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Original article

Mental health in Primary Care: A rhizomatic network for childhood and adolescence*

Saúde mental na atenção básica: uma rede rizomática para infância e adolescência

Salud mental en la atención primaria de la salud: una red rizomática para la infancia y la adolescencia

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Abstract

Objective: to map mental health care for children and adolescents, its flows, lines and connections based on the articulation of the Psychosocial Care Centers for Children and Adolescents (*Centros de Atenção Psicossocial Infantojuvenil*, CAPSi) and Primary Health Care (PHC). **Method:** a qualitative and cartographic research study conducted between August and December 2017 in a municipality from Rio Grande do Sul. The study participants were CAPSi and PHC professionals. **Results:** the cartographic experience with the rhizomatic network made it possible to monitor CAPSi's articulation with PHC services; planning and sharing care according to workers' collective action, and also the "knots" and challenges of the child and youth mental health network. Insecurity to deal with the demand, lack of knowledge and the need for training as a support modality are challenges mentioned by PHC professionals for networked assistance. **Conclusion:** care-related arrangements can articulate/share the assistance provided, evoking a "rhizomatic network" of connections, flows and varied lines.
Descriptors: Mental Health; Primary Health Care; Health Policy; Child; Adolescent

Resumo

Objetivo: cartografar o cuidado em saúde mental à criança e ao adolescente, seus fluxos, linhas e conexões a partir da articulação do Centro de Atenção Psicossocial Infantojuvenil (CAPSi) e Atenção Básica (AB). **Método:** pesquisa qualitativa e cartográfica, realizada em município do Rio Grande do Sul, de agosto

a dezembro de 2017. Participaram do estudo profissionais do CAPSi e AB. **Resultados:** a experiência cartográfica com a rede rizoma permitiu acompanhar a articulação do CAPSi com serviços da AB; o planejamento e compartilhamento do cuidado segundo o agir coletivo dos trabalhadores, e também os "nós" e desafios da rede de saúde mental infantojuvenil. A insegurança para lidar com a demanda, com a falta de conhecimento e a necessidade de capacitação como forma de apoio são desafios mencionados pelos profissionais da AB para uma assistência em rede. **Conclusão:** arranjos assistenciais podem articular/compartilhar cuidados, evocando uma "rede rizomática" de conexões, fluxos e variadas linhas.
Descritores: Saúde Mental; Atenção Primária à Saúde; Política de saúde; Criança; Adolescente

Resumen

Objetivo: cartografiar la atención en salud mental para niños y adolescentes, sus flujos, líneas y conexiones a partir de la articulación de los Centros de Atención Psicosocial Infantojuvenil (CAPSi) y la Atención Primaria (AP). **Método:** investigación cualitativa y cartográfica realizada en un municipio de Rio Grande do Sul entre agosto y diciembre de 2017. Los participantes del estudio fueron profesionales del CAPSi y de AP. **Resultados:** la experiencia cartográfica con la red rizomática permitió monitorear la articulación del CAPSi con servicios de AP, la planificación y cooperación en la atención conforme a la acción colectiva de los trabajadores, y también los "nodos" y desafíos de la red de salud mental infanto-juvenil. La inseguridad para lidiar con la demanda, añadida a la falta de conocimiento y a la necesidad de capacitación como forma de apoyo, son desafíos mencionados por los profesionales de AP para brindar asistencia en red. **Conclusión:** implementar disposiciones asistenciales específicas puede ser útil para articular/compartir la atención provista, evocando una "red rizomática" de conexiones, flujos y líneas variadas.
Descriptores: Salud Mental; Atención Primaria de Salud; Política de Salud; Niño; Adolescente

Introduction

The Mental Health Policy guided by the Psychiatric Reform guidelines recommends that care for people in psychological distress should take place in the territory, based on different health care devices. Comprised by the Psychosocial Care Centers (*Centros de Atenção Psicossocial*, CAPS), the Primary Health Care (PHC) services are considered important to incorporate mental health care into their actions and strengthen the articulation with the Psychosocial Care Network (*Rede de Atenção Psicossocial*, RAPS).[1] The need to articulate and devise joint actions is based on the prerogative that PHC should be the preferred contact for users, the main gateway, and also for early identification and treatment of mental disorders, and it is up to it to order the care network, welcome and guide whenever necessary.[2]

A number of studies consider this articulation a challenge for public health policies and recommend, in order to guarantee care quality and effectiveness, that the articulation between teams and services be evaluated to ensure expanded care, through dialogical interactions between various knowledge areas.[3-4] This will provide PHC with greater visibility of user care in the psychosocial field, in addition to a strategic and opportune space for identification, access, care and

longitudinal monitoring of these demands,[5-6] with integrated actions and in a collaborative manner, with the other sectors and the production of intersectoral actions standing out.[7-8]

Thus, in the various political instances, it is a consensus that it is necessary to integrate services and teams, both in terms of consolidating the policy and organization of services and in relation to collaborative work in the mental health of children and adolescents with other sectors and devices in the territory.[9] Therefore, it is noted that collaborative work allows not only integrated teams to improve access and quality of care, but teams from the same service that collaborate with each other and with other services, in the logic of networking. It is understood that this involvement generates co-accountability for the mental health cases, intersectoral work and better quality in health care.[10]

Based on the above, the analysis is presented articulated with the idea of rhizomatic network. The idea of rhizome is inspired in Botanics due to its variable format, with branches at any point and horizontal growth. Under this logic, one can approximate the concept of network to the figure of a rhizome as a non-linear thought proposal to discuss the praxis that encompasses a multiplicity of connections, crossing all knowledge fields, without privileging any specific knowledge area.[11] With regard to the concept of Network, it is defined as a system of formal and non-formal organization, with sharing and implication of a multiplicity of actors involved, workers and users, with co-accountability and agreement, aimed not only at services, but connected to the weaknesses and needs of these users in their existential territories.[12]

This way of perceiving the relationships and the production of psychosocial care, in a diverse rhizome network, which has multiple connections, makes it possible to understand that in a network that intends to be rhizomatic, it is possible that there are ruptures. However, this does not mean the end, as the rhizome always resumes its growth based on one or another of its lines and, as it has multiple entries, the rhizome is susceptible to constant modifications.[13] These rhizomatic movements, in which professionals operate their work process, are in a tangle of transversal lines, which mediate, limit or drive the flows through which the users will walk to solve their health problem. These force lines can be hard or flexible, escape, horizontal, vertical and cross-sectional. In networking, it is possible to visualize different force lines that permeate the care territory, compose with them, with their critical nodes, their inventive displacements, and create new ways of acting, producing and transforming, which escape the rigidity of hard lines to promote flexible lines, setting other possibilities in motion.

Therefore, the current study is based on the premise that the articulation between the Psychosocial Care Centers for Children and Adolescents (CAPSi) and PHC facilitate the construction of a "rhizome network", which favors the formation of connective flows and the power of collective action and engenders unique and relational arrangements to produce the psychosocial care advocated by the policies aimed at childhood and adolescence. The agency service concerns movements and thoughts, and only occurs if there are two or more bodies, because it is the movement itself, it is in between, in the combination or connection of elements – without any hierarchy or organization – in the case of fragments or flows of the most varied and different natures, be them ideas, statements, things, people, bodies or institutions.[11] The agency service is always collective; it links, connects, conjugates, composes, combines, produces, manufactures, relays, distributes, and consumes bodies and minds, movements and thoughts. Under this conception, by associating mental health care with a negative power agency service, care based on the centered medical model is obtained. On the other hand, by associating it with an affirmative power agency service, care is articulated with the psychosocial model and with the Psychiatric Reform.

Given the above, the objective is to map the mental health care provided to children and adolescents, its flows, lines and connections based on the articulation between the CAPSi and PHC.

Method

A qualitative study that used cartography as a theoretical-methodological strategy to monitor care movements in the scope of psychosocial care for children and adolescents. This research modality allows mapping the paths taken by the subjects and their relationships in the psychosocial landscapes: places where life, care and affects are produced. To follow the process of events is to follow something that happens and which, in turn, cannot be reduced to things or proposals, but can only be understood at the moment it happens. To understand the event is to participate in it happening[11] in the rhizomatic compositions, in the force field and singularities, pointing out lines and leading roles that are observed in the encounters between people and institutions.[14]

For this, the study is grounded on main concepts, such as the rhizome and its lines, the flexible or molecular lines, the hard or molar lines and the escape or deterritorialization lines. These three lines are inseparable, that is, they do not act in isolation; they are present in the encounter between subjects and actions. The flexible lines are fluid, rely on the alternative

movements and facilitate subjectivation processes that may transform relationships and produce new connections between people involved in mental health care. The hard lines represent the normatization plane, the one of bureaucratization, of the institutional processes, of what is already established. And the escape lines correspond to the traditional regulations; they open up to new experimentations and allow transitions to new ways of acting. In this perspective, there was the intention to look at the field of psychosocial care for children and adolescents and, from the articulation between the CAPSi and PHC, to monitor the relational and assistance compositions, in addition to the modifications of these landscapes. It is in this dynamic that actors and feelings are in action, that it was sought to trace a rhizome network that produces care and other singularities.

The study was developed in a municipality from the inland of Rio Grande do Sul, in the following settings: CAPSi, Primary Care services (Primary Health Care teams - PHCts; Family Health teams - FHts), Expanded Center for Family Health and Primary Care (*Núcleo Ampliado de Saúde da Família e Atenção Básica*, NASF-AB), and Harm Reduction (HR) service. A total of 40 professionals participated in the study and, of these, nine are CAPSi workers, in the Nursing, Psychology, Social Work, Occupational Therapy, Pediatrics, Therapeutic Companion and Pedagogy areas; 23 are FHt/PHCt workers in the Nursing, Medicine, Dentistry and Community Health Agent areas; three are professionals in the Psychology, Social Work and Nutrition areas at NASF-AB; two are Harm Reduction Officers; and three are municipal managers trained in Nursing and Psychiatry. However, this article presents the testimonies of the professionals that comprise the CAPSi and PHC services.

The following inclusion criteria were defined: having worked for at least three months in the service and being directly involved in the health practices process. These criteria were established considering the importance of the professionals having a broad view of the health actions carried out in the services, in order to better ground the interviews. The professionals excluded from the research were those that were on holiday or on some type of leave during the data production period.

Data production took place from August to December 2017, and the strategies used were participant observation, semi-structured interviews, field diary records and material restitution for joint analysis with the teams involved. Participant observation places researchers actively in the entire process, because they remain in the field in direct contact with people, in which the observer and the observed become partners open to the plane of affects and existential

territories.[15] To enter this territory of observation and events, a script was adhered to that included everyday activities, visits to services, meetings, shared work processes, daily care situations, estrangements and contradictions. Those events and feelings were recorded in a field diary, an instrument used to take down the actions observed and the activities in which the researcher participated. The field diary allows taking notes about the impressions and affections produced in each experience,[15] in addition to transcribing conversations captured in everyday life, and giving voice to the various subjects and knowledge areas present in the field of study.

The interview in cartographic research approaches a conversation and, as such, welcomes the opinions and the watchwords that appear throughout the interview, but without focusing on them, lying in wait, taking advantage of the moments of greater expressiveness, variations and ruptures. It is important to let oneself go, taking the subject matter for oneself, letting oneself be affected by everything that is happening there (flows of speeches and ideas, among others), and go through with the interviewee the different lines that are being drawn.[16] The interviews were carried out in order to deepen aspects not elucidated during the observations, and they contained questions about children's and adolescents' mental health care, demands of the territory and articulation with other observed network devices that needed to be deepened. The interviews lasted from 20 to 40 minutes and audio-recorded using a digital device. Afterwards, a prior data analysis was carried out in order to organize the preliminary results and allow the participants to access the set of all the information collected, so that everyone could have the opportunity to change it or guarantee its credibility.

For cartography, the restitution process is inseparable from research, and its meaning goes beyond giving feedback when the research is finished. Restitution enables the creation of a collective field of analysis by exposing the data collected, putting them up for debate, allowing each participant's positioning in relation to the problem-situations they experience in their everyday life, proposing criticism and new actions.[15] The interviews were transcribed in full for later analysis, with the purpose of dialoguing with the concept-tools developed by Deleuze and Guattari[11], which support the cartographic research proposal, and by national authors who work in this area and with the theme of mental health.

The study was conducted according to the ethical standards required in resolutions 466/2012, 510/2016 and 580/2018 of the Ministry of Health, and approved by the Research Ethics Committee of *Universidade Federal do Rio Grande do Sul* under protocol

number 2,350,300, on October 26th, 2017. The participants accepted to take part in the research by signing two copies of the Free and Informed Consent Form.

Results

This cartographic experience allowed monitoring, within the scope of the CAPSi articulation with the PHC services, meetings and crossings between professionals and services to think about and provide care for children and adolescents in psychological distress. To systematize these findings, themes were established, in which encounters were identified in the relational field of workers that generate differentiated care, forces of molar and instituting order that interfere, limit or mobilize new care practices.

Rhizomatic network: Integration with Primary Care services

A rhizomatic network is built when there is a desire or willingness to care, to create possibilities for encounters, betting, collectively and in solidarity, on care production, as shown in the following excerpts:

> *We manage to work together, something that didn't happen before, from some time we've defined it so, each worker is a reference for a FHS or BHU* [...] *So the professionals organize themselves in the way they think is best to be in contact* [...] *in the inland itself, you need to have transport available, there are locations far away from the city* [...], *I became a reference in the* [inland], *so I called, introduced myself, said that I would be here for anything they wanted to talk about, they could also call me, or likewise me, if I had any user* [in common service] *I would call them and we would exchange information, sometimes I go to their meeting* [...]. (PR CAPSi)
>
> [...] *We meet once a month, we talk on the phone, we sit down for an hour, once a month to discuss mental health cases at the top, I mean, the CAPS leaves the cocoon and goes to primary care to talk about that case* [...]. (PR CAPSi)
>
> *We have our monthly matrix meeting* [meeting with CAPS and FHt professionals to discuss cases], *where we find a reference professional from each CAPS, children, CAPS AD, CAPS I, I think this moment is very important, you can link the points of certain users.* (PR PHC)

Rhizomatic network: Spaces-encounters to plan and share the care provided

A rhizomatic network presupposes producing articulated care, connected to people, actions and services. In this sense, it can be noticed that the professionals seek spaces to plan joint actions and share co-accountability for the care to be provided.

> *I see that it has already improved a lot, the contact with the teams, the teams are already looking for us* [...] *I think it could even be better, perhaps, who*

> *knows for the next year to have more systematic meetings.* (PR CAPSi)
> [...] *there are several things that have improved a lot, because years ago there were things that worked much more slowly, today it has evolved a lot, I think mainly the communication between the units and the CAPS, I think they are closer and that they also like us, there are the teams that discuss the cases* [matrix support]*, so I think that also brought them together a lot* [...]. (PR PHC)
> [...] *when we assist the user here and soon the user frequently misses appointments, with a psychiatrist or psychologist, we do an active search, in this active search we already involve the FHS, call there, talk to the nurse, talk to the Health Agent himself, and ask for some feedback* [...]. (PR CAPSi)
> [...] *we are always in contact by phone, we met at the beginning of the year with all the CAPS representatives, a representative from each CAPS comes, who is* [a reference] *for a given unit and we talk about all the cases of users who are in follow-up.* (PR PHC)
> *We have no difficulty referring to the network, it follows the normal protocol that is the referral system, but we like it, and I think it makes the conversation easier, even though we had to follow that formal referral, we made verbal contact over the phone, "Look, we are referring a child like this, like this", we tried to report a little more about the case, what we know about this child* [...] *we have very good access with the CAPSi* [...]. (PR PHC)

Rhizomatic network: Collective actions and work dynamics

The way in which the professionals organize themselves in their work dynamics and relate to each other to produce this care allows for collective action, focusing on people and their health needs, with a perceived strength for psychosocial care:

> [...] *welcoming is done at any moment, by any professional and during the team meeting we see what the need is* [...]*; sometimes children, adults arrive here in pain, we welcome them, and we see them during the team meeting, because everyone has contact, the Community Agent has more bond than us sometimes* [...]. *So, whatever a person says about that situation, family, person or the whole family context, it already changes our line; we're not going to pass it on to the psychologist, the doctor says: "Leave it to me that I have a better bond". Everybody changes an idea for us to work better.* (PR PHC)
> *The fewer patients in the CAPS, the better for us; it's a sign that we're doing good work here, welcoming these situations.* (PR PHC)
> *We have a map of all the patients in distress* [...] *whether they are children, adults or alcohol and drug addicts, we have colored pins on the map we review them with the Community Agents in the weekly team meetings* [...] *And in the CAPSi there are few cases, so I can tell you the name of the person I sent, I know the patients who are under follow-up there and I know the feedback* [...], *because then, my patients, my territory, I need to know what's going on, this is our personal reading, of our strategy.* (PR PHC)
> [...] *in the group of mothers and babies, the mother said that her 4-year-old child was very aggressive, too hyperactive, she wanted some medication for him. Then we talked, that it's not like that, you don't give medication directly to the child, what they sometimes lack is attention* [...] *so we talked, we did a consultation with the father, with the child and with the psychologist from the NASF, who continues to care for him here, she didn't need to refer him to the*

> *CAPSi, he didn't need medications* [...] *we were able to identify that the child wanted attention and was doing all that because of the baby that he didn't have before and the attention it was all about him.* (PR PHC)
> *There is no need for a referral* [...] *we first try to follow up with the NASF, the psychologist tries to intervene with us, if it is more complex, we make the referral to the CAPSi, through the referral system, they do the consultation* [...] *if necessary, keep the follow-up there or they will refer to us again. We have good articulation, if I need to call them to find out information about the user, it's fine* [...] *here in the territory there are teenagers involved with drugs, there are drug points, we are working together with the guy from Harm Reduction, trying to do work together.* (PR PHC)

Rhizomatic network: The molar plane and the several network "nodes"

It is also possible to notice crossings of molar forces in the care flows for the child and youth population:

> *We don't have any specific group for children and adolescents in psychological distress, but we monitor the cases when that demands comes in* [...]. *We have a good bond with all users and we welcome them, they go to the doctor and, if necessary, we refer them to the CAPSi, if not, they only do follow up here, also with the help of the NASF psychologist.* (PR PHC)
> *Our unit lacks a specific project exclusively devoted to this part of childhood, of adolescence, directed to mental health. It's spontaneous demand and referred cases here, but there's no such thing as a specific project.* (PR PHC)
> *We don't work at all with this age group. We provide guidelines about prevention just like any other strategy. It is oral health care that we carry out in schools, and also in this part of adolescence we are very much on top of the HPV vaccine. We have one of our users referred to the psychologist [NASF], we don't have other cases* [NASF], *we don't have other cases* [...] *and if there is one, we will first refer it to the psychologist and she will do the consultation, and if there is any need, she will refer to specialized care.* (PR PHC)
> *Access to the CAPS is only through the referrals, we don't work at all with the CAPS. We see the problem, the doctor refers and if there's a need continuous medication, for a prescription* [...] *there is no integration, it's the same thing if you asked me who works in the CAPS, I don't know, who the doctor there at the CAPS is, I don't know that* [...] *so there's lack of communication, I think there's lack of integration* [...]. (PR PHC)
> *There are a lot of unnecessary referrals, we receive many children and adolescents from the Units through the doctor.* (PR CAPSi)
> [...] *there is the difficulty of commuting, as many need to go to the inland, it ends up being really bureaucratic, especially by telephone. What also happens, many times your work, you have your schedule that you can't move around, and it's flawed, there's a certain gap. I believe it could be here too, in our service, I think it would be good, not only for us to go to them* [FHS], *but they also have the chance to come to our service, even to meet, to see what we have to offer, what our conditions are too, I think that would be quite valid.* (PR CAPSi)

Rhizomatic network: Desire as power production for psychosocial actions

The professionals recognize their weaknesses, and this acknowledgment can trigger desire as power production for psychosocial action, generating deterritorializing movements in the ways of caring, and inventing new ways to promote and produce care:

> *We have a reference person from each CAPS that we look for* [...]*sometimes there are meetings, a professional from each CAPS comes here to the unit, for us to discuss the case and telephone communication. But I think it's not enough, matrix support is missing here in the inland, there is this gap in the city and in the inland, because many things we don't feel capable of solving* [...] *there are issues that we prefer to discuss in a meeting, with the presence of other professionals, lack of matrix support, this issue of meetings, to discuss cases.* (PR PHC)
>
> *I wonder a lot: has the number of specialized services we have now improved? If suddenly it wouldn't be the right moment, rethinking and training more the service teams that we already have and trying to improve this articulation more and more. Being trained for us to understand exactly what each person's role is* [...]. *I believe that training is fundamental, when you know what you have to do and how to do it, it eases things a lot.* (PR CAPSi)
>
> *There are professionals who don't work with mental health, who lack* [knowledge]*, the NASF gives us legal support, but I think we needed more support, and the doctors also need support from a psychiatrist, our doctors are the ones who keep the medication prescriptions controlled, I believe they also need support for this management and we don't have that, matrix support in psychiatry, I think it's important.* (PR PHC)
>
> [...] *I don't know how to do false advertising. I think we are more in the healing part itself, unfortunately, in my opinion.* (PR PHC)
>
> [...] *Does your child have any indication of being in such a service? Or can he be treated by the family doctor, by the team?* [...] *Or is the professional overloaded with tasks within the service and doesn't have time to do that look?* [...] *it is not criticizing the colleague. Is the team helping to think?* [...] *I think that not look by all the services is very important, it's not this one, not that one, it's not even pointing, but all. Where are they until a child arrives at the specialized service?* (PR CAPSi)

Discussion

Any and all rhizomes include hard or molar lines, as well as flexible or molecular and escape ones. The hard lines ensure homogenization of the rhizome, which is heterogeneous in itself; they comprise the organization plan and also horizontal and vertical relationships present between the teams and between the sectors of which they are part. On the other hand, the flexible ones are responsible for the affects that occur in relationships, creating conditions to establish agency services, also constituting a combination of various and heterogeneous flows. And those identified as escape lines (they are powerful lines of deconstruction, transformation, involved in seeking alternatives, other ways, new ways of connecting, multiplying, desiring) are

formed in the gaps or fissures of these other lines, giving way to countless creative and inventive care modalities, necessary movements for the articulation to be put into practice and displacements to happen.[11,15]

It is possible to see that, in the work process, the professionals seek to integrate their actions with PHC services, recognizing themselves as partners in care and pointing to advancement and qualification in the relationships, although they emphasize that qualification is in permanent construction. Regarding the actions they develop together, these professionals mention holding monthly meetings, an organizational arrangement which provides that each CAPSi professional is a reference for a given Primary Health Care unit. The purpose of the meetings was to promote discussion and analysis of the practices concerning the field of children' and adolescents' mental health in PHC, providing a space for exchanging experiences, discussing cases and health situations of the population assisted in PHC, providing workers with some questioning of their practices and reflections on new ways of acting, demands and needs.[4] Likewise, they value informal communication, via telephone contact, as another ally for solving mental health actions.

For the network to work effectively, another element pointed out by the research participants is the active collaboration of all the professionals. This relational connection, constituted by the bonds that the professionals have with the various health services in the city, tends to occur more frequently via telephone contacts to establish direct and informal communication, especially when quick decisions are required, or when there is an urgent need for some type of care, aiming to report referrals, courses of action and counter-referrals.

These spaces-meetings mentioned to carry out joint actions were designed not only for specific resolutions, but to prioritize multidisciplinary dialogue, exchange of experiences and the promotion of singular care measures,[17] incorporating in their work processes "desiring connections" that produce life and health.[18] Informal communication, referred to by professionals as another tool for integration between services, is considered an ally in organizing the flow of users between network points, in identifying demand and a way of putting the network and subjects in motion.[17] This rhizomatic work logic, designed to promote psychosocial care in the municipality under study, acts contrary to what has been pointed out in the literature, whose articulated actions between CAPSi and PHC are restricted and merely occur in a punctual manner.[19]

The professionals also indicate psychosocial care practices when mentioning ways of doing and interacting with users that make a difference in the organization of work dynamics and production of new knowledge/actions. This implied mode that mobilizes and affects workers towards unique possibilities of experimentation and multiple care modalities in the face of each situation, is a power trigger and a way to build new modes of existence and new ways of living (with) and experiencing mental distress.[20]

And, by including among their everyday practices mental health care built from the perspective of welcoming, strengthening bonds of affection, trust and listening availability, in addition to providing assistance, Primary Care services weave support networks not only for the service users but also for the professionals, valuing different knowledge areas and contexts, that is, including them in co-accountability for care.[21] The articulation between CAPSi and PHC proves to be promising when performance of joint activities is visible. At the same time, the partnership with the HR service and NASF-AB, based on matrix support, is highlighted by the professionals as a device of power and network care; a possibility of interlocution and shared work.

In this study, partnerships and articulations with other services were evidenced, such as NASF-AB and the HR service. These new organizational arrangements strengthen the creation of live networks and build connections that increase the power to produce care. As NASF-AB, matrix support was reported by the participants as an articulation device that helps Primary Care professionals to welcome their users, and also in therapeutic conduction and intervention in cases considered to be less complex in mental health, which would not need specialized treatment in the CAPSi. However, although this support is understood as potentially positive in the construction of collaborative and problem-solving care, it requires that a discussion be expanded beyond the clinical-assistance scope, and also in the technical-pedagogical perspective, in which these professionals also share their knowledge and practices with other colleagues,[22] paying attention so that this service generates the leading role of PHC professionals and not a dependency.

In addition to the integrated work with NASF-AB, it is observed that there is certain concern to work together with the HR service, especially in cases involving the adolescent population that makes use of psychoactive substances. It is noted that the service professionals began to reorganize the work dynamics to accommodate the adolescent population, seeking to establish networks and alliances between the various existing services, indicating that the clinic

goes beyond the office walls, and sometimes even the service itself.[23]

It is possible to identify crossings of molar forces in the care flows for the child and adolescent population since, although there are reports which include actions that consider the particularities of mental health care for children and adolescents, lack of specific actions for the age group childhood and adolescence office was noticed. This is because the appointments are generally targeted at specific and clinical actions. Primary Care professionals reported that there are no specific practices for this population, only developing provision of groups for mothers and babies, childcare and care in the gynecological and dental spheres, as well as actions related to guidance for the prevention of pregnancy and sexually transmitted infections, in line with existing studies in the literature.[24]

This reality shows that the PHC work process is still anchored in the molar field of clinical knowledge, centered on curative action; therefore, the construction of a way of care becomes a challenge for these workers. Another crossing imprisoned by the instituted logic and taken by the hard lines of bureaucratization was the referral to the specialized network. The professionals reported that the demand due to mental distress that reaches Primary Care is oftentimes referred to the CAPSi under the justification that many professionals are not duly trained to deal with these issues. It is for this reason that they frequently request evaluation, course of action and treatment, transferring care to the CAPSi. There is predominance of the logic of referral to the CAPSi, supported by the still hegemonic notion that mental health problems are not part of Primary Care actions, and that the professionals do not consider themselves capable or responsible for these situations.[21] However, the referral does not exempt them from shared responsibility, as referrals to other services are sometimes necessary, especially when the Primary Health Care network cannot solve the users' demands, requiring greater understanding of the way in which this process is conceived and carried out. Thus, the referral arises as a result of the saturation of PHC's solving capacity, in which the professionals understand the need for more complex actions, aiming to maintain care integrality; in this way, the referral and counter-referral system is activated and directs the user throughout the network, to other care services and levels, in order to respond to their health demands in a resolute and articulated way.[25]

Another aspect pointed out by the professionals concerns the fact that joint care actions are restricted to the physical limits of the service, referring to access difficulties due to lack of

transportation and busy schedules that take up all the work time. In these bureaucratic dynamics of the organizational level, which insist on capturing new ways of providing care, preventing deterritorialization of the workers, that is, from recreating themselves in the face of institutional demands, there are, on the one hand, the PHC professionals, taken by such forces, and, on the other, the CAPSi professionals, who state that they do not integrate more actions together with PHC because of the busy schedule due to high demand and infrastructure difficulties with transportation to commute to the most distant health units. Thus, the CAPSi work process is also captured by the routine of the service, as it is limited to the actions in institutional spaces, disregarding the potential of the territory, aiming at care in networks.[26]

In both scenarios there is a field of forces that makes it impossible to institute changes and possible escape lines since, on the one hand, the simple and instituted referral reinforces actions based on the specialties and, on the other hand, the clinic is absorbed by structural issues and busy schedules. These configurations promote fixity in the care network, allowing it to be captured by a rigid structure, pre-established by isolated courses of action, preventing inventive processes. However, when the professionals recognize the need to include themselves in the other's network, they allow themselves to be more of a collaborator in this network and an agent of connections; they can destabilize determined and instituted forms, develop multiplicity of agency services and inventions in the psychosocial space.[27]

In opposition to the molar forces, a perspective of rupture with the instituted forms of knowledge and the need for resistance and singularization processes were identified in the professionals, when they assume their limitations and passivities to face the centered medical care model. In addition to that, it is understood that psychological distress demands investments in training and in reinventing knowledge and practices. These movements are experienced by some professionals when they talk about their limitations and passivity to break with the traditional clinic, based on the symptomatology of mental health disorders, when they assume the need for support in the sense of a specialized assistance rearguard. In this way, they avoid unnecessary referrals to other care levels and increase the solving capacity of the reference team,[28] providing technical and pedagogical support in order to enhance community care and co-accountability of existing mental health cases in the territories.[26]

In the reports, it is noticed that the professionals recognize their weaknesses in terms of carrying out care actions and devising new health practices, allowing themselves to be affected

by the lives of users who are in psychological distress, and inventing other ways to promote and produce care. Given the above, it is reasserted that psychological distress demands investments in training and in reinventing knowledge and practices. This lack of knowledge can be the guiding thread in the search for more (in)formation and (trans)formation in their care productions, especially in the mental health area; when they confide this professional weakness, they announce the rupture of rigid and established knowledge, as some areas are restricted to specialized knowledge. And they call for the creation of other lines that enable new flows, agency services and becomings, in the context of child and youth mental health.

With regard to the study limitations, it is noted that the research presents a cartographic clipping that accompanied the dynamics of the mental health care process for children and adolescents in a small city, the articulations between mental health and PHC, its paths, connections and crossings in a given period of its history. However, it is understood that the methodology developed and the results will contribute to the field of child and adolescent mental health, as there are still few studies that have addressed the care and complexity inherent to psychosocial care for children and adolescents in psychological distress in different devices of the health network. Such being the case, it is worth reinforcing the investment in research studies that privilege debate and reflection on the PHC role and actions on the care to be provided to this population. Carrying out the research using the cartography framework allowed for a procedural look at mental health care for the child and adolescent population, which is an innovation in the Nursing and health area, requiring investments in this field that is still little explored.

Conclusion

This research made it possible to map the child and youth mental health care space, the movements carried out by the services to break with their ways of acting, and to reflect on the importance of producing connections/partnerships in the psychosocial perspective based on the articulation between the CAPSi and PHC services. The results evidence the importance of mental health actions being carried out in a shared way, favoring the opening of new agency services of psychosocial care for children and adolescents. These new arrangements have been devised in monthly meetings, in matrix support and in partnership with other services, whether for the discussion of cases about users involving mental health, in the construction of shared therapeutic care projects, or to bring services closer together, aiming at more collective flows.

In this care territory, crossings in the molar plane were also observed, such as referrals,

as the professionals do not feel capable of dealing with the mental health demand that arrives at PHC, and also the nonexistence of specific mental health activities for the young population, restricting the activities to more specific actions of a clinical and dental nature. These configurations instituted in hard lines preclude inventive processes, urging the subjects to implement breaking points in the psychosocial care perspective. This lack of knowledge, or the need for support and training revealed as a weakness, can also be the guiding principle for the deterritorialization of hardened practices and the possibility of creating other lines that enable new flows, agency services and becomings, in the context of child and youth mental health.

Therefore, the professionals need to understand that the CAPS is not the only space for mental health care. They also should understand the power place of PHC in collectively devising ways of care and, thus, that they apply the possibilities of networking.

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