php/episteme/article/view/1306

36. Ito SI, Azevêdo AVS. Educadores Sociais em Abrigos Destinados a Crianças e Adolescentes: revisão sistemática. Contextos Clínic [Internet]. 2021 [acesso em 2025 dez 17];14(1):276-303. Disponível em: https://pepsic.bvsalud.org/scielo.php?script=sci_arttext&pid=S1983-34822021000100014

37. Penna LHG, Guedes CR, Ribeiro R, et al. O profissional educador social no cotidiano de adolescentes de unidade de acolhimento institucional: uma revisão integrativa. Res Soc Develop. 2021;10(17):e239101724690. DOI: https://doi.org/10.33448/rsd-v10i17.24690

38. Goffman E. Manicômios, prisões e conventos. 2ª ed. São Paulo: Perspectiva; 1987.

39. Lemos A, Moraes MCMB, Alves DG, et al. Evasão nas unidades de acolhimento: discutindo seus significados. Psicol Soc. 2014;26(3):594-602. DOI: https://doi.org/10.1590/S0102-71822014000300008

40. Epifânio TP, Gonçalves MV. Crianças como sujeitos de direitos: uma revisão de literatura sobre crianças em situação de acolhimento institucional. Cad Bras Ter Ocup. 2017;25(2):373-86. DOI: https://doi.org/10.4322/0104-4931.ctoAR0736

41. Ministério da Saúde (BR); Conselho Nacional do Ministério Público. Atenção psicossocial a crianças e adolescentes no SUS: tecendo redes para garantir direitos. Brasília, DF: Ministério da Saúde; 2014. 60 p.

42. Tãno BL, Matsukura TS. Intersetorialidade e cuidado em saúde mental: experiências dos CAPSij da Região Sudeste do Brasil. Physis. 2019;29(1):e290108. DOI: https://doi.org/10.1590/S0103-73312019290108

43. Surjus LTLS, Moysés MAA, organizadores. Saúde mental infantojuvenil: territórios, políticas e clínicas de resistência. Santos: Unifesp/Abrasme; 2019.

Received on 03/23/2025
Approved on 12/27/2025
Conflict of interest: Non-existent
Data availability: The research data is contained in the manuscript itself
Financial support: Non-existent

Editor in charge: Marcelo Moreira Rasga, Fundação Oswaldo Cruz (Fiocruz), Estratégia Fiocruz para a Agenda (EFA2030), Rio de Janeiro (RJ), Brasil. Lattes: http://lattes.cnpq.br/7851702065010431, Orcid: https://orcid.org/0000-0003-3356-7153, *e-mail*: rasgamoreira@gmail.com