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Matrix support in children's mental health in Primary Health Care: institutional socio-clinical intervention research*

Apoio matricial em saúde mental infantojuvenil na Atenção Primária à Saúde: pesquisa intervenção socioclínica institucional

Matriz de apoyo en salud mental infantil en Atención Primaria de Salud: investigación de intervención socio-clínica institucional

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ABSTRACT

Objective: To analyze matrix support for Family Health Strategy teams in relation to Mental Health in Children and Adolescents. **Method:** This is a research-intervention with a qualitative approach, based on the Institutional Analysis framework, Socio-clinic, carried out with eighteen health workers from two Family Health Strategy and Psychosocial Care Center teams of a small municipality in the countryside of the state of São Paulo, through eleven reflection meetings. **Results:** The following themes emerged: *The dynamics of relations in the FHS territory*; *Matrix Support as a technological device: unveiling established practices*. Subsequently, the results were discussed based on the principles of Institutional Socio-clinic. **Conclusion:** Matrix support in children's mental health, based on Institutional Socio-clinic, favored the deterritorialization of professionals, revealing how mental health care is provided for children and adolescents, and the crossings that occur in the production of this care as well as possible paths to be followed to improve health actions.

DESCRIPTORS

Nursing; Mental Health; Family Health Strategy; Patient Care Team; Professional Practice.

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INTRODUCTION

The Sanitary and Psychiatric Reforms, which took place during the 1970-80s, changed the mental health care model in Brazil. Assistance, previously centralized at a Psychiatric Hospital, is now directed to territorial-based services, with the valorization of social reintegration, care practices centered on people, on their way of life and not only on symptoms related to some psychiatric problem[1]. Particularly in relation to children and adolescents, the creation of the Unified Health System (SUS – *Sistema Único de Saúde*) in 1988 and the promulgation of the Child and Adolescent Statute (*Estatuto da Criança e do Adolescente*) in 1990 allowed children and adolescents to be considered subjects of rights, valuing the singular way they present to be in the world, safeguarding the universal right of access to health and education[1].

In 2004, the Brazilian National Forum on Children's and Adolescents' Mental Health (*Fórum Nacional de Saúde Mental Infantojuvenil*) promoted a discussion between various sectors of assistance and protection (health, education, justice, and social assistance) and civil society on the attention to Children's and Adolescents' Mental Health (CAMH), pointing out as fundamental and desirable strategies the articulation between specific mental health services, such as Psychosocial Care Centers (CAPS – *Centros de Atenção Psicossociais*) and Primary Health Care (PHC), represented mainly by Family Health Strategy (FHS)[2].

The discussions at the aforementioned forum were consistent with the logic of care advocated by the World Health Organization (WHO) and the Psychiatric and Health Reform movements that prioritize mental health care as quality of life for children and adolescents[2].

When developing care for CAMH in FHS, it is important to establish a therapeutic relationship with children, adolescents, and their families, especially those in situations of social vulnerability or in the context of violence[3]. However, it is still a challenge to recognize that CAMH care must be present in all actions carried out for children and adolescents, not only in cases where the child/adolescent already has a psychiatric/emotional problem[4].

Articulation between FHS and CAPS teams is necessary for the development of comprehensive care for children and adolescents. However, it has been a challenge to establish effective articulation between these teams[5].

Strategies that allow professionals to look at their practice, rethink their work, producing new senses and meanings are relevant. Thus, in this study, one highlights matrix support (MS)[6] as a strategy used to bring PHC and mental health closer together[5].

MS is considered a health technology, classified as hybrid when it intervenes in the field of soft and soft-hard technologies[7]. MS provides the opportunity to restructure the standards of health work relations, the meeting of workers with other workers and with users, contributing as professionals/teams establish the care management they perform, for example, with a view to interdisciplinary and interprofessional practices[6-7].

In general, support is provided by a professional who assists teams developing their actions. Case discussions, collective formulation of a unique therapeutic project (PTS – *Projeto Terapêutico Singular*), home visits and joint care may occur. From this perspective, MS uses field and nucleus concepts, because professionals from different nuclei of knowledge exchange knowledge among themselves, in order to build an adequate field of practice. Each profession, through a democratic relationship, with its knowledge and practices, seeks to support and dialogue towards a common goal: resolvability and comprehensive care[6]. MS can be developed in several health care actions, mainly related to PHC.

However, practical challenges still persist for the full consolidation of MS as an extended care tool, especially in the field of CAMH's performance[5]. These challenges involve an understanding and exercise of MS close to the practice of referral/triage or as punctual care of cases that cover specific mental health issues[5].

Nurses are important members of CAPS and FHS teams, as they perform functions that include everything from the coordination and articulation of teams and between services to the role of therapeutic agent in direct care to users. Thus, one bets on the potential of this professional in the development of MS and the integration and articulation of these teams and specific fields (CAPS and FHS).

Given this context, in an attempt to inspire new practices, this study proposed an intervention research aiming at analyzing MS for FHS teams in relation to CAMH. It is taken as a guiding question: how can MS, guided by the principles of Institutional Socio-clinic, contribute to the provision of shared care between CAPS and FHS aiming at CAMH?

METHOD

Type of study

This is a research-intervention with a qualitative approach, supported by the Institutional Analysis theoretical-methodological framework, Institutional Socio-clinic line[8].

Institutional Analysis is one of the Institutionalist Movement's currents, whose objective is to provoke processes of self-management and self-analysis in communities[9]. Institutional Socio-clinic, developed by Gilles Monceau, is an improved development of Socioanalysis, an interventionist aspect of Institutional Analysis founded by René Lourau and Georges Lapassade. Socio-clinic aims at producing knowledge and collective analysis of professional implications, taking into account the subjectivities of social agents, their encounters and mismatches[8,10]. It has been presented as an important reference for research in nursing and public health[10].

Gilles Monceau[8] developed eight guiding principles for the Socio-clinic intervention method: "Analysis of order and demand"; "The subjects' participation in the device"; "Work of the analyzers"; "Analysis of the transformations

that occur as the work progresses"; "Application of restitution modalities"; "Analysis of primary and secondary implications"; "Intention to produce knowledge"; "Attention to institutional contexts and interference"[8].

Population

The study took place in a small city, located in the countryside of the state of São Paulo, where there were no effective initiatives for MS in mental health. The articulation between CAPS and FHS was fragile, being commonly performed through paper referrals.

The study was produced with health professionals from two teams from FHS and CAPS, being separated into two groups (A and B). Each group was formed by professionals from a FHS team and a CAPS worker (chosen by the CAPS coordinator). Group A comprised a nurse, a nursing technician, four community health workers (CHW), a dentist from the FHS team and a psychologist from CAPS. Group B comprised a CAPS psychologist, a nurse, two nursing technicians, a dentist and five CHW from FHS. Possible participants were considered workers who were not removed from their duties due to leave or health problems and were available to participate in the meetings held.

In a research-intervention, data were co-produced between the researcher and research participants, supported by the premise of transforming to know[11]. Thus, the researcher, in addition to promoting the intervention, was also an effective member[12]. The first author of this study participated as the coordinator of the reflection meetings. She is a nurse at a CAPS for children, holding a master's degree in science by a professional master's in nursing and member of a study group on Institutional Analysis.

Data production and analysis

Reflection meetings were held, understood as spaces of speech and listening shared between researchers and research participants, which are guided by a double ambition of producing scientific knowledge and participants' professional development[13]. The meetings aimed to promote a discussion and analysis of aspects and practices concerning CAMH in PHC.

In the reflection meetings, it was discussed how participants would like to carry out the discussions, whether through themes or cases. All professionals opted for using triggering themes, sometimes chosen by the researcher or by them. The thematic discussions were comprehensive and ended up also including discussion of cases of children/adolescents monitored by the teams. The main themes worked on were: the work developed at FHS and CAPS with children and the youth population; care for family members of people with intense psychological distress; the possibilities of working in the School Health Program; prevention of suicide in adolescence. In all meetings, one sought to encourage the inclusion of debates on concrete cases and situations in professionals' and teams' daily lives.

Moreover, restitution meetings took place[12] (3rd and 6th group A meetings; 2nd and 5th group B meetings) through the reading of syntheses made by the researcher with notes and analyzes of discussions held in previous meetings.

Jointly, it used the notes of the first author's research diary as a tool to support the intervention.

Data production took place, from August to September 2017, through 11 reflection meetings between the research participants. There were six meetings with members of group A, in a meeting room of the first unit of FHS, and five meetings with members of group B, in a meeting room of the second unit. The meetings lasted from 60 to 120 minutes, being recorded on digital media and transcribed in full. The data were ordered for analysis according to transcription, transposition and reconstitution processes[14], and were analyzed having as a framework the Institutional Socio-clinic[8].

Ethical aspects

The research is in compliance with Resolution 466/12 of the Brazilian National Health Council and was approved by a Research Ethics Committee, under CAAE (*Certificado de Apresentação para Apreciação Ética* – Certificate of Presentation for Ethical Consideration) 640.02117.2.0000.5393. Contact was made with participants to present the objectives, methodological path and ethical aspects for production of the study, at which time they signed an Informed Consent Form (ICF). It was reported that the first author would coordinate the research meetings, despite not having a management or hierarchy relationship with the health workers in the studied municipality. The reflection meetings took place at a time and place suggested by each group of professionals.

RESULTS

Results were presented based on two themes: *The dynamics of relations in the FHS territory*; *Matrix support as a technological device: unveiling established practices*.

The first intended to portray the relationships established between workers, the population, sectors and health equipment in the FHS coverage area and in the municipality. The second concerns the process of deterritorialization of participants caused by the MS device, supported by the Socio-clinic framework.

The dynamics of relations in the FHS territory

At the meetings, conversation rounds were held, with active participation and collective analysis of the teams, enabling reporting their experiences and approaching the practice of caring for CAMH.

(…) *sometimes there is a teenager that you notice is not normal, but the mother says, "Oh, he is like that, stranger, he doesn't talk to anyone". I'm afraid he'll think I'm invading his space, you know, and then wanting me to move away, ending up not welcoming the way he welcomes* (...) *there was a case in my area of a pregnant teenager that I only found out after she gave birth* (CHW 1, group A, 1st meeting).

(...) *how to deal with this boy who doesn't have a family, right? He doesn't have support and sees trafficking as support often* (...)

I came to a little boy who is 11 years old and asked, "Are we going to play?", he looked at me and replied, "Ms., wake up, I have never played in my life", then I replied, "So let's talk". So, I went there to understand what drugs he was dealing with, so I could understand his language (...) (CAPS psychologist, group B, 1st meeting).

The difficulty of communication and articulation with sectors outside the health area were considered important, being exemplified by the relationship with the Reference Center for Social Assistance (CRAS – *Centro de Referência em Assistência Social*):

(…) *we are not aware of exactly what* (...) *CRAS does, when they have some demand, something that they think is health, then they pass it on to us, but we don't have a report of what they do and what they don't* (CHW 3, 4th meeting, group A).

Experiences of inserting activities of FHS members in the school were reported:

(...) *I do an internship in health promotion in the community, so it is an internship that is optional in college and then I chose to do it* (...) *we worked on life skills with the children here at* (school name). (...) *we used a lot of playful questions with them, and we worked on respect, space recognition, self-knowledge, we did an activity with a lot of interaction* (…) (Nursing technician, 2nd meeting, group B).

This aspect illustrates the recognition of the importance of intersectoral actions for PHC teams' work in relation to CAMH.

Matrix support as a technological device: unveiling established practices

The MS device enabled the identification and problematization of different perspectives of CAMH care:

(...) *about mental health, 80% of those registered today use CAPS, and I believe that this percentage is really people who take controlled drugs or to sleep, or to take away anxiety; children, many children, there are about 7 children who attend APAE* [Association of Parents and Friends of the Exceptional] (CHW 1, group B, 1st meeting).

(...) *a community worker is playing a psychologist at home. You arrive there and the father has a problem, the mother has a problem, they tell everything to community workers about home problems, couple fights, these things, everything* (CHW 2, group B, 1st meeting).

The discussion about the meaning of MS culminated in the reflection on CAMH care, the co-responsibility of services and historical-cultural crossings.

(...) *I think it would have to start from here because, whether we want or not we are the ones to take it first* (...). *It is that then primary care being Family Health is not just referral* (...). *So, sometimes we are sinning a little in that too* (...) *the person is being followed up there, but is being followed up here too* (...) (Nurse, group A, 2nd meeting, restitution).

(...) *we don't have a psychologist here; I can't call people here and have a meeting* (...) *how is primary care going to do?* (...) *but it has to start from somewhere, I think that primary care is not the place to start this, it has to start there* (CAPS) (...) *I am not a psychologist, I don't understand it properly* (...) (Nursing technician 1, group A, 2nd meeting, restitution).

(...) *I think that this difficulty with mental health is kind of costly, it comes from all the prejudice that existed in mental health in the past, of isolation* (...). *Sometimes we don't stop to listen, because we are on a hurry due to all service we have; sometimes you're checking a pressure and it is the moment you could listen to a patient, but there's a vaccine, a bandage waiting* (...) *and I think that in this rush we make mistakes a little* (...) (Nurse, group A, 2nd meeting, restitution).

MS in action provoked, in the course of reflections, the rupture of the established way of practice and the reframing of concepts, as demonstrated in the following statements:

(...) *the terms exist, but it's a reality that doesn't match what we live in* (...) *we don't do matrix support, we don't do permanent education and if you take it you will have a list, a lecture set up* (...) *we are still very stuck in the biomedical model, it is very easy for me to give an ICD* (International Disease Code), *treating this ICD than to actually promote something for that person* (Nursing technician, group B, 4th meeting).

(...) *it is important because now I can call here in FHP* [Family Health Program] *and tell the girls, "Look, can you help me with so-and-so?"* (...) *today I was with a patient, then I asked, "What is your FHP? It is interesting in that sense because you know where you can have the resource"* (…) (Psychologist, group B, 6th meeting, restitution meeting).

(...) *when I started thinking about this project, the question was that we are in high demand* (reference to specialized mental health services) *and primary care has to be held accountable, but it was more a matter of sharing* (...) *we didn't pass on. We share, we do it together, we need to be a partner* (...) *but this was a difficult process to analyze, because until reaching this thing that "Look, in fact, I wanted to pass the problem on" was not easy, it is something that comes with time and we need to allow ourselves to analyze, so we need to question* (...) (Researcher, group A, 6th meeting, restitution).

As the statements above illustrate, in addition to lack of knowledge about what services in the territory do, there is a need to discuss the difference between passing on cases and sharing care.

DISCUSSION

The guiding principles of Institutional Socio-clinic were considered in an interconnected way, permeating the entire intervention process and guiding the MS device. For didactic purposes, the discussion of the results will signal each principle and its contribution to the practice of MS, also contrasting with current scientific literature.

MS was considered an analyzer device, based on the *work of the analyzers* principle. The analyzer triggers and sustains analysis in and of the intervention, enabling the explanation of contradictions, conflicts, desires[9], and their function is to destabilize what was instituted. In this way, they allow social workers to look at their practice[8].

One of the objectives of Institutional Analysis is to understand a certain social and organizational reality through speeches and practices of its subjects[15]. The subjects are, for Institutional Analysis, the agents, all the people who speaking or keeping silent move and mobilize the institutions. Thus, institutions speak through one's discourse[9].

Thus, the MS device was taken as an analyzer, providing the meeting between FHS and CAPS workers, and the researcher, in addition to favoring reports of experiences and collective analyzes about CAMH through which the institutions that cross them are explained.

For Institutional Analysis, "… institutions interpenetrate and articulate with each other to regulate the production and reproduction of human life on earth and the relationship between men"[9]. Health is mentioned as an institution that presents visible (ordinances, resolutions) and invisible (conceptions that are present in the health-disease process, the way professionals put into practice what is defined in the ordinances) norms/rules. Health Institution also goes through the relationships between social agents as well as regulating the way that people considered healthy live with those who are considered sick; this institution regulates professional relations, being crossed by other institutions, such as the technical and social division of labor, education, research, party politics[9,16].

Developing this MS device, it was sought to enable participants to talk about their daily practice. The purpose was to allow the *subjects' participation in the device*[8]. This process can occur in different ways, but, in this study, it took place through "group sessions with an analytical objective"[8], providing a space for exchanging experiences, discussing cases and health situations of the population assisted in FHS, allowing workers to question their practices and reflect on new ways of acting.

Discussing and problematizing the ways professionals are taking care enables learning about and from work, a factor that converges with the permanent health education's perspective[17]. In this way, the participants and the researcher were direct collaborators in the process of collective construction of knowledge about production of care in CAMH, putting into practice the *intention to produce knowledge*.

Spaces for collective discussions and analysis with health teams can be used as a strategy to strengthen the integration of its members, optimizing communication and designing interventions[18]. These spaces minimize the consequences of the institution's technical and social division of labor[9], such as fragmentation of the care process.

The reports show FHS professionals' difficulties to take up listening, which explains the crossing of technical and social division of labor. They still consider it secondary to other forms of care, such as performing procedures. However, listening is a powerful work tool that allows creating a bond and a sensitive look[19-20].

It is also noted a care still based on hard technologies or a technification of soft technologies, a fact pointed out in another research[21] by showing the welcoming practice in a technical way, with ready answers and with the listening process focused only on complaints. The welcoming practice performed is justified by history, in the institutionalization of biological knowledge and a doctor-centered care, especially curative, represented as resolving.

Using relational/soft technologies[20] allows deepening the understanding of the construction of subjects' subjectivity, important technologies for caring for children and adolescents. As portrayed in the results, workers initially reported a certain approximation with children and adolescents in their care. However, the relationship was fragile, subject to mediation by parents or guardians.

In this regard, it is necessary to look at the quality of the bond that health professionals have with children and adolescents. CHWs, for instance, play an important role in accessing families, children and adolescents as a result of their work of insertion in the population life territories. However, changes in the roles of these professionals in the current Brazilian National Primary Care Policy (*Política Nacional de Atenção Básica*)[22], as well as encouragement of other forms of organization of primary care that do not include them in the teams, can trigger fragile bonds between the population and CHW as well as with health teams[23].

In cases of intense psychological distress, such as children and adolescents with drug use and abuse problems, bonding is a substantial factor. Addressing the situation of drug use is always challenging for health professionals, as highlighted in this research by the CAPS psychologist's speech. A study[24] showed that the relationship between professionals and adolescents can act as a factor for better or worse involvement in their treatment.

The theme regarding relationships is at the heart of the Psychiatric Reform movement, with the adoption of the psychosocial model exercised by CAPS, and in the care model adopted by FHS[25]. Both models seek to problematize the concept of health-disease process and role of subjects in the care process[25].

This problematization allows explaining the powers, because users recognize a therapist's power, because they think they need an expert's knowledge; however, they recognize the power they also have in their care process[25]. Professionals' behavior in the logic of psychosocial care and FHS is to monitor and not prescribe conducts[25]. This contractuality is essential in assisting children and adolescents[4-5].

CAMH care calls for an intersectoral mode of action; therefore, analyzing how the sectors communicate and articulate is necessary. In this study, little articulation between sectors is identified, and professionals do not even know the function of some social facilities in the municipality, a result also found in another study[5]. However, there are instituting movements[9], such as the school insertion initiative with the aim of linking with children and adolescents, approaching self-knowledge and life skills.

During the research, restitution moments took place based on the *application of restitution modalities*. A restitution moment would be an occasion when "it supposes that there is a need and one can speak of some things that, in general, are left in the dark. These things would be commonly silenced, spoken only in corridors, cafes (...)"[12]. These

moments allowed an *analysis of the transformations that occur as the work progresses*, with the collective problematization about the practice of MS. The restitutions allowed reflections on health care and *attention to institutional contexts and interferences* such as the Psychiatric Institution and the Institution technical and social division of labor, which crosses the workers' way of caring.

When analyzing Health Institution, in this study, the expression of a mode of care based on biological psychiatry, in the model centered on the figure of the doctor or specialist, with health actions aimed at the treatment of diseases, although FHS and CAPS have been proposed for organization of services with the aim of reorienting the health care model. This fact signals the possibility that "institutions are often able to produce the opposite of the purpose for which they were founded"[26].

The changes that occurred in the research path were analyzed in restitution moments, being linked to *analysis of order and demand*[8]. Participants were able to look at their practice and reframe it, changing, for instance, the way of thinking about listening. Restitution moments are pointed out as an important tool, as they provided the group with an analysis of the transformations of their perceptions and practices as the meetings occurred, and not only at the end of the research, promoting a more unique participation of subjects[27].

For the supporter, team participation will always be a challenge, because it is required that they give professionals the opportunity to present their point of view on a certain situation. During this process, it is necessary that the supporter accepts to analyze workers' and team's opinions, even if they are different and have a direction contrary to their understanding on a certain topic.

Thus, an *implication analysis* is shown to be potent in the practice of MS. The concept of implication for Institutional Analysis deals with the relationships that the researcher and study participants have with the research (primary implications) and the involvement of the researcher and participants with other institutions such as family, church, profession, researcher's beliefs, ideological and libidinal relations, among others[8,28].

In the case of MS, analysis of the implication helps the supporter to analyze their implications, i.e., the involvement, the relationships that everyone has with MS as well as about the methods used in matrix support (meeting, joint service, case discussion, etc.), the expected from matrix (sharing or transfer of care) and the secondary implications related to themes or lines of care addressed.

An analysis of the implications was carried out in some statements such as that of the nurse in group B, when problematizing their practice in relation to previous learning in the field of mental health care and the way society dictates this care. Mental health care is considered to suffer *institutional interference* and is centered on the Psychiatry and Psychology institutions, without often considering other courses and comprehensive care.

The researcher's own change of thought also explains the power of analyzing the implications[28]. She was able to look at her role as a nurse at a CAPS and as a supporter/researcher, understanding that her thinking was also crossed by segmentation of care, in relation to what belongs exclusively to CAPS or FHS.

The MS device supported by Socio-clinic enabled an analysis and reframing of professional thought and practice, the need to share care, support in the development of forms of care that integrate actions of promotion, prevention and treatment within the scope of CAMH[5-6], in addition to bringing back to light the reasons for which (in the sense of the founding myth or initial prophecy) each modality of health service was founded[29].

CONCLUSION

In this study, MS favored the deterritorialization of professionals, revealing how the care provided in CAMH is practiced and the crossings that occur in its production as well as possible paths to be followed to improve health actions.

It was found that PHC workers are still guided by the biological psychiatry paradigm, limiting care and identifying it as restricted to experts' performance. Important clues to nursing in the experimentation of MS are revealed, as well as the possibility of a (re)look at the insertion and practice of nursing in the development of care in CAMH. One emphasizes that important experiences of the MS stand out in points of health care, such as FHS and CAPS, which present the social mandate of reorganizing the ways of caring and considering the health-disease process in all its dimensions.

As a limitation of this study, it is pointed out the non-participation of physicians in the discussions, which reveals the way health teams work. Nurses, nursing technicians, CHW, dentists participate more frequently in MS actions, permanent health education and team meetings. The non-participation of physicians can make it difficult to rethink practices and interprofessional and collaborative work.

The principles of Institutional Socio-clinic favored developing CAMH MS in FHS, and may function as clues for the exercise of MS in other contexts and themes, contributing to reorient the health work process and articulation between health teams and services.

RESUMO

Objetivo: Analisar o apoio matricial para equipes da Estratégia Saúde da Família em relação à Saúde Mental em Crianças e Adolescentes. **Método:** Pesquisa-intervenção de abordagem qualitativa, fundamentada pelo referencial da Análise Institucional, a socioclínica, realizada com dezoito trabalhadores de saúde de duas equipes da Estratégia Saúde da Família e do Centro de Atenção Psicossocial de um município de pequeno porte, localizado no interior do estado de São Paulo, por meio de onze encontros de reflexão. **Resultados:** Foram apresentados a partir dos temas: *A dinâmica das relações no território da ESF*; *O apoio matricial como dispositivo tecnológico: desvelando práticas instituídas.* Posteriormente, foi realizada a discussão dos resultados a partir dos princípios da Socioclínica Institucional. **Conclusão:** O apoio matricial

em saúde mental infantojuvenil, pautado no referencial da Socioclínica Institucional, favoreceu a desterritorialização dos profissionais, revelando como se dá o cuidado em saúde mental para crianças e adolescentes e os atravessamentos que ocorrem na produção desse cuidado, assim como possíveis caminhos a serem trilhados para aprimorar as ações de saúde.

DESCRITORES

Enfermagem; Saúde Mental; Estratégia Saúde da Família; Equipe de Assistência ao Paciente; Prática Profissional.

RESUMEN

Objetivo: Analizar la matriz de apoyo a los equipos de la Estrategia Salud de la Familia con relación a la Salud Mental en la Niñez y la Adolescencia. **Método:** Investigación-intervención con enfoque cualitativo, con base en el marco de Análisis Institucional, el socioclínico, realizado con dieciocho trabajadores de salud de dos equipos de la Estrategia Salud de la Familia y del Centro de Atención Psicosocial de una pequeña ciudad, ubicada en el interior del estado de São Paulo, a través de once encuentros de reflexión. **Resultados:** Se presentaron a partir de los temas: La dinámica de las relaciones en el territorio de la ESF; El soporte matricial como dispositivo tecnológico: revelando prácticas establecidas. Posteriormente, se discutieron los resultados con base en los principios de Socioclínicas Institucionales. **Conclusión:** La matriz de apoyo en salud mental infantil, con base en el marco Socioclínico Institucional, favoreció la desterritorialización de los profesionales, revelando cómo se brinda la atención en salud mental a la niñez y adolescencia y los cruces que se dan en la producción de este cuidado, así como en lo posible caminos a seguir para mejorar las acciones de salud.

DESCRIPTORES

Enfermería; Salud Mental; Estrategia de Salud Familiar; Grupo de Atención al Paciente; Práctica Profesional.

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