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Primary care and collaborative care in children and adolescents psychosocial interventions: facilitators and barriers

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Abstract *Considering the care gap in child and youth psychosocial care, the articulation of the intra-sectoral network is an important strategy to promote less fragmented care flows. The study analyzes facilitators and obstacles to collaborative care between the Family Health Strategy (ESF) and a Child and Youth Psychosocial Care Center (CAPSi) in Rio de Janeiro/RJ. This is an exploratory study with a qualitative approach, which main methodological tools were focus and intervention groups. From the proposed thematic axes, we identified that the perception of child and adolescent mental health problems by ESF workers was named by the behavioral changes located in a context of vulnerability. The main obstacles to implementing actions were lack of knowledge about how to provide care, work process-related issues and network disarticulation. Even if ESF professionals are able to identify mental health problems of children and adolescents, care actions are fragile and network articulation is practically nonexistent. Collaborative care was recognized as a strategy to validate child psychosocial care.*

Key Words *Community mental health services, Primary care, Health promotion, Children, Adolescents*

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Introduction

Child and adolescent mental health care (SMCA) has brought important challenges to workers and managers in this field, both in terms of consolidating the policy and organizing services[1] and in relation to concrete practice, daily case management and dialogue among the different stakeholders involved.

One of the guidelines for SMCA care – as a strategy to address the care gap and the lack of care continuity, which marked Brazilian history up to the current policy[1] – is networking, which requires, among its competencies and attributions, the collaborative work between SMCA and other sectors and equipment of the territory[2]. The expanded public SMCA care network *presupposes the articulation of services from different sectors, with varying levels of complexity and different levels of intervention*[3], as a minimum condition for the organization of coverage.

Collaborative work allows the development of more creative and effective possibilities for the articulation of institutions, sectors and stakeholders with different public mandates or social places. It combines with the concept of collaborative care – a complex, multifaceted intervention that implies new work processes involving different players toward greater health care[4] effectiveness.

In the SMCA policy, intersectoriality is the foundation of the organization of care networks[1] and finds a real way forward in the idea of collaboration and sharing. The partnership between public sectors, with specific functions, users and families requires modes of operation based on the recognition and legitimacy of the varied specialized or lay knowledge, as well as the establishment of innovative work processes that transcend traditional forms of articulation, in which services interact, but actually do not produce significant changes. National[5] and international[6] experiences have indicated possibilities and challenges in the development of intersectoral action, including users and family members. The innovative nature of experiences suggests the need for critical studies to enhance intersectoral and collaborative action, aiming to overcome inequities in access and ensure quality of care.

On the assumption that a powerful intra-sectoral articulation between the Child and Youth Psychosocial Care Center (CAPSi) and Primary Health Care (PHC) facilitates intersectoral collaborative construction[7] and can positively impact SMCA care actions, this study analyzes facilitators and obstacles to building collaborative care between PHC, through the Family Health Strategy (ESF), and mental health, via CAPSi in a large urban center territory.

Emphasis on SMCA-PHC articulation is justified by the evidence that expanding access to SMCA relies on PHC – due to its proximity to the population, because it is the gateway to the health system, by reason of its less stigmatizing character for families and the possibility of early reception of more serious or complex cases[8]. In Brazil, recent studies have confirmed the importance of PHC, with emphasis on ESF, in the SMCA network, mainly to increase access[5,9], also highlighting CAPSi's strategic role in the validation and organization of the territorial demand[1,10].

Mental health actions in PHC, integrating an expanded network, can reduce unnecessary referrals and increase user and family adherence to treatment. When strongly articulated with CAPSi, such actions tend to promote less fragmented care flows, facilitating continuity of care, sharing of care strategies and increased effectiveness of psychosocial actions[7].

Different modalities of SMCA-PHC articulation have been analyzed. In the international context, while reviewing the topic, Bower et al.[11] point out the three most frequently used strategies: a) PHC's own validation to develop SMCA actions; b) inclusion of SMCA professionals in PHC teams; c) conducting mutual consultations. In Brazil, studies have indicated the importance of validating PHC to detect SMCA needs[12], as well as the relevance of CAPSi's strategic role in PHC, which, at the same time, contributes to qualify actions, boost care flows and minimize case loss, inscribing the SMCA as an indispensable component of health care networks. As of 2008, the NASF – Family Health Support Centers were implemented[13]as a strategy for qualification and integration of PHC actions. Matrix-based strategies and other forms of collaborative care were progressively gaining prominence as means of integrating mental health in PHC, within the scope of the Brazilian psychiatric reform[14].

Despite the relevance of SMCA-PHC articulation, national studies have pointed out a set of deadlocks for its consolidation, among which the following stand out: a) PHC professionals lack of SMCA training, compromising the reception of problems, the possible interventions and qualified referrals[15]; b) scarce information about existing services in the territory, work functions and processes, overburdening users and family members in the independent search for care[15]; c)

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lack of knowledge of the mandate of each sector, including SMCA, weakening the best use of resources[10]. The potentialities and challenges registered suggest the need to advance and evaluate SMCA-PHC articulation experiences.

Methods

This is an exploratory study with a qualitative methodology informed by the perspective of the Social Research in Health – understood as a modality of investigation of the human being in society, by conceiving the complex health-illness process, represented by the institutions, services, professionals and users[16]. It encompasses a survey component for the production of information and a knowledge-sharing component[17] in the rationale of Health Promotion[18] supported by the concept of Health Education[19] as the axis of dialogue between CAPSi and PHC professionals.

The research performed in two phases was developed in a region of the city of Rio de Janeiro/RJ, where one CAPSi is a reference for SMCA coverage. The population covered by the three ESF facilities studied consists of 27,316 inhabitants, with about 30% of children and adolescents[20], mostly low-income population living in a situation of social vulnerability and violence.

The preliminary phase included a survey of referrals to the CAPSi in 2013 and 2014 and revealed a low demand from the ESF and/or health in general (only 17% of cases received), indicating a poor articulation between services. This phase allowed for the sensitization of CAPSi professionals for the following stage and was developed in ESF facilities.

In the next phase, focus groups (FG) and intervention groups (IG) were carried out in three ESF facilities from September to December 2014. All workers from the three ESFs were invited to participate, through the presentation of the objectives and methodological strategies in the respective team meetings. In all, 25 workers from the three facilities – here called Facilities A, B and C – participated in the study: 14 Community Health Workers (CHW), 4 family doctors, 3 nurses, 1 dentist, 1 oral health assistant and 1 nursing technician. Facilities A, B and C had 7, 8 and 10 workers, respectively.

This phase was organized in three stages, called Meetings 1, 2 and 3, all held at the ESF. The focus group strategy was used in Meetings 1 and 3, whereas the intervention group strategy was used in Meeting 2. The main investigator, a CAPSi professional, and an observer conducted all groups. In all, six focus groups and 3 intervention groups provided the material that facilitated the description and review of the strategies and challenges for articulating the CAPSi with the ESF in a specific territory.

Meeting 1 (FGF) aimed at seizing and recording ESF workers' perception about SMCA problems. Guiding questions were proposed as a way to facilitate discussion, as shown in Chart 1.

Meeting 2, called Intervention Group (IG), was structured as a Health Education action based on the perceptions recorded in Meeting 1 and from a Health Promotion perspective. The roadmap used in the IG was intended to contribute to sharing knowledge on SMCA-related nodal themes, such as the concept of development, symptom status and modes of organization of mental health care for children and adolescents, as well as others, as detailed in Chart 1. The IG was structured in three stages: a) returning to the group of professionals' own narratives during FG-1; b) discussing general principles and guidelines for the identification of SMCA problems[2,21]; and, c) discussing CAPSi's role in SMCA care.

Meeting 3 (FG2) aimed to evaluate the intervention (IG), pointing out possible developments for interinstitutional partnerships and establishing between the CAPSi and the ESFs sustainability actions for a collaborative work in SMCA in the territory.

The material of the nine groups was recorded, totaling 13 hours, transcribed and submitted to Content Analysis[22], with emphasis on thematic or categorical analysis that, according to Bardin[22] *works by text splitting operations into units, categories and according to analog regrouping*, to enable the *inference of knowledge regarding the production conditions* of the object studied. The material's thematic review was guided by the three axis-themes established in the organization of the meetings: 1) Identification of SMCA issues; 2) SMCA actions in the territory; 3) Network coordination. Members of the SMCA Study Group of the Research Center of which the authors are part collaborated in the process of coding, generation and validation of the analysis categories.

The professionals involved agreed to participate in the research through an Informed Consent Form. The consolidated opinion of the Ethics Committee was approved on July 28, 2014. To ensure the preservation of the identity of participants, each facility was represented by a letter, and each participant by a number.

Chart 1. Structure of Focus Group (FG) and Intervention Group (IG) .

Axis	Focus Group 1 (FG1) Guiding questions	Intervention Group (IG) Roadmap
Identifying SMCA issues	✓ What are the SMCA problems that come to the facility? ✓ How is evaluation performed? ✓ What is done when the child/ adolescent needs specialized help? ✓ Are there situations in the child or adolescent's life context that make them more prone to SMCA problems?	✓ The notion of development in childhood and adolescence ✓ Health promotion / mental health ✓ The child, the adolescent and the family ✓ Vulnerability and context assessment ✓ Risk and protection factors ✓ Major childhood and adolescence issues/ symptoms ✓ General guidelines for the identification of SMCA problems
SMCA actions in the territory	✓ What are the actions geared to children / adolescents developed by the professionals of the facility? ✓ Which of these actions do you identify that involve mental health issues?	✓ Strategies to identify the needs of children and adolescents ✓ Strategies to boost the potential of children and adolescents and families ✓ Recognizing leisure and cultural activities that allow the experience of belonging and social inclusion
Network's articulation	✓ What are the actions/services for children and adolescents in the territory? ✓ Do you know the role / function of each service? ✓ To which service are children and adolescents with mental health problems referred?	✓ Notion of network, territory and intersectoriality ✓ Services available in the territory, their attributions and *modus operandi* ✓ Defining CAPSi and its function ✓ Line of intersectoral care in mental health in the territory

Results and discussion

Results will be presented by Special Interest Theme, according to the axes that guided the fieldwork and analysis of the material.

Perception about SMCA issues

ESF workers' perception about SMCA problems was delineated by behavioral changes – mainly agitation and aggressive behavior – that occur at home, related to social issues and violence, and those manifested in schools related to the learning difficulty:

We have the behavioral phase, which is what I surveyed, at home. The child reflects in society what she suffers at home, which is often lack of attention, lack of affection, lack of care, which is violence, right? Mental health, in my opinion, encompasses many things, from behavior at home to behavior at school. I believe this is mental health, because our body works at the base of the head. If the head does not work, the body does not work well. (A-04/ GF1)

Recognizing SMCA problems from behavioral changes located in contexts of violence and vulnerability suggests that, on the part of ESF workers, there is no predominance of biomedical rationality to understand SMCA-related phenomena in the studied territory. When using diagnostic classifications, professionals do so critically, in close dialogue with the life context of children and adolescents.

And we have attention deficit, which I raised, that is now being trivialized: a hyperactive child has attention deficit. Sometimes it shows, sometimes not, and people are unable to differentiate it... Then the child does not do well at school, it is the father who does not have much patience because the school is all the time extolling this lack of the child's attention, and the father does not know how to solve it. (A-04/ GF1).

The discursive resort to diagnostic categories appeared more frequently in the speech of CHWs than in that of the physicians, contrasting with a study of 2006, with PHC pediatric physicians, in which the prioritization of medical-bi-

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ological determinants was remarkable as a way of understanding SMCA's problems[23]. The fact that physicians in this study are trained in Family Medicine, where the construction of diagnoses through the evaluation of problems and contexts and not through classification standards[24] is emphasized can contribute to clarify the difference pointed out.

Changes in behavior and learning were largely related to situations of violence to which many children and adolescents are exposed: intrafamily violence, sexual abuse, abandonment, neglect and others. The violence component was considered a triggering or aggravating factor of SMCA issues, confirming that, in ESF's perception, the severity of situations is more directly related to social vulnerabilities than to psychiatric diagnoses.

[...] *we realize that the child also suffers domestic violence... this is a somewhat common thing here, and I think it is a bit troubled because of this. Children become more violent at school, cause a stir with teachers who, in turn, call in parents, who are also people that sometimes have a violent attitude towards children at home. Then the child does not want to stay at home, stays in the street, then the mother wants to have control over the child, but she has not, she only manages to do so violently ...* (B-03/ GF1)

Studies show that children subjected to frequent violence tend to evidence learning difficulties and behavior disorders, especially self-destructive behaviors, social isolation and low self-esteem[25], not always associated with the experience of violence when evaluated in health services[23]. Paula et al.[26], when analyzing risk factors and protection for mental health, identified intrafamily violence as the main risk factor for mental problems in adolescents, who, when exposed to this situation, would be three times more likely to show problems than when exposed to urban violence.

In this study, the effects of the social context on adolescence were scarcely thematized and there were few problems associated with this period of life, such as drug use and violence. Only two references to adolescent users were recorded: one related to a young man with severe mental disorders, already followed-up by CAPSi; and another, a hopeless account, which stated that the pathway of neglected childhood is inevitably a future offender career. The lack of perspective and ability to construct life projects for young people with high social vulnerability seemed to delimit, in the studied period, the relationship between ESF and adolescence. The "invisibility" of mental health events in adolescents has been reported in studies[26].

In summary, in relation to the perception of SMCA problems, it is possible to affirm that: a) there is, on the part of the FHT, sensitivity vis-à-vis SMCA issues, greater for childhood than adolescence problems; b) SMCA problems are recognized based on behavioral changes located in contexts of vulnerability and are not restricted to the existence of diagnosed mental disorders; c) care actions, however, are rare or nonexistent, both in relation to those that can be developed in the ESF itself and in relation to those that depend on the establishment of partnerships with other services in the territory, which makes effective SMCA care impossible.

Primary Care Actions

Despite the sensitivity of ESF workers to SMCA problems and the understanding of their multi-determinate nature, care actions are practically non-existent at the primary care level of the studied territory, which, to a large extent, is attributed by professionals to the lack of SMCA training and impediments derived from the work process (such as short medical visit times and pre-established care goals that do not include mental health, let alone SMCA). Even in relation to the general evaluation of SMCA problems, some insecurity was reported due to a lack of a "differentiated look" to discern issues specific to child and youth development from those that suggest a need for intervention, culminating in hesitant attitudes before cases and recurrent demand for referrals to specialized services.

We have no notion or a differentiated look at this thing, so how do we say which cases are more serious and less serious? Sometimes the child is apparently calm, so the mother comes here asking for treatment and we do not provide it because there are no professionals in this area. (A-04/GF1)

We identify, but at the time of solving the issues, we cannot really do it. (B-05/GI).

I am unable, as a family doctor, to see this child enough to be able to get closer to him/her and try to achieve a diagnosis. I have neither the training nor the time available. (C-08/GF1)

The training of ESF professionals in SMCA care presupposes, besides the availability to tackle problems, to gather enough elements to deal with the situations. The construction of this condition depends on the provision of strategies that allow the real sharing of knowledge and care actions between the ESF and mental health, through the

joint construction of care projects that contribute to greater safety of ESF workers in the development of psychosocial interventions, positively affecting the access and qualification of SMCA care. Delfini and Reis[5] point out that joint work among teams is crucial for the development of SMCA actions in ESF, both in relation to those that can be performed in the very PHC – less complex situations and health promotion actions – and the validation of referrals required, ensuring greater adherence of users and their families to the care process. Paula et al.[27] affirm that PHC professionals need a partnership with mental health professionals, less to address specific pathologies and more to respond to issues related to the effects of violence and vulnerability on children and adolescents – a problem that calls for frequent dialogues between these two areas of action.

SMCA care in ESF, when it exists, has resulted more from voluntary action strategies rather than from a public management capable of targeting actions and allowing results evaluation:

I started out on my own, my idea, treating W. as a child, playing with him, got it? I had to do something and I did not know what this was. (A-01/ GF1)

The recurrent demand for referral to specialized services recorded in this and other studies[5] has been analyzed as the expression of contradictory aspects in PHC[28] performance. Despite the relevant evaluation of the complex factors involved in the emergence of mental health problems, in general, the ESF has oriented its actions through the traditional and hierarchical model of care, using specialized care, without achieving comprehensive care. Workers acknowledged the joint case discussion as a tool to advance the conditions of SMCA care in the ESF and other services integrated in the care network. The implementation of matrix-based strategies, however, which could account for this strategy, appeared timely in the groups' reports, often reduced to the bureaucratic referral of cases to specialized mental health services. Joint work experience is still incipient in the studied territory, and matrix-based support translates into sorting to specialized services.

Also highlighted as obstacle to work is the high turnover of professionals, which hinders linkage with the user and longitudinal care: *we have a very big issue here because doctors' turnover is high, so we fail to establish a connection. I have been here for six months and I'm already with the third doctor* (A-03 / GF1); besides the establishment of goals incompatible with the rationale of universal and comprehensive care that should operate in the ESF. Reports such as *we are run over by the* [diabetes, hypertension] *programs* (C-01/GF01) or *mental health is not included in the* [ESF] *goals* (C-08/GF01) were frequent in the groups. Mendonça et al.[29] point out hardships related to the work processes as producers of lesser subjective availability on the part of the professionals to create strategies of care within PHC. On the other hand, Janssens et al.[30] affirm that collaborative care cannot be carried out without a favorable political and management structure, otherwise it will be restricted to timely and sporadic experiences carried out solely through the professionals' goodwill.

In summary, with regard to SMCA actions in the ESFs of the surveyed territory, it can be stated that they are rare, they do not integrate the list of population coverage goals, depend on the voluntary action of the workers and do not make up the set of agreements between health / mental health management and services. The demand for specialized professionals for case referrals was a prevalent issue among ESF operators, who did not reach a consensus regarding the insertion of these specialists as to whether integrating the ESF team or allocating them to referral services. Matrix-based strategies did not operate toward sharing, generating contradictorily more demand for specialization and consequent postponement of care, referral red taping and disbelief of workers regarding the real possibility of partnership for the reception and shared SMCA care.

Network articulation

Regarding the relationship with the other services, ESF professionals quoted in a nonspecific and imprecise way some services of the network, among them CAPSi. The lack of knowledge of the existing resources and the lack of clarity regarding the way the services of the territory operated were the keynote of the reports.

The network is very complicated for PHC people. We feel very helpless. (C-01/GF1)

It feels like table tennis, sending back and forth, left and right. (A-04/GF1)

We are still trying to figure out... (B-05/GF1) ... *who can or cannot go to CAPSi.* (B-02/GF1)

Delfini and Reis[31] point out that the questioning of what each piece of equipment entails in networking reveals, on the one hand, *isolation of services around themselves and a disarticulation of their actions*[31] and, on the other hand, the lack

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of guidance for the effective organization and supply of care. They also point out that, in this logic, cases in which management is not possible in ESF – and they are not considered serious or complex enough to be referred to the CAPSi – are often not receiving attention and follow-up, subjected to pilgrimage or waiting for a worsening of the situation to be inserted in the CAPSi, which is what could be called non-inclusive circulation dynamic. In the studied territory, disarticulation and fragmentation of care were also expressed vis-à-vis CAPSi: *I have been here for 5 years and I have come to get know it more closely now. CAPSi started last month for me.* (B-07/GF1)

As for the intersectoral issue, reports were also marked by obstacles, mainly with Social Assistance and Guardianship Council. Given the lack of official guidance and low success in establishing partnerships, professionals are ambiguous: they recognize that more effective care will only be possible with shared action, but they discredit that this articulation may happen at some point, resulting in a feeling of powerlessness and helplessness.

I have a child in a shelter that was referred by the Guardianship Council because parents were unable to cope. They no longer had the reins of a 12-year-old child. I believe this is a very critical case, to be worked on, be followed-up, to be seen by health and other sectors, and that we do not know where we stand, because: are we in charge? Who is in charge? To whom do we refer this child? Who has this responsibility? (A-07/GF1)

Distrust, discontinuity of care and lack of expectation in the effective articulation of the intra- and intersectoral network mark the reports of ESF professionals regarding the functioning and dynamics of the network: *Which would have to be a continuous thing, right?* (A-03/GF1)

Couto and Delgado[32] emphasize that, given the deadlocks and hardships in the construction of the expanded SMCA network, it will be incumbent upon the mental health sector to strategically start the network assembly process, by taking responsibility for the problem, so that later all professionals / sectors involved in care are *on the same level of equality, as they will be engaged in a truly common problem*[32].

The joint construction of the problem and the strategies of overcoming, by escaping from the common practice of delegating responsibility or of one sector's sovereignty over others can potentiate work partnerships and positively affect the access and validation of care. However, the effective role of mental health services in the construction of the expanded SMCA network relies heavily on a clear public direction affirmed by local management bodies, an almost non-existent feature in the territory studied.

What territory is this, which is lacking so many references? (C-03/GF1), asked a CHW, in highlighting their perception about the lack of partnerships. The lack of references, however, seems to be related more to the lack of articulation than to the lack of services. CAPSi, PHC/ESF, matrix-based strategies actions, social assistance services, guardianship council, schools and others coexist in the territory, but do not establish effective partnerships to respond to the mental health needs of children, adolescents and their families. The SMCA issues have not produced consistent dialogues between the services of the territory and care has been predominantly provided by red tape referrals, without regular exchange among professionals and without continuity.

Proposals to overcome challenges

The perception of the set of problems and challenges for the advancement of SMCA care did not prevent the alternatives proposed by the ESF to overcome deadlocks:

I believe this partnership is simpler than we think. They could arrange a monthly meeting. If we work servicing the same public, with the same intention to improve, I think there are conversations, we have emails, we have the facility manager and we have professionals. Send an e-mail, take a case, get to know whether this person received care: and then, how did it go? What can we do? Because information is usually lost (A-04/GF1).

[If we have a partnership] *we will not need, in anguish, to seek help blindly. The patient arrived in CAPSi, how is he/she? The patient got here, how did it go?* (C-01/GI)

The overcoming of the fragmented logic of care, with proposed joint actions and establishment of regular and systematic communication between the different stakeholders involved indicated the possible change of the local reality, through the leading role of workers. Closer communication between professionals can reduce the gap between teams, contribute to the establishment of continued care for children and adolescents and enhance the actions of psychosocial and intersectoral care in the territories. Part of this strategy was put into practice in the facilities studied as an effect of the intervention performed during the research. At the end of the first

FG, CAPSi guided the ESF in relation to the functioning of its gateway and provided the service's telephone and electronic contact, expanding the dialogue channel. During the IG, situations were discussed, general guidelines presented and some guidance provided. In the last FG, when discussing joint work's sustainability, the short-term organization of two actions was suggested: a) joint monitoring of the cases already attended in the CAPSi, through the assembly of a virtual spreadsheet with a common access between ESF and the CAPSi, and a monthly agenda of meetings between services; b) construction of collaborative projects for the cases identified by the ESF that do not require insertion in the CAPSi, but cannot be well served only with traditional ESF resources, requiring the support of mental health to expand the possibilities of care. In the end, professionals recognized that an initial step toward collaborative care had already been taken: *We've done the talking, we have already built and cleared something, including the case that V. spoke about. I think work has already begun*. (A-01/GF2)

Bower and Gask[33] affirm the advantages of the PHC-mental health articulation collaborative model in order to extend care conditions to people with mental health needs when compared to the traditional model based on the rationale of referral. In the collaborative model, mental health service, in close partnership with PHC, is integrated into the cases and situations care process and can increase the overall effectiveness of the care system in a delimited territory.

Final considerations

The construction of expanded SMCA care networks with ensured access and validated care in the territories is one of the main challenges for the consolidation of the SMCA policy nationwide. A powerful intra-sectoral articulation between CAPSi and PHC can be the foundation for the development of collaboration, sharing and co-responsibility between different sectors of child and adolescent care, allowing the establishment of new ways of providing care that transcend fragmentation and dispersion.

The analysis of the practiced strategies in a specific territory and the perceived challenges in the approximation between CAPSi and PHC/ESF enabled the identification of facilitating factors to as hindrances in the process of collaborative SMCA care. Two favorable factors stood out in the studied territory. First, the perception of SMCA problems by ESF professionals seems to build on an expanded view of the determinants of psychic suffering and on the understanding of the complex mental phenomenon, in contrast to studies cited, where biomedical reductionism predominated as an explanatory key for SMCA's issues[23]. Another factor is related to the fact that ESF professionals responded positively and swiftly to the intervention proposed in the study, focusing on the identification of issues, possible actions and ways of articulating in a SMCA network, indicating that there is a favorable ground for the implementation of collaborative work under the premises of psychosocial care.

However, concurrently with facilitating factors, a set of obstacles was recorded, the main ones being: a) hesitation before SMCA problems and consequent demand for 'experts' on the part of ESF, indicating that a more comprehensive understanding of the determinants of suffering, when not accompanied by knowledge sharing, results in conservative care strategies that do not overcome the fragmentation of care; b) lack of directionality on the part of management to establish intersectoriality and collaboration as ways of building the expanded SMCA network, leaving to stakeholders at the 'tip of the system' the responsibility to innovate without having a guiding compass; c) lack of knowledge of the resources, modes of operation and key players in the territory, including CAPSi, indicating that strategies for disseminating information were fragile or non-existent in the territory.

While this study is restricted to PHC/ESF, we could infer collaborative and territorial action difficulties by the CAPSi, suggesting the need for further studies that can analyze in depth and debate the aspects raised. At the time of the research, CAPSi was 'invisible' to PHC/ESF, although it has been in place for over a decade. Regarding the territorialization of actions, CAPSi and ESF indicated fragility; the first, due to the low capillarity in the territory; the second, being in the territory without seeking to know the available care resources.

In the researched context, child or adolescent social representation is for one that suffers, is in pain, has own voice and history and is not reduced to a set of behaviors, showing operators' sensitivity to the complex subjective and mental phenomenon. However, the lack of clear psychosocial direction leaves operators without a *savoir-faire* that is dynamic and co-responsible with the child or adolescent who suffers. The implementation of SMCA as a public policy requires dis-

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semination, evaluation, monitoring and sharing (including users and families) formal strategies to respond to the mandate of inclusion.

Even considering the limitations of this study – restricted to a specific territory and PHC/ESF – we hope that the results found and the discussions proposed contribute to the debate and the advancement of Brazilian community mental health.

Collaborations

MR Teixeira participated in all phases of the study, from the bibliographic review and data collection to the analysis and preparation of the manuscript. MCV Couto was responsible for project supervision, data analysis, discussion and final review. PGG Delgado was responsible for the design and orientation of the study, methodological approach and final review.

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