ARTIGO ORIGINAL

PSICOLOGIA E SAÚDE EM DEBATE
ISSN (eletrônico) 2446-922X

DEMANDS AND OFFERS OF PRIMARY CARE IN CHILDREN'S MENTAL HEALTH

DOI: 10.22289/2446-922X.V10N1A43

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ABSTRACT

The objective was to understand the demands and offers of Primary Care with regard to mental health care for children and adolescents, from the perspective of workers. This is a qualitative research, made with 41 primary care (BA) health workers in a municipality in the Southeast region. As an adopted methodology semi-structured interviews were used and two focus groups, in the latter, 20 workers participated among those who were interviewed. This was followed by a lexical analysis of the Descending Hierarchical Classification type with the help of the IRAMUTEQ software, resulting in five classes. Conceptions of childhood and adolescence appeared in the reports, still marked by ideas of incompleteness and a logic of specialized care.

Keywords: Mental Health Assistance; Child; Adolescent; Intersectoral Collaboration; Health Policy.

DEMANDAS E OFERTAS DA ATENÇÃO BÁSICA EM SAÚDE MENTAL INFANTOJUVENIL

RESUMO

Objetivou-se compreender as demandas e ofertas da Atenção Básica no que se refere à atenção em saúde mental infantojuvenil, na perspectiva dos trabalhadores. Trata-se de uma pesquisa qualitativa, realizada com 41 trabalhadores de saúde da Atenção Básica (AB) de um município da região sudeste. Como metodologia adotada, foram utilizadas entrevistas semiestruturadas e dois grupos focais, neste último, participaram 20 trabalhadores dentre os que foram entrevistados. Seguiu-se com a análise lexical do tipo Classificação Hierárquica Descendente com o auxílio do software IRAMUTEQ, resultando em cinco classes. Compareceram nos relatos concepções de infância e adolescência ainda marcadas por ideias de incompletude e por uma lógica de cuidado especializado.

Palavras-chave: Assistência À Saúde Mental; Criança; Adolescente; Colaboração Intersetorial; Política De Saúde.

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Recebido em 21/03/2024. Aprovado pelo conselho editorial para publicação em 01/06/2024.

DEMANDAS Y OFERTAS DE ATENCIÓN PRIMARIA EN SALUD MENTAL INFANTIL Y ADOLESCENTE

RESUMEN

El objetivo fue comprender las demandas y ofertas de la Atención Primaria en relación a la atención de la salud mental infantil y adolescente, desde la perspectiva de los trabajadores. Se trata de una investigación cualitativa, realizada con 41 trabajadores de la salud de la Atención Primaria (AP) de un municipio de la región sureste. Como metodología utilizada se utilizó entrevistas semiestructuradas y dos grupos focales, en este último participaron 20 trabajadores entre los entrevistados. A esto le siguió un análisis léxico del tipo Clasificación Jerárquica Descendente con ayuda del software IRAMUTEQ, resultando cinco clases. Aparecieron nuestros relatos de concepciones de la infancia y la adolescencia aún marcadas por ideas de incompletitud y una lógica de atención especializada.

Palabras clave: Atención De Salud Mental; Niño; Adolescente; Colaboración Intersectorial; Política De Salud.

1 INTRODUÇÃO

The historical background of the constitution of mental health care for the child-juvenile population in Brasil is quite unique and late, when compared to the initiatives related to assistance aimed at the adult population. This reality directed the care of children and adolescents towards total institutions of a private nature and of a philanthropic nature, which, for the most part, act in a fragmented way (Taño & Matsukura, 2019). This way of providing care lasted until the end of the 1970s, with the beginning of the Psychiatric Reform Movement, which criticized the conditions of psychiatric care and promoted new proposals for mental health care, with psychosocial care as a guiding principle. It sought to promote the reorganization of services in order to favor the creation of care strategies from the perspective of social inclusion, in addition to fostering the recognition of the person in psychological distress as a being with a life story and possessing desires (Belotti et al., 2017).

Specifically, regarding child and adolescent mental health care (SMIJ), it was only in 2005 that the Ministry of Health published a document with guidelines for the effectiveness of SMIJ public policy, which produced significant impacts on the construction and effectiveness of the network of services for this population. The document emphasizes the universal welcome, the implicated channelling, the permanent construction of the network and the intersectoral actions aiming to "enable emancipatory actions", governed by the ethical commitment to the uniqueness of children and adolescents and their right to speak (Brazil, 2005).

It is important to note that the Child and Youth Psychosocial Care Center (CAPSij) is the first specialized public equipment, implemented in Health Unic System (SUS), designed to promote the care of children and adolescents, under the logic of psychosocial care. Defined as a territorial-based

service with interdisciplinary and intersectoral action, CAPSij was established through Ordinance No. 336 in 2002 (Brasil, 2002) and reaffirmed in 2011, with the enactment of Ordinance No. 3088, which regulates the Psychosocial Care Network (RAPS). When Ordinance #336 was published, CAPSij became the main device responsible for articulating and coordinating the networked care of its users.

Although the primary role of CAPSij is recognized, since the institution of RAPS is also possible to identify the relevance of Primary Care (Atenção Básica – AB in Portuguese) in the process of care in the field of mental health, in view of its proximity to the territory. Characterized as the preferred gateway to the system, AB is responsible for organizing care in Health Care Networks (RAS). Therefore, for the effectiveness of its attributions, it is essential that the teams that make up AB recognize the health needs of the population under their responsibility, including the demands of SMIJ (Brasil, 2017).

According to Lourenço et al. (2020), there are still few studies directed to the field of SMIJ from the perspective of care in the context of AB. In a study guided by Nogueira and Campos (2017), which addressed the construction of mental health policies and equipment and the care actions for the child and youth population in a city located in Minas Gerais's countryside, it was identified that the mental health demand of this population, in AB, is not understood as legitimate and that the actions developed are limited to medical consultation and drug treatment. Given this scenario, this research aimed to understand the demands and offers of Primary Care regarding the care in SMIJ, from the perspective of the workers.

2 MATERIALS AND METHODS

This is a qualitative research, made by health workers in Primary Care (AB) in a municipality of the southeast region. The health network has 29 Basic Health Units (BHU), a Reference Center for Elderly Care and for treatment of Sexually Transmitted Infections, four Psychosocial Care Centers (CAPS - CAPS II, CAPS III, CAPS III for alcohol and drugs, and CAPS for children and adolescents), an Attention Service for people in violent situations (SASVV), two Emergency Departments (PA) and a Municipal Center for Specialties. The data were collected after approval by the ethics committee.

Different methodologies were adopted for data collection, to broaden the knowledge of the reality studied. The first stage of the collection was carried out through an individual interview with professionals from BHU. Professionals from 25 of the 29 BHU that make up the health network participated, totaling 41 participants: 20 service directors (Dir), 18 psychologists, one nurse, one social worker , and a speech therapist. For the interviews, the directors of the services, who had been informed of the research by the municipal health secretary, received a phone call from the

research team informing them of the research's objectives and requesting an appointment to interview the BHU professionals who developed activities aimed at children and adolescents. Then, upon arriving at BHU, different professionals were indicated as possible participants. This strategy was adopted not to induce the participation of any specific professional, but to access those who developed some work with children and adolescents. The interview was guided by a script of questions that began with broader questions about child and adolescent health care, leading to specific questions about the most common demands for care in SMIJ in the AB, such as the actions/activities developed for children and adolescents, the professionals involved, and the specific actions for care in SMIJ; identification of a profile of the public served; equipment and/or actors, inside and outside the territory, involved in this care in SMIJ; among others.

The second stage of data collection occurred via two Focus Groups (FG), in which we sought to access the participants' conceptions of care for children and adolescents in distress, since in this type of collection the participants are placed in a situation of discussion, debate and reflection on the issues presented (Gondim, 2003). This stage was attended by primary care workers from different professions (nurses, social workers, psychologists, speech therapists, and physicians), totaling 20 participants in the two groups. Some of the FG participants had also participated in the interview. To conduct the FG, the health secretariat sent an invitation to the professionals of the AB through the institutional communication network, informing the research objective, date, time and place of the groups. The professionals who expressed interest in the theme responded to the e-mail and subsequently attended the scheduled meeting. The discussion was mediated by the main researcher and a moderator, based on a pre-defined script with the following topics: the role of children and adolescents in care; guidelines that guide the work in the field of SMIJ; demands of SMIJ; resources or devices (public or not) partners for carrying out the work; conceptions about networking; difficulties in working with children and adolescents in the field of mental health, among

Both the FG and the interviews were recorded, after signing the Free and Informed Consent Form, and transcribed. The FG transcripts were analyzed as being discourses of the group and not of an individual sender, unlike the interviews. For analysis, all the material was organized into a single corpus and submitted to IRAMUTEQ (Interface de R pour les Analyses Multidimensionalnelles de Textes et de Questionnaires), for lexical analysis of the material produced). In this research specifically, we adopted the Descending Hierarchical Classification (DHA), which regroups the lines of text segments from their similarity, using, for this, several chi-square (x2) tests and, finally, partitioning the corpus into classes (Camargo & Justo, 2018, 2013). After this step, we proceeded to the interpretation of the material organized by the software, since in "interpretative level, the meaning of the classes depends on the theoretical framework of each research" (Camargo & Justo, 2018, p. 16)

For the presentation of each class, extracts from the participants' reports were explained. The reports taken from the interviews were identified by means of the profession and the participant's

identification number, for example Psi 1. Those extracted from the FG were represented by profession, followed by the acronym FG, as in AS FG.

3 RESULTS

The transcription of the interviews and the FG resulted in the composition of a single text corpus, which was submitted to the CHD and unfolded into 1,790 text segments with 4,744 distinct forms and 61,673 occurrences. CHD had a 94.86% utilization rate, considered satisfactory according to Camargo and Justo (2018). The corpus was partitioned into two subcorpus (A and B) and in sequence, subcorpus A compartmentalized twice, giving rise to class 5 and then classes 1 and 2, and subcorpus B to classes 3 and 4, as shown in Figure 1:

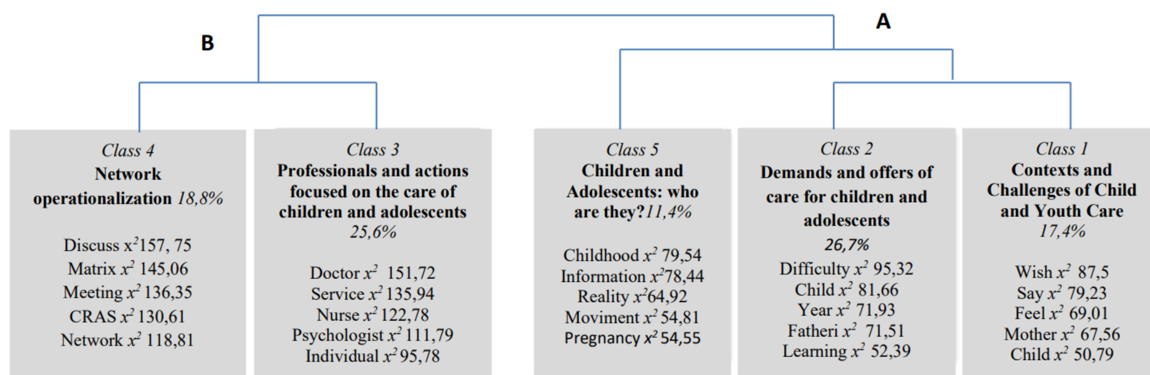

Figure 1. Dendrogram SM IJ in Primary Care - Source: Iramuteq.

Subcorpus A gathered classes 1, 2 and 5 and brings contents that allow us to know the participants' understanding of what it is to be a child and adolescent, to characterize the demands and offers of care in SMIJ and its articulation with the life context of these subjects, not to mention the challenges of this care.

Class 5 corresponds to 11.37% of the material analyzed and presents who the children and adolescents assisted in the services are, and is entitled "Children and Adolescents: who are they? There appears among the participants a conception of children and adolescents as beings in development and marked by lack and incompleteness, being fragile. The participants recognize, however, that it is necessary to consider the context of life and the socio-historical moment in which these subjects live.

Thus, in the attempt to conceptualize childhood and adolescence, the professionals bring many stories crossed by violence, by the difficulty of access to rights, among others: "(...) here in our community many people suffer sexual violence, without realizing that they are suffering. Because that is their reality, they don't know any other" (Psi 3).

With regard to adolescents, they are presented as those of difficult access, which associates to pregnancy in this phase of life, a reality present in many territories, according to the participants, recognizing the difficulty of services in accessing them:

> (...) because adolescents have a lot of this, [difficulty] to fit into this very hard flow of the US: getting up at dawn to come, it's not very much their profile. I can't want them to come to have access to health things that are interesting for me, for my indicators of pregnancy, of syphilis. I can't want to catch them in this sense (...) putting a lot of obstacles that the system imposes. We need to speak their language, know what the language of this tribe is to be able to attract them (Psi 12).

Class 2, named "Demands and offers of care to children and adolescents", represented 26.74% of the material analyzed and refers to the demands for care of children and adolescents who arrive at the BHU, indicating the type of difficulties they present and the offers of services. According to the participants, the demands are varied, predominantly the referrals of children and adolescents by the school to the BHU for issues such as: neglect or violence in the domestic context, learning difficulty, accompanied by school tardiness, agitation (associated by the school and family to hyperactivity), conflictive behavior with peers, leading to the assumption of Oppositional Defiant Disorder (ODD). Among adolescents, issues such as: suicidal behavior or ideation, self-injurious behavior, aggressiveness, violence suffered, among others, appear. On the other hand, according to the participants, the referrals of children are still predominant to the detriment of adolescents, and the latter have more difficulty in attending the service with mental health demands, as expressed in the report: "(...) they don't come, because they are sometimes called crazy, (...) these kinds of things like that" (Fon 1). In this debate, one of the participants interviewed pondered that there are attempts to make schools rethink some of these referrals:

> "We do a tireless job of explaining to schools that there is no point in sending learning disabilities" (Dir 2). In FG, participants report initiatives to break with this logic of pathologizing behavioral difficulties in the school context: "Because they [the school] want us to transform the child into docile bodies and it's our disciplining role. [And] they get very angry when they find out that we don't do that" (Psi GF).

The participants bring their perception of how the school and the family itself have difficulties in dealing with issues that are typical of childhood or the development process, and with those that make up the experiences of childhood and adolescence today, such as the use of new technologies and the speed of information. According to them, the lack of interest in school, the difficulty in following the formal content, the conflict with peers, the resistance to follow rules, are almost always

taken as representatives of psychopathological diagnoses such as hyperactivity, language delay, presumed Autistic Spectrum Disorder (ASD), cognitive deficits or ODD, decontextualizing the subject from his or her history and life environment.

Professionals address the demand for SMIJ care by implementing strategies involving parents, such as individual receptions or psycho-educational groups. The focus is on attentive listening, providing necessary care, or referring to the child's needs. They prioritize engaging with parents first and extending support to children when required. The approach has shown positive outcomes. Additionally, the professionals highlight variations in service organization across different territories. Some lack specific actions for SMIJ, either due to a perceived absence of demand or because the service primarily offers spontaneous individual psychological care, typically initiated by families. Meanwhile, other services make diverse attempts to connect with local services and resources.

In association with class 2, as expressed in the dendrogram, class 1, called "Contexts and challenges of child and adolescent care", with 17.43% of the analyzed content, presented segments of text that try to contextualize the care demands presented by children and adolescents, besides bringing other elements that indicate the challenges and difficulties in working with this public.

This class expresses the relationship that the participants make between the difficulties presented by children and adolescents and their family dynamics, focusing on the mother figure. Some participants bring examples of how many children assisted by the program present family conditions marked by neglect or omission. They report that many difficulties encountered in the work with children and adolescents stem exactly from the little co-responsibility of some families, who outsource not only the daily care, but also the possible "solution" to the child's difficulties.

In this direction, the demand for medicalization or for "quicker and simpler" answers appears: "So, for the parent to take off his responsibility and the school to take off hers, (...) they want the neurologist to evaluate the child. So everything is evaluated by the neuropediatrician. It became a mania" (Psi GF) or still: "(...) we didn't see any problem with him, no diagnosis. And the mother insisting: 'no, but he has a problem, I need to take him to the psychiatrist, he doesn't obey'" (Psi 7).

In this setting, they point out that it is a challenge to the care of children and adolescents to deconstruct this demand for medicalization and psychiatric diagnoses that somehow justify the difficulties. In this regard, some professionals mentioned the difficulty they find in some families adhering to other work proposals that escape the medical-biology logic or the individual psychological care as the only possibility of care, and that it is difficult to operate group services, for example, for parents or even for children and adolescents, pointing out different reasons for this: "The mothers started to say that they couldn't do it at that time, and then the number of absences was extremely high" (Dir 9) .

Another difficulty mentioned by the participants is to break with the logic of guilt and tutelage by the health services to these families:

> "(...) look at the level that comes from a desperate mother wanting support, not knowing how to deal with the situation, and we specialists have a lot of guilt in this, because we absorbed for a long time this responsibility of saying: I know what is best for your child" (Psi GF).

Furthermore, some participants emphasize the need to consider the diverse realities of these families, taking into account life stories that pose challenges to parenthood. They acknowledge the evolving social role of women, who, in addition to domestic responsibilities, have increasingly taken on work outside the home, a common occurrence among working-class individuals: "(...) many mothers are single and work extensively, often lacking professional qualifications" (Psi FG). Participants also express an awareness that many parents in these situations are themselves experiencing hardship due to challenging living conditions in socially vulnerable areas or life experiences marked by violence, neglect, and abandonment. Additionally, they note that the interaction with the school and the demands of work routines, often characterized by feelings of isolation, presents difficulties in caring for SMIJ. While professionals comprehend the challenges faced by schools, their reports suggest a perspective that views the school not as a solution but as part of the problem in SMIJ care. In this regard, the report follows:

> Because we know that school is a very complicated place, with crowded classrooms, unprepared teachers, lack of material, a series of problems. But it is another problem. Because the school sends the children there, even with a diagnosis (Psi GF).

With regard to the feeling of loneliness, some professionals identify difficulties in teamwork, absence of spaces for regular meetings among the network workers and a misunderstanding that mental health care is the exclusive work of the psychologist, which often results in more ambulatory practices than in teams: "It is a very lonely job, I don't know if it is because here the demand is big, or if people really have difficulty working in a team" (Psi 11).

Subcorpus B groups classes 3 and 4 and brings us elements that allow us to know, from the participants' perception, the SMIJ network, the child and juvenile care actions, the professionals involved, the articulation tools between different kinds of services, such as health, education, and social assistance, and the difficulties related to the operationalization of this network.

Class 3, named "Professionals and actions focused on the care of children and adolescents", with 25.6% of the analyzed material, describes the professionals involved and the actions of the health services focused on the care of children and adolescents. Doctors and nurses appear as the professionals who offer care related to more general health issues, such as childcare, immunization, and development monitoring, but also as those who receive and refer for evaluation, in case of demand for specific care in mental health. Physicians' actions, in general, were mentioned in the

context of physical health care, with almost nonexistent participation in mental health matrix, shared care, and SMIJ groups.

Participants said the coexistence in services of different ways of organizing the reception in mental health. In some, the host is focused on the figure of the psychologist: “Mental health here is the responsibility of psychology. Here it works like this, each one in his square, unfortunately” (Psi 16). In other services, the reception is carried out by any professional on the team, who then shares the demand with the other professionals: “Even more if it is a serious case (...) they should welcome whoever is available (...) no necessarily the psychologist will welcome, the speech therapist, the social worker, the nurse will welcome, whoever can from the team will welcome” (AS GF).

It was mentioned as actions focused on mental health care the individual, group and shared care by different professionals, offered to children and adolescents and their families/guardians, organized in different ways in each service. In some, all the demands for SMIJ care are received in a parent group and then the necessary referrals are made (to another service, for the child's evaluation, for psychological care for the child or adolescent, for the family member, or even the deconstruction of the demand); in others, they are received individually by psychology; in others, by professionals from the Extended Core of Family Health and Primary Care (NASF). In any case, the participants affirmed that the actions offered as responses to these care demands - individual and group care, individual consultations, groups with children or parents - count on the participation of psychologists social workers, speech therapists, nurses, and doctors, as well.

Class 4, entitled "Network operationalization", represents 18.79% of the material analyzed and in it the participants reported some tools of articulation between the services and sectors for the care in SMIJ in the network perspective, as well as the difficulties for its operationalization. They reported that some tools of articulation for this networking are important, especially the discussion of cases, either in team meetings in the UBS, or in matrix meetings with the CAPSij or NASF-AB, or even in meetings of the extended network, in which devices such as the Specialized Reference Centers for Social Assistance (CREAS), Reference Centers for Social Assistance (CRAS), and schools are present.

Matrix support appeared as another important tool/work space according to the participants, being considered "a very powerful space within the UBS" (Dir 16) for the construction of the service's responses to the care demands, allowing the "approximation of the territory and what we have in terms of demand" (Psi 6) with professionals from other care levels. According to them, the space also ends up favoring learning in the work context, qualifying the care actions: "My experience with the matriciamento has always been very positive (...) we have already studied anxiety, suicide...". (Fono GF).

Despite this, some participants consider that this space is not always used as it could be, losing part of its effects, sometimes because the team does not organize itself to take the cases to the matriciamento, not following up on something agreed upon in a previous matriciamento;

sometimes because, in the participants' view, the matrix team does not present the level of knowledge and offers answers that meet the team's expectations and needs.

The participants reported how it is possible to share situations and care strategies by other means besides the monthly matriciamento meeting with CAPSij. Thus, in other ways this network of care is being woven, citing institutional communication through a computerized network and even phone calls as a way to trigger different actors and devices.

About the role of CAPSij in this network, the professionals reported to be essential and important: "it is a partner of the AB" (Psi 15) with "many dedicated professionals in this space, who have taken care of children who develop a more severe disorder, who need a greater complexity than" (Psi 3) can accompany in the AB. However, they consider that having only one service of this type to serve the entire municipality is a weakness in the network, considering the geographic distance from more peripheral neighborhoods of the city: "The distance. It has no social voucher, so people stop joining the follow-up because it is distant from the territory" (AS GF).

About the expanded network meeting, some participants regretted the fact that professionals from CAPSij were removed from it. According to them, many cases followed and discussed in these meetings are directly related to mental health and the presence of professionals from the reference service was important:

> Because there was a time that CAPSij was present in our network meeting with the school, and we discussed the cases, it was very interesting [...] because the child involves this issue of school, family, there are other circumstances there (AS FG).

Also about the meeting of the extended network, called the Social Assistance Network, the participants reported that it is held monthly, usually organized by CRAS, and brings together, besides the UBS, other equipment present in the territories, such as CREAS, the guardianship councils, schools, some social projects, among others. In these meetings, cases are discussed, referrals are defined, and agreements on actions to be taken are made. In all interviews with professionals in the UBS, this network was mentioned as important in the promotion of collective proposals in actions of health care for children and adolescents. About the effects of this network on the organization of actions, the participants reported:

> (...) one of the most consistent problems that the school brings is learning difficulty (...) Now, if people live in the same place, have very close experiences and have the same difficulties in learning, it is not the individual, it is something in this environment that is in this process. So, we also think of collective answers, and that is why this strategy of thinking in a network (Psi 6).

But in spite of their power, there were difficulties and some impasses with some equipment in the territories. According to the participants, difficulties are often encountered when working with the Guardianship Councils and the CREAS.

Concerning the ways in which this network is being organized, we observe differences depending on each territory, the ways in which the devices manage to articulate themselves locally and outside the territory. In some places, health services and other kinds of services manage to promote actions that heat up the network with the participation of different territorial equipment and secretariats.

4 DISCUSSION

The classes presented by Iramuteq allow us to understand the conceptions of the participants about what it is to be a child and adolescent, the main problems of SMIJ that appear as complaints in AB, the tools and actions implemented for a psychosocial care, the professionals involved in this care, as well as the difficulties experienced for the mental health care to children and adolescents.

Among the participants, there was a conception of childhood and adolescence still marked by the ideas of lack, incompleteness, by an opposition to what one is not yet: a full adult. This conception corroborates the literature in articulating the discussions on the historical characteristics of care provided to children and adolescents in this country (Taño & Matsukura, 2020), which obliterated the possibility of care that recognized them in the place of legal subjects and desire, able to address their demand for care to the service (Brasil, 2005; 2014).

In this sense, institutions such as the school and the family appear as the main claimants of specialized care in mental health for this audience, sometimes based on a prescriptive and stigmatizing logic. These are the two instances that initially identify the possible 'deviations' and are authorized to say what is going on, as expressed in class 2: children and adolescents have learning difficulties, suspected hyperactivity, aggressiveness manifested in different ways, self and hetero-aggressiveness, among others, which are addressed to health services by the school and family. The reasons identified as those for which these subjects reach health care devices are not different from those found in other studies, which highlight the increasing number of children referred by schools seeking specialized evaluation for mental health problems (Cabral & Sawaya, 2001; Nunes et al., 2019; Ribeiro & Miranda, 2019).

It is worth noting that this refers to an intention of care by these instances (school and family), and marks the importance of these institutions in the construction of care, for their proximity to the life of this age group; however, it requires the transformation of the way of affirming these subjects in their life contexts, able to talk about themselves. In this sense, the participants of this study point out that they have managed, in some moments, when looking at those demands for care, to advance

in the direction of analyzing and transforming them. The professionals involved in this research question, then, the very concept of childhood and adolescence initially formulated, advocating that it is crucial to consider the existential territory and life backgroun, without which a simulacrum of subject is produced, taking it as a-historical and a-social. As a result, even though timidly, they call on the school to rethink its referrals by questioning the demands and complaints presented.

This questioning of school complaints and referrals, which at some moments go in the direction of an attempt to deconstruct the demand for pathologization and excessive medicalization, guiding principle of the SMIJ policy in Brasil (Brasil, 2005), does not always enable the joint construction of answers to what appears in the school environment as a possible difficulty of the child and adolescent. On the contrary, the school, in the perception of the participants, does not seem to be part of an expanded network of care in SMIJ, showing itself, along with the family, incapable of dealing with the discomfort presented by the subjects and of taking co-responsibility for the care. Many of the participants' reports point to the school as part of the problem, but not of the solution.

Thererfore, although the participants are not restricted to a purely biological conception of psychological suffering, understanding the complex nature of this phenomenon in its origin and manifestation, they sometimes approach the context as represented by a single agent, attributing the responsibility for the difficulties of the child and adolescent to something or someone (the school, the family, the mother, poverty) subtracting it, therefore, from a network of complexities. The family, especially the mother figure, was stressed by the participants as being the main source of suffering and difficulties of the assisted subjects. As Taño and Matsukura (2020) state, what is perceived in this dynamic is the individualization of the processes of suffering of children and adolescents, with their families generally being blamed for what happens to them. Thus, in the participants' discourse there is the notion that the suffering of children and adolescents, often expressed by disruptive and disturbing behaviors, has a single causality, generally related to family and/or school conduct.

In contrast to the guilt of any instance in relation to the psychological suffering of this public, one must consider the need to think about a network of care to SMIJ that articulates with devices such as the school, social projects and other instances that make up the existential territory of the subjects, including the family. Fernandes et al. (2020) emphasize that among the 10 participants in the research they conducted, only four reported conducting a partnership with the school, the others referred only to health equipment in the composition of networked actions for the care of children and adolescents. This network limitation to health services compromises the effectiveness of the intersectoriality principle, advocated by scholars in the field as favorable to the expansion of care, considering the complexity of the situations experienced by children and adolescents in distress (Fernandes et al., 2019; Silva et al., 2019; Taño & Matsukura, 2019; Tavares, 2021).

This way, the AB also needs to problematize the way it receives these demands and complaints coming from schools and families: whether in a restrictive response that "there is no point

in sending" or in a proposal to question and build together the possibilities of caring for these children and adolescents in the different places they circulate. In this case, this questioning would extend, for instance, to the educational system, which, with its content-based matrix, restricts the possibilities for educational professionals to also act on other issues present in the school routine, beyond the transmission of knowledge; and to health, which still, to a great extent, responds to the needs of children and adolescents solely from a biologizing perspective.

According to the participants, the school, as well as families, demand from health professionals immediate solutions to possible problems of children and adolescents. Yet, one must consider the role of psychology itself, other sciences, and the health services themselves, by building in the social imaginary the idea of health specialists as those who are authorized to deal with problems or deviations in the educational development of children and adolescents, presenting possible solutions, as stated by Taño and Matsukura (2020).

As a result of this intention, also of the health professionals, byt building, by themselves, solutions for mental health issues of children and adolescents, constitute certain mismatches between demand, supply and needs of the territories. In accordance to reports from the professionals who participated in this research, families often do not adhere to the offer of assistance made, such as the parents' groups. Little progress is observed in the provision of care in possible formats to the user, for example, in terms of schedules, and articulation with the territories, their culture and reality, which was also identified in a study by Teixeira et. al. (2017).

Hence, this study advocates collaborative efforts. Rather than outright rejecting the demands from schools and families, it emphasizes the importance of jointly analyzing and developing alternative approaches based on life stories and territorial needs. The belief is that this approach will effectively address the challenge highlighted by participants – the difficulty of reaching adolescents in the territory. This involves scrutinizing tools and methodologies for communication, investing in territorial actions to dismantle the stigma around adolescents seeking mental health care – those who refrain due to being labeled as "crazy" (Fon 1).

A study conducted by Teixeira et al. (2017), which sought to understand the barriers and facilities for collaborative care between the Family Health Strategy (FHS) and CAPSij, observed that there is more space for the debate on mental health about childhood than adolescence in the BHU, which is one of the barriers observed for care in SMIJ. Thus, issues related to adolescent mental health seem to remain invisible in many territories (Paula et. al, 2008).

Similarly, Silva et al. (2019) argue that there's limited demand for adolescent mental health care in the AB. This is attributed to the predominantly medical-biological nature of services, like those addressing pregnancy prevention and sexually transmitted infections. This service orientation creates a specific demand profile, as evident in queues of children awaiting evaluation for school issues, which may not align with the expected care for this demographic in the AB. While there are challenges in recognizing adolescents' mental health needs in BHU, the BHU is acknowledged for

its effectiveness in adolescent care, given its proximity to the territory and potential support networks (Devis et al., 2009).

For Félix (2016) a paradigmatic change is underway that recognizes the AB as a prominent place in the care of subjects in psychic suffering, with a shift of focus from the disease to people in suffering. However, as observed in some reports, the centrality of the search for a nosographic diagnosis still persists, the idea of mental health care performed exclusively in reference services, such as CAPSij and, the attention in SMIJ restricted to psychology professionals, making the work solitary and sometimes of an outpatient nature. In this same direction, Teixeira et al. (2017) identified a demand for specialists coming from the professionals of the BHU, whose care is based on the traditional and hierarchical model of care, marking a fragmentation of care.

As per participants, certain BHU services don't acknowledge SMIJ demands in the territory. Frateschi and Cardoso (2016) mapped mental health practices in BHU since 2008, concluding that this complexity isn't recognized as a care reference by health professionals. This situation underscores the need for increased training across the network, exploring the potential of this care level for mental health, providing various services to children, adolescents, and families, including case discussions, coordination with territory services, matrixing, computerized network communication, and extended network meetings, as suggested by participants.

Matrix support has been affirmed as an important method of learning through the sharing of knowledge and practices, in the direction of a qualification of mental health care, although it still deals with challenges related to the organization of cases by the teams and the expectation of the AB to respond to their needs, as also brought in the results of this research (Iglesias, 2015; Lima & Dimenstain, 2016; Fagundes et al., 2021). Hence, there is the "extended network meeting", which brings together assistance, education, health, guardianship council, and social projects, apparently presenting itself as important in the implementation of the intersectoriality principle, in order to also align some organizations that are important to SMIJ care: such as the reception by the several services, actors, and sectors that make up this network, as well as by any health professional member of the team, and not only by the psychologist, as highlighted by some participants.

In this argument, Kantorski et al. (2014) emphasize the importance of psychosocial care to this audience not being restricted to a single institution. It is essential to bring together sectors of the Primary Health Care Network, School/Education Department, Guardianship Council, Social Assistance (CRAS/CREAS), and Justice, which, once sharing responsibilities, can facilitate and speed up the process of inclusion of these children and adolescents in psychological distress in a mental health care cycle.

As reported by the participants in class 4, caring for these children and adolescents calls for different devices, actors, and services in the territory and outside it, which demands the activation of a network that goes beyond the health field. For Félix (2016), the care of children and adolescents in distress presents specificities that go beyond the strategies directed to the adult population.

It is believed that those articulation tools mentioned in this research, as the matriciamento and the "extended network meetings", have the potentiality to deal with certain difficulties brought up by the participants regarding the work with children and adolescents, such as: teamwork, effective meeting spaces, deviation from the medicalizing logic, expansion of the possibilities of doctors and nurses to work beyond individual care focused on the physical health of children and adolescents.

In this last case, as discussed by Tanaka and Ribeiro (2009), it is possibly a matter of a certain deficiency in their training regarding the SMIJ theme, as well as a lack of possibility of acting concretely when facing the complaint of psychological suffering of children and adolescents. These are difficulties that those tools have the potential to overcome, incorporating psychosocial discussions in the daily practices of BHU, plus a management that institutionally guarantees the participation of these workers in activities such as matrix support, shared care, and SMIJ groups, amd alsos the presence of important organs in the constitution of the mental health network, as CAPSij.

Given the results of this research, we highlight the great challenge that is still faced in the implementation of a mental health network that is effectively capillary and offers territorial care. The "effort to expand this care to include the primary level is one of the undeniable advances of the psychiatric reform" (Félix, 2016, p. 94), but there is certainly a long way to go to strengthen mental health care at this level of care

5 FINAL CONSIDERATIONS

This research aimed to understand the demands and offerings of Primary Care (BA) regarding child and adolescent mental health, from the perspective of the workers. It highlights the coexistence of two conceptions of individuals: passive in decision-making processes regarding their lives and participative in the construction of effective health care. These are conceptions that equally guide diverse practices in mental health care: prescriptive, doctor-centered, and comprehensive - as they involve various social actors in care.

In this diversity of conceptions and practices, there is a certain mismatch between supply and demand. For example, offering a parent group that the target audience does not attend, or an absence of demand and supply due to a lack of identification of the territory's needs in child and adolescent mental health care, which requires problematizing the relationships between the actors, sectors, and services that could potentially constitute a care network for this audience, and between these children, adolescents, their families, and these services.

It is about analyzing the opening of possible network devices to accommodate the psychic suffering of children and adolescents in their complexity, as well as the connection of these services with the territory in its needs, beyond what appears as demand, towards an offering of

comprehensive care. Together, transforming a demand historically produced, focused solely on the search for nosographic diagnosis and specialized care in psychiatry and psychology, which appears in PC, into an offering that calls for the unique indispensability of each of these social actors, including school and family, in child and adolescent mental health care.

It is worth highlighting once again the importance of constantly analyzing these partnerships, as no blame should be placed, as brought up in this research, especially in the current context of the deterioration of the Unified Health System (SUS) and specifically mental health, which requires everyone to think and act collectively and responsibly for a more democratic society in the distribution of general living conditions.

This research hopes to contribute to daily reflections on child and adolescent mental health care, specifically highlighting the potential of Primary Care due to its position and potential in this care. Other studies are deemed necessary that could also present the understandings of these other possible network components, such as school and family, highlighted in this study, in child and adolescent mental health care.

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