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PSYCHOSOCIAL ATTENTION OF CHILDREN AND ADOLESCENTS: INTERFACES WITH THE HEALTH NETWORK BY THE REFERRAL AND COUNTER-REFERRAL SYSTEM

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ABSTRACT

Objective: describing the characteristics of the articulation between the services that compose the mental health network of children and adolescents, through the referral and counter-referral system.

Method: descriptive study developed in 25 services, based on information obtained from self-administered questionnaires applied to coordinators through the Ministry of Health electronic system. Data organization and descriptive analysis were performed in the *Stata* statistical program version 12.0.

Results: the existence of referral and counter-referral systems are evidenced between the basic healthcare and psychosocial healthcare centers for children and adolescents, and a partnership with other mental-health services and expanded care. However, psychiatric hospitals are still used as a reference for treatment, among other limitations, such as difficulties in dealing with mental health demands due to recurrent referrals and inexperience in this type of care/treatment.

Conclusion: emergency services for children and adolescent mental healthcare which meet the expectations of the psychosocial paradigm need new practices that may contribute to strengthening actions in this scenario. Such actions should be based on a referral system that can demonstrate effectiveness among the healthcare network in order to promote comprehensive and continuous care focused on strengthening the psychosocial care network.

DESCRIPTORS: Health services. Mental health. Health care. Children. Adolescents.

ATENÇÃO PSICOSSOCIAL INFANTOJUVENIL: INTERFACES COM A REDE DE SAÚDE PELO SISTEMA DE REFERÊNCIA E CONTRARREFERÊNCIA

RESUMO

Objetivo: descrever as características da articulação entre os serviços que compõem a rede de saúde mental infantojuvenil, através do sistema de referência e contrarreferência.

Método: estudo descritivo desenvolvido em 25 serviços, a partir de informações obtidas em questionários autoaplicados aos coordenadores, através do sistema eletrônico do Ministério da Saúde. A organização e análise descritiva dos dados foram realizados no programa estatístico *Stata* versão 12.0.

Resultados: evidenciou-se a existência de sistemas de referência e contrarreferência entre a atenção básica e os centros de atenção psicossocial infantojuvenil e uma parceria com os outros serviços de saúde mental e ampliação do cuidado. No entanto, o hospital psiquiátrico ainda é utilizado como referência no tratamento, dentre outras limitações, como dificuldades em lidar com as demandas de saúde mental, devido a encaminhamentos recorrentes e inexperiência neste tipo de acolhimento/tratamento.

Conclusão: a emergência para o cuidado em saúde mental infantojuvenil que atenda os pressupostos do paradigma psicossocial suscita novas práticas que possam contribuir para o fortalecimento das ações neste cenário. Estas ações devem ser pautadas num sistema de referência que demonstre efetividade na rede de saúde, de modo a promover um cuidado amplo, contínuo, tendo em vista o fortalecimento da rede de atenção psicossocial.

DESCRITORES: Serviços de saúde. Saúde mental. Assistência à saúde. Criança. Adolescente.

ATENCIÓN PSICOSOCIAL INFANTOJUVENIL: INTERFACES CON LA RED DE SALUD DEL SISTEMA DE REFERENCIA Y CONTRA-REFERENCIA

RESUMEN

Objetivo: describir las características de la articulación entre los servicios que componen la red de salud mental infanto-juvenil, a través del sistema de referencia y contra-referencia.

Método: estudio descriptivo desarrollado en 25 servicios, a partir de informaciones obtenidas en cuestionarios auto-administrados a los coordinadores, a través del sistema electrónico del Ministerio de la salud. La organización y análisis descriptivo de los datos se realizaron utilizando *Stata* versión 12.0.

Resultados: se evidenció la existencia de sistemas de referencia y contra-referencia entre los centros de atención psicosocial infantojuveniles y la asociación con otros servicios de salud mental y la atención primaria en expansión. Sin embargo, el hospital psiquiátrico todavía se utiliza como referencia en el tratamiento, entre otras limitaciones, tales como dificultades para hacer frente a las exigencias de la salud mental debido a la falta de experiencia y referencias recurrentes en este tipo de atención/tratamiento.

Conclusión: la emergencia para el cuidado en salud mental infanto-juvenil que cumpla con las condiciones del paradigma psicosocial, suscita nuevas prácticas que pueden contribuir al fortalecimiento de las acciones en este escenario. Estas acciones deben guiarse en un sistema de referencia para demostrar la eficacia del sistema de salud, con el fin de promover una atención integral, continua con el fin de fortalecer la red de atención psicosocial.

DESCRIPTORES: Servicios de salud. Salud mental. Asistencia en salud. Niño. Adolescente.

INTRODUCTION

With the advent of the Brazilian Psychiatric Reform, a new care model for people suffering psychologically was created based on a network to replace the asylum/sanatorium model, which comprises several services and community resources. Psychosocial Care Centers (CAPSs - *Centros de Atenção Psicossocial*) emerge in this perspective as one of the mental healthcare devices.[1] In addition, they seek to offer differentiated care within a new health logic and daily care regime representing open and regionalized institutions, and formed by multidisciplinary teams. This new healthcare logic/modality focuses the care and service on the user in its entirety instead of focusing on psychopathological diagnoses and drug therapies, thus proposing a social reintegration of the users.[2]

In this new political sphere of redirecting/recreating the care model, the provision of mental care assumes a new practice focused on the age group. In this context, the Child and Adolescent Psychosocial Care Center (CAPSi) is dedicated to meeting the demands of children and adolescents with intense and persistent psychological suffering.[3]

Thus, considering the specificities and needs of this population, it is imperative to develop articulation between the various services within the mental health care network, not only assuming their functions of direct assistance. It is also necessary to work together with other segments, linking the existing resources in the network, whether to attend affective, sanitary, social, economic, cultural, religious, educational or leisure demands.[2]

In this new mental healthcare model, new care proposals suggest that mental healthcare of children and adolescents are developed in several health services, involving the territory, intersectorality and the care network in an inseparable way so they can act in an articulated and collaborative manner to meet the challenge of expanding access and qualifying care. Thus, it is important that CAPSi work in an integrated way so that the responsibilities of the demands can be shared, thus assuming greater resolution in dealing with situations that involve psychological suffering.[2,4]

The referral and counter-referral system can be considered as an important point in this context, since referral user flow to different levels of care is facilitated from this structure. Therefore, we must highlight the need for integration between services and establishment of formal procedures for client referral, as well as the continuity of care to the user in the community in a more effective and committed way.[5] From this perspective, we perceive the importance of the existence of referral and counter-referral systems, which in addition to being a mechanism for mutual referral between the services of different complexity levels, is also recognized as an important element for promoting communication and integration toward strengthening the healthcare network.[6]

In order to promote integration between services, it is understood that the referral system should occur when the user requires a greater degree of care complexity, and therefore they need to be referred to a service with a more complex level of expertise. On the other hand, counter-referral concerns attending these specialized needs/demands when the user is referred back to the service of origin. This organiza-

tion form in health services allows for professional follow-up of the user and favors their access to all care levels of attention.[7]

Although the orientation of the Unified Health System (SUS – *Sistema Único de Saúde*) is that the population's access to the healthcare network occurs through primary health services, and that these services should be referred and counter-referred to reach the higher levels of complexity such as the secondary and tertiary levels of attention,[5] some limitations and difficulties of the reference network can be recognized, especially in terms of accessibility, difficulties in the referrals to the network, as well as resolving/meeting the demands.[8]

User flow within the health system should occur in an integrated way and communication is an indispensable factor, since it allows for a link between specialized services and primary care, thus favoring healthcare for the population. It is understood that breaks in communication and in the reference system (especially in the counter-reference), compromise the continuity of care to SUS users.

In this context, this article aims to describe articulation characteristics between the services that make up the mental health network of children and adolescents through the referral and counter-referral system. We believe that the present article can contribute to reflection on mental health practices which still have weaknesses in resolving and strengthening mental health actions for children and adolescents.

METHOD

This is a descriptive study that integrates the research of "Evaluation of the Psychosocial Care Centers of the Southern Region of Brazil (CAPSUL II)" carried out in the States of Paraná, Santa Catarina and Rio Grande do Sul. This study aimed to evaluate CAPSs, regardless of their classifications (I, II, III, for children and adolescents, or alcohol and drugs), and also with access to the information obtained by the coordinators of the participating services under study.

This integrative study only used data from the coordinators' CAPS questionnaires for children and adolescents, which represents a total of 35 CAPSi from the three southern states of Brazil. All coordinators from the 35 CAPSi centers were invited to respond to the structured self-administered questionnaire, divided into three modules (Part I, Part II and Part III), through the online FORMSUS electronic system. The coordinators who reported difficulties in answering the online questionnaire received it through their professional and personal email upon request. Moreover, trained and qualified researchers went to 23 cities to deliver the printed out questionnaire to the coordinators who referred having difficulty in answering it upon telephone contact. After all the questionnaires from the online system, printed out or by e-mail were answered, the data were then entered into the FORMSUS electronic system by trained and qualified researchers. The final sample of this study consisted of 25 CAPSi coordinators in the Southern Region of Brazil. The data obtained were transferred and analyzed in the Stata 12.0 statistical program.

Data collection took place from June 2011 to November 2012. The inclusion criteria were: being a coordinator of a CAPSi in the Southern Region of Brazil, having more than six months work experience in that position, and having post-secondary or higher education. Coordinators who were on leave, sick leave or vacation during the period of data collection were excluded from the study. All participants who accepted to participate in the study signed the Free and Informed Consent Form.

In order to characterize how these services are articulated with other services through the referral and counter-referral system that compose the health network, the following variables were used in the analysis: is there a referral system to other services?; reference to: harm reduction; Therapeutic Residential Service; Psychiatric emergency; Basic Health Unit; Emergency care; other CAPSs; General hospital in and out of the municipality; Psychiatric hospital, in and out of the municipality; Is there a counter-referral system for other services? Counter-referral to: harm reduction; Therapeutic Residential Service; Psychiatric emergency; Basic Health Unit; Emergency care; other CAPSs; General hospital, in and out of the municipality; Psychiatric hospital, in and out of the municipality.

Data analysis included the use of statistical methodology, divided into two moments; the first, being where the study of frequency distribution was performed to classify and characterize each variable used. With this, it was possible to individually visualize the values/events occurring in order to group them together when they presented similar characteristics. In a second moment, the results were organized into tables, allowing for obtaining the descriptive statistics used to summarize and describe the collected data for a better understanding, according to the type of variable that was being studied.

The project was sent to the Research Ethics Committee of the Faculty of Nursing of the Federal University of Pelotas on March 21, 2011, minutes number 001/2011, under internal protocol number 017/2011. All participants involved in the study were informed about the details of volunteering, and after agreement they signed the free and informed consent form, which complied with the guidelines of Resolutions number 196/96 and 466/12 of the National Health Council regulating research involving human beings.

RESULTS

This article is composed of a sample of 25 coordinators of CAPSs for children and adolescents, from a total of 35 existing services in the Southern Region of Brazil. The state of Rio Grande do Sul represented the highest percentage of coordinators with 64%, followed by Paraná (20%) and Santa Catarina (16%), according to table 1.

Also according to table 1, it is possible to notice that among the services that participated in the study, 70.8% were open for both shifts - mornings and afternoons - without closing for lunch at noon, while 25% closed at noon, and 4.2% were only open for one shift, morning or afternoon.

Table 1 - Distribution of Child and Adolescent Psychosocial Care Center in the Southern Region of Brazil, according to State and working hours. Brazil, 2011. (n = 25)

Variable	n	%
State		
Rio Grande do Sul	16	64
Paraná	5	20
Santa Catarina	4	16
Total	25	100
Working hours*		
Opened mornings and afternoons (open for lunch at 12 - 1pm)	17	70.8
Opened mornings and afternoons (closed for lunch from 12 - 1pm)	6	25
Opened only for one shift (morning or afternoon)	1	4.2
Total	24	100

Source: CAPSUL II Assessment Survey Database, 2011. * Considering the total of 24 coordinators who answered this question.

It should be noted that the instrument (the self-administered questionnaire) used in this research consisted of three modules (parts I, II and III) and that some of the 25 coordinators did not respond to all the modules by their own choice. Despite this representing a limiting factor of self-administered questionnaires, the topic addressed in this study is not directly affected by it, nor does it diminish the importance of the debated theme.

Regarding the referral and counter-referral system, it can be found that 80% (n = 20) of CAPS coordinators for children and adolescents from Southern Brazil reported having a referral and counter-referral system with other sectors of the Brazilian health services network. The other 20% (n = 5) did not answer the question.

Table 2 shows the services that integrate the Brazilian health services network to which CAPSs children and adolescents more frequently use the referral system (where users are referred to).

Table 2 - Distribution of Child and Adolescent Psychosocial Care Center in the Southern Region of Brazil, according to the existence of the referral system in the health services network. Brazil, 2011. (n = 20)

Referral services*	n	%
Another CAPS	18	90
General Hospital	17	85
Emergency unit	17	85
Basic Health Unit (*UBS*)	16	80
Neurologist	16	80
Social assistance	15	75
Psychiatric emergency	13	65
Psychiatric hospital	13	65
Psychiatrist	12	60
Pediatrician	11	55

Source: CAPSUL II Evaluation Survey Database, 2011; * Considering the total of 20 coordinators who answered having a referral system and performing referrals with these services.

In the CAPSi reference system (Table 2), the services that appear the most are other CAPSs, followed by General Hospitals, Emergency Units, Basic Health Units and Neurologists. Thus, 90% of the CAPSi from Southern Brazil reported referring users to other types of CAPSs (I, II, III and AD); 85% of the CAPSis reported referring to General Hospitals and Emergency Units, and 80% of the CAPSis reported making referrals to Basic Health Units and Neurologists.

Table 3 shows the services to which the CAPSis most use the counter-referral system, meaning from where the CAPSis received returns regarding the users who have been attended.

Table 3 - Distribution of CAPSis in the southern Region of Brazil, according to the existence of the counter-referral system in the health services network. Brazil, 2011. (n= 20)

Referral Services*	n	%
Basic Health Unit	18	90
Social assistance	17	85
Other CAPS	16	80
General Hospital	14	70
Neurologist	14	70
Emergency unit	13	65
Psychiatric hospital	11	55
Psychiatric emergency	10	50
Psychiatrist	10	50
Pediatrician	9	45
Harm Reduction	8	40
Therapeutic Residential Service	4	20

Source: CAPSUL II Evaluation Survey Database, 2011; * Considering the total of 20 coordinators who responded as having a counter-referral system.

CAPSis in southern Brazil reported having a counter-referral system with all the services presented in table 3. However, it was noted that 90% of CAPSis reported having a link with Basic Health Units, and 85% with organs providing social services. Articulation with other types of CAPSs in the counter-referral system was not in the first place, as for the referral system; however, they circulate among the most cited services in 80% of the CAPSis.

DISCUSSION

Given that CAPSs should be everyday community care services and function according to the logic of the territory recommended by the Ministry of Health, CAPSis working hours are from 8 a.m. to 6 p.m. Monday to Friday; and there may be a third period other than the recommended period until 9:00 pm, in order to provide a greater offer of mental healthcare to these users.

In this study, according to the coordinators it was found that the services do not follow the organization regarding the hours offered to users. It was observed from the obtained data that the services mostly operate during the mornings and afternoons, and are not open at night. This is particularly important for the discussion regarding the referral and counter-referral system, since one of the first challenges of the mental health service is to accept and establish a bond of trust with the child or adolescent and their family in order to provide and manage mental healthcare, ensuring the psychological continuity of this care. This implies a process of intense and continuous accountability and follow-up, particularly in times of crisis, both inside and outside CAPSi.

It should be noted that the longer the working hours (in the sense of offering service continuity), the greater the possibility of monitoring the users. The experience gathered in services that already operate according to this logic indicates that the possibilities for successful treatment of children and adolescents are amplified when care begins as soon as possible, and extends continuously without break(s) throughout the day.

In this sense, it was observed that CAPSs tend to reproduce the same form of organization of traditional health units, such as Basic Health Units, outpatient clinics and health centers. However, this data confronts precognitive recognition of the suffering subject and the extended care in the territory, their engagement in society and the humanization of care according to the logic of psychosocial care.[9] The traditional organization does not respond to the logic of psychosocial attention, which is based on valorizing human relations, on human contact with respect and affection.[9] This logic implies in determining factors in the care process and healthcare of children and adolescents with mental disorders, who demand a high level of accountability and continuity.

With regard to CAPSs for children and adolescents, they have articulation with other network services (referral and counter-referral); it can be seen that this system can function in formal and/or informal ways with other health service network organs. The formal referral and counter-referral system is the referral carried out in a standardized way by the institution, in which norms and regulations are established to carry out the referral. While the informal system is one in which the referral and counter-referral of subjects only happens verbally through a partnership mediated by personal and non-institutional relationships.

The formal and/or informal referral and counter-referral system aim to increase availability, accessibility and acceptability. These three characteristics are directly influenced by the formal procedures that the professionals perform. However, in the healthcare context it must be considered that these people are in delicate situations, in which it is difficult to have expectations, and which directs them to care among their contact network. As a consequence, they end up seeking, by themselves,

other informal health systems that increase the resolvability of their problems.[10]

Regarding articulation with other services, the coordinators affirmed that it was carried out by them through the referral system, whenever CAPSis professionals needed to refer the user to other health services. Referrals of this nature stood out in this study as a common practice, mainly to other modalities of CAPS, followed by general hospitals, emergency care and Basic Health Units. These data corroborate a study carried out in 2012, which investigated articulation by CAPSs of the Metropolitan Region of Porto Alegre-RS with other health network services, and how professionals evaluate the referral and counter-referral system. It was found that 90% of the referral services are quite common in the studied CAPSs, mainly for psychiatric beds in general hospitals and clinics or Basic Health Units.[11]

Regarding the referral relationship between CAPSis and other CAPSs, it was possible to deliver comprehensive care to the individual from this articulation since these services are health units that converge toward a common goal; namely, mental healthcare and constructing a model that aims to ensure better care solutions for children and adolescents. In CAPSi, as in all other modes of care for psychological suffering, access and reception must be guaranteed, as this is every individual's right and more than an offered service. Access is considered a way of welcoming, listening and responding to each one of the individuals and to each situation that they experience.

When referring to another service, the current orientation has been that of an involved referral, where the service responsible for the referral is jointly and actively responsible for participating throughout the whole process; from conducting the case to another service, and providing necessary care until the return of the individual back to the initial service. This is an important step, since working in this perspective with the other services guides the intersectoral network of care. In addition to being one of the principles of mental health work for children and adolescents, this practice constitutes permanent partnerships with all involved, especially with the education, social assistance, justice and rights sectors; historically relevant sectors /in child and adolescent care.[12]

Along with referrals to general hospitals and emergency care, CAPSis coordinators reported referring individuals to psychiatric hospitals and psychiatric emergencies. These findings are comparable to other studies carried out in relation to the referral process, albeit developed in CAPS types I and II.[13]

Given the strategic role of CAPS in building a community network of care articulated with each other in order to abolish psychiatric hospitals, and in order to constitute a set of references capable of absorbing and accommodating individuals in psychological distress,[14] this type of referral should no longer be part of this care process. In this case, the situation may even be more worrying, since the public health network presents difficulties in making beds available for children and adolescents in general hospitals, which causes insecurity on the part of psychosocial care.

Considering that the psychosocial mode[4] demands construction of an articulated and engaged community care network to meet the needs of individuals in psychological distress, the availability of beds in general hospitals is a viable alternative that meets the requirements of the Ministry of Health, who oversee/provide for these units. However, it is believed that the main difficulty for implanting psychiatric units in general hospitals (not only for adults, but also for children and adolescents) lies not only in the embedded stigma and present in the culture of a society, but in the limitations regarding the lack of an affirmative policy for such units.[15]

It can be understood that hospitalization in a general hospital bed outside CAPS when necessary contributes to shifts of paradigm, reducing prejudice and the stigma that involves individuals in psychological distress. It enables health integration as a whole, as well as having other therapeutic resources that meet the comprehensive health of children and adolescents.

In psychiatric emergency, that is, in situations in which users present intense suffering such as a psychological crisis, it is necessary to broaden concepts and overcome the episode in order to promote continued care. Psychological crises are part of the daily lives of subjects who are constantly dealing with moments that generate disorganization in their lives.[16]

Along these lines, the need for a new mode of care and organization is increasingly relevant, guided by the community territorial logic and by articulation with other points of the healthcare network responsible for emergencies and urgencies, such as the Mobile Emergency Care Service (SAMU) and the Emergency Care Units (PMU), which can provide a higher quality of care and follow-up.[17] This articulation reinforces the network expansion process beyond CAPSs, minimizing or avoiding

hospitalizations and expanding therapeutic resources; thus integrating it with other services in the challenge of care attention that children and adolescents occupy.

Recognition of mental health problems in children and adolescents is recent. Accordingly, efforts have been made to expand the resolution of such problems, in addition to it being necessary to improve the network of services and actions capable of responding to the complexity and distinct levels of intervention, striving to effectively respond to the mental health demands of children and adolescents.[4] Primary care has been considered a new strategy of mental healthcare for children and adolescents, representing a partner in the referral system that is also mentioned in this study.

Primary care is considered a privileged place for constructing a new logic/modality of mental healthcare due to its proximity to the community; as such, its ability to handle and resolve many situations that may unfold is favorable. Moreover, the professionals and the community know each other in these services, establishing personal bonds and creating channels for contact. As a consequence, dealing with the mental health of children and adolescents becomes less problematic.[12]

It should be stressed that in order to make this articulation possible and to visualize comprehensive and resolute care, it is necessary that the services work in an integrated way, and that they know and qualify the reference and counter-reference processes. Only then will it be possible to promote a comprehensive and satisfactory network that can share responsibilities, and thus guarantee greater coverage and quality in meeting the demands that involve psychological suffering.

The presence of a doctor presence was also mentioned among the articulations carried out based on the reference system. As much as the desire for immediate response to suffering continues to be places in medicine and knowledge of psychiatry, this functioning does not always seem to support the continuity of mental healthcare, since it focuses on punctual visits, which heal immediate complaints.

In addition to biomedical reinforcement, the movement to be performed must be outside the offices, assisted in its own territory. To do so, it is fundamental to break the barriers of prescriptions and referrals, to intervene in the social space where the community lives and where the network care is proposed.[1]

Thus, it can be understood that centralized care in the medical profession and the perspectives of care/assistance focused on controlling and directing specialized health practices must be overcome.

Regarding the counter-reference, most of the coordinators reported a return of their articulation with the various organs present in the territory in which CAPSi are inserted. When carried out in an effective and coherent way with follow-up and return of the case, counter-reference is seen as something relevant for network articulation. However, it is worth emphasizing that in the daily routine of the services, this organization logic is still fragile and little used, as found in this study. The most mentioned services were those that make counter-referrals, namely the Basic Health Units, followed by social services and other CAPSs.

In general, the logic of co-responsibility and of shared work has been intended to override the logic of mere referral, which means that care is not a sole responsibility of those who receive the users, instead they (the service receiving the user) have the responsibility to share, follow-up and to return with the information on the users who have been attended to.

In this perspective, the referral and counter-referral system makes articulation between the services provided by the SUS possible within the health network, in order to guarantee access to all users.[14] As a result, the health units have incorporated greater responsibilities, considering that they are entrusted with not only carrying out the referral, but also the need to think about the continuity of care to the user. This requires that the performance of all the professionals involved is based on a commitment to the counter-referral system and scheduling the user's return, guaranteeing resolution of their demands.[5]

In this sense, we emphasize the importance of articulating services as a challenge for developing psychosocial networks, in a country marked by regional diversities and impasses in the consolidation of care based on intersectorality. Work/performance guided by the principle of collaboration, based on the reference and counter-reference system among the other health services involved in the care of children and adolescents requires key actions to leverage the expanded network of mental healthcare. These actions should be supported with a view to address the different types of problems and broaden access, based on an ethical foundation of care in freedom and territory.[4]

By analyzing the counter-referral system in this study, it was possible to observe that the services that least met this partnership are Harm Reduction and Therapeutic Residential Service. The

lack of communication between these services and/or professionals that make up the psychosocial care network and CAPSis is also an aspect that directly acts as an inhibitor of access, and consequently leads to fragility in the constitution of the care network.[18]

It can be highlighted that this fragility in the response system regarding the user's health situation/condition or the incipient articulation of the investigated services is related to a lack of communication between workers in this service, a lack of knowledge about network services or the lack of more responsible care flows.

In agreement with the present study, another study carried out on the effectiveness of referral and counter-referral processes in health services of a municipality in the south of Brazil, showed the study participants reporting difficulties in its effectiveness due to the lack of return from services to which the user was referenced to, and a lack of accountability of professionals involved in care. The study suggested the need of working in networks aiming to offer comprehensive care to users and awareness/training for multiprofessional and interdisciplinary teams.[19]

In this context, the defense for a therapeutic care model based on new proposals and care strategies for those experiencing psychological suffering arises, favoring care technologies that value the singularities of the subjects, promoting their social insertion. In this psychosocial context, care is oriented towards building bonds, welcoming, and creative practices that include the territories and the social relations of the subjects.[20]

Thus, CAPSis are important places for the care of children in need of treatment; however, in order for the referral and counter-referral system to be effective, the different services that receive users must understand the clinical conditions of the child.

The services that provide mental health care to children and adolescents should adopt a social function that surpasses the technical performance of care, that is, they must carry out actions of welcoming, listening and caring. They should also enable emancipatory actions to improve the quality of life of children and adolescents with mental suffering, understanding them as an integral being with the right to full participation and inclusion in their community. This is implied in a care network that considers the singularities of each individual and the constructions that each subject makes based on their (mental) health state.[16]

Thus, we point out that in order for psychosocial care to be effective, it depends on a complex network; and that mental health alone does not encompass all the necessary resources. Therefore, there is a need to articulate with various social institutions,[21] as we understand that the subjects' course and restoration of their health needs to happen in life and in society, which consists of their daily life, the exchanges, the involvements, the negotiations, the thoughts and the relationships between the subjects. A well-defined referral system carried out by the health network contributes to strengthening actions in the field of psychosocial care.

CONCLUSION

The performance of this study made it possible to describe the articulations that are developed between the CAPSis and the other services that compose the health network through the referral and counter-referral system. The results indicate that the CAPSis are able to carry out actions directed to the mental health of children and adolescents in an articulated way with other services, highlighted by the other CAPSs, Basic Health Units, general hospitals, emergency and urgency units. Thus, we can notice the possibility of the mental health of the child and the adolescent to be included in the scope of care actions of the health network and no longer be restricted to the specialized universe of CAPSi.

The services studied presented logic in care organization consistent with the guidelines advocated by mental health legislation, which moves towards a mental health model compatible with the psychosocial mode in most of the articulations that are established with other services. CAPSis are moving towards building an alternative network that includes other health services and community resources. On the other hand, working in the perspective of reference and counter-reference goes beyond making partnerships with existing organs in the territory. This is because we see the need to understand that reference is not sending away only, and that it is necessary to strengthen relations between workers and services through dialogue, so that the subject can be seen and cared for comprehensively. At the same time, it is necessary to strengthen referral and counter-referral organization to ensure consistency with the psychosocial care logic.

It is evident that comprehensive care and co-responsibility of the health teams regarding the referral system (referral and counter-referral) are necessary and fundamental in the care process, since they promote a more dignified care in their territory and social context. In this way, we enable the recovery of autonomy, citizenship and rights of having

effective care and with the support of healthcare network. In this sense, it is considered that the CAPS for children and adolescents have strategies focused on comprehensive care for children and adolescents, involving actions not only within the clinical scope, but also to promote intersectoral actions**.**

Thus, this study has brought contributions to the little explored theoretical and practical field, as well as evidence that there are difficulties that need to be overcome by professionals and managers as facilitators who act in the mental health of children and adolescents in the field of articulation with the other network services. This study can be of great assistance to broaden the discussion and build a more adequate service for this population, especially with regard to identifying factors that potentiate, hinder or fragment the articulation between actions and services.

We emphasize the difficulties involved in carrying out the research as a limitation of the study, which limited data collection: some of the coordinators did not complete all the modules of the questionnaire, and chose to leave blank or chose to not answer some parts; a greater concentration of services was found in one of the three States of the Southern Region; extended data collection time (one year and five months) due to the precariousness or lack of internet network in the services or difficulties in completing the questionnaire.

We hope that the results of this study can contribute to re-think the way forward regarding comprehensive healthcare to children and adolescents through the referral and counter-referral system of the psychosocial care network. This implies an attentive care process that promotes unique projects, serving the demands of children, adolescents, family and community, contributing to their [re]-integration into society.

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