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Child and adolescent mental health policy: history and paths to participation

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Abstract *People with mental disorders play an important role in the mental health reform process, which involves the creation of new public policies, practices, knowledge, and ways of relating to this experience. Using a guiding question addressing the history of child and adolescent mental health in Brazil and the participation of child and adolescent mental health service users in the policy construction process, a narrative literature review was undertaken framing the main policy developments and advances in this area within the overall context of the Brazilian mental health reform. A search of technical, institutional, and legal documents in the thematic area Mental Health was conducted using a national database. The material analyzed addressed milestones in child and adolescent mental healthcare, highlighting the paths taken in building this field. The article also discusses the participation of child and adolescent mental health service usersin this process in the form of a commentary. Finally, the article highlights the need to guarantee the participation of this group to enable them to play a leading role in the struggle for the construction and realization of rights.*

Key words *Mental health, Child, Adolescent, Public policy, Social participation*

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The construction and consolidation of child and adolescent mental health in the Brazilian mental health reform

Brazil's mental health reform process began at the end of the 1970s against a backdrop of struggles for redemocratization[1]. With the creation of the Mental Health Workers Movement, 1978 can be regarded as a milestone for the social movement that criticized the state of the country's mental health services and sought new proposals[1-3]. This process resulted in the creation of the National Mental Health Policy, which aims to consolidate the psychosocial services network within the country's Unified Health System (*Sistema Único de Saúde* - SUS) and provides that mental health services shall be community-based, promote social reintegration and citizenship, and tailored to the everyday reality and needs of people with mental disorders[1].

The participation of psychosocial care network service users in the mental health reform movement is of fundamental importance, taking on a leading role in the construction of mental health policy and in the struggle to establish and protect rights.

Within this context, major advances have been made in child and adolescent mental healthcare in terms of practice and knowledge development, despite the fact that this issue only found its way onto the public agenda somewhat later. In light of the above and considering the 15th anniversary of Law 10.216/01[4] celebrated in 2016 and the implementation of the mental health reform resulting in the creation of public policies, it is important to understand and highlight the history of the development of child and adolescent mental health policy. This paper gives visibility to the main milestones in this process based on the understanding that there is an ongoing need to broaden the participation of child and adolescent mental health service users in the creation and development of public policies.

Dimensions of mental health reform in Brazil

The history of mental health reform in Brazil constitutes a complex social process that goes beyond the simple restructuring of the care model, comprising an ongoing movement with the innovation of actors, concepts, and principles[2,5]. According to Amarante[2], in the Brazilian context this movement is made up of four intertwined dimensions: epistemological, technical-assistance, judicial-political, and sociocultural.

The epistemological dimension refers to a paradigm shift in psychiatry involving the elaboration, critique, and production of new knowledge[2]. The deinstitutionalization perspective, which emerged during the Italian experience and had an important influence in Brazil, is characterized by strong criticism of the psychiatric institution itself, with its scientific, care, relational, administrative, legislative, and cultural apparatus. A rupture also took place in the function and social mandate of the professionals working in this institution. According to Basaglia[6], to constitute a fictional object of intervention (i.e.; the illness) the discipline of psychiatry separates the experience of suffering and the global and concrete existence of the person. In a critique of the existing model, Basaglia[6] proposes that the illness rather than the person should be "placed in brackets", thus breaking with the psychiatric model that objectifies the person around a notion of illness and making it possible to get closer to concrete and complex life experiences.

Thus, the deinstitutionalization approach seeks to deconstruct existing ways of knowing and doing with practical and reflective actions, creating unprecedented forms of action. Referring to this epistemological dimension, Amarante[2] highlights the need to consider that deinstitutionalization designates "multiple ways of treating subjects in their existence and in relation to concrete living conditions"[2]. It therefore amounts to a process that involves the deconstruction of the problem, knowledge, and practices, and the establishment of new relations with the experience of mental disorders.

The technical-assistance dimension, which encompasses care models, is linked to the epistemological dimension, since the development of services is based on concepts and theories[2]. If the object of care is illness and dangerousness is a key component of the care model, as it is in the psychiatric model, institutions should be normative and disciplinary; however, if the guiding principle of care is to enter into a relationship with the complex existence of people with mental disorders, care services and strategies should be created to support the multiplicity of elements of the recovery process[6]. That is why proposing new support and care models requires the reconstruction of conceptions and the production of unprecedented ways of understanding[2].

Within this dimension of mental health reform, Psychosocial Care Centers (*Centros de Atenção Psicossociais* - CAPS) are a key services in Brazil's Psychosocial Care Network (*Rede de

Atenção Psicossocial – RAPS), created by Ministerial Order Nº 3.088/11, which was republished in 2013[7]. CAPS are defined as community-based services with territorial characteristics responsible for organizing the users' care network of the RAPS. Actions and strategies aimed at promoting care and fostering exchanges between services include, among other things, day and night care and support, counseling, psychosocial rehabilitation, and coordinated intra and inter-sectoral actions[8]. For both people and groups, territory, which goes beyond geographical space, is understood as a plural space with various histories and ways of living and inhabiting and therefore constitutes modes of belonging with multiple meanings[1,9].It is also important to highlight that the RAPS has another six care components besides the different modalities of CAPS[7].

The creation and consolidation of this care network, which views people with mental disorders first and foremost as citizens, would not have been possible without interlocution between the field of politics and law, resulting in the third dimension of the mental health reform process, the judicial-political dimension. It is important to note that legality and rights are fundamental elements of struggles for emancipation: the gains made by social movements are translated into law, becoming "legal accomplishments". One of the first milestones within this dimension was the Caracas Declaration (1990), which sets out principles and guidelines for restructuring mental healthcare. However, the most notable landmarks in this respect in Brazil were the creation of Law Nº 10.216/01, which addresses the rights and care of people with mental disorders and redirects the mental healthcare model[4], and creation of the National Mental Health Policy.

In his discussion of the history of this law, the result of a tense and heated dispute over a bill presented in 1989 involving various institutions and social apparatuses, Delgado[10] highlights the emergence of the mental health service user as a political subject. Engaging in dialogue with professionals, family members, and the state, users participated in the creation and consolidation of the consensual bases underlying this law and other mental health policies[10]. The guarantees provided by this law boosted the mental health reform process in all its dimensions, influencing the creation of other pieces of legislation relevant to the consolidation of the deinstitutionalization process and mental health reform.

Another vital component of the judicial-political dimension were the four National Mental Health Conferences held in 1987, 1992, 2001, and 2010, with the progressive increase in participation and protagonism of service users and their families. National conferences have played a key role in organizing, constructing, and consolidating the mental health reform process, leading to complex changes in mental health and having important ramifications beyond the judicial-political dimension, intertwining with the other dimensions of this process.

Social movements also played an essential role in the struggle for rights and change, notably the *movimento antimanicomial* or anti-asylum movement. In response to denunciations of violence in psychiatric hospitals, mental health workers began to mobilize themselves and demand concrete changes to mental healthcare. A milestone in this process was the II National Mental Health Workers' Congress, held in Bauru in 1987. Adopting the slogan "For a society without asylums", the movement grew and began to include mental health service users and their families[2]. The broadening and strengthening of the participation of this group is indicative of the creation of new social spaces for people with mental disorders under the mental health reform.

The fourth dimension of the mental health reform process, the sociocultural dimension, is linked to the recreation of new forms of action and relation with people with mental disorders[2]. This dimension refers to "the set of actions aimed at transforming the conception of madness in the social imaginary, transforming the relations between society and madness"[2]. Thus, within the sociocultural dimension, experiences and projects that articulate fields of health and culture seeking to transform is understandings and discrimination against people with mental disorders are essential. The sociocultural dimension plays a key role in mental health reform given its reverberations in the general social fabric. This dimension is intrinsically related to the other three, given that it is possible to change the social imaginary of madness through the creation of new concepts and conceptions regarding mental disorders, transformative practices performed in the RAPS, and the consolidation of laws that establish the rights of people with mental disorders. In this respect, the social and political participation of social actors is an essential aspect of this dimension and enables intrinsic articulation with the others.

It is essential to emphasize that, understood from the deinstitutionalization perspective, mental health reform is a complex and living process.

The pursuit of transformation in the relations between mental disorders and the social fabric and of the protection of the human rights of people with mental disorders involves the production of knowledge, the development of innovative practices, and the formulation of policies and legal foundations to enable and support this process[2,3]. Within this process, the participation of people with mental disorders in the construction of mental health policy is paramount. The essence of this process is the struggle for rights and affirmation of citizenship and, in this sense, it amounts to "an ethical and aesthetic process of recognizing new situations that produce new subjects of rights and new rights for subjects"[2].

Method

This article describes the results of a narrative literature review, defined as a non-systematic review suitable for discussion and development of a given subject from a theoretical and contextual point of view[11]. The review was conducted using the following guiding question: considering the centrality of the participation of people with mental health disorders in the policy development process, what are the main elements and milestones in the history of Brazilian mental health reform and currently specifically related to child and adolescent mental healthcare? By conducting a narrative literature review focusing on the creation and implementation of policy supported by legislation, this study seeks to frame developments and advances in the field of child and adolescent mental health within the overall context of the Brazilian mental health reform, taking into account the participation of this group in this process.

A search of primary sources was conducted using the database Scientific Electronic Library Online Brazil, focusing on technical, institutional, and legal documents (including legislation and guidance documents)in the thematic area Mental Health of the Virtual Health Library. Exploratory reading of the results of this search was carried out to select key documents in the field of child and adolescent mental health. Relevant key books and articles published in indexed journals were also selected based on the citations and references of these key documents.

This set of documents (technical, institutional, and legal documents and books and articles) was read and the theoretical discussion was organized into two core themes: paths to building child and adolescent mental healthcare; and child and adolescent mental healthcare within the Brazilian mental health reform. Finally, a critical reflection of the importance of ensuring that the voices of child and adolescent mental health service users are heard was undertaken, which comprised the commentary of the narrative review. The intention of the narrative review was therefore to discuss and reflect upon developments in child and adolescent mental healthcare and the paths to broadening the participation of these subjects in policy formulation.

This study is part of a broader study that investigated the reasons for admission of children and adolescents to a psychiatric hospital characterized as a total institution in the context of the mental health reform based on the perspectives of the institution and children and adolescents admitted/institutionalized[12].

Paths to building child and adolescent mental healthcare

Despite only being included on the public agenda somewhat later, the development of child and adolescent mental health policy occurred in the macro context of the mental health reform process and consolidation of National Mental Health Policy[13].Thus, the transformation of this field is a recent action that fills a gap in care provision for child and adolescent users of mental health services.

Historically, due to lack of investment and political will, total institutions were created for children and adolescents based on care models that do not prioritize comprehensive care and fail to focus on social reintegration and articulation with other social services[14]. According to Couto[15], a look at the history of care provision for children and adolescents at national level shows that this group experiences two situations: children and adolescents living in "shelters for the mentally deficient", which follow the asylum logic and are at the margin of the formal mental health system; and children and adolescents "diagnosed with autism or a psychotic disorder" who "are found wandering in search of specialist treatment, without finding them".

Thus, the type of care provided up until this point engendered "a set of measures rooted in social hygiene logic and of normative-legal inspiration that greatly extended the supply of institutions closed to care" and resulted not in social integration from a children's and adolescents' rights perspective, but rather "the institutionalization of care" and "criminalization of poor children", generating "a situation of lack of care, abandonment, and exclusion"[14]. It amounted to a logic of conformation and confinement of children and adolescents considered to display deviant behavior. In the judicial-political sphere, this situation was initially corroborated by the 1927 Minor's Code, known as the Mello Mattos Code, replaced by 1979 Minor's Code. While the goal of the former was "social hygiene", the latter understood that there were situations of risk in childhood and adolescence that needed to be addressed through mass institutionalization, preferentially for socially vulnerable children and adolescents that had committed minor offences[16].

The redemocratization movement and struggle for mental health reform gave visibility to the need to think of children and adolescents as citizens and led to the transformation of this issue. The 1988 Federal Constitution confirmed that children and adolescents were citizens and subjects of rights, resulting in the creation of the Child and Adolescent Statute (CAS, Law Nº 8.069/90)[17]. This instrument emphasizes that children and adolescents are citizens and aims to guarantee their rights, stating that the state shall ensure, among other things, the full protection of these subjects through the creation of environments and affective social and family ties, the right to belong to a community and its social fabric, school education, and health promotion, protection, and recovery[17]. The CAS is therefore a milestone in the construction of new policies and modes of care directed at children and adolescents.

With regard to the care of child and adolescent mental health service users, the consolidation of the CAS concomitantly with the mental health reform process and implementation of the National Mental Health Policy required the restructuring of child and adolescent mental healthcare. In this respect, Delgado[10] draws attention to the "absence of the theme children and adolescents in the debate surrounding mental health reform" in the 1990s and divergences in discussions about child and adolescent mental health policy. In fact, it was only in 2001 that the government would create concrete conditions for the construction of policy directed at this population group, with the introduction of Law 10.216/01[4]. In the same year, during the III National Mental Health Conference, this theme was elected one of the priorities of mental health reform, signaling that the "elaboration and execution of actions in the field of child and adolescent mental health should comprise, necessarily, mental health policies respecting the guidelines of the Brazilian mental health reform process and the principles of the CAS"[18].

Child and adolescent mental healthcare within the Brazilian mental health reform

An important milestone in the effective transformation of child and adolescent care stemming from the primordial context created by Law Lei 10.216/01 was Ministerial Order Nº 336/02[19], which creates the conditions for funding the construction of CAPS, including the modality CAPSi, which provides child and adolescent mental health services, leading to a significant expansion of the psychosocial care network. With the creation of the RAPS in 2011 and Ministerial Order Nº 854/12, which seeks to enhance information about the practices of the CAPS, the legislation confirmed the coordination and integration of different points of care[7] and defined strategies and actions in the everyday practice of the services, including theCAPSi[8].

Regarding the history of child and adolescent mental healthcare, it is important to highlight Ministerial Order Nº 1.946/03, created largely as a result of the deliberations of the III National Mental Health Conference, which established a Working Group responsible for "providing the necessary conditions for implementing the National Child and Adolescent Mental Healthcare Forum, which works as space for intersectoral articulation"[20].

Stemming from this initiative, the National Child and Adolescent Mental Health Forum was created in 2004 by Ministerial Order Nº 1.608/04[21] under the coordination of the Technical Area for Mental Health, Alcohol, and Other Drugs of the Ministry of Health. The forum has 32 permanent seats held by representatives from different levels of government from the fields of health, education, culture, justice, social assistance, mental heal, and human rights. Through thematic meetings and plenary sessions, the forum's collegiate aims to "debate different issues related to child and adolescent mental health, providing inputs to inform the construction of policies directed at this population group"[22]. The collegiate plays a key role in developing the underlying principles and guidelines for child and adolescent mental health policy, ensuring the construction and consolidation of new strategic services, the CAPSi, and unprecedented modes of care.

The guiding principles underlying the construction of child and adolescent mental health policy, laid out in a document published in 2005, confirm that child and adolescent mental healthcare shall envisage the universal provision of welcoming care, implied referral, permanent network building, and an intersectoral approach to care, thus "enabling emancipatory actions" and creating "a care network that takes the uniqueness of each person and the constructions that each subject makes from his/her situation into account"[14]. One of the premises of the document is a broader notion of life experiences and the health-disease process, understanding that the latter has multiple dimensions. With respect to services, premises include a radical and deep ethical commitment to the uniqueness of the subject and taking true responsibility for care. From a perspective that takes into account the uniqueness of life experiences, effective healthcare delivery requires attentive listening to understand the needs of subjects and ensure that their voice is heard and that they are able to talk about themselves and their suffering. This implies ensuring the right to speak, legitimizing their knowledge, and creating possibilities that allow children and adolescents to narrate their experiences, signal their perspectives, and be subjectively accountable for their experiences.

This document, which outlines the paths to constructing child and adolescent mental health policy, also states that coordination and cooperation between different sectors and the permanent construction of the network are vital, and that services are responsible for the universal provision of welcoming care and responsible referral, with joint accountability of the various actors involved. In this respect, services should tailor their actions to the specific characteristics of their catchment areas and the territories in which users live, which include, among other things, social ties, history, and the relations that people establish and the places they frequent[14].

Based on this set o guiding principles, the National Child and Adolescent Mental Health Forum held nine national Thematic Meetings between 2005 and 2012, in addition to its regional meetings. Addressing themes such as the challenges of deinstitutionalization for child and adolescent care within the RAPS, coordination and cooperation between mental health service operators and the judiciary, and network care strategies and intersectorality[22], these meetings produced three recommendations for psychosocial care and the child and adolescent support network, as well as debate syntheses, producing understandings, enhancing discussions, and strengthening the construction of policy. It is important to note that the IV National Mental Health Conference held in 2010convened other sectors involved in the implementation of mental health policy, such as legal practitioners, and fields involved with social assistance and culture[23]. Thus it can be said that while intersectorality had already been confirmed as a necessary foundation for the construction of the child and adolescent mental health policy, including intense dialogue between various sectors based on the concept of an expanded public network[24], this theme was strengthened even further in the context of the IV National Mental Health Conference and continued to be discussed in the meetings of the National Child and Youth Mental Health Forum.

Perhaps the most notable meeting was the IX and last Ordinary Meeting of the National Child and Youth Mental Health Forum, held in 2012 with the theme "Challenges for the field of child and adolescent care within the psychosocial care network (RAPS)" as part of a discussion that "intended to enhance the debate about RAPS and its care services, formulate paths to broadening access among children, adolescents, and young people, and enhance the interface between the rights protection system and youth leadership"[22]. This meeting produced a set of 41 proposals, notably the need to enable the participation of adolescents in local, state, regional, and national forums, strengthen the RAPS and intersectoral actions, and develop CAPSi sustainability mechanisms[22]. It is also important to note that the presence and participation of adolescent mental health service users in this process was made possible through a partnership between the Technical Area for Mental Health, Alcohol, and Other Drugs of the Ministry of Health and the Adolescent Citizenship Program of the United Nations Children's Fund (UNICEF). The adolescents participated as listeners, debaters, and rapporteurs of the working groups and plenary sessions. One of the various recommendations made by the adolescents that has gained prominence is "the need to tailor the next forums and services provided by the psychosocial care network to the specific demands and language of the adolescents"[25].

With respect to people with autism and their families, a working group was created in 2011, and in 2013 a document was published that "aims to contribute to the expansion of access and improve the quality of care" for this population group within the RAPS[26]. Despite not being specifically directed at child and youth mental health, this document is relevant considering the population treated in the CAPSi.

Continuing discussions in this field, the I Brazilian CAPSi Congress (CONCAPSi), held in 2013, addressed the multiplicity of practices adopted in the child and adolescent psychosocial care network that are sensitive to the uniqueness of the experiences, stories, and life contexts of service users[27]. This meeting provided an opportunity to share experiences and reflect upon challenges, comprising the plurality of actions developed not only in the field of direct psychosocial care, but also in key areas such as training, management, and policy, indicating a wealth of actions in the field[27].

Also in 2013, the Technical Area for Mental Health, Alcohol, and Other Drugs held a public consultation in partnership with the National Council of Public Prosecutor's Office aimed at "establishing a common language and understanding to advance access and enhance actions directed at the population of children and adolescents within the judicial and healthcare spheres"[28]. As a result of this process, a document was produced outlining the main challenges facing child and adolescent care in the context of the RAPS, including the abuse of alcohol and other drugs and the socioeducational measures, and highlighting the importance of education, full social protection, comprehensive healthcare, and the provision of assistance to children and adolescents subjected to violence[29].

This document reflects the significant force for change within psychosocial care. Within this context and from a broader care perspective which recognizes the subject from what "is peculiar and unique" to him/her"[30], the aim is to ensure the production of care that includes actions such as "listening, caring, enabling emancipatory actions, and tackling stigmas and determinisms"[29]. Thus, there has been a shift from a field marked principally by social exclusion, violence, and neglect and in which the issue was absent from the agenda, to a living field of service interventions, policies, and ways of relating to the experience of child and adolescent mental health service users, with actions committed to the different dimensions of the mental health reform.

Ensuring that the voices of child and adolescent mental health service users are heard

From the deinstitutionalization perspective, broadening protagonism and social participation is one of the main pillars and a central aspect in the rehabilitation processes, insofar as rehabilitate means "build (rebuild) real access to rights of citizenship, to the progressive exercise of these rights, to the possibility of seeing them recognized and acting from them, and to the capacity to practice them"[31]. Fully exercising rights is the emancipatory horizon and this requires that mental health service users, who are citizens and subjects of rights, have the opportunity to express themselves and be part of society. In other words, the voices of these subjects must be validated and enunciated in spaces that legitimize them, whether in assemblies in the services, the broader encounters of the social movements, or in the different spaces and institutions of the territory and society. The possibility of broadening social participation is therefore intrinsically linked to strengthening contractual power in social relations.

As highlighted above, this has been and continues to be a complex process within mental health reform, whereby changes have only been made possible by the debates and deliberations operated in the public sphere, in which all actors – workers, families, people with mental health disorder, and society as a whole – participate. Thus, considering the history of child and adolescent mental healthcare in Brazil and the need to increase the participation of these subjects in the debate, it is important to reflect upon on how to expand the possibilities of contractuality and social participation in this process, guaranteeing rights and paths to transformation.

Therefore, generally speaking, ensuring a voice for children and adolescents goes hand in hand with their recognition as subjects of rights and responsibilities, building possibilities so that they can be protagonists in their processes. Based on these premises, within the struggle for mental health reform and its actions, policies directed at children and adolescents emphasize, as mentioned above, the importance of respecting the rights of child and adolescent mental health service users, whether in political spaces, as with the meetings of the National Child and Youth Mental Health Forum, in psychosocial care services, or in everyday life, since:

> [...] *within the dimension of health as the production of a community of subjects responsible for caring for themselves and others, guaranteeing the right to speak is essential. Accountability is not possible without the right to be heard of those who want to hold themselves accountable. By talking about themselves and identifying with their own history, children and adolescents see possibilities of finding new meanings and new ways of inclusion in society and the family*[28].

To this end, willingness to listen and the legitimization of what children and adolescents have to say are vital to the process of social validation. In this respect, it is interesting to note that holding periodic assemblies in which professionals, families, and service users have the right to speak is routine practice in community-based adult mental healthcare services. This practice was widely used during the deinstitutionalization process in Italy. Incorporating shared decision-making strategies like this one into the everyday practice of child and adolescent mental health services can therefore play an important role in broadening participation.

According to Vasconcelos[32], enabling service users to speak about their experiences and validating these experiences means strengthening, or "empowering", each person's voice, and engenders movements that promote change, because the voice is "an instrument of social, cultural, and institutional change in civil society". The polysemous concept of empowerment may be understood as "an increase in the personal and collective power and autonomy of individuals and social groups in interpersonal and institutional relations"[33]. It therefore amounts to strengthening the power of contract of subjects in various relations, enabling broader participation in social exchanges. According to Kinoshita[34], the power of contract is established in relations with other subjects in the social sphere through exchange processes and is related to the exchange of goods, affects, and messages. On the path to broadening social participation, autonomy, and contractual power of people with mental health disorders, professionals can lend their contractual power to the other, creating joint recovery processes, enabling the other to gradually build his/her own unique trajectory. Therefore, while on the one hand guaranteeing service users contractual power is the point of departure for establishing more horizontal relations in mental health practices within the mental health reform and increasing autonomy, social participation, and contractuality, ensuring that the experiences of these people are heard is a vital for promoting empowerment.

Also according to Vasconcelos et al.[32], the narratives of service users regarding their experiences allow them to express their experiences from a personal, social, and political perspective in a process of "affirmation of subjective human experience and his/her role as a subject, to the detriment of the authority and the narratives formulated from outside and above by professionals and specialists". Regarding children's and adolescents' right to speak, it is important to note that from the outset of the policy building process has been considered that:

> *Placing children and adolescents at the center of institutional arrangements, as subjects and with all their peculiarities and responsibilities over the course of their existence, is the only way of ensuring that the act of discoursing about them and of knowing what is best for them is not reproduced in their care*[14].

Vasconcelos et al.[32] holds that when the experience narrated by service users can be shared with those of other service users it is possible for people to situate themselves as "more universal spokes persons for the repressed dimensions of the being, and demand concrete changes in the ways society looks at and treats these dimensions and these people". In this sense, being attentive to the way in which subjects understand their process means opening up a field of possibilities for change based on the concrete experiences of these subjects.

Based on this understanding, it is necessary to create various strategies and possibilities so that these narratives may have a place, whether in the everyday practice of the services, or in expanded political spaces. Despite the many advances, building such actions remains a permanent challenge of mental health reform.

Paths to follow

The construction of policy and modes of mental health care from a perspective that views people with mental health disorders as citizens is a continuous struggle for the construction and realization of rights. Major advances have been made in the field of child and adolescent mental healthcare within the different dimensions of mental health reform in Brazil; notably the creation and expansion of child and adolescent mental health services, guaranteed by legislation and social and political mobilizations in the pursuit to ensure that the voices of child and adolescent mental health service users are heard. However, it is important to note that the last meeting of the forum was held in 2012 and, given that new proposals and monitoring of policy depend on a an expanded political field, we fear that these advances will likely face setbacks. In this respect, permanent investment in the development of this process is needed, creating possibilities in the everyday practice of mental healthcare services at various levels, with the development of projects truly committed to broadening the social participation of children and adolescents and guaranteeing citizenship.

Collaborations

CP Braga participated in study conception and design and in drafting the final version of this article. AFPL d'Oliveira participated in the critical revision of the manuscript and final approval of the version to be published.

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