Clinics at Psychosocial Care Center for Children and Adolescents: diagnoses on adolescence is written in pencil

A clínica no Centro de Atenção Psicossocial Infantojuvenil: na adolescência, o diagnóstico se escreve a lápis

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ABSTRACT This article aims to analyze the practice of the clinic with adolescents in psychosocial care, in Psychosocial Care Center for Children and Adolescents. The Fourth Generation Evaluation was used as a theoretical-methodological approach, having as evaluative parameters the following aspects of health practices, from the perspective of psychosocial care: care in freedom, intersectoral, territorial, multi-professional and singular, seeking as results social inclusion, autonomy and citizenship. Interviews were conducted with service professionals and participant observation. The analysis was performed by Constant Comparative Method. The task of building a clinic that overcomes the knowledge and practices of traditional psychiatry is evident, which incorporates the adolescents' context, and that does not have diagnosis as its central axis. There is essential to change the attention from the disease to the adolescent, considering their desires, relationships and the meanings attributed by them to possible perspectives and paths resulting from clinic's knowledge. It is important to maintain the process of constant wondering regarding the psychosocial clinic with adolescents, its repercussion and its incorporation as a transitory and singular therapeutic possibility.

KEYWORDS Adolescent. Health evaluation. Community mental health services.

RESUMO *O artigo tem como objetivo analisar a prática da clínica com adolescentes na atenção psicossocial, em um Centro de Atenção Psicossocial Infantojuvenil. Utilizou-se a Avaliação de Quarta Geração como percurso teórico-metodológico, tendo como parâmetros avaliativos os seguintes aspectos das práticas em saúde mental, na perspectiva da atenção psicossocial: o cuidado em liberdade, intersetorial, territorial, multiprofissional, e singular, buscando como resultados a inserção social, a autonomia e a cidadania. Foram realizadas entrevistas com os profissionais do serviço, e observação participante. A análise ocorreu mediante o Método Comparativo Constante. Evidencia-se a tarefa de construir uma clínica que supere os saberes e as práticas da psiquiatria tradicional, que incorpore o contexto dos adolescentes, e que não tenha como eixo central o diagnóstico. Os resultados sugerem o deslocamento do foco da atenção na doença para o adolescente, considerando seus desejos, suas relações e os sentidos que atribuem às possíveis perspectivas e aos caminhos resultantes dos saberes da clínica. Conclui-se, sobre a necessidade da manutenção do processo de constante questionamento em relação à clínica psicossocial com adolescentes, sua repercussão e sua incorporação enquanto uma possibilidade terapêutica transitória e singular.*

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Introduction

The title of this article is inspired in the work of psychiatrist Allen Frances, titled 'Diagnoses in Kids Should Always Be Written in Pencil', and convokes health professionals to (re)think what has been done with the specific population – children and adolescents –, regarding their needs and the considered problems in children-youth mental health. This author reveals concern with the medicalization process of these age ranges, and the psychiatric diagnoses attributed to the adolescents and to the children[1].

It is understood that 'write by pencil' refers to the necessary dynamics in the clinical dimension in mental health directed to childhood and adolescence, since these are phases marked by diverse changes, that occur in a rapidly, varied and singular manner. Then, this shall be considered in the construction of the clinical praxis in mental health directed to this type of population. With the expression 'by pencil' the clinical normative practices of psychiatry are questioned, in which labels are produced, disregarding other possibilities of explaining a certain suffering condition of the adolescents.

The questions involving clinics are related to the place it occupies in the field of interventions in mental health, where sometimes it is overestimated, sometimes it is underestimated. Are also considered clinics in mental health the psychological, psychiatric or psychoanalytic interventions, produced by assistance structures that, sometimes, are reduced to individual or group practices centered on the illness[2].

The clinics in psychosocial assistance makes it possible to widen these horizons, considering the interaction of the subject with: with another subject, social aspects, and life contexts and its specificities, in an equivalent manner to the interventions in the 'psi field', especially relating to the level of prestige and importance given to the practices themselves by the professionals that perform them.

To broaden the discussions about clinics in the health care services, while practices performed by all the professionals that deal with diagnoses, treatment, rehabilitation and prevention, the concept of broadened clinics emerges, aiming to move the attention from the illness to the subject, with its biological, social, individual and historical aspects, and with the empowerment of varied services that provide assistance to one same user.

Therefore, in the transformation of the clinical practices in mental health in the last decades, the psychosocial perspective permitted to foresee the mental disorder beyond signs and symptoms, as a way of expression of suffering and of different human experiences. It can be observed its experiential sense, through the search and the broadening of therapeutic strategies directed to the protagonism and to the respect to the singularities of subjects.

Therefore, it is questioned the practice of clinics in mental health directed to the adolescents is being performed under this perspective, representing one of the most difficult challenges presented in the field of the mental health regarding adolescence. In this respect, the objective of this paper is to analyze the practice of the clinics with adolescents in psychosocial assistance, considering the work developed in a Psychosocial Children-Adolescent Care Center (Capsi).

Material and methods

It is a study of qualitative approach, that has used the Fourth Generation Evaluation[5] as theoretical-methodological path, and the perspective of psychosocial care as evaluation parameter, according to *box 1*.

Box 1. Assessment parameters, having as its guiding axis the psychosocial attention

Parameters	Perspective of the psychosocial attention
Mental health public policies	Public health care problem in the perspective existence-suffering
Deinstitutionalization	Care in freedom
	Territorial and intersectoral
Broadened clinics	Multiprofessional and interdisciplinary
	Focus on the subject/subjectivity
	Therapeutic approaches
Rehabilitation	Social insertion
	Autonomy and citzenship

Source: Pavani[4].

The Fourth Generation Evaluation focuses in a participative process, in which the demands, concerns and questions of the interest groups serve as organizational focal points to determine which information is necessary. It is implemented through methodological assumptions of the constructivist paradigm, and the groups of interest that are defined as people that have some connection with the evaluation's object[5].

In this research, the group of interest included was composed by the professionals of the service's team, inasmuch as the evaluation involved their own practices. It was understood that such participation would be crucial, both in the direction of their expertise, in relation to the object of the assessment, and of their role using the results.

As a scenario, it was chosen a Capsi located in the municipality of Porto Alegre (RS), in the north/northeast territory, that assists an average of 200 patients monthly. Reference amongst the units in the area, it works from 8:00 to 18:00, from Monday to Friday, and has a multidisciplinary team composed by: nurses (2), social assistants (2), occupational therapist (1), physicians (3), nutritionist (1), nursing technicians (2), psychologists (3), physical education teacher, visual arts teacher (1), pedagogue (1) and administrative assistants (2). As it is also a place of formation, it also receives students of the multiprofessional residence and nursing interns.

The field work occurred between August and December of 2018, being developed according to the adapted steps of the Fourth Generation Evaluation[6]: contact with the field; organization of the evaluation; identification of the group of interest; developing and broadening of the joint constructions; and preparing and execution of the negotiation.

The 'contact with the field' was characterized, initially by the meetings with the coordinator and the Capsi's team, when the research was presented, aiming acceptance in participating. This phase was crucial to the participative study, in order to allow all to understand the proposal and to compromise as participants.

In the 'organization of the evaluation', the main task was to gain the right to enter and the achievement of the previous ethnography, that can be comprehended as the period in which the evaluator lives and experiences the context of the service to be researched, without not yet being involved in the evaluation activities, however getting to know social, political and cultural norms of the customs, of the practices and of the conventions of the context to be researched. This makes possible to go beyond common sense, deepening perceptions and observations that help to interpret the interviews and the results. This stage

involves the construction of a trust relation of the evaluator with the interest group and the knowledge of the context of the routine of the service, without yet initiating the evaluation[5]. For this purpose, it was utilized the participant observation, totalizing around 150 hours. Concomitantly to this stage, it was held the identification of the interest group, including all the professionals that compose the team of the Capsi at the moment of the research, totalizing 15 participants.

Afterward, the following stage was the 'development and broadening the joint constructions', that consisted in interviews through the application of the Hermeneutic-Dialectic Circle. The term 'hermeneutic' refers to the interpretative character, and 'dialectic', to the possibility of comparison and contraposition of divergent points of view in the process, aiming to obtain a synthesis elaborated by all participants[5]. The first interview was held with an opened question, asking the participant to speak freely about the mental health practices directed to adolescents in the Capsi. Later, during the transcription and the analysis of the first interview, were obtained questions, concerns and initial demands. In the second interview, with another participant, it was asked initially, that he also talked about the opened question presented to the first interviewed. At the end of his manifestation, there were presented questions that had not been addressed spontaneously by himself, however they emerged in the previous interview, asking him to manifest his opinion about it. The same process was repeated with the other participants, so that each interview was followed immediately by the participant's analysis. This made the material of the previous interviews available to the followings, in which, besides talking about their own constructions, the participants were invited to comment the subjects mentioned in the previous interviews. The broadening of the joint constructions seeked for the deepening and the sophistication of the questions that emerged in the Hermeneutic-Dialectic Circle, through the second moment of the participant observation. This stage focused on the practices developed in the Capsi directed to the adolescents, and totalled 150 hours.

At last, the stage of preparation and execution of the negotiation involved the organization of the empiric material and its presentation to all the participants. This presentation occurred on the day of the team meeting, what allowed all to participate. The negotiation was held in order to honor the principles of the participative evaluation, in which the evaluator was a mediator and facilitator, and everything that emerged of the group was considered a result of the deliberation and decision of the participants. The negotiation is a mechanism that allows the participants of the research to modify or to affirm the credibility of the constructions accomplished[5].

The method utilized demanded that the analysis and the production of the data were concomitant, and the method chosen was the Comparative Constant Method[7]. The questions that emerged in the evaluative process were grouped in two great categories: organization and work process in the Capsi, and networks and politics. In this paper, are presented the results that constituted one of the subcategories of the organization and of the work process in the Capsi: the practices in mental health related to the clinics in the Capsi. This subcategory is composed by themes related to the clinical practices directed to adolescents, such as: the depathologization of adolescences; the consideration of the life context; the emphasis in their potentialities, rather than in the incapacities, and the relation of the adolescents with medication.

The present study was approved by the Committees of Ethics in Research of the Federal University of Rio Grande do Sul (CAEE – 88236718.0.0000.5347, opinion – 2.728.346) and of the co-participant institution (CAEE-88236718.0.3001.5530, opinion – 2.805.823). The ethical principles were assured by the signing of the Inform Consent Form by the participants. The confidentiality of those was

assured by the substitution of the names by the letter 'P', of professional, followed by the number of the interview.

Results and discussion

The characteristics of adolescence can be comprehended when the changes in the individual ambient, such as desire for originality, the constitution of the identity and the affirmation of self-image and biological changes are considered. In the social level, we can mention the search for autonomy, authenticity, the construction of new codes of conduct and social behavior[8].

In the evaluation process, the team considered that one of the challenges of the clinical practices with adolescents in the Capsi is related to the necessity of identification and the recognition of the characteristics that are expected in this stage of life.

> *It is complicated because the parents pathologize many questions of the adolescence: 'Oh, because he does such thing, the bedroom is a mess, it is dirty, it has stinky socks, I don't know why'. 'Ok, but just a little bit, this is a part of adolescence'. She wants to put that inside of a process of becoming ill, and this is a part of a normal process of an adolescence.* (P11).

> *We try to make them think about what is happening, that this adolescent is this way, because adolescence is a phase that passes, and as it passes, the symptoms can pass with it to. Depends on how the adults will work this manifestations, that are being presented by 'N' reasons. We talk a lot about the question, that his behavior is that is similar to a pathology, that he presents.* (P12).

This way, we highlight the importance of considering the ways of development and the different marks that each adolescent has in the path child/adult. The individuality and the immaturity cannot be confused with illness. And since them, we suggest that a careful and detailed evaluation be an aspect considered important in the clinical practice in mental health with adolescents, in the psychosocial direction.

This question is related to the tenuous line between normality and abnormality established with the pathologization movement of adolescence, in which the behaviors of this phase can be detached from the ways of interaction with life and with the world, disregarding, thus, all the other factors that are involved in these manifestations.

The pathologization of adolescence can be comprehended by the search for fitting of the 'deviant' adolescents, through organic explanations, statistic methods of classification, physiology- based diagnoses and adaptation therapies for those who do not obey the rules, norms and standards established by society[9]. Namely, all that do not behave adequately to the normative pattern can be considered deviants, and therefore, are submitted to processes that identify and attest them mental disorders and, as a consequence, the incapability to correspond to the social expectancies: to grow up, to study, to work, to marry etc.

The pathologization of adolescence has been occurring through processes of judgment, conviction and sentence, commonly related to medicalization, to control and judicialization of the adolescent, supported by medical, psychological and phonoaudiological reports, among others[10]. It is pointed, yet, the tendentious character of the pathologization, not only of the adolescents, in the actual social-political Brazilian context, through the blaming of people for the structural problems related to precarious socioeconomic conditions in which they live[11].

A constant critical analysis of the practices performed in the services, mainly of mental health, is crucial, seeking the confronting of the pathologization processes, which, under the perspective of normalization, represent a retreat of the movements of deinstitutionalization and of the psychiatric reform in the field of childhood and adolescence.

This does not mean that there are not adolescents in serious mental suffering, and the necessity of diagnosing as one of the dimensions of the practices in mental health. The problem is in the superficial and early diagnosis of the mental disorder before manifestations of the own adolescence phase, seeing as 'annoyance'. We seek for alerting about the existence of a gradual movement[11] that has been occurring, with the constant precocious entry in the psychiatric career, in psychiatric hospitalization, as the main care action in mental health for the youth population.

Not all behavior, physical and psychological manifestations have to be referred to pathologic conditions. The inclusion of the specific phases of adolescence, added to their context and to a detailed, longitudinal and singular evaluation, can help in the early identification of the cases, refining, thus, the effective tracking to diagnose moderate/serious cases, in detriment of the tracking, yet imprecise, as proposed by the Law nº 13.438, of April 26t th 2017[10,12].

In this regard, the importance of the diagnoses not overlap the practices of the Capsi is defended in the evaluation process. The diagnoses in mental health is important, but it is not everything.

> *It is a difficult dilemma that I face quite often, and the colleagues might also face: to provide or not to provide a diagnoses? When to provide a diagnoses? Which diagnoses to provide? [...] In adolescence, there is a question, that they do not accept certain labels. Sometimes, you've got problems with your patient. You solve a legal question for the parents and you've got a terrible conflict with your patient. He revolts against you because you said he is something. It is not easy.* (P5)

> *To diagnose is certainly crucial, and I can say that we do it. This is quite controversial... I can say we make a lot of diagnoses here. To diagnose is to give a word, a name or even various names, various words for what is happening to the adolescent, and this does not necessarily need to be an specific psychiatric disorder. The diagnoses is important, but it is not everything.* (P10).

To diagnose in adolescence is considered a practice with challenges because adolescence is a phase in which the adolescent goes through situations that goes beyond the act of defining which is the diagnoses, or the therapeutic options.

In the clinical practices with adolescents, the diagnoses is not only a nosological construction, but it also refers to the social, familial and institutional conditions that involve each case, and that, in fact, make possible to construct useful interventions to the adolescents, since knowing the name of the infirmity rarely helps in the integration of the care actions. One of the main difficulties resides, in some cases, in diagnosing of symptomatic frames, distinguishing it, structurally, of the subjective and behavioral alteration occurred in adolescence itself. The practices can be oriented by diagnoses hypothesis that do not plaster the listening and that orient the intervention[12,13].

In general, it is emphasized that the evaluation in mental health with adolescents must be made gradually, and, regarding diagnoses, this must be constructed in a contextualized manner, since "a serious episode of disorganization in adolescence, by itself, does not define the diagnoses"[14(98)].

The traditional clinics also assumes its relation with a determined etiology in a future perspective in terms of prognosis. When the practices are directed to the perspective of the broadened clinics, it becomes crucial the deconstruction of the closed and crystallized explaining modes, in order to avoid that the diagnoses overlaps the varied questions surrounding the adolescent.

> *There is a confusion between diagnosis, etiology and prognosis, that sometimes, people do not understand so well, they put all this togheter. [...] For example, the patient is in a depressive condition and the father, that spanks, mistreats and abuses him. It may even be that he has depression symptoms,*

sadness, worthlessness, hopelessness, that he may present all those things, however it may be only the name of the syndrome. The etiology of this can be varied: genetics, mistreatment and, sometimes, it confuses a bit, thinking about the diagnoses as if it was an etiologic matter. People also confuse that diagnoses also is not prognosis. Then, a person may receive a diagnoses in a certain moment, but it does not mean that it is going to be for the rest of the person's life, and that the person will not be allowed to do this or that. We learn that the diagnoses is made in the gerund. (P10).

The prognosis of the adolescent is an important question, related to concern with the adolescent's future. In the asylum mode, the mental disorder is related to deficiencies, handicaps and inabilities, among other characteristics that mark a person as ill or incapable. The prognosis sentences the impossibility of the subject to live in society, due to his mental insanity. In the psychosocial mode, centered in the subject and not in the illness, the work is done with an universe of possibilities for the subject's life, considering the adolescent's potentialities, necessities and desires[15].

At the same time in which there is a concern that the diagnoses will not configure a label to be carried throughout life, defining this adolescent, the diagnoses is considered an important tool in the direction of the clinical practice, in the mental health care. This leads to a great dilemma, identified by the participants.

If you label an adolescent, he will carry it throughout his life, in some way. Then, it is not easy, it is not easy. This is a quite present dilemma here. (P5).

We have to think in a broaden way; are we also contaminated with prejudices and think that a certain diagnoses is some sort of a dirty word? Then, certainly we would have to work with people's and society's questions, in itself, to accept that we need to call a spade a spade. Things must be said, because otherwise they stay in a very dark limbo, and people pretend they are not there. (P10).

Beyond the necessity to overcome the traditional clinics, that are the issues related to the prejudice and the stigma that involve having a psychiatric diagnoses, already widely studied in the field of mental health[16-20]. However, the stigma related to the mental disorder with the adolescent public continues to be a scarcely researched theme, in the development science and also in the literature about mental health.

The social context of the adolescents is identified as a factor that influences the development and the maintenance of the stigma, along with the necessities and abilities that are being developed in this phase.

In the evaluation process, the relation stigma-diagnoses highlighted tensions in the field of the practices in the psychosocial attention, arising from the incorporation of the knowledge of clinics. An example are the social policies, that demand that the beneficiary has a established diagnoses, as the policy of Continuous Cash Benefit, of the Social Assistance[23].

There is a high demand, due to diverse interests – sometimes, even financial – , to establish a diagnoses, to define if the patient has this, has that, has the right to the benefit, has the right to the free pass, does not have the right to the free pass, and things like that. This is a conflict that happens almost daily here, mainly with the doctors, because, when the legal question arises, in front of the judge or in front of the INSS expert, they say they want a medical certificate that the patient has that thing. (P5).

I believe it has to do with each case and why that person needs that benefit at that moment. For this mother, it was a light at the end of the tunnel, the way she was seeing herself in face of the situations with her son. (P8).

In this case, it is about to make possible the access to this policies, providing answers to the families' real necessities, perpetrating the vision of the illness as incapacitating. Confronted with this, that question arises:

how is it possible to work that question in the perspective of the psychosocial assistance?

The act of diagnosing an adolescent must consider the impact of this diagnoses on the family and the suffering it may cause. To inform the diagnoses demands sensibility of the professional, to evaluate the repercussion that this revelation may cause in the family.

> *One thing is to diagnose the problem, the other is to tell the relative this diagnose. This is also a part of our evaluation. We tell the relative everything he is capable of listening. If we detect that the relative has a difficulty or a great fear, or does not want to know the diagnoses by no means, it is obvious that we will not disclose the diagnoses. Or, if the relative really wants to know what the case is at that moment, I think that is no problem if we disclose the diagnoses.* (P10).

The aspects discussed, related to the clinics in the practices with adolescents in a Capsi, raise reflections about the organization of these practices. We have concluded that the evaluations must include multiple dimensions, among which: the diagnoses, the functioning of the family, the social questions and the stigma, considering the singularity of each case. The time demanded for each consultation, in this perspective, confronts the productivist thinking, focused on the number of consultations, yet existing.

> *The psychiatric consultations, they take 45 minutes, an hour, a bit more. Today, I was, in a first evaluation, sitting for two hours. If all people were exactly the same, I would not need to sit for these two hours here, talking to the patient. If all people were exactly the same, I could prescribe the same medication or say the same things, but this is not like that.* (P10).

Hardly ever, the care strategies of adolescents follow the same pattern, being necessary to be flexible with the interventions during all the route in the Capsi, considering that the adolescent is a subject in constant modification (physical, psychosocial and social) and that, almost always, there are institutions involved (school, health care services, social assistance, justice)[12].

It is pointed, also, the necessity that the evaluation of the aspects related to the clinics may not be restricted to the individual consultation, but that it can also be contextualized, in its implications, in the ways the adolescent relates to people and in how this ways of relating impact the adolescents daily life. For this purpose, on one hand, the professionals that, traditionally, dominate the clinical tools, shall participate in activities that do not focus on psychological dimension of care, and on the other hand, the professionals that do not have, in their education, this centrality, shall reframe such evaluations in another direction, not illness-centered.

> *We end up prioritizing this individual question, in detriment of the groups. If I could work half of my workload with a group, I would certainly do it, it is quite rich work. Next year, when I have the new planning, I certainly will enter some group or bring new ideas to have that. This is very important.* (P10).

> *I do not have a psychotherapy formation, then, I, in a group, sometimes, prefer this music thing, of the workshop, where these realities can be transmuted, can gain another color, a melody, a rhyme. And then, in this subtle work, maybe these themes will be able to arise, but not necessarily I will have to stick the finger on the wound.* (P2).

Besides that, it is necessary that the evaluation embraces the physical aspects of the adolescents.

> *Oh, I understand the clinical question. If you see a patient that is quite constipated, show me, that I can also assist [...] I said this in the meeting with the nursing, along with the physicians, to see if they can also do that.* (P11).

There are yet challenges to overcome in order to materialize the policies in mental

health, in the direction of practices focused on the integrality of care in this field, and to meet people's demands.

This is, probably, the most important point to be discussed between primary attention and specialized attention in mental health. Although metabolic and cardiovascular disorders, sexual dysfunctions, or cancer and obesity prevail in general population, the impact of such disorders is significantly higher in subjects presenting mental disorders, since such comorbidities make them more likely to develop many health problems.

Finally, it is highlighted the importance of the adolescent's health evaluation, inasmuch as varied medications are applied, and that need to be assisted also considering the necessities developed by the own administration of psychopharmacological drugs and their side effects. Therefore, the question of the comorbidities and of the physical health of the adolescents treated at the Capsi needs to be considered in the development of practices, as well as further studied, in order to subsidize the integrality of care in psychosocial attention.

Regarding the medications, it was assessed that the lack of construction of a consensus implies the non- adherence of the adolescent and of the family to the treatment, which involves a challenge, according to the exposed thereafter:

> *Most of them say they don't need medicine: 'I don't have to be here'. 'Isn't it possible to abandon medication?'. They don't like taking medication, then, I always ask myself about the adolescent's relation with the medicine, if they perceive that the medicine is in function of the other, to make things easier for the other – 'Oh, this is to shut me up, so I won't bother them'.* (P1).

> *He said he only needed sleeping pills, because he could not sleep, he was always hyper. Then, you say: 'Look, the Capsi is not for this'; explained: 'The Capsi is like that, it is going to be a treatment like that, and that'. And none would agree with the terms of what was supposed to be the treatment in the Capsi. Consequently they (adolescent and the family) did not connect. They did not go to any consultation, nor to the psychiatrist, and that happens because the mother, who lives with her son, he does one thing, she thinks it is another, and they do not come to an agreement. And then, they come to a service thinking it is going to be 'I want exactly this, I define the treatment', without knowing exactly what the adolescent needed. And they disappeared, again... Then, that happens.* (P4).

> *A boy, for a long time, he has his own delusions, his questions, he does not want to take his medication. He has already taken varied medications, but came and said: 'Oh, this made me sleepy, this accelerated me'. And then, what do you do?* (P13).

It can be observed that there is not a trivialization of the use of medication, but there is a constant concern in considering the comprehension and expectancy of the adolescent about the treatment, in which the medication shall be agreed between the adolescent, the professionals and the responsible.

The best practices, in such cases, are based on the relationship therapist-adolescent, in which there is the pactuation and the repactuation of a group of actions between different actors[25], what presupposes organizing the routine and the definition of which actions participate, after the taking of responsibility and the sharing of tasks. This happens because there will always exist divergences amongst the integrants. It can happen that the team wants to choose a conduct and the adolescents or the relatives are resistant to adopt it.

The mental health practices directed to the adolescences are built in an artisanal, continuous and gradual work, in which the connection is the tessitura of the work in mental health, and it is in it that the team should invest as a route to welcome, accompany, treat and think, together, better ways of taking care of the mental health of the population that they assist.

Final considerations

The evaluation process, when highlighting as one of the focus of the evaluation was the question related to the clinical practice directed to adolescents in a Capsi, brings to the scene some of the great challenges of the Brazilian Psychiatric Reform: besides the constitution of opened, community services, that make possible the care in freedom, it is worth to transform, indeed, the attention model. In this direction, the overcoming of the traditional psychiatry and the incorporation of its knowledge and practices in the perspective of psychosocial assistance have not been easy tasks. However, its evaluation in the daily routine of the services and of the practices of the teams that makes it possible to look at its unfoldings. This look needs to consider the singularities of each context, and, in particular, the ones related to the mental health care of the adolescents.

It stands out the question of the pathologization of the adolescence, the way the diagnostic interpretation is extended to the majority of behaviors considered deviants, without relating them to the forms of interaction of this adolescent with life and with the world. Besides this, considering the important moment of transition and change, any diagnostic evaluation also needs to be situational, avoiding crystallized and permanent labels, that do not orient action properly. In this direction, arises the proposal of broadened clinics, considering possible symptoms and diagnoses in a contextualized manner, without centering in the disease and in the incapability.

The stigma and the prejudice are also important concerns inasmuch as, frequently, can negatively impact the life and the future perspective of these adolescents. Contradictorilly, the team evaluates the some social policies go against the psychosocial attention, since the access to them is conditioned to a psychiatric diagnoses.

This transformations in the incorporation of the knowledge of the clinics, in a Capsi, demand that the organization of the practices also transform. The critics to the separation of the consultations directed to the diagnostic and therapeutic evaluation, of the activities focused on the development of the potentialities beyond the illness, makes it possible to question also the role of the professionals themselves. The multiprofessional work, originated in different formation centers, acting together, sometimes, enhances this compartmentalisation. Even though some professional categories have, in their formation, a higher focus on clinics, this shall be resignified through different looks and practices.

As a theoretical-methodological path, it is highlighted that the potence of the Fourth Generation Evaluation has made possible the deepening by the team, considering the specificities of the practices in a Capsi and the experiences of its team, while a group of interest central in the evaluation process. It has contributed also, along its conduction, the inclusion of the process of teaching-learning, to the participants and to the researcher herself, about the themes that emerged.

Regarding the limitations of the study, it is highlighted that, although it was not p roposed to exhaust the discussion about clinics, it was possible to observe that a few topics could be approached more than once, for example, the implications of the hospitalizations in the practices of the Capsi and the work with legal aspects (underage patients) in the decision making of care. Confronted with this, a few aspects comprehended the limitation of the researcher, considering the time required to allow her to appropriate of these subjects and to seek for materials, aiming the necessary qualification for the discussions.

Collaborators

Pavani FM (0000-0002-3858-8036)* and Wetzel C (0000-0002-9125-0421)* have contributed to the conception , planning, analysis and data interpretation, elaboration of the draft, critical revision of content and approval of the final version of the manuscript. Olschowsky A (0000-0003-1386-8477)* have contributed to the analysis and data interpretation, elaboration of the draft, critical revision of content and approval of the final version. ■

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