

Original Article

Child and adolescent mental health from the perspective of Primary Health Care managers: possibilities and challenges¹

A saúde mental infantojuvenil sob a ótica de gestores da Atenção Básica à Saúde: possibilidades e desafios

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Abstract

This study aimed to identify the understanding of managers of family health units that do not count on CAPSij (Child and Youth Psychosocial Care Center), about child and adolescent mental health, and their perception of the understanding of the team about child and adolescent mental health. This is qualitative descriptive-exploratory research, based on the theoretical reference of Public Health Policies, Mental Health, Psychosocial Care for Children and Adolescents, and Primary Health Care (PHC). Twenty-one Primary Care professionals participated, who were managers of Family Health Units linked to three municipalities in the State of São Paulo, of different dimensions. Participants were interviewed based on semi-structured scripts. The interviews were recorded, transcribed, and analyzed with a technique of the Collective Subject Discourse (CSD). Some of the results showed: (a) the belief of the participants that the family, economic and social experiences of children and adolescents in their life contexts directly affected their mental health; (b) the failure to identify cases of child and adolescent mental health by the managers of the participating units; (c) managers' divergent perception of the team's understanding of the child and adolescent mental health. Based on the results, it is suggested that if the strengthening of matriculation and/or continuing

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education strategies are planned in a contextualized way according to the territories can be effective to support mental health care actions in PHC for those municipalities with less human and institutional resources.

Keywords: Mental Health, Child, Adolescent, Primary Health Care.

Resumo

Este estudo objetivou identificar a compreensão de gestores de Unidades de Saúde da Família de municípios que não contam com CAPSij (Centro de Atenção Psicossocial Infanto-juvenil), sobre saúde mental infantojuvenil, assim como a sua percepção sobre o entendimento que as equipes têm da saúde mental infantojuvenil. Trata-se de pesquisa descritivo-exploratória de caráter qualitativo, aportada no referencial teórico das Políticas Públicas de Saúde, Saúde Mental, Atenção Psicossocial para Infância e Adolescência e Atenção Básica (ABS). Participaram 21 profissionais da ABS, gestores de Unidades de Saúde da Família vinculadas a três municípios do Estado de São Paulo, de diferentes dimensões. Os participantes concederam entrevistas a partir de roteiros semiestruturados. As entrevistas foram gravadas, transcritas e analisadas com a técnica do Discurso do Sujeito Coletivo (DSC). Os resultados indicaram, entre outros: (a) a crença dos participantes de que as experiências familiares, econômicas e sociais vivenciadas por crianças e adolescentes em seus contextos de vida têm impacto direto em sua saúde mental; (b) a não identificação de casos de saúde mental infantojuvenil pelos gestores das Unidades participantes; (c) a percepção divergente dos gestores quanto à compreensão das equipes sobre saúde mental infantojuvenil. Com base nos resultados, sinaliza-se que o fortalecimento das estratégias de matriciamento e/ou formação continuada, se planejados de forma contextualizada em função dos territórios, podem ser efetivos para apoiar as ações de cuidado em saúde mental na ABS para aqueles municípios com menos recursos humanos e institucionais.

Palavras-chave: Saúde Mental, Criança, Adolescente, Atenção Básica à Saúde.

1 Introduction

When focusing on children and adolescents, we note that the first Brazilian legislation regarding the rights of children and adolescents is from the 1920s, having been replaced in the late 1970s and, more recently, in 1990, with the Child and Adolescent Statute (ECA) (Brasil, 1927, 1979, 1990). From that moment, the children and adolescents had their right to health ensured through the implementation of public social policies, through the Unified Health System (SUS), which includes the attention and care for all children and adolescents' health needs (Brasil, 2014, 2017a).

Care directed to children in the first years of life can play an important role in their emotional, cognitive, and social development. Thus, care policies are organized in strategic axes, based on specific guidelines for each phase of the development, and the Primary Care is the originator of this care in the territory. For adolescents, strategies are needed for a new way of producing health, given the complexity of this phase of life.

Thus, the SUS recommends access to intersectoral policies that promote physical, mental, and social well-being, emphasizing Primary Care in sectoral policies, with its ability to work in the individual and collective spheres (Brasil, 2014).

The National Policy for Primary Care (*PNAB*) has as a priority strategy for the expansion and consolidation of Primary Care for Family Health (Brasil, 2013, 2017b). As a set of actions and services that must be structured based on the needs of the population, the Family Health Strategy (*ESF*) has the principle of raising such needs by structuring a link between service users and healthcare professionals. For this, professionals must be in constant contact with the territory, prioritizing health actions integrally and continuously, especially actions of promotion, protection, and recovery of health (Oliveira & Pereira, 2013).

The Family Health Support Centers (*NASFs*) were also created to expand the scope of the actions in Primary Care (Brasil, 2013), which, in 2017 was called “Extended Nucleus of Family Health and Primary Care” (*NASF-AB*), constituted by a multidisciplinary and interdisciplinary team, composed of professionals from different areas of knowledge, complementary to the teams that work in Primary Care and that must act in an integrated system to support these professionals (Brasil, 2017b).

One of the principles of Primary Health Care is to enable the population to access the health system for the first time, including people who need mental health care. The mental health care in Primary Care is strategic because it allows actions to be developed in known territory, facilitating teams' access to users and vice versa. However, in addition to their importance, Primary Care professionals have many doubts, curiosities, and fears about Mental Health practices in the service (Brasil, 2013).

The prevalence rate of mental health problems in the adult population worldwide is around 30%. This index also corresponds to the child and adolescent population (Lopes, 2020). Based on the literature, we observe that these rates have increased in recent years (Lopes, 2020; Organização Pan-Americana da Saúde, 2016).

Lopes et al. (2016), in a prevalence study conducted between 2013 and 2014, with adolescents aged 12 to 17 years, old in 124 Brazilian municipalities, identified that 30% of the population studied had common mental disorders (identified mainly by the experience of symptoms of depression and anxiety, and somatic complaints).

The Ministry of Health (Brasil, 2013, p. 103-104) states that more recent epidemiological studies “[...] demonstrate negative impacts, coming from untreated or cared for problems, in sociability and education, which tend to persist over the years”. It also adds that most children and adolescents with mental health issues do not receive adequate care or have access to health services that are compatible with their needs. Thus, for Primary Care be resolvable and contribute to improving care, “[...] it needs to increase its acuity for the different and inventive ways of expressing the problems that children and young people present and to offer support to them and their families” (Brasil, 2013, p. 104).

The policies for ensuring rights, specific mental health policies for children and adolescents should be in line with those aimed at the adult population (Couto, 2001). At *SUS*, the Psychosocial Care Center for children and adolescents (*CAPS*) was established with Ordinance 336, in 2002 (Brasil, 2002), which establishes and regulates *CAPS*, in all its modalities and reaffirmed in 2011, with the publication of Ordinance

3,088, which regulates the Psychosocial Care Network (*RAPS*) in Brazil (Brasil, 2011a). On Ordinance 336, *CAPSi* became the main responsible for the articulation of the network care of its users assisted in singular therapeutic projects (Taño & Matsukura, 2014).

Although the fundamental role of *CAPSi*² is recognized, we identify the relevance of the Primary Care in Mental Health Care and the power of this care in the territory because, since the publication in the *RAPS*, the UBS (Basic Health Units) are part of the Mental Health Care network (Gryschek & Pinto, 2015; Brasil, 2011a, 2013; Moliner & Lopes, 2013; Minozzo et al., 2012). The PNAB (Brasil, 2017b) defines the organization in Health Care Networks (RAS) as the strategy for comprehensive care that can address the population's health needs, and highlights Primary Care as the first point of attention and the preferred gateway of the system, responsible for ordering the flows and counterflows of people.

However, the Primary Care would be the organizer of the RAS if the health needs of the population under its responsibility are recognized (Brasil, 2017b) and the needs in the mental health area must be included.

Data from the Ministry of Health (Brasil, 2015) indicate that, in 2015, the State of São Paulo had 58 *CAPSi*. According to the Psychosocial Care Network - *RAPS* (Brasil, 2011a), this equipment is intended for municipalities with a population above 70,000 inhabitants. In the cities without *CAPSi*, such as smaller municipalities in the interior of the State of São Paulo and most cities in the country, child and adolescent mental health care may be compromised and/or poorly systematized, which reinforces the need for actions in this Primary Care area.

Some studies are concerned addressing mental health practices in Primary Care, the intersectoral actions, and action strategies even not being specific to the children and adolescent mental health area. Frateschi & Cardoso (2016) mapped the scientific production on mental health practices developed within the scope of Primary Health Care (PHC) from 2008 and analyzed 54 articles.

The authors found reports of actions highlighting those centered in team preparation and care based on a centered medical perspective and those studies that focus on dialogical and collective strategies, with an emphasis on psychosocial resources in the description of mental health care offered. Regarding the specific mental health practices in PHC, some productions report group practices and workshops, medicalization, home visits, individual therapies, and others. Based on the study, the authors concluded that, although users, professionals, and managers consider Primary Care as a space that should offer mental health actions, "[...] this level of care is often not recognized as a reference for this demand" (Frateschi & Cardoso, 2016, p. 165).

Prata et al. (2017) discussed the challenges for the implementation of mental health actions in the Family Health Strategy from the perspective of deinstitutionalization and territorialization of care through semi-structured interviews with managers at first, and then with family health team group interviews, and monitoring networked care actions through regular visits to the territory, in two communities in the city of Rio de Janeiro.

²Although the acronym "*CAPSi*" is recognized in the official documents for Children and Adolescent Psychosocial Care Centers, in this study the acronym "*CAPSi*" was used from the Ordinance of the Municipal Health Secretariat of the Municipality of São Paulo, Ordinance 2,375, of December 27, 2016 (São Paulo, 2017), as justified by Taño & Matsukura (2019).

In the results, the authors identified the difficulty of territorial actions due to characteristics of the peripheral location of the community and the situations of violence in these spaces and discuss the processes of illness with the social and vulnerability characteristics of groups and communities in the studied territories.

In a literature review that considered national publications from 2010 to 2015 and aimed to identify the publications in the national scientific literature on mental health care practices in Primary Health Care, Fernandes et al. (2018) revealed that the practices of Mental Health care are limited by the lack of knowledge and proximity of professionals to the area and there is a relevant need for investments in continuing education. The authors also identified that the mental health care practices developed in Primary Care continued to focus on the biomedical, medicalizing, and excluding model.

In the studies analyzed in the review by Fernandes et al. (2018), the research by Moliner & Lopes (2013) stands out, aimed to know the configuration of mental health care practices in Primary Care, from the perspective of a Family Health Strategy team. This study showed that the professionals' understanding of mental health comes from the concept of health as the absence of disease, that is, a biologist concept that does not look at the subjective issues and the social dimension of the subjects and in addition to understanding, a change of the practice of the service is needed to answer to a new way of caring.

Regarding the conceptions and concepts involving the mental health area and Primary Care, Oliveira et al. (2017) present a recent study aimed to analyze the conceptions that guided the practice of Primary Care professionals in the mental health care in the city of João Pessoa, Paraíba. They used semi-structured interviews with 16 professionals, from different categories (nurse, physician, dentist, nursing technician, oral health assistant and community health agents) and concluded that the professionals' conceptions about mental health still focus on the idea of the absence of serious mental illness/disorder, that is, an idea that remains in the biological dimension due to the complexity and multiplicity of factors related to psychological suffering.

In the specific child and adolescent mental health area, a smaller and more recent number of studies addressed the reality of care aimed at this population, with a focus or tangential perspective of Primary Care, and revealed several gaps to be addressed in future research. For example, the study by Nogueira & Campos (2017), dealing with an experience report developed in a city in the interior of the state of Minas Gerais, which did not have CAPSij, addressed the construction of the region's Mental Health policies and equipment and care actions for children and adolescents. The authors identified that the mental health demand of this population is not understood as legitimate and that care is limited to medical and medication assistance with a psychiatrist and/or neurologist through referrals made by Primary Care.

Teixeira et al. (2017) present the results of the study analyzing the barriers and facilitators for collaborative care between Primary Care, through the Family Health Strategy (ESF) and a CAPSij in the city of Rio de Janeiro. These results showed a broader understanding of Primary Care professionals in the determinants of psychological distress by the children and adolescents, and the understanding of the complexity that involves Mental Health issues, as facilitators. The barriers presented by

the authors were: the professionals' hesitation regarding the mental health issues of children and adolescents; the demand for specialists from ESF professionals, whose care is restricted to conservative care strategies that maintain the fragmentation of care despite a more comprehensive understanding of suffering; the lack of knowledge of the existing resources in the territory, how these resources work and the key actors, among others. Such barriers reinforce the gaps in the children and adolescent mental health area and should be a suggestion for future studies.

In this sense, in the absence of these strategic equipment (CAPSij), the role and challenges for child and adolescent mental health care are linked or strongly dependent on Primary Health Care. At the same time, it cannot have reference and important collaboration that could come from the CAPSij, needing to improve and respond as already mentioned to the challenges of implementing mental health care in an articulated and territorial way, both for adults and for children and adolescents.

This research was focused on understanding the need to expand studies on mental health in Primary Care and the gap specifically in the Mental Health for Children and Adolescents and considering the reality of most cities in São Paulo and Brazil, where they are not strategic mental health equipment for childhood and adolescence.

Thus, this study aims to identify the understanding of managers of Family Health Units in municipalities without CAPSij, on children and adolescent mental health, as well as their perception of the teams' understanding of children adolescent mental health.

2 Methodology

This is qualitative, descriptive-exploratory research, based on the theoretical reference of Public Health Policies, Mental Health, Psychosocial Care for Children and Adolescents, and Primary Care.

2.1 Participants

Twenty-one Primary Care professionals, USF (Family Health Units) managers³, who were trained in nursing, participated in the study. They were from three municipalities that do not have strategic equipment in children and adolescent mental health. The inclusion criteria were to have worked at the unit for at least six months and to accept to participate in the study. Table 1 shows the number of participating managers in each municipality:

³Since 2017, with the approval of Ordinance 2436/2017, all health establishments that provide Primary Care actions and services have been called the Basic Health Unit (UBS). However, as the study was carried out previously, we decided to keep the denominations so that the reader can understand the organization and choice of the researcher at the moment.

Table 1. Distribution of participating managers in the studied municipalities.

	Total USFs in the municipality	USFs Participants	Study participants
Municipality A	13	10	12
Municipality B	5	5	7
Municipality C	3	2	2

The discrepancy in the number of units with the number of study participants is because some units have more than one Family Health team.

2.2 Place

The study was carried out in three municipalities of different dimensions without CAPSij strategic equipment and members of a Regional Health Care Network (*RRAS*), of a specific Regional Health Department (*DRS*) of the State of São Paulo. This *DRS* is located in the interior of the State with 68 municipalities and with only three CAPSij, one of them for alcohol and drugs.

To answer the objectives of the study, the inclusion criteria for the choice of municipalities were that none of them had CAPSij as part of their care network, but had Primary Care Services - Basic Health Unit (UBS) with or without ESF - which will be designated in this study as Family Health Units (USF).

The municipalities were identified as Municipality A, Municipality B, and Municipality C to guarantee confidentiality, especially to participating professionals. Table 2 shows the corresponding data:

Table 2. Characterization of municipalities regarding the number of inhabitants and PH services.

	Population (Instituto Brasileiro de Geografia e Estatística, 2015 estimate)	UBS	USF	Polyclinic
Municipality A	139.483	5	13	2
Municipality B	40.367	2	5	0
Municipality C	9.299	0	3	0

As already mentioned, according to Ordinance 3088/2011 (RAPS), CAPSij is intended for municipalities with a population above 70,000 inhabitants. This situation has a relevant factor because as in most Brazilian cities, the existence of a CAPSij is not expected in municipalities B and C, which makes the role of Primary Health Care in Mental Health care even more important and ordering care, as well as the articulation of regional actions. However, Municipality A could count on CAPSij due to population size, even if it does not happen.

This municipality has a Mental Health Network with a Psychiatric Hospital, Mental Health Outpatient Centers, CAPS I, CAPS II and CAPSad II, Therapeutic Workshops and Residences, Extended Family Health Center and Primary Care (NASF-AB), Child and Adolescent Mental Health Outpatient Clinic, hospitalization service for alcohol and drugs, *Hospital-Dia* and Psychiatric Ward. However, only the services of CAPS I which are the Children and Adolescents Outpatient Mental Health (municipal level), and the hospitalization service for alcohol and drugs assist the children and adolescents. Municipality B has a Mental Health Team, the only reference for health professionals in the city that only assists adults and adolescents aged 16 and over. Municipality C does not have any mental health services.

2.3 Instruments and materials

For data collection, we used: 1) a service characterization form containing information such as service operating time, coverage area, population assisted and proportion of mental health cases of reference in the unit to understand the structure and organization of each service contacted; 2) a participant identification card with information, such as professional training, experience in Primary Care, experience with children and adolescent mental health, among others; and 3) a semi-structured interview script that addressed the professional's understanding of children and adolescent mental health, among other issues.

2.4 Procedures

The Ethics Committee approved the research and all the ethical procedures were ensured. At first, authorization was requested from the Municipal Health Secretariats (SMS) of the selected municipalities and a survey of the units was carried out through a website or telephone contact with the SMS. All units in each municipality were invited to participate. The interviews were established for those who accepted the invitation to participate.

We scheduled the interviews with the managers - from the units and/or from the family health teams since, in the units with more than one team, each one has different management. After acceptance, all interviews were conducted in person on one day, time, and place determined by the participant. All interviews were recorded on audio and later transcribed.

We used the Collective Subject Discourse (CSD) technique for the data analysis, which “[...] seeks to reconstruct a collective opinion, by aggregating in a synthesis discourse written in the first person of the singular, the contents of individual statements that have similar or complementary meanings” (Lefevre et al., 2010, p. 94).

3 Results and Discussion

The results from the interviews showed some convergences and also specificities in the understanding of the professionals in the Family Health Units about the Children and Adolescents Mental Health.

First, we present the results identified as convergent among the managers and that were gathered under the denomination “The relationship between the mental health of children and adolescents and the contexts of social vulnerability”. Subsequently, under the denomination “Other understandings about the mental health for children and adolescents”, the results presented also deal with the understanding of mental health for children and adolescents but verified more punctually. Finally, under the heading “Perception of managers regarding the team's understanding of children and adolescent mental health”, we present the results on the understanding of the teams, under the perspective of managers.

3.1 The relationship between the mental health of children and adolescents and the contexts of social vulnerability

In the three municipalities, the participants believe that the experiences of children and adolescents in their life contexts, especially in family relationships, have a direct impact on mental health, both in childhood and in future life. There is an understanding that the mental health of children and adolescents is directly related to the opportunities, or the lack of them, in the context in which they live. Also, the participants believe that experiences, especially family ones, impact mental health not only in childhood but in all future life. The CSD below shows this understanding shared by some managers from the three municipalities.

I think it goes from the environment in which he [child] lives, his interaction in society, at school. Also, the more specific issues to the child, how he understands the world, how he relates. At home, it depends a lot on a structure and the experiences he has gone through. Some very well-structured children are in completely crazy families, but who had another support network. Some unstructured families already have a mental health problem, I see it perpetuates, that it seems to continue (CSD Municipality A).

I think that mental health involves the patient as a whole, how he will develop, the social construction of the person, especially the family problem. I believe that the family is the emotional support of the individual, especially the adolescent. And I think everything is very much linked to the culture that he grew up in. There is also the environmental and social factor and this child gets sick because I believe that the environment has a very important role in training and caring. I believe, today, that if most of our adults had a good childhood, good adolescence, they would not be sick today (CSD Municipality B).

Health, not only mental health but health, I believe that the environment influences a lot, especially in the child's mental health. Often, I believe that if there was greater communication within the family, the child would not even have this need to continue using a medication, because these disorders, for me, usually come from a social cause rather than from a genetic cause. In fact, what is lacking in society is this communication that does not exist, between father and son. The family, the grandparents, uncles, cousins. If I had more communication, a

conversation, I think I would avoid this lot of depression in the world (CSD Municipality C).

The professionals from two municipalities also more clearly present an understanding that relates economic and social fragility to children and adolescent mental health issues.

We deal with a poor population with many demands, not only of a physiological, biological order but a universe that is very complex in the social aspect, even the psychological one. I think that teenagers and even children get a little lost in this process. In our neighborhood, we have many issues of mental health problems, socio-family problems, many demands are raised by the community agents during home visits. I see that there is a lot of demand for parents, because the child has a problem at school, because of many social problems involved (CSD Municipality A).

We end up having a lot of demand for a social and financial problem. Here we see many hungry people, the father and mother are in prison and the child is on drugs. Could it be that if this child, this teenager, had support in the first events, they would be like this today? (CSD Municipality B).

The perspective of relating mental health to environmental and relational factors shared by some participants finds an echo in some approaches on development (Reppold et al., 2002; Maia & Williams, 2005; Paula et al., 2008). Among them, there is the approach to risk and protection, presented by Rutter (1999), in which the author discusses the vulnerability and resilience of children in environments causing psychosocial risks. Considering these factors and understanding about these impacts on the individual's health is beyond relating them to a negative prognosis, enabling an intervention based on the investment of something protective in the interconnection of these different aspects.

In this study, the complexity of the experience of the psychological distress is recognized by the managers, opposite to the studies previously presented, such as the study by Moliner & Lopes (2013). This study highlighted the understanding of mental health by professionals as a biologist concept that perceives health as the absence of disease, failing to look at subjectivity and the social dimension of the individuals. Nogueira & Campos (2017) also showed that the Primary Care team in the studied city did not understand the mental health demand of the children and adolescents as legitimate and summarized the care provided by medical and medication assistance.

This study shows a significant advance in the understanding of Primary Care professionals for the issues of mental health and the children and adolescent mental health and such changes make a strong dialogue with the precepts of psychosocial care. It also shows the demands of mental health as legitimate and contextualized more broadly, distanced from the results of the relatively recent study by Nogueira & Campos (2017).

This advance in the conception of mental health revealed in this study is supported by investment and the qualitative consolidation of public health and mental health policies.

Thus, we can consider that this positive change in the professionals' discourse is related to the advances in public mental health policies or even more broadly to permanent education, to the participation and training of Community Health Agents, to a greater understanding of the processes citizenship, among others.

Although some speeches highlighted to family issues as an important impact factor on children and adolescent mental health, it is not part of the scope of this study to focus on these possible relationships. However, it is important to highlight the need to not maintain a common path of blaming the families, and assuming that they should be inserted in the care process and the development of actions that consider and enhance the support coming from this group and essential in addressing the care of children and adolescents in psychological distress.

The challenge is to assume that this set of vulnerabilities is present and that it is in this scenario that the demands for mental health care arise, not only for children, adolescents, and their families but for the entire community in the territory.

Thus, based on the unit's daily actions, the fact that Primary Care professionals face the socio-economic difficulties of the assisted population must add to the expanded perception of the situation and enable an analysis of the conditions of life of users involved in the health-disease process. As already highlighted and in agreement with Vecchia & Martins (2009), we need to be aware that, in more peripheral regions, this type of finding does not corroborate the idea that these circumstances are impossible to change.

3.2 Other understandings about the mental health of children and adolescents

Other ways of understanding children and adolescent mental health were manifested and, in the same municipality, divergent conceptions were expressed by the participants. At first, the understanding is related to the fulfillment of social rules determined by the family and/or the school and the non-compliance of these as addressed in the CSD below:

Mental health involves several things, from the adolescent's behavior towards his mother, who has her rules, with the school, who has its rules to be fulfilled and, sometimes, he doesn't want to comply. The teenager does not understand that many things have rules and that need to comply and, in the end, they end up breaking the rules and then do not know how to talk (CSD Municipality A).

In a second moment, there is a discourse with a broader conception, which places the child and the adolescent as an individual of rights, as shown by the following CSD:

It is well-being. It would be for the child to have the right to school, leisure, health, care, to live with parents, as this experience is, to have good food, clothing, care as the whole and not subdivided as often happens. You have to think about everything, for example, if this child can go to school, [...]. How he is treated at

home, especially in early childhood, I think it covers every psychic of a child and an adolescent (CSD Municipality A).

The broader understanding that is the concepts of autonomy, coexistence, and citizenship is a reverberation of the Brazilian Psychiatric Reform, focused on Psychosocial Rehabilitation. Such discourse was spread in Primary Care after the approach of the professionals of the reference teams in mental health, through Matrix Support (Figueiredo & Onocko-Campos, 2009).

Studies indicated that it is possible to identify the confrontation between the Biomedical paradigms and the expanded Clinic in Primary Care, and affirmed that the change from one to the other is possible but difficult. If there is no investment both in professionals and in the transformation processes health practices and complement that, the advances achieved so far can be reversed (Onocko-Campos et al., 2011).

Professionals from Municipalities A and B also reported some difficulty in answering their understanding of the mental health of children and adolescents, defining the question as “complex” or “complicated”. Such adjectives were not presented in an enlightened or in-depth way and it is understood that the definition is difficult, even for professionals in the mental health area. An example is that there is no definition common to all and that it is discussed by scholars from different cultures, but as a common point that, as health is not just the absence of disease, mental health goes beyond the absence of mental disorders. Among other aspects, it is linked to autonomy, competence, and self-performance of the individual's intellectual and emotional potential (Organização Mundial da Saúde, 2001). These results certify the importance and the need to qualify and problematize the child and adolescent mental health area with Primary Care professionals so that new possibilities of care can be created.

Nevertheless, even though they occupy this place when expressing about children and adolescent mental health, professionals did not fill the gap with a biologizing discourse that is very common. We found in the literature, the anchoring of Primary Care professionals in biological conceptions to health problems since they are more familiar to the team and can present more possibilities for intervention (Tanaka & Lauridsen-Ribeiro, 2009). Thus, the results of this study regarding a possible departure from the biologizing paradigm may represent an important advance and should have repercussions on the actions developed in the health units.

On the other hand, managers linked to Municipalities B and C said that there are no cases related to the mental health of children and adolescents in the area covered by the units. Such discourse may represent the difficulty that some professionals find in understanding child and adolescent mental health, which causes a limitation in the identification of cases that arrive at the unit or, even, awakens to the need for reflection on the real reason why children or adolescents in psychological distress do not arrive at the unit.

As pointed out by the Organização Mundial da Saúde (2001), the prevalence of mental disorders in children and adolescents associated with situations of social

vulnerability issues to be considered, especially in Health Units located in regions with a high rate of violence and precarious economic situation.

All the participants in this study were nurses - managers of the USFs - who declared to be the main responsible for the reception of children and adolescents with mental health demands that arrive at the units. Thus, when they are responsible for both assistance and management, which dictates the work dynamics of the service and teams, it is necessary to think and discuss the training of these professionals for Mental Health as studies indicate a weakness in this area (Neves et al., 2012). However, the result of this study can and should be extended to the training in the mental health of other health professionals who work in Primary Care.

In addition to graduated training, we need to consider the relevance of continuing education work with Primary Care teams, contributing to the broader understanding of the mental health area for children and adolescents and, consequently, for the expansion of welcoming, care, promotion and prevention actions in the territory.

Even though nurses declared to be the main responsible for the reception of this population, according to the Mental Health care guidelines in Primary Care, practices in this area can and should be performed by all health professionals (Brasil, 2013). The PNAB establishes that user-welcoming is a common assignment for all members of the teams that work in Primary Care (Brasil, 2017b).

Expanding the professionals' understanding of the theme tends to facilitate the identification of mental health cases in the territory, especially those that do not reach health services spontaneously, and to expand the promotion and care actions, extending them to the family and the community.

3.3 Perception of managers regarding the team's understanding of children and adolescent mental health

Considering that the care provided in the Health Units represents the work of a team and that the present study involved only the participation of managers, we sought to understand whether the participants believed that their understanding of Children and Adolescent Mental Health also represented the understanding of their team and this questioning was part of the interview script.

Some professionals responded in the affirmative, justifying the fact that mental health care actions for children and adolescents are frequently discussed in team meetings, as revealed in the following CSDs:

Yes, for sure! [...] I see that the whole team is concerned and has that look of care and of passing on either to me or to the doctor. I think there is a team effort. This topic was already the subject of discussion at the team meeting because I think that this is our role, to bring these issues up and awaken the health unit's view of the topic. This team is a team that we work a lot with, sharing care, both doctor and nurse, as well as case discussions with community agents and with all team members, nursing assistants, the administrative assistant who often is the gateway (CSD Municipality A).

For sure! [...] We discuss it at the team meeting and they mobilize a lot. Even CHAs, when they are visiting, if they see the need, they already pass the case on to me and we already schedule and call. So, I think so, the whole team believes it (CSD Municipality B).

We can observe that the professionals' speeches show team discussions, even though they show that the centrality of attention in Children and Adolescent Mental Health is focused on doctors and nurses.

However, based on the CSDs, issues related to child and adolescent mental health care are based on the discussions of cases that arrive at the unit and that policies in the mental health area do not seem to be discussed. Also, there are care actions that should be carried out by the entire Primary Care team such as qualified listening, team meetings to discuss cases, home visits, the elaboration of Unique Therapeutic Projects (UTP) and matrix support, for example.

Matrixing is an important tool, in which two or more teams create an intervention proposal, in a process of shared construction. This model has been used in the integration process between mental health and primary care since its formulation, in the late 1990s. This proposal aimed to transform the traditional logic of health services, organized vertically, by a horizontal organization, in which there is the integration of knowledge, at different levels of care (Brasil, 2011b).

Thus, matrix support can be understood as “[...] specialized technical support that is offered to an interdisciplinary health team to expand its field of action and qualify its actions” (Figueiredo & Onocko-Campos, 2009, p. 130).

Other professionals, also from Municipalities A and B, believe that the sharing of ideas is only part of the team and in their speeches they that the care actions are centered on the doctor, and the nurse and, only in Municipality A, on the team matrix support. Only Municipality A has CAPS and it is estimated that this factor is implicated in the indication of matrix support only by this municipality since the others do not have the opportunity for this experience.

Yes! Because of all the problems that I have, I discuss with the NASF and the doctor, and I see that during our discussions we manage to have this scope of the social part influencing the environment. This is shared by us. We have a good partnership in this (CSD Municipality A).

Yes. The professionals, I mean, by the doctor. As a nurse, I do not understand very well this part of working with a child's mental health, but when it falls into the doctor's hand, he knows the procedure to direct (CSD Municipality B).

Thus, according to the team managers, the issue of complaint-conduct stands out in the professionals' understanding, which seems to reinforce the hypothesis that mental health is not discussed with the units' teams and/or when discussing as a team, possibly the same perspective is adopted.

In Municipality B, the professionals also refer to the team's sharing that the children and adolescent mental health is difficult to understand. They justify that this is one of

the factors by which the cases that arrive at the unit are not monitored by the team, being referred to other services, as revealed in the following CSD:

I think everyone on my team has a hard time understanding. I think we don't have a lot of notions and we don't have a lot of access either, because we never follow, it is always withdrawn. So we send it forward (CSD Municipality B).

As the guidelines for care in Mental Health in Primary Care, we should reflect on the needs for daily interventions in Mental Health by the Primary Care team and the countless doubts and insecurities that afflict these professionals. Often, the professional does not have enough resources or a network that is responsible for interdisciplinary and territorialized work, which, in turn, would allow shared and contextualized care actions when identifying a mental health demand (Brasil, 2013).

In this sense, for the team to be able to get closer to the possibilities of mental health care, “[...] it is necessary to reflect on what is already happening daily and what the territory has to offer as a resource for health professionals to contribute to the management of these issues” (Brasil, 2013, p. 22).

In the answers of the managers, only in Municipality A, there is the discourse of sharing cases with mental health issues, with NASF-AB. Such speech is understandable since municipalities B and C do not have sharing experiences, even though Municipality B has a Mental Health Team. The difference in the support network of the three municipalities deserves to be highlighted and brings up a necessary reflection on care in municipalities B and C to be centered on the doctor and the nurse since they seem to be the only possibility of care in the services, envisioned by the professionals. Despite this, the municipalities, especially those with fewer resources, should articulate the possible network for each of them, whether in Social Assistance, Culture, Sports, and/or Education. Possible articulations in the region should also be considered with larger municipalities and more possibilities for recourse. Such articulation is within the scope of Primary Health Care functions, as previously presented.

In Municipality C, professionals reported that the team does not share their understanding, justifying an overload of work, which causes the professionals to be disinterested in carrying out their actions in the best possible way, as explained in the following CSD:

I don't think they share the same thinking, you know? There may be one or the other that you share, but in total, I don't think so. Because, due to work overload, the professional loses that intention to work and do the best possible for the client, you know? This is a big problem (CSD Municipality C).

In Municipality C, the issue seems to be even more serious because the municipality does not have any mental health equipment and, consequently, no support team for the actions in the units. This scenario certainly highlights that this topic is not discussed by any professional on the team, including the doctor and the nurse, as pointed out in other speeches.

This study found that, even though municipality A has a greater amount of resources related to mental health, there are similarities regarding the weaknesses in children and adolescent mental health care offered in Primary Care. Also, the existence of resources in the region is not a sufficient condition for effective expansion and understanding of issues related to children and adolescent mental health by the Primary Care team, as pointed out by some studies in the area (Fernandes et al., 2018; Silva et al., 2018).

The implementation of actions, such as matrix support, case discussions in team meetings, and continuing education for professionals, must be an important strategy for services to be structured and strengthened for the care of children and adolescents in psychological distress. Regarding the reality of the municipalities focused in this study, strengthening existing equipment and structures - such as NASF-AB in municipality A and the Mental Health Team in municipality B - tends to be less costly to the State and, at the same time, it would enable to achieve more articulated and territorial care strategies.

4 Final Considerations

This study aimed to identify the understanding of managers of Family Health Units in municipalities that do not have CAPSij, on the children and adolescent mental health, as well as their perception of the teams' understanding in the assistance of children and adolescent mental health. Therefore, this study involved the participation of managers of Family Health Units and Family Health Strategy, from three municipalities of different dimensions in the interior of the State of São Paulo that do not have CAPSij.

The results indicated that the professionals' understanding relates mental health issues directly to economic and social issues experienced by children and adolescents. Nevertheless, the results showed that care for children and adolescents in psychological distress seems to be centered on the doctor and the nurse, from a perspective of complaint-conduct. Adjectives such as "complex" and "complicated" were also used to define children and adolescent mental health, and difficulties in identifying cases of children and adolescents in psychological distress in the territories of these Units involved in this study.

Based on these results, there is a need to strengthen and expand the matrix support strategy with the Primary Care teams of those municipalities that have equipment capable of carrying out such action, as is the case with Municipality A. For the realities of municipalities with less human and institutional resources, such as B and C of this study, the development of continuing education processes can be a powerful path, as well as the implementation of regional agreements by municipalities so that strategic actions can qualify care at that level of care.

This study contributes to the promotion and expansion of understanding and discussion about children and adolescent mental health with Primary Care. However, the results presented here must be considered based on the limitations of this study such as participation, which was limited to Primary Care managers.

Even though all participants were nurses, the results of the study can and should be extended to health professionals who work in Primary Care, as the understanding of children and adolescent mental health in a broader way and all its complexity must be discussed by the entire multi-professional team, including occupational therapists.

Also, we need future studies that can address the understanding and care provided in children and adolescent mental health by Primary Care from the perspective of professionals, family members, and other members involved in this process.

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Mariana Santos De Giorgio Lourenço contributed to the entire process of preparing the article. Thelma Simões Matsukura contributed to the writing, review, and discussion of the article. Maria Fernanda Barboza Cid contributed to the discussion and review of the article. All authors approved the final version of the text.

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