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Childhood and adolescence in mental health policy: an analysis through health counselors and conferences

João Mário Cubas (https://orcid.org/0000-0002-3263-3836) [1]
Victoria Grassi Bonamigo (https://orcid.org/0000-0002-3476-1970) [1]
Rodrigo Alvarenga (https://orcid.org/0000-0001-8546-4442) [2]
Deborah Ribeiro Carvalho (https://orcid.org/0000-0002-9735-650X) [3]

Abstract *This qualitative, descriptive, and exploratory documentary and field research aimed to analyze how children and adolescents are included in the formulation of public mental health policies. The document analysis database consisted of reports from Health Conferences (national, state, and municipal), minutes of meetings of the Health Council (national, state, and municipal), and memories of the Thematic Commission on Mental Health (state and municipal). Nine counselors or former health counselors participated in this study through an individual interview with a semi-structured script. Furthermore, the theoretical framework for the analysis of this research was based on the communicative action of Jürgen Habermas. The themes that emerged from the documentary research included the guidelines for intersectoral processes, as well as the expansion of beds for children and adolescents. In addition, the interviews indicated the lack of discussion on the subject, predominance of the punitive perspective, and need for a broader debate. The lack of intersubjective spaces for democratic listening compromises communicative action, resulting in the invisibility of children and adolescents in the policy formulation process and reduced opportunities for participation and social control.*

Key words *Social control policies, Mental health, Health Councils, Child, Qualitative research*

[1] Pontifícia Universidade Católica do Paraná (PUCPR). R. Imac. Conceição 1155, Prado Velho. 80215-901 Curitiba PR Brasil. joao.cubas@gmail.com
[2] Programa de Pós-Graduação em Direitos Humanos e Políticas Públicas, PUCPR. Curitiba PR Brasil.
[3] Programa de Pós-Graduação em Tecnologia em Saúde, PUCPR. Curitiba PR Brasil.

Introduction

Mental health and psychosocial care policies in the Unified Health System (SUS) are directly related to the health reform movement and the construction of the Democratic State. The proposal of Bill (*Projeto de Lei* - PL) No. 3,657/1989 by Deputy Paulo Delgado resulted in the enactment of Law No. 10,216/2001[1]. This law is a milestone in the Brazilian Psychiatric Reform, which is achieved by social movements and human rights activists opposed to asylum practices.

In this context, Brazil has enacted laws ensuring the right to health care, but formulating public policies for children and adolescents remains a mental health challenge. Researchers and professionals in the field have identified this gap, emphasizing the need for increased oversight in existing policies and programs. They also advocate for the implementation of measures that fosters the healthy development of this demographic through a collaborative and shared-responsibility network[2,3].

According to Couto and Delgado[4], mental health in childhood and adolescence was included much later in the Brazilian public health agenda and the national Psychiatric Reform process. The authors noted that the actions contributing to this new agenda only began in 2001[4].

The social invisibility of childhood and adolescence in mental health policy formulation is evident, which may be due to the failure to recognize others as holders of rights[5]. This can be seen in the difficulty of consolidating mental health care networks for this group, the lack of professional training, and the fear of family members about exposing children and adolescents, which can intensify their suffering. Therefore, it is important to extend beyond mere treatment to include the aspect of reception[2,6,7].

Invisibility can also be observed in the exclusion of children and adolescents from social and political participation. Braga and D'Oliveira[8] emphasized the need for effective guarantees of the participation of this population, enabling them to take a leading role in the fight for their rights. According to Tironi[9], a child will feel socially valued when their political contribution is valued as much as other individual contributions.

Social control of health policies is interpreted through public regulatory bodies within the SUS[10]. Law No. 8,142/1990[11] provides for community participation in the management of the SUS, identifying Health Conferences and Health Councils as control mechanisms[12].

Health Conferences are decision-making mechanisms for developing and reformulating health policy. They are conducted across three levels of government – namely, national, state, and municipal – focusing their deliberations on policy guidelines. The Health Councils, which are also deliberative, aim to formulate, monitor, evaluate, and control compliance with health policy[12]. Furthermore, concerning the Health Councils' spaces, there are Thematic Committees tasked with proposing, overseeing, and tracking measures to implement health policy, specifically in their field of operation. They are permanent, consultative, and comprise representatives from all segments of the government[13].

Although there is a legal framework guaranteeing the right to care, public policies do not align with this guarantee. Therefore, this study aimed to analyze how children and adolescents were involved in the participation processes for the formulation of mental health public policies. Identifying potential barriers to integrating this group into the health sector can contribute to discussions among the State, managers, civil servants, and all of civil society, enabling democratic actions and the formulation of health right policies for children and adolescents.

As a theoretical framework for analyzing this invisibility, Jürgen Habermas's communicative action[14] is proposed, emphasizing the importance of understanding the diverse perspectives involved in the vocalizations of various social actors[15]. As communicative action is steered by an intense process of mutual acceptance and listening, various actors are presumed to reach a consensus on the best decisions and proposals[14]. In social control spaces, communicative action and the pursuit of understanding are essential to ensure the health rights and services provided to children and adolescents.

Materials and methods

This study is the outcome of a qualitative and an exploratory research[16] based on both documentary and field methods, and is divided into four stages, as shown in Figure 1.

The research question raised was as follows: how is mental health manifested in childhood and adolescence in social control spaces?

The research was approved by the Research Ethics Committees (CEP) under Opinions No. 4,133,452, No. 4,585,413, and No. 4,474,160.

The first stage involved obtaining conference reports, minutes, and records of Health Council meetings via a *web* environment (websites of the National Health Council, a State Health Council from southern Brazil, and the Municipal Health Council of the mentioned state's capital). The time window for document search was defined based on the enactment of Law No. 10,216/2001[1], covering the period from 2001 to 2019.

The data were organized and results were extracted using Bardin's[17] content analysis method: (i) pre-analysis; (ii) material exploration; (iii) results treatment through inference and interpretation.

Electronic spreadsheets were developed to quantify the collected material, including (i) minutes (year, governmental level, regular or special meeting); (ii) records (year and governmental level); (iii) Health Conference reports (year and governmental level); and (iv) Mental Health Conference reports (year and governmental level).

Following the stage mentioned above, the qualitative data analysis software ATLAS.ti[18] was used, enabling the analysis and management of various types of documents or data collection instruments[19].

After the documents were imported into the software, they were categorized as follows: (i) by document type (minutes, record, conference report); (ii) by governmental levels (municipal, state, and national).

Based on the principles set in the Municipal and State Health Councils' regulations and in Law No. 8,142/1990[10] concerning the instances, the Health Councils, Health Conference, and the Thematic Committee served as the basis for the coding process, with three initial categories of analysis (first cycle coding). These categories were designed to identify content related to child and adolescent mental health, excluding other content (Chart 1).

During the categorization process, it was necessary to narrow the categories, incorporating emerging themes from proposals, reports, and guidelines. Saldaña[20] emphasizes the importance of the researcher remaining open-minded during the initial data collection and review before deciding on the coding methods to use.

Further, current and/or former members of the Curitiba Municipal Health Council and Paraná State Health Council were interviewed.

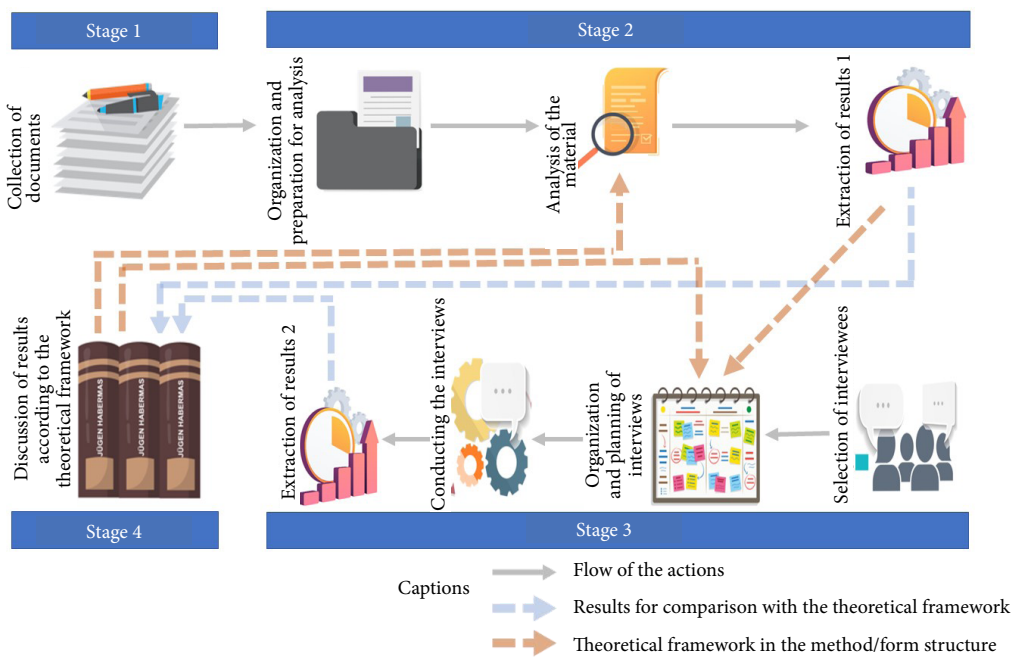

Figure 1. Flow of Research Steps.

Source: Authors (2022).

To select interviewees, letters explaining the research objectives were sent to the Municipal and State Health Councils' presidents, requesting the nomination of at least four individuals over the age of 18 years per council.

As the inclusion criteria, nine current or former health councilors (either full or alternate) who served at least one term on the Municipal Health Council of Curitiba and the State Health Council of Paraná participated in this interview. The study did not have any exclusion criteria.

Considering the social isolation context due to the COVID-19 pandemic, the interviews were conducted in a virtual environment following a pre-established script. The script considered the principles of communicative action and deliberative democracy, such as the public sphere, civil society, and life. It aimed to understand the counselors' perspective on the topic, whether it was indeed facilitating communicative action, and whether the state's influence was altering the discussion on the topic[15]. Another point of inte-

Chart 1. Concept definitions for analysis categories, analysis categories in the first coding cycle, and analysis subcategories in the second coding cycle.

Social Control Instance	Conceptual Guiding Framework	Definition of the concept	Analysis Categories (First Cycle Coding)/Definition of Analysis Category	Examples of analysis subcategories identified in the second coding cycle
Health Conferences	Law No. 8,142 of 1990[11]	The Health Conference, with representation from various social sectors, will convene every four years to evaluate the health situation and propose guidelines for health policy formulation at the respective levels. It is summoned by the Executive Branch or, in extraordinary circumstances, by the Health Council.	Guidelines for childhood and adolescent mental health/ (Proposed guidelines for childhood and adolescent mental health)	Access and Territoriality - Children's SM Guideline Expansion of CAPSi - Children's SM Guideline
Health Advice	Law No. 8,142 of 1990[11]	The Health Council, a permanent and deliberative collegial body composed of government representatives, service providers, health professionals, and users, formulates strategies and controls the execution of health policy in the corresponding instance, including economic and financial aspects. Its decisions will be approved by the head of the legally constituted power in each level of government.	Proposals for childhood and adolescence mental health/ (Resource allocation, new equipment, projects for this demographic, etc.) Childhood and Adolescent Mental Health Reports/ (Complaints, Equipment Status, and Other Discussed Situations)	Proposals . Proposed Intersectoral Action (Child Protection Network) SM . CAPSi Expansion Proposal Reports . Report on the application of child SM legislation . Report on the presentation of the children's SM subcommittee project
Thematic Commissions	Curitiba Regiment (2017)[13]	The Thematic Committees of the Municipal Health Council aim to propose, oversee, and follow measures that enable the implementation of health policy in Curitiba, specifically in their area of operation, supporting the Municipal Health Council. The Thematic Committees of the Municipal Health Council are permanent and consultative, composed of representatives from all segments of the Council.		

Source: Authors (2022).

rest was to check if civil society interest groups had assured communication (claim to validity) within these spaces, facilitating democratic principles in these instances.

All interviews were conducted online and recorded. After each interview was recorded, an MP4 file was generated. For conversion, we opted for Google's voice-to-text API as an automatic transcription tool.

The main researcher reviewed the transcription file and the final version, which was post-processed in .docx format. Subsequently, it was integrated into the ATLAS.ti qualitative data analysis software. This was done to establish analysis categories based on the themes that emerged from the interviews, aiming to answer the research question. Networks were established to graphically demonstrate the results. This step enhanced the data from the documentary research, as it allowed identifying situations that were not highlighted in the documentary records.

The compilation of results from the documentary research combined with field research, in relation to the guiding theoretical framework, enriched the previous stages. This further promoted the study's aim to address the low representation and vocalization of the topic of childhood, analyzed through Habermas's theory of communicative action[21].

Results

Based on the methodological steps developed in this study, a four-stage collection and analysis model, anchored in the principles of qualitative research, was proposed.

It should be noted that the model's timeframe involved analyzing documents issued between 2001 and 2019, and field analysis in 2021.

Documentary research

A total of 1,046 documents were analyzed. Among the collected documents, the following information is mentioned: State Minutes (n=222), Municipal Minutes (n=263), National Minutes (n=243), State Conference Reports (n=9), Municipal Conference Reports (n=10), National Conference Reports (n=7), State Thematic Commission Records (n=175), and Municipal Thematic Commission Records (n=117).

After the category review process, subcodings were performed in the texts during the second cycle, where necessary, to define the themes that emerged from the guidelines, proposals, and reports. Table 1 shows some examples of the subcodings.

The text segments in the reports were first-cycle coded, according to the following frequency: Mental health guidelines for the general public (to highlight the invisibility of children and adolescents) (n=466), Mental health guidelines for childhood and adolescence (n=155), Proposals for mental health in childhood and adolescence (n=147), and Reports on mental health in childhood and adolescence (n=299).

To illustrate the behavior of each level regarding the development of guidelines and proposals, a timeline was created. To the right of the line, the guidelines for childhood and adolescence in the three levels are shown (Health Conferences), and to the left, the proposals for childhood and adolescence (Health Councils) are shown with their respective quantities (Figure 2).

Furthermore, the six main themes discussed for this stage were identified from the survey of the frequencies of both the guidelines and the proposals, as shown in Table 1.

Interviews

Nine interviews were conducted from March 23 to May 7, 2021. Most respondents were women (seven), with an average age of 49 years (standard deviation = 13.04). The interviewees belonged to various professions, with a few being highlighted: psychologist (three), social worker (one), pedagogue (one), physiotherapist (one), nurse (one), retiree (one), and social educator (one).

Regarding the councils to which the interviewees belonged, seven were from the Municipal Health Council, one was from the State Health Council, and one represented both. Regarding the segment these interviewees belonged to within the Health Councils, one was from Health Managers/Providers (11.1%), three were Workers (33.3%), and five were Users (55.6%).

From Figure 3, we can identify the main discourses on how this topic was debated within social control spaces.

The topic was discussed more punitively, encompassed by protective measures or under the socio-education debate. The topic was not discussed within these spaces, but in Child and Adolescent Rights Councils. Furthermore, the dilution of thematic commissions ultimately suppressed the topic.

The topic was discussed as a subtopic within broader themes (adult mental health). Given

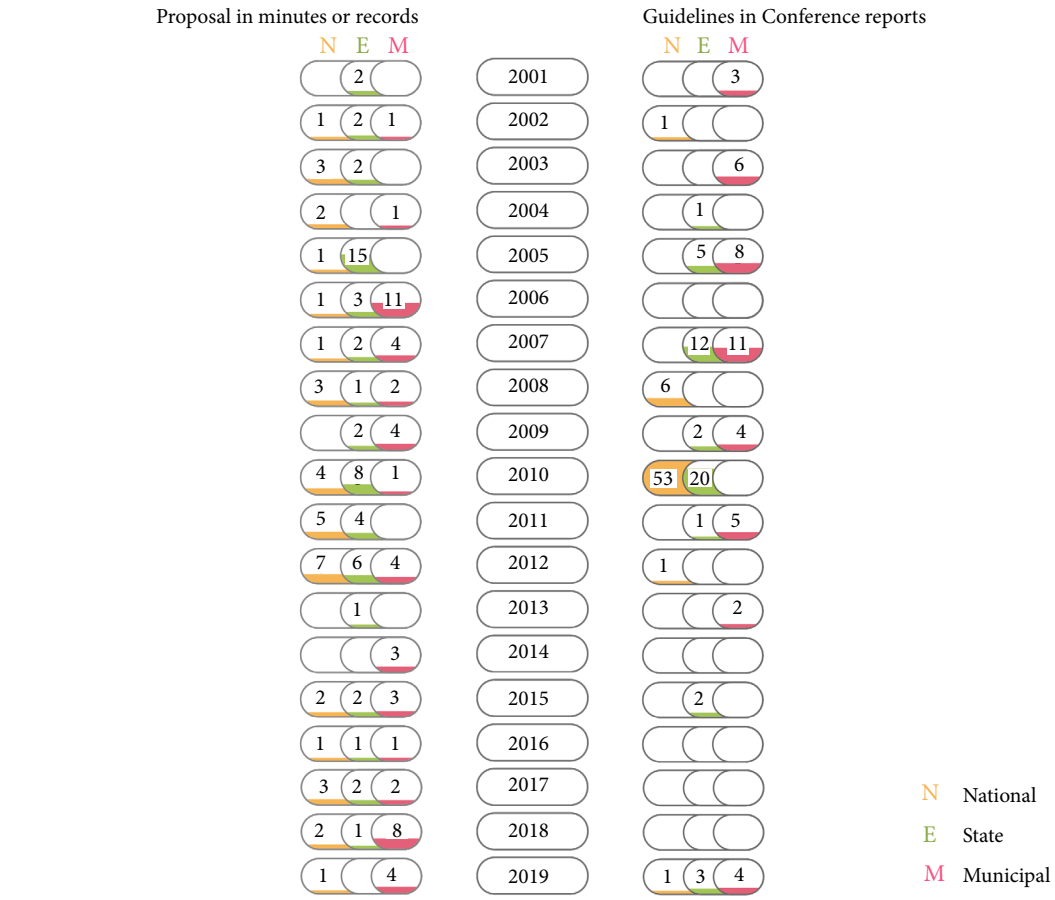

Figure 2. Timeline of guidelines and proposals for childhood and adolescent mental health.

Source: Authors (2022).

Table 1. Explored Guidelines vs Proposals.

Guidelines	Frequency	Proposals	Frequency
Intersectorality - Child's SM	28	Proposed Intersectoral Action (Child Protection Network) SM	7
Service Expansion - Children's SM Guideline	18	SM Children's Services Proposal	9
Prevention Programs - Children's SM Guideline	18	Project Proposal for Substance Use Prevention	16
Implementation of programs/policies - child SM guideline	13	Policy proposal for children's SM	7
Expansion of CAPSi - Children's SM Guideline	12	CAPSi Expansion Proposal	21
Child and Adolescent Hospitalization - SM Children's Guideline	9	Proposed expansion of children's SM hospital beds	15

Source: Authors (2022).

the above discussion, the counselors' discussions was shown to exclude the topic of mental health in childhood and adolescence. In interviewee 6's report (Figure 3), it is evident that childhood is often overlooked, as the demand for other subjects is high, and this topic is not addressed.

The interviewees identified groups of mothers (family members) as those who were the most vocal about the issue, but it was still primarily addressed by Guardianship Councils in a protective manner (interviewee 3).

Another point about groups or movements concerns the discussion in the Child and Adolescent Health Commission. However, as it was diluted in other spaces, this topic was compromised (interviewee 2).

Even in the counselors' speech, it was clear that such discussion did not occur (interviewees 4, 5 and 7).

The topic was widely accepted during the development phase. When discussed, it was presented as a subtopic, such as socio-education (interviewee 3). When accepted, it was not considered within the Health Councils, but rather in spaces such as the Council for the Rights of Children and Adolescents (interviewee 4). The interviewees also mentioned that the topic was welcomed in the Children and Adolescents Commission, but after its dilution, it was no longer debated (interviewee 7).

Regarding the pursuit of greater public and topic representation, the need for intersectorality (education, health, and social assistance) (interviewee 2) and grassroots work through local Health Councils (interviewee 5) was identified, enabling accessible communication for all (interviewees 3 and 5). It was noted that sometimes, older members prevented new groups from debating within these spaces (interviewee 5).

Compilation of documentary and field research results related to the guiding theoretical framework

Habermas' logic of communicative action[21] emphasizes the significance of coercion-free communication, which is aimed at achieving mutual understanding and problem resolution. In this context, the Thematic Conferences on Mental Health serve as a crucial platform for collective deliberation, enabling citizens to participate in informed and reasoned discussions to find solutions that address societal needs in mental health. However, numerous gaps still exist that hinder the occurrence of communicative action and generation of effective results.

An interval of non-occurrence of Thematic Mental Health Conferences (in the three levels) was identified during the study period. The interviewees identified the following causes for this interval: current political instability (interviewee 4), lack of national movement (interviewee 6), anti-democratic movements (interviewee 6), and managers' lack of interest (interviewee 6).

Anti-democratic movements can foster distrust in democratic institutions and diminish citizen participation in such events. The disinterest of managers may suggest a deficit in dialogue and interaction between public administration and citizens, implying that communicative action and the principles of deliberative democracy are compromised in this context.

The minutes recorded the dissolution of the State Thematic Commission on Mental Health in 2014 into other commissions, leading to fewer proposals in this area. The Municipal Commission for Child and Adolescent Health collapsed at the municipal level in 2018.

The participants in this study stated that issues arose within the Municipal Commission for Child and Adolescent Health, but after their dilution, they remained dispersed (interviewees 2, 5 and 7).

The findings show that democratic formation is not legitimized due to insufficient space for deliberation of communicative assumptions[21]. Even though policy formulation debates occurred in the three levels, participants indicated that the topic's development did not take place within the council spaces.

The interviewees mentioned the following as reasons for this gap in policy formulation: lack of training in child and adolescent mental health in primary care, which hinders actions (interviewee 1); discussions taking place in other areas, and not specifically in health (interviewee 4); and discussions being part of broader subjects, without a specific focus (interviewee 6). As interviewee 6 highlighted, public debate often focuses on minimizing setbacks, resulting in specific topics (such as those concerning children and adolescents) being left off the agenda.

The prospect of formulating a specific policy, despite discussion, is not implemented because the topic of mental health still needs public debate to avoid opposition. Specific cases (children and adolescents) are often overlooked in the pursuit of larger issues, as the regression of overall mental health policy is still evident (interviewee 6). One of the themes also emphasized in the documentary research is the expansion of pediatric beds. In this context, interviewee 6 stated that the matter of psychiatric hospitals is a challenge.

In the three levels, proposals and guidelines were presented for the expansion of children's beds. In 2012, the National Health Council discussed that Paraná was among eight states with beds allocated for children and adolescents, accounting for 6% of the beds. In the same minu-

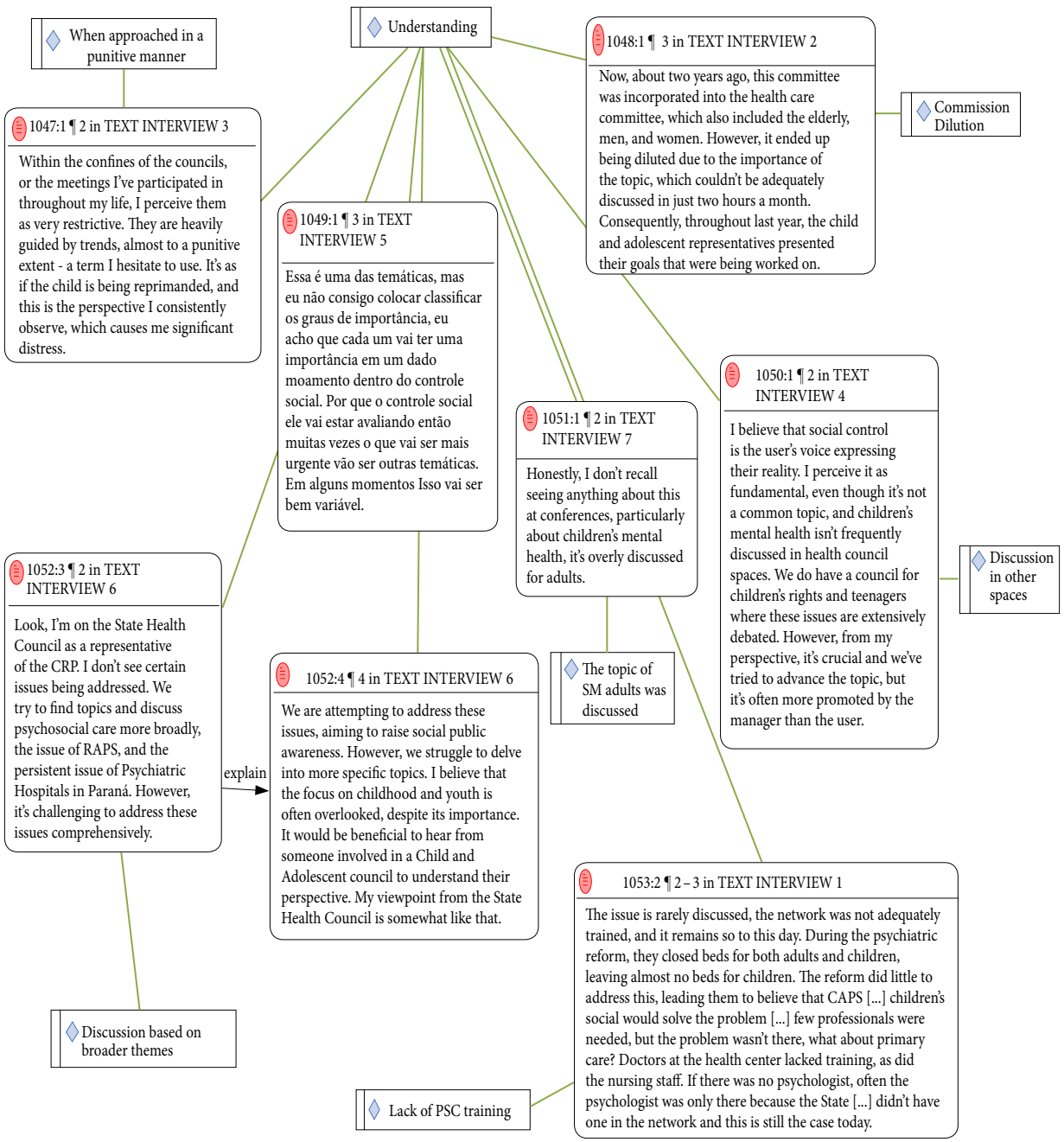

Figure 3. Network: Understanding of mental health in childhood and adolescence within social control spaces.

Source: Authors (2022).

tes (2012), the council declared the need for an immediate audit in Paraná's psychiatric hospitals, which still had children admitted.

Discussion

There was a lack of proposals and guidelines for intersectoral actions at specific points in the timeline used in this study. Even though the "intersectorality" subcategory was the most prominent in the documentary research, the period without actions on this topic could have significantly compromised the creation of programs for this demographic.

Couto and Delgado[22] highlight that, considering the historical debt to child and adolescent mental health care, intersectoral actions are the starting point for implementing for mental health services for this demographic.

One of the "nodes" in the network requiring this intersectoral perspective is the challenges in the school environment, as outlined in the proposals and guidelines for this demographic. Taño and Matsukura[23] emphasize in their study the need for enhancing relationships with schools, as they are the primary places where children and adolescents spend time and can provide access to mental health services.

The need for specific services for children and adolescents is questioned, given that much of the current focus is on services for adults. This study identified a range of general guidelines, but they end up rendering this audience invisible, requiring a different perspective (Couto *et al.*[24], p.391) contribute to the debate, suggesting that the care of this demographic cannot be addressed "by merely extending adult care strategies to the child and youth population".

There has been a regression in the country's mental health policies in recent years. Regarding CAPS, Cruz *et al.*[25] indicate a nationwide decline in implementation. Between 2004 and 2015, approximately 130 pieces of equipment were added in Brazil. However, there was a stagnation in 2017 and 2018, specifically in 2018, with only 30 services being implemented.

Regarding the time interval for the Thematic Mental Health Conferences, some causes for their non-implementation, such as political instability, were identified, corroborating Silva and Araújo's findings[26]. However, it seems that currently, other forms of social control are threatened or even depleted. The case of the National Conference on the Rights of Children and Adolescents is notable. From 2018, under the previous federal government, it began to experience a dismantling of participatory institutions. This was due to the authoritarian principles of the previous government, posing a threat to democracy[26].

Even though Decree No. 9,759/2019 did not directly impact the National Council for the Rights of Children and Adolescents, as it is governed by a law, the current scenario is not participatory, as the main objective of the document was indeed to weaken mobilization[26]. This implies regression, negligence, and exclusion, as it curtails the right to health[27].

Even when focusing on democracy themes, children and adolescents' mental health had less representation at Health Conferences. Both conferences and Health Councils can be perceived as ongoing public forums, where civil society and social movements can influence the public agenda to incorporate new topics and demands, such as those for specific and vulnerable groups[28].

Given the scenario discussed above, the low representation and vocalization of the childhood theme can be analyzed using Habermas' theory of communicative action[21]. According to Habermas, communication is a crucial process for consensus building and conflict resolution in the public sphere. For effective communication, the involved actors must interact in a way that fosters a common understanding of their actions, meanings, and intentions. In the context of childhood, the low representation and vocalization of the issue may suggest that the involved parties are struggling to interact effectively and agree on children's rights.

This may occur because councilors are pressured to approve opaque accounts, under threat of being held accountable for municipal losses due to the non-approval of certain proposals. The councils then become mechanisms for legitimizing the ruling class's power, transitioning from controllers to controlled[29].

The dilution of commissions, as Vieira[30] postulated, traces back to Habermas's concept that consensuses are social coordination mechanisms, tied to linguistic understanding, with the aim of reaching agreements. Thus, the absence of intersubjective spaces for democratic listening undermines communicative action.

Habermas[14] suggests that consensus from acts of understanding can determine the success in mastering a situation. The lack of consensus due to the absence of effective participatory and deliberative spaces hinders interactions between various social actors. These interactions

occur in the "lifeworld" and are centered around the communicative actions performed by individuals[31]. Precisely because individuals share a common sphere of lived world experience, symbolically shaped by human language turned into culture, it would be possible to establish basic consensus in the pursuit of the best possible public policy. However, the consensus often established in these participatory spaces is merely apparent, as conditions for a more horizontal and democratic dialogue are not provided. This explains why Habermas' theory of communicative action is deemed insufficient by some of his interlocutors.

Based on the consensus attributed by Habermas, Miguel[32], anchored in the criticism raised by Chantal Mouffe, considers that consensus as support for ethical and political values is inconceivable. This is because it would require neglecting the interests of those involved, resulting in a denial of politics.

The pursuit of consensus often entails the defeat of one side as a means of resolving the conflict. From this perspective, dominated groups are incentivized to challenge as the manifestations of antagonistic politics mirror their own domination relations[32]. Some counselors highlighted this difficulty in advancing discussions within the realm of social control, as observations and notes – derived from dialogue and deliberation – are not sufficiently impactful on the development and implementation of public policies. This is because democratic practices are not ensured in other areas of public management, resulting from disputes in the political environment where communicative action often appears naive.

The sporadic emergence of childhood and adolescence themes in social control spaces may suggest the denial of a child's otherness by adults. There is a comprehension barrier concerning child and adolescent mental health, as the otherness of children and adolescents can be overlooked due to the lack of a democratic and deliberative perspective in the development of public policies and social control spheres[33].

Alongside the issue of mental health, as discussed by Rizzini and Couto[34], the importance of involving children and adolescents in the development of proposals related to their care is emphasized. The authors stress the need for creating spaces for participation and decision-making, where these youths can voice their demands, fostering the practice of citizenship. However, in this study, the participants' statements (interviewee 7) reflected the discrediting of adolescents as subjects who do not possess a consciousness to claim their rights.

From the perspective of communicative action, social participation in the context of health policy formulation opposes the self-limitation of civil society actors' influence, to prevent them from assuming management roles, as this would result in the loss of their ability to vocalize social demands[28]. Considering that movements enabling this perspective for children or adolescents are not part of the debate, and that participation of this group is denied, spaces for social control and policy formulation are not truly democratic.

Mental health policy is at a challenging juncture, with the need to expand psychiatric beds for children and adolescents highlighting the demand for its advancements. Psychiatric Reform[1] posits the gradual reduction of psychiatric beds and the establishment of the Psychosocial Care Network (RAPS). The aim is to provide care within the community, facilitating social reintegration and reducing hospitalizations.

The CAPS, in their various forms, were established as a restructuring proposal based on the Psychiatric Reform. These are devices that emerged in response to segregation; these were territorially-based and followed the logic of deinstitutionalization. They should promote territorial transformations concerning the stigma and discrimination of madness[35]. However, when confronted with bigger challenges, reference is made to the "network," where the need to serve the child and youth population requires the expansion and coordination of existing services. Therefore, the implementation of RAPS – in the operationalization of its services – reveals policy contradictions, which has functioned more instrumentally and bureaucratically, simultaneously expanding and denying rights[36].

According to research by Silveira and Dias[37], comprehensive health care requires complementary actions, including the creation of communicative spaces to reduce inappropriate treatments.

In this study, one interviewee (interviewee 1) reported that even at present, basic teams lack training for child and youth work. Moreira *et al.*[38] reported similar findings, noting that some professionals were not technically and emotionally equipped to handle the equipment.

Enabling free care practices requires the development and implementation of programs that facilitate this care within the territory. However, there is still a limited number of CAPSi available for this population[4,39,40]. Furthermore, the handling of cases that do not fit the profile of

this equipment has been discussed in the literature[40,41], highlighting the need for debate on professional training policies to serve this demographic.

Based on the results of this study, it can be inferred that the feasibility of specific mental health policies for children and adolescents presents a contemporary challenge. This challenge is often marked by the disinterest of their representatives, or even their invisibility due to an adult-centric perspective which ultimately silences their interests[42].

Final remarks

The issue of mental health in childhood and adolescence within these spaces is addressed through reports and proposals that often do not gain traction, as they are not put to a vote. If the involvement of new civil society members, family members, and users is continued to be threatened, the deliberative process is not fully realized.

Mostly, the guidelines are formulated within the conference spaces, without any prior discussion of the theme at Health Council meetings. Even though it is not the focus of this work, the repetition of conference guidelines may signal a warning regarding whether they are truly being integrated into health plans across the three levels.

In this context, there is a depletion of spaces that could appropriately handle this subject, indicating the denial of the otherness of children and adolescents and the resulting challenge in enhancing the democratic and deliberative approach in the formulation of public policies. This depletion of discussion and deliberation spaces, which should include the active involvement of children and adolescents, hinders the development of more inclusive public policies that are sensitive to their needs.

By denying the otherness of these groups, society risks perpetuating structural inequalities and ignoring their voices, which is crucial for a deliberative democracy. Therefore, it is crucial to foster environments for listening and dialogue, promoting the active role of children and young people, to ensure their perspectives and experiences are effectively acknowledged and incorporated in government planning and the development of a more equitable and participatory society. Only by implementing these practices can we build a society that respects, protects, and promotes children and youth rights.

Collaborations

JM Cubas, VG Bonamigo, R Alvarenga and DR Carvalho conceived the study design, analyzed and interpreted the data, prepared and critically reviewed the article, as well as approved the final version to be submitted. Data collection was carried out by the first author, JM Cubas.

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In the interest of promoting Open Science ethically, both the original and pre-processed databases are available in a virtual repository for queries and other analyses. These databases can be accessed via the link: https://github.com/joaocubas/Cubas.git. In addition to the databases, other documents, images, and reports are available.

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