Children and Youth Mental Health from the perspective of workers in a health network

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Abstract
The objective was to understand the difficulties and potential of a Mental Health (MH) network aimed at children and adolescents, identifying how professionals understand and operationalize the principles of the policy of SM for children and adolescents. Five Focus Groups were held, with the participation of 43 workers. We used lexical analysis through the Iramuteq software, originating four classes: "*What is being a child and adolescent*?"; *"What do children and adolescents suffer from*?"; "*On the relationship between services*" and "*Potentials and challenges of the Mental Health Network*". Difficulties in sharing care were identified, articulating the network outside of oneself. Capsij is perceived as a priority for user embracement, and there is still difficulty in providing care in MH in Primary Care (AB). It is concluded that the complexity of care in MS for children and adolescents imposes the need to continue strategies to strengthen the AB and intersectoral actions aimed at an expanded clinic.
Keywords: Mental Health Assistance; Child; Adolescent;

Saúde Mental Infantojuvenil na Perspectiva de Trabalhadores de Uma Rede de Saúde

Resumo
Objetivou-se conhecer as dificuldades e potencialidades de uma rede de Saúde Mental (SM) voltada a crianças e adolescentes, identificando como profissionais compreendem e operacionalizam os princípios da política de SM infantojuvenil. Foram realizados cinco Grupos Focais, com participação de 43 trabalhadores. Utilizou-se da análise lexical por meio do software Iramuteq, originando quatro classes: *"O que é ser criança e adolescente?"*; "*Do que sofrem as crianças e adolescentes?"; "Sobre a relação entre os serviços"* e *"Potencialidades e desafios da Rede de Saúde Mental*". Identificou-se dificuldades em compartilhar o cuidado, articulando a rede para fora de si. O Capsij é percebido como prioritário para o acolhimento, havendo, ainda, dificuldade em efetivar os cuidados em SM na Atenção Básica (AB). Conclui-se que a complexidade da atenção em SM para crianças e adolescentes impõe a necessidade de continuidade de estratégias de fortalecimento da AB e de ações intersetoriais visando uma clínica ampliada.
Palavras-chave: assistência em saúde mental; crianças; adolescentes

La salud mental infantil y juvenol desde la perspectiva de los trabajadores de una red sanitaria

Resumen
El objetivo fue comprender las dificultades y potencialidades de una red de Salud Mental (SM) para niños y adolescentes, identificando cómo los profesionales entienden y operacionalizan los principios de la política de SM para la niñez y adolescencia. Se realizaron cinco Grupos Focales, en los que participaron 43 trabajadores. Se utilizó el análisis léxico a través del software Iramuteq, originando cuatro clases: "¿Qué es ser niño y adolescente?"; "¿Qué padecen los niños y adolescentes?"; "Sobre la relación entre servicios" y "Potencialidades y desafíos de la Red de Salud Mental". Se identificaron dificultades a la hora de compartir los cuidados, articulando la red para fuera de sí. El Capsij se percibe como una prioridad para la acogida, existiendo aún dificultades para implementar los cuidados en SM en Atención Primaria (AP). Se concluye que la complejidad de la atención en SM para niños y adolescentes impone la necesidad de continuidad de las estrategias de fortalecimiento de la AP y de acciones intersectoriales, visando una clínica ampliada.
Palabras clave: Atención a la Salud Mental; Niños; Adolescentes;

Introduction

Mental disorders represent a significant cause of suffering, disability and dependence in the population, affecting about 15% of children and adolescents worldwide. In Brazil, it is estimated that the prevalence of psychopathologies in this group varies between 7% and 20%, and there is still a shortage of services aimed at this public (Tszesnioski, et al., 2015).

In Brazil, the implementation of a Child And Adolescent Mental Health Policy (PSMIJ) is recent. Historically, actions directed at children and adolescents in psychological distress were based on restrictive practices of freedom and institutionalizing, reparative character. This assistance was mainly made by philanthropic entities, and its recognition in the scope of public policies and guarantee of rights was recent (Tãno & Matsukura, 2020). Despite the advances

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achieved by the Brazilian Psychiatric Reform initiated in the 1970s, it was only in 2005 that the Ministry of Health published a document guiding the organization of a psychosocial care network for the care of children and adolescents (Brasil, 2005). In line with the National Mental Health Policy, the Child and Adolescent Psychosocial Care Network should be organized based on principles and guidelines such as: universal reception; recognition of children and adolescents as subjects of law and involved in their care demand; permanent construction of the network; and intersectoral actions (Brazil, 2005; Ministry of Health, 2014).

By taking children and adolescents in psychological distress as subjects of rights and desires, being, therefore, implicated in their demand for mental health care (MH), a break with care practices is proposed. These practices make up the dominant paradigm still in health oriented by guardianship, segregation, asylum and, above all, by understanding these subjects as unable to say about themselves and their suffering (Tavares, 2021). Nevertheless, from the PSMIJ the perspective of children and adolescents assisted in freedom, in contact with their territory and taken as complex subjects, able to contribute to their care process, together with their families and health professionals (Brazil, 2005; Taño & Matsukura, 2020).

The assistance to children and adolescents provokes and demands the articulation of different actors and services that somehow cross the existence of these subjects, guided by the intersectoriality principle. This principle represents one of the challenges of the MH network when caring for children and adolescents in distress, which would be the ability to articulate outwards, involving devices as the school, the justice system, social welfare, leisure and cultural institutions, in the prevention, promotion, and health care. The composition of this network requires the existence of an articulated collective, capable of producing care that includes resources in the territory, interdisciplinary work, and permanent dialogue (Couto & Delgado, 2010; Nunes et al, 2019; Tszesnioski, et al., 2015).

Considering the historical trajectory of violation of children and adolescents' rights in Brazil, as already mentioned, and the need to reorganize practices that can guarantee rights, it is important to investigate the construction of networks in aiming at identifying how professionals in this network and in the management understand and implement the principles of SMIJ policy..

Method

This is a qualitative study, made in a medium-sized municipality in the southeastern region of Brazil. The municipality has a health network composed of 29 Health Care Units (HUs), a Reference Center for Elderly Care and a Center 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 Youth/Capsij), a Service for the Care of People in Situations of Violence (SASVV), two emergency rooms, and a Municipal Center for Specialties.

Forty-three workers participated in this research, including professionals from Primary Care (Atenção Básica - AB), two reference centers (Capsij and SASVV) and a management team (Technical Reference Team in MS). The participants, statutory public servants, belonged to different professional categories, such as: psychologists, physicians, nurses, social workers, speech therapists, physical educators and nursing technicians. These professionals made up a convenience sample with the inclusion criterion of having worked in child and adolescent mental health for at least 6 months. After a telephone invitation from the researchers, 12 professionals from the Capsij, seven from the SASVV and four from the management team participated. The professionals from the PCU received, through the municipality's computerized network, an e-mail with information about the research, day and time of the Focus Group (FG) with an invitation to participate. Thus, 20 workers responded to the e-mail expressing interest, resulting in the composition of 2 FG.

From the months of October 2019 to March 2020, five FG were held: one with professionals from the Technical Reference Team in SM (Prof. ETR), two with professionals from BA (Prof. BA), one with professionals from SASVV (Prof. SASVV) and one with professionals from Capsij (Prof. Capsij). All the FGs had heterogeneous composition in relation to the participants' backgrounds, with the exception of the technical team, formed only by psychologists. These FG had the participation of four to 12 members, with an average of eight participants in each group. It was decided to hold two FG with workers of the PCU because they are the largest number of servers in the municipality.

Each of these FG lasted from 1:30 to two hours, mediated by the main researcher plus one or two researchers. The group discussion was guided by a script (the same for all the FG) and was triggered by a

question: "For you, what does it mean to be a child and an adolescent? After this, the researchers led the discussion so that the participants debated questions such as: "What is the demand for SMIJ in your service?; Do you have guidelines that guide the work in the field of SMIJ?; What is the process of referring users to other services? What resources or devices/partners do you have to carry out your work? If you had to list difficulties in working with children and adolescents in the field of MS, what would they be? How?". After signing the Informed Consent Form (ICF), according to Resolution No. 466/12 of the National Health Council (Brazil, 2012), the FG were audio-recorded and transcribed (CEP Opinion No. 2.899.493).

All the material was organized in a single corpus, differentiating the participants by FG and not by formation, since for the analysis the reports are taken as group and not individual productions. After that, we proceeded to the lexical analysis of the data using the software IRAMUTEQ (Interface of R for Multidimensional Analyses of Texts and Questionnaires), which "allows different forms of statistical analysis on textual corpus and on tables of individuals by words" (Camargo & Justo, 2013, p. 513). In this research, we adopted the Descending Hierarchical Classification (DHA), which regroups the lines of text segments based on their similarity, using several chi-square (x2) tests and, finally, dividing the corpus into classes (Camargo & Justo, 2013). After this step, we proceeded to the analysis of the material processed by the software, since it is up to the researchers to interpret it based on the theoretical reference adopted.

Results

The corpus submitted to the CHD unfolded into 1,476 text segments with 4,711 distinct forms and 51,367 occurrences. CHD had a performance rate of 80.56%, considered satisfactory according to Camargo and Justo (2013). The corpus was partitioned by the software into four classes, as shown in Figure 1.

Class 3, called "What is it to be a child and an adolescent?" corresponded to 19.09% of the material processed by the software and grouped text segments that express the participants' conception of childhood and adolescence, having as words with the highest chi-square (x2): adolescent, year, child, adult, age and phase.

The word *adolescent*, in general, was used to refer to a phase of life, being almost always associated with the word child, year, age, and phase. The participants defined adolescent as a subject in development, who is no longer a child, but is not yet able to behave as

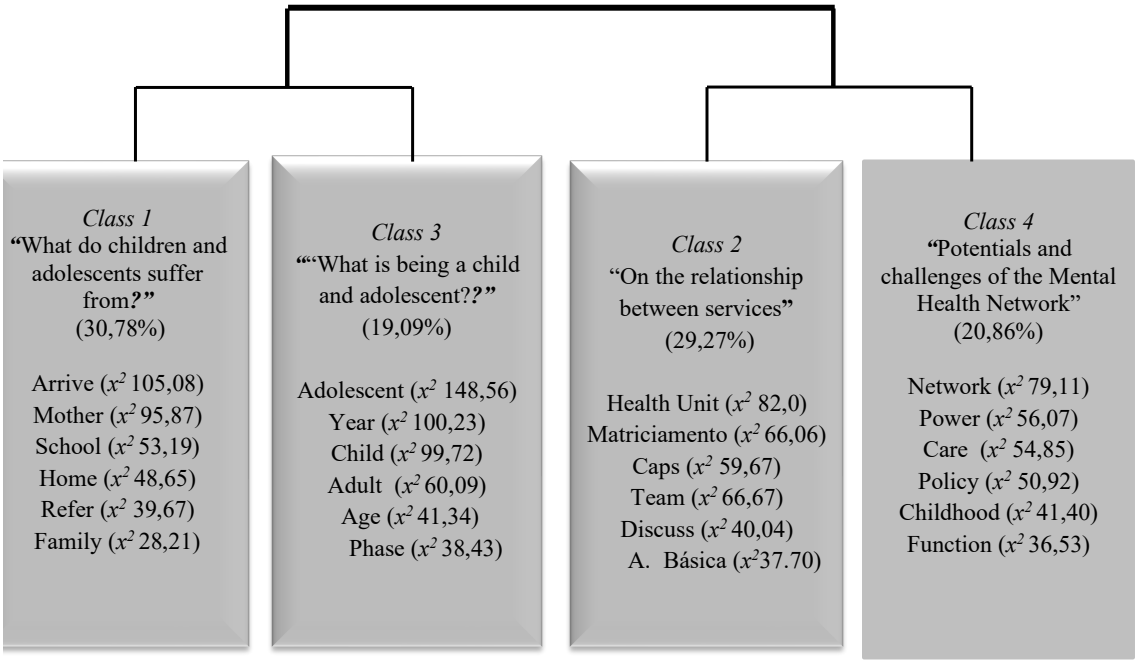

Figura 1. CHD dendrogram of the corpus workers.

an adult. A large part of the participants brought a representation of adolescence as a period of lack, of incompleteness, of someone who is not yet a subject.

One participant pondered the importance of considering the complexity of the stories and life contexts of these adolescents. Other participants point out that many children and adolescents who access medium complexity services seem to be invisible in the territory, because they come to the service with a history of rights violation never before identified by other devices, on account of health, education or social assistance:

The first opportunity that the child accesses because of sexual violence, and at no time was this detected by the territory. This is common, (...) chronic cases, of severe rights violation, of children and adolescents, that seem invisible in the territory (Prof. SASVV).

In this discussion about the low visibility of this public by the network services, the participants highlight the even lower prioritization of adolescents when compared to children in the provision of care. In the words of the participant: "There are people raising flags to many things, it's Autism, the rights of the disabled, but very few embrace the adolescent who needs to be seen, who uses substances, that we need to welcome" (Prof. Capsij). For another participant:

> *I think that the weight of childhood ends up being in survival, in infant mortality, in the puerperium period, and after these first two years pass, I feel a certain relaxation from the team, it seems that "it's over and now it's going. And then the follow-up of the development from childhood to adolescence, many times, the team doesn't see itself as being responsible. I have already had cases of 12 year-old boys with a history of delayed development, who had never been sent for evaluation, but had many records that he had delayed development (Prof. ETR)*

Regarding children, the participants conceive them as subjects up to 12 years old, who experience a transitory phase of life. Like adolescence, childhood is mentioned as synonymous with incompleteness and lack: "Child still has no will" (Prof. AB). On the other hand, other participants highlight the role of the child in their treatment process. The following is the account: "what is the role of the child and the adolescent in his treatment? It is of a subject considered, listened to, and respected in what he brings, be it suffering, be it joy, (...) because here (...), unlike other spaces, he can be what he is" (Prof. Capsij).

Class 1, called "What do children and adolescents suffer from?" corresponded to 30.78% of the material analyzed and had as words with the highest chi-square: arrive, mother, school, home, refer, and family. This class refers to the way and the reasons why children and adolescents access health services for care in MS.

The word *arrive* refers to the reasons why users are referred. Among the professionals from AB, the reasons related to the school context predominate, such as agitation, Attention Deficit Hyperactivity Disorder (ADHD), learning disabilities, and violence. The Capsij professionals report an increase in cases of self-inflicted violence and substance abuse as manifestations of suffering. Among SASVV professionals, due to the very characteristics of the service (the public attended), cases related to suspected or confirmed violence, especially sexual.

Concerning specifically the referrals made from school to health services, the participants highlight the attempt of categorization and medicalization by the educational institution. Here is the report:

> *(...) education professionals trying to categorize the kids that give problems and the ones that don't give problems. The ones that give problems, "we medicate", we give them Ritalin or Risperidone. And, many times, when this child comes here, we see that he has nothing to do with mental health, or that he needs to be medicated. It is a child being a child (Prof. SASVV).*

This medicalization movement also appeared linked to families, as undercore by the participant:

> *... children come here with a complaint of illness and we see that it is a reflection of the family context. And the mothers come with the need to medicate the child and we say: no... But many times it is in the mother's imagination that there will be a medicine that will make the child stop signaling the dysfunction of the family (Prof. CAPSij).*

The words *mother and family* refer to the person who brings the child/adolescent to the service, addressing the demand for care to him/her; but the school was mentioned as responsible for most of the referrals of children and adolescents to the services. The participants highlight the excessive production of demand for care in HS by this institution, as well as its omission in some cases. In the words of the participant: "... I used to receive 15, 16 children in a class. I had, at least at the beginning of the year, 300 kids to talk to me" (Prof. AB).

Class 2 named "About the relationship between services" corresponded to 29.27% of the analyzed material and had the following words with the highest chi-squares: *Health unit, matriciamento, Caps, team, discuss,*

AB, meeting and Capsi. The word *Health Unit* appeared in segments of text in which the participants report the potentialities and difficulties in the relationship with this equipment. The participants of medium complexity services highlight that, although they receive many referrals from PCU, they are not capable to establish more integrated work processes with all the PCUs, which is a result, according to them, of the fragmented way many PCU teams are organized. For the participants, many times, the integration between services for the provision of comprehensive care to the user depends on the professionals getting to know each other previously. The following account: "Sometimes I have the feeling that we depend a lot on our previous personal knowledge. So, if it is a person who is from a US where I already know a professional, then I go straight to that professional" (Prof. SASVV).

With specific reference to the relationship between the PCU and the Capsij, the participants affirm that there is a certain difficulty of some professionals or PCU teams in taking care of SMIJ, which apparently also interferes in the relationship between these services: "When a mental health or alcohol and drug issue appears, it is seen as a specialty issue. If a demand related to SMIJ arises, the first thought is: 'to whom am I going to refer it?).

> *In this class, the words matrix, Caps, and Capsi also appear prominently. For ETR, the matriciamento managed to operate an approximation between Caps and the BA and between the different Caps, removing this service from a certain "encapsulation":*
>
> *..In fact, CAPS didn't even meet each other. ... While CAPS is only inside CAPS, we will not be able to strengthen the care we are offering. We talked about the encapsulated CAPS and the matrix support was the main strategy for us to open this service and activate these tensions (Prof. ETR).*

In Spite that, the ETR considers that many US, in the matriciamento space, demand little discussion around SMIJ: "There are US that don't demand anything from children, but we know that there are children's issues there" (Prof. ETR).

> *... the issue of childhood and the issue of alcohol and drugs are the two points that remain in the background ...)First, there is a difficulty of BA teams, even in understanding childhood issues that are more particular, very basic things. Generally, they tend to trivialize the issues, saying that this is a phase and that it will pass. There are issues of knowledge, many prejudices that make the professional not to have a technical look when faced with suffering in childhood, when faced with the suspicion of abuse (Prof. ETR).*

In this context, the participants of PCU describe in their relationship with Capsij the moments in which the articulation happens satisfactorily and the difficulties they encounter in the relationship with the service. Among the difficulties reported, one participant from the PCU mentions situations in which she refers the user to the Capsij and he returns for exclusive monitoring in the PCU:

> *I discuss a case, I put forward a position. It goes for reception at Capsi ... And they come back, saying "no, this is not Capsi's". I said: if it's not Capsi's, who is it for? Because I can't handle it alone, and he will come back and keep coming back to me and I have no other place to refer to (Prof. AB).*

The words *discuss* and *meeting* appear linked to the idea that they are essential tools for the team's work, or even as something missing in the network, as highlighted in the excerpt: "We want to discuss, talk about what I am doing ... But in general, we are in a productivist demand, that we need to review what we are doing too" (Prof. BA).

Finally, class 4, called "Potentialities and challenges of the Mental Health Network" represented 20.86% of the analyzed material and had as words with the highest chi-square: network, power, care, policy, childhood, function. The SMIJ network was characterized as under construction, presenting potentialities and weaknesses. Among the potentialities, the participants identify the fact that the vast majority of workers in the health network are permanent employees, which allows them to be trained by/on the job and accumulate experience and knowledge about public health policies. For the participants, this context makes the actions more qualified and enables continuity of care. Furthermore, they highlight as a potentiality for the construction of the network the fact that these workers work in multiprofessional teams. It is "a multiprofessionality that is committed, that is resistant, that faces management, that suffers, but has autonomy" (Prof. SASVV).

Matriciamento also appears as an activator of networking processes and the resolutive capacity of teams, by having in this space the possibility of joint construction, of agreeing responsibilities and defining possibilities of care.

Another potentiality was the municipality's computerized network, which, according to the participants,

allows professionals from different services to communicate through the electronic medical record.

> *Having a computerized medical record and institutional communication eliminated problems that I had before. We had care that overlapped. We had a child going to three services and receiving three prescriptions. Today this is more difficult, because any employee looks at the [computerized municipal] network and already knows. So, I think this is a power (Prof. ETR).*

Another potentiality pointed out is the fact of having a technical reference team in MH and child and adolescent health. According to the participants, these teams activate the network by convening the participation of different services, both clinical and non-clinical, promoting intersectoriality, and extrapolating the municipal network, when necessary, to provide care in SMIJ.

Moreover, they mention as a power of the network the community itself, the territories in which the services are inserted: "What the network has as strength, as power, are these connections that we make, the territory itself. Partnership with the community itself, which supports us, which gives us tips, which helps us produce something different" (Prof. BA).

The participants also mentioned what they considered to be challenges for this network: the continuity of articulation strategies between services, monitoring and evaluation of cases followed by more than one service, communication between services, material scarcity, ranging from lack of resources, such as toys for children, to insufficient numbers of workers.

> *For the participants, the difficulty of some services to articulate and communicate with each other ends up breaking the lines of care to the user, making their continuity fragile:*
>
> *We received a child whose rights were super violated. When she goes to the hospital, they didn't look at the medical record to hold that child, to make contact with us (...) So, like this, the network is pierced and we need her to talk (Prof. Capsij).*

The existence of an overlapping of two modes of care also appeared: one of a more biomedical nature, which is characterized by being hierarchical, and another of a psychosocial nature, of sharing care and co-management of work processes. These two modes cross the daily life of the services and overcoming the first presents itself as an additional challenge.:

> *... the idea of breaking the reference and counter-reference, that the case needs to be passed on, is an idea that we try to overcome. How to print this logic in a network in which other health modes are placed, in a hierarchical way, in the logic of reference and counter-reference? How to keep alive issues such as the unique therapeutic project, the reference technician, basic concepts of the psychiatric reform, in a network that we can't officially demonstrate this way of operating? (Prof. ETR).*

It was also shown as a challenge to the Child and Adolescent Health Network the ability of health services to articulate with other services, establishing connections with other devices such as education, social assistance, justice, in order to strengthen intersectoriality.

Discussion

The classes presented made it possible to know, from the professionals' perspective, the conceptions of childhood and adolescence that cross the practices of the participants of this research; the reasons why these children and adolescents are referred to health services; the relationship established between the services and the characteristics of the SMIJ network in this municipality.

It is seen that there is heterogeneity in the conceptions of children/adolescents (Class 3) and that they have repercussions in different care practices. These different modes of care appear in this research in overlapping, described by the participants (Class 4) as biomedical, characterized by hierarchical interventions, and another of a psychosocial nature, marked by actions built in a shared way between professionals and users, as in cases where they articulate with the community.

It is understood that conceptions of children and adolescents also influence the relationship between the services of this network. The conception of childhood and adolescence restricted to the idea of a phase, composed of incomplete beings, which are not yet characterized as subjects, more present in this study among the professionals of the PCU, will possibly be converted into little demand for discussion about the SM of this public, for example, through the matriciamento (Class 2). This conception has marked for decades the history of assistance to this public in the country and still runs through the daily life of services (Taño & Matsukura, 2020). Thus, if there is no subject of desire and rights, there is little need to bring together so many services and social actors for the proposition of a networked care for these children and adolescents.

Frota (2007) claims that this diversity of conceptions about childhood and adolescence has repercussions

on the practices aimed at these age groups, with the offer of care often focused exclusively on the biological development of this public or even on their categorization and medicalization based on a diagnosis.

The dominant paradigm in health care is based on the precepts of the biomedical model, which is characterized by hierarchical practices that fragment health services and actions into individualizing curative professional knowledge (Ojeda & Strey, 2008). This leads to that demand presented by the participants, of medicalization and categorization of children and adolescents by the school, family and other social actors. Therefore, possibly, the lives of these children and adolescents become circumscribed in "disorders", to the extent that they are more interested in the disorders (whether they are "learning disorders", "motor skills", "attention deficit", "hyperactivity", among others) and less in the subjects, the history and the context linked to their suffering (Oliveira, 2018).

Still, the effectiveness of care in SMIJ has been associated with intersectoral practices (Fernandes et al., 2019; Silva et al., 2019; Taño & Matsukura, 2019; Tavares, 2021), which consist precisely in the integration of two or more sectors with a view to consolidating the integrality of health care. In this study, intersectoriality is highlighted as promoted mainly by the technical reference team in MS.

This perspective of integration is in line with the psychosocial care paradigm, which positions the user (in this case, children and adolescents) no longer as a passive patient in the processes that concern their lives, but, on the contrary, affirms them as subjects with rights and desires, who have to contribute with their history and context in the production of their care, pointing out their protagonism in the construction of care (Brazil, 2005; Ministry of Health, 2014; Tavares, 2021). Then, it is possible to state that this new paradigm supports that notion brought by the participants, of children and adolescents as citizens and unique subjects.

It is, as pointed out by the participant of this research, to consider the complexity of the stories and life contexts of these subjects in the construction of care, which necessarily refers to the promotion of their visibility in the territory, understood as dynamic, alive, composed of multiple interrelationships and that influences the constitution of subjectivities, just as these subjects interfere in the production of this territory (Lima & Yasui, 2014). As brought by the participant (Class 4), it is the "partnership with the community itself, which sustains us, which gives us tips, which helps us produce something different" (Prof. AB).

The fact that children and adolescents in psychological distress have belatedly entered the Brazilian public health agenda is partly explained by the belief that these subjects would not experience psychological illness and madness (Couto & Delgado, 2015). However, as even brought by this research (Class 1), this public brings the most diverse sufferings, linked to learning (inattention, delays in schooling), behavior (agitation, hyperactivity, aggressiveness), the most varied types of violence - including that self-provoked, the use of psychoactive substances, among others, also found to be prevalent in other studies (Nunes et al, 2019; Ribeiro & Miranda, 2019). And, if on the one hand, in some territories children and adolescents in distress seem to remain invisible, the results show us that in others there is a growing demand for interventions in SM for this public: "... I had, at least at the beginning of the year, 300 children to talk to me" (Prof. BA).

In this context, public policies have a role in remedying this historical debt with this age group, and the BA is an important space for promoting this care, which, due to its principles and privileged place of proximity to the territory where people live and move around, has the potential to expand adherence and access of this public to care in MS (Gomes et al., 2015; Teixeira et al., 2017).

Yet, research has identified that the expansion and qualification of care in MS in the PC in Brazil is still a challenge to the provision of care in MS (Delfini & Reis, 2012; Silva et al., 2019; Teixeira et al., 2017). A study conducted by Delfini and Reis (2012) identified as the main challenges to the care of children and adolescents in the PC: the lack or little training of family health teams to propose and implement care within the logic of psychosocial care; the lack of spaces for reflection and analysis about the work and about madness; the difficulty in sharing care between the FHS teams and the specialized services; and the shortage of services or professionals in the field of MH. Another study (Silva et al, 2019) identified among PHC workers the absence of reports on adolescent care in MS. In the authors' view, this speaks more to the supply of care that the service provides to this population, of a more medical-biological nature, than to the actual demand in the territory. This makes it possible to understand why, in some territories represented in this research, there is an absence of demand for SMIJ care.

In part, some of the difficulties identified in the literature on the care of children and adolescents in suffering are common with the context in which this research is inserted, highlighting, for the participants, the challenge of the shortage of material resources and workers in sufficient numbers, in addition to the continuity of strategies of intra and intersectoral articulation and communication, which is understood as directly related to the loss of "collective spaces of discussion", as brought by the participant (Class 2). The professionals of this municipality highlight the importance of regular meetings of the SM involving professionals from Caps, BA and management, which were extinguished with the change of municipal management, even though this space is provided in the proper document (Iglesias & Avellar, 2016).

Iglesias and Avellar (2019) when dealing with the matrix support in SM highlight the indispensability of regularity of these meetings for the construction of more transversalized relationships between the services involved in the care, favorable to the effective exchange of knowledge and practices in the production of the integrality of care to this public.

The matrix is brought in Class 2 as an important working tool, enabling the sharing of care between the PCU and the ICPC teams, as well as removing the latter service from a certain "encapsulation". This refers to the potential of the matriciamento to promote benefits for both services, the PCU appropriating the discussions on MS and the Caps of the dynamics of the territories.

For Santos et al. (2020), the matrix support opens the possibility of developing the professionals' skills, with exchange of information, strengthening of interdisciplinary work, co-responsibility and construction of new intervention strategies. However, as reported by the participants, issues related to the MS of children and adolescents are not always present in the matrix meetings, being absent in some territories, something also identified in the study of Cavalcanti et al (2012).

In the participant's words: "if a demand for SMIJ arises, the first thought is: 'who am I going to refer it to? This perspective assumes the existence in this network of referral practices such as case referral, in a process of transferring responsibility, as well as the difficulty of identifying and handling situations related to the SM of children and adolescents. According to Tanaka and Ribeiro (2009) there are still, among pediatricians, difficulties to recognize and deal with problems of MS, finding it easier to refer the subjects to specialized services, such as the Capsij.

It is possible to affirm that this difficulty is not exclusive of pediatricians, but of many other professionals working in the PCU, who still have difficulty in appropriating the issues of MS as a responsibility also of this level of care, especially when it involves the care of children and adolescents in distress, which was also identified in other studies (Cavalcante et al., 2012; Delfini & Reis; 2012; Esswein et al, 2020; Silva et al, 2019).

It is understood that Capsij, as a matrixing team, also has an important role in encouraging the territory equipment, including the PCU, to articulate themselves for health promotion to these children and adolescents (Oliveira et al. 2020). The participants recognize the school as an important place in the lives of service users and the need to build a closer relationship between health and education as a way to care for these subjects, thus making effective the intersectoral approach also starting from the services.

This implies also including in the matrix the school, pointed out by the participants as the main requester of specialized services - along with the families - besides being highlighted as a space of stigmatization of this age group, which converges with the findings of other studies (Collares & Moysés, 1992; Gomes, et al., 2015).

In the proposal to reverse this logic by schools and families as well, it is necessary to build and insist on offers of care to this public by PC and the Capsij, which is not exclusively medicalization, and this can happen by using the existence of multidisciplinary teams. Multiprofessional teams have the potential to expand the scope of care actions through collaborative work, which, according to Teixeira et al. (2017), favors the creation and implementation of partnerships between institutions, actors, and different sectors in the articulation of care actions.

Another potentiality pointed out by the participants (Class 4), the computerized network of this municipality, with regard to communication, can contribute to closer relations. It is important to consider that no matter how much the services demand SM care, diagnosis and psychiatric care, none of these services want to be alone in this challenging task of care in SMIJ. As brought by the participant: "... I can't handle it alone..." (Class 2).

In this sense, it is possible to ensure an integration beyond that dependent on a personal contact, as brought by the participant (Class 2), through the guarantee of collective meeting spaces, as well as the institutionalization of some care flows between services. With this, it

does not mean denying the importance of the contact/connection between workers in the constitution of the network, heated and activated by these relationships also between professionals, but to affirm the need for the organization of certain work processes based on institutional guarantees.

It is understood that these guarantees of meeting spaces, for example, may allow analyses by this network, including those paradigmatic hybridisms experienced (biomedical care and psychosocial care in coexistence), with regard to the conception of the subject and the understandings about important partners such as the school, understood sometimes as a promoter of excessive demand in SMIJ, sometimes as omissive in the composition of this care network for this public; as well as the family, conceived sometimes as responsible for the suffering/difficulties of children and adolescents, sometimes as indispensable in this care and also someone to be cared for.

Final considerations

This study discussed SMIJ from the perspective of professionals and managers of a municipal health network. Even though the results cannot be generalized, they reflect the challenges in organizing a network of care for these individuals, which necessarily demand intersectoriality as a possible way to offer comprehensive care and the effectiveness of care from a psychosocial perspective.

In the speeches of the research participants, there is a reference to the hegemony of the biomedical paradigm guiding the care practices and conceptions of childhood and adolescence marked by the notion of lack and incompleteness. Yet, the participants identify movements to break with this logic, generally triggered by work technologies such as matriciamento, collective discussion spaces and the actions of workers from different backgrounds..

Participants report the difficulties in sharing care, whether in the health services themselves, or in articulation with other sectors in intending to articulate the network outside themselves, implementing intersectoral policies. Care in the territory and consideration of the subjects' lives and stories are perceived as guidelines to be followed. The identification of reference services, especially Capsij, as priorities for the reception of the psychological suffering of children and adolescents, appeared in the reports, having as one of the effects the difficulty in providing care in MS in the BA and the invisibility of the suffering of these subjects in some of the territories.

This study presents, as a limitation, the analysis of the potentials and difficulties of a SMIJ network from the perception of workers and managers, being necessary that other studies also consider what the users themselves think, in this case, children, adolescents and their families.

It is concluded that the complexity of care in MS for children and teenagers imposes the need to continue strategies to strengthen the BA and intersectoral actions based on the notion of expanded clinic. It is believed that these analyzes have the potential to have direct repercussions on the attention to this public, due to the possible care for these families as well, without blaming, and building a partnership for the transformations in the way of seeing the other, which has its weaknesses, but which can be minimized, specially by the exchange of knowledge and practices made possible in the meeting.

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