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RESEARCH

THE EXPERIENCE IN TEACHING CHILDREN AND ADOLESCENTS WITH MENTAL DISORDERS: CHALLENGES TO THE MAINSTREAMING

A EXPERIÊNCIA EM LECIONAR PARA CRIANÇAS E ADOLESCENTES COM TRANSTORNOS MENTAIS: DESAFIOS À INCLUSÃO

LA EXPERIENCIA EN LA ENSEÑANZA DE NIÑOS Y ADOLESCENTES CON TRASTORNOS MENTALES: DESAFÍOS DE LA INCLUSIÓN

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ABSTRACT

Objective: to know the experiences of teachers in teaching children and adolescents with mental disorders and their needs in the teaching-learning process. **Method:** this is a descriptive, qualitative study, carried out with 11 teachers from public high and elementary schools in a municipality in the north of the state of *Mato Grosso do Sul*. The data were collected through an openin-depth interview, from August to September 2017 and submitted to thematic content analysis. The experiences were grouped and separated into two categories: "teaching - difficulties, needs and strategies" and "the challenges of mainstreaming". **Results:** feelings such as frustration, fear and concern about not playing an appropriate role as an educator were mentioned. It was identified the lack of knowledge of teachers and the lack of institutional structure foran adequate teaching-learning process that promotes inclusion. Also, the fragility of the articulation between school and health services. **Final considerations:** there is a need for the articulation of education and health institutions, which can assist the co-responsible planning of strategies that favor the teaching-learning process of children and adolescents with mental disorders, comprehensive care and inclusion.

Keywords: Mental Health; Mainstreaming (Education); School Teachers; Child Health; Adolescent Health; Intersectoral Collaboration.

RESUMO

Objetivo: *conhecer as vivências de professores em lecionar para crianças e adolescentes com transtorno mental e suas necessidades no processo ensino-aprendizagem.* ***Método:*** *trata-se de estudo descritivo, qualitativo, realizado com 11 professores de escolas públicas do nível médio e fundamental de um município do norte do estado de Mato Grosso do Sul. Os dados foram coletados por meio da entrevista aberta, em profundidade, no período de agosto a setembro de 2017 e submetidos à análise temática de conteúdo. As vivências foram agrupadas e separadas em duas categorias: "o lecionar - dificuldades, necessidades e estratégias" e "o desafio da inclusão".* ***Resultados:*** *sentimentos como frustração, medo e preocupação em não desempenhar adequado papel como educador foram mencionados. Identificou-se a falta de conhecimento dos professores e de estrutura das instituições para um processo de ensino-aprendizagem adequado que promova a inclusão. E, também, a fragilidade da articulação entre escola e serviços de saúde.* ***Considerações finais:*** *destaca-se a necessidade da articulação das instituições de educação e saúde, que pode auxiliar o planejamento corresponsável de estratégias que favoreçam o processo de ensino-aprendizagem das crianças e adolescentes com transtornos mentais, a assistência integral e a inclusão.*

Palavras-chave: *Saúde Mental; Inclusão Educacional; Professores Escolares; Saúde da Criança; Saúde do Adolescente; Colaboração Intersetorial.*

RESUMEN

Objetivo: *conocer la experiencia de los docentes en la enseñanza de niños y adolescentes con trastornos mentales y sus necesidades en el proceso*

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de enseñanza-aprendizaje. ***Método:*** *se trata de un estudio descriptivo, cualitativo realizado con 11 docentes de escuelas públicas de enseñanza primaria y secundaria de un municipio del norte del estado de Mato Grosso do Sul. Los datos se recogieron a través de una entrevista abierta en profudidad, entre agosto y septiembre de 2017, y después se analizaron según su contenido. Las experiencias se agruparon y separaron en dos categorías: "enseñanza – dificultades, necesidades y estrategias" y "el desafío de la inclusión".* ***Resultados:*** *se manifestaron sentimientos tales como: frustación, temor y preocupación por no desempeñar un papel adecuado como educador. Se identificó la falta de conocimiento de los docentes y de estructura de las instituciones para un proceso adecuado de enseñanza- aprendizaje que promueva la inclusión. También quedó evidente la fragilidad de la articulación entre la escuela y los servicios de salud.* ***Conclusión:*** *se realza la necesidad de articulación entre las instituciones educativas y de salud, con miras a respaldar la planificación corresponsable de las estrategias que favorezcan el proceso de enseñanza-aprendizaje de niños y adolescentes con trastornos mentales, la atención integral y la iclusión.*

Palabras clave: *Salud Mental; Propensión (Educación); Maestros; Salud del Niño; Salud del Adolescente; Colaboración Intersectorial.*

INTRODUCTION

The period of life defined as childhood and adolescence begins with birth and lasts until the age of 18 or 19, depending on the framework adopted.In the Child and Adolescent Statute (Portuguese acronym: ECA), the main legal and regulatory framework for the rights of this population in Brazil, childhood encompasses the age group up to 12 years old and adolescence between 12 and 18 years.[1]

Regarding this population, the prevention and treatment of mental disorders are one of the main challenges to the public health.[2]The worldwide prevalence of these disorders in children and adolescents is estimated at 13.4%, and in Brazil at 13.1%.[3]

Mental disorders or mental illnesses are characterized by changes in mental functions such as levels of consciousness, cognitive state, thinking, language, sense-perception, mood/affect and psychomotricity, which result in changes in the individual's psychological and biological process and interfere in social and productive life.[4]It is noteworthy that in childhood and adolescence the main disorders are those of the autistic spectrum, of attention deficit/hyperactivity, disruptive (of behavior and challenging of opposition), of anxiety, of separation and schizophrenia.[4]

Although global developmental disorders are the best known, epidemiological studies that have investigated the worldwide prevalence and in Brazil have indicated that the most prevalent in childhood and adolescence are disorders associated with depression and anxiety, attention deficit and hyperactivity, disruptive and those resulting from substance use.[3]

These disorders are associated with greater impairment of social functioning, learning and negative impacts on quality of life.[5]In this sense, considering the usual spaces for children and adolescents to live together, in addition to the family context, educational institutions are the places where they spend a large part of their time, characterized as an important environment in the acquisition of social, cognitive and learning experiences.[6]

Thus, since 2003, the "Inclusive Education Program: right to diversity" has committed to implementing an inclusive educationpolicy and systems,to guarantee access and permanence for children and adolescents with special education needs, such as those with mental disorders, in regular schools and education in Brazil.[7]In 2014, the National Education Plan (Portuguese acronym: PNE) ensured the right of access for children and adolescents with disabilities and mental disorders.[8]

In this context, the act of teaching, for the teacher, starts to involve other knowledge and challenges, daily and continuous, because disorders can affect the learning process and interpersonal relationships. However, the knowledge of teachers to identify needs and the development of differentiated strategies for teaching this population are not always sufficient, which can generate insecurity and difficulties in the inclusion process (mainstreaming).[9]In this sense, intersectoral and interprofessional partnerships are essential with a view to implementing training and joint strategic actions that favor the inclusion of these students.[10]

Among the intersectoral actions, strategies and programs, special emphasis is given to the interprofessional relationship between professionals in the education and health sectors. This is because the school space is conducive to the development of integrated and outlined actions. For that, it is necessary that there is a continuous articulation between school and health services, especially through the dialogue between these two spheres, to achieve the objective of the universal right to health and education and to better meet the needs of children and adolescents.[11]

The School Health Program proposes integrated actions from the perspective of health promotion, prevention and education and multidisciplinary work. However, this dialogue and articulation are still fragile, because, in addition to the educators having difficulties in teaching children and adolescents with mental disorders, they are unaware of the structure and organization of the care network for this population and of its role in school. On the other hand, the primary health care network is unaware of the needs of educators, especially in the area of mental health, even with the implementation of the School Health Program.[11]

In this sense, the question is: how have teachers been teaching children and adolescents with mental disorders? What are the needs experienced in the learning process? And to answer these

questions, the present study aimed to know the experiences of teachers in teaching children and adolescents with mental disorders and their needs in the teaching-learning process.

METHOD

It is a descriptive study, of a qualitative nature, which allows exploring the experiences and perceptions of the participants, capturing the aspects of the phenomenon in its completeness. In this article, the Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist was used to follow the methodological rigor required for this approach.

The study was carried out in three state and one municipal schools located in a municipality in the northern region of the state of *Mato Grosso do Sul* (BR). They were selected because they concentrate the largest number of students with mental disorders, according to the Municipal Secretariat and the Regional Coordination of Education. The municipal school had a total of three students enrolled, and the three state schools, 23 students, 11 in one, eight and four in the others. Participants included in the study were teachers who taught at the study sites for elementary and/or high school, of both sexes, with at least one year of teaching experience, without necessarily having previous experiences in inclusive schools. Those who taught at night, were on vacation or were on leave from work at the time of data collection were excluded.

Initially, the principal investigator made personal contact with school principals to request permission to start the research. Thus, she personally consulted the teachers who taught, in the morning or afternoon, in the schools included in the study, for presentation of the study objectives and subsequent invitation to participate. In case of acceptance, the best date and time for the interview was scheduled. Of the 21 invited professors, six were excluded because they did not meet the inclusion criteria, three did not accept to participate in the research, as they reported unavailability of time for the interview, and one gave up participation at the beginning of the interview when the guiding question was asked. Thus, 11 teachers participated in the study.

Data were collected from August to September 2017 through an open, individual interview, in a private environment at the school institution itself, conducted by a single trained researcher, who had no previous contact with the study participants.

They were recorded on digital audio media and had an average duration of 60 minutes each. As a tool for data collection, a guiding question was established: "what is your experience in teaching children and adolescents with mental disorders?" Followed by auxiliary questions to guide and deepen information relevant to the objective of the study. A sociodemographic questionnaire was also applied to characterize the participants.

All interviews were transcribed in full and all names of participants or other persons cited were removed and replaced with codenames. For categorization, everyone received a code with the acronym P (Teacher) and the numerical order of the interviews (for example: P1, P2, etc.).

Two independent researchers, based on the thematic content analysis technique, carried out data analysis in three stages. In the first stage, called pre-analysis, identified by organization phase, a mapping of all data obtained in the field work was carried out, such as transcription of recordings, re-reading of the material, organization of reports and data.[12]

In the second stage, entitled exploration of the material, the coding units were chosen (the teaching experience, the difficulties encountered, strategies used, knowledge needs, available resources and inclusion) and then the categories were established. In the last stage, called treatment of results, the inference and interpretation of the data were carried out; in the inference, the script of the interview was the instrument of induction to investigate the causes from the effects; and in the interpretation of the data, it was necessary to return to the theoretical frameworks relevant to the investigation, as they contributed to the background and significant perspectives of the study.[12]

To validate the data analysis, all the material from the second stage, exploration of the material, was organized in the software IRaMuTeQ® 0.7 ALFA 2.3.3.1 (*Interface do R pourles Analyses Multidimensionnelles de Textes et de Questionnaires*), which is available for free and from open source type.

For this study, the word cloud was used, which groups and organizes the words graphically according to their frequency in the text, enabling their identification from a single file, called textual corpus, which is built from the participants' statements. The corpus is divided into segments of text or in elementary context units (ECU) and simple lexical analysis is performed, which is graphically interesting, as it allows quick identification of keywords in an image.[13]

The study was approved by the Committee for Ethics in Research on Human Beings of the *Universidade Federal de Mato Grosso do Sul* under the Opinion number 2,148,881, according to Resolutions nº 466/12 and nº 510/2016 of the National Health Council (*Conselho Nacional de Saúde* (BR)). All study participants signed the Free and Informed Consent Form in two copies of equal content.

RESULTS

Eleven teachers aged between 25 and 40 years participated in the study, most of them female. The length of experience and training ranged from six to 10 years and from five to 10 years, respectively. Almost half of the participants had a *lato sensu* postgraduate course, three of which had a postgraduate degree

in Special Education, two had postgraduate courses in Portuguese Language, two had *stricto sensu*, master's level, one in School Management and the other in Animal Science.

From the construction of the *textual corpus*, 588 text segments were detected, of which 457 were analyzed, corresponding to 77.72% of the total. Through the word cloud, the words stood out: student (n=219), material (n=206), teacher (n=197), attention (n=144), different (n=114), difficulty (n=96) and support (n=85), and others that allowed the content to be connected (Figure 1).

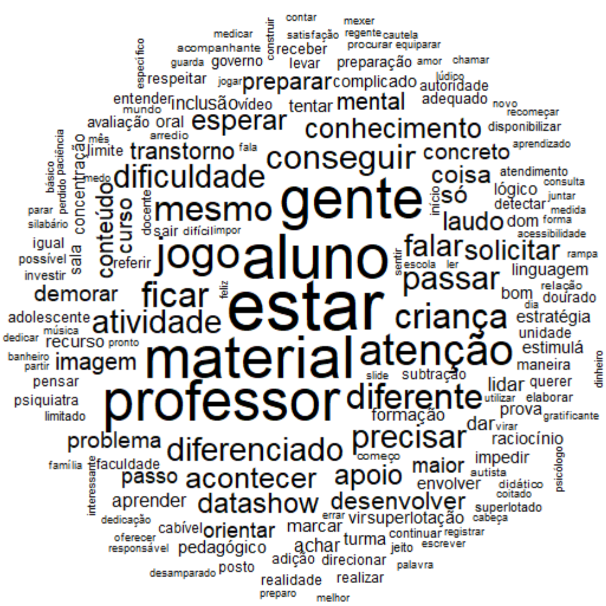

Figure 1 - Word cloud. Featured words extracted from testimonials. Municipality in the northern region of the state of *Mato Grosso do Sul*, Brazil, 2017

Of these, in the previous analysis two categories emerged that could describe the experiences of teachers in teaching children with mental disorders: "Teaching: difficulties, needs and strategies" and "The challenges of mainstreaming".

Teaching: difficulties, needs and strategies

The study participants reported that teaching children with mental disorders generates different feelings, especially due to difficulties and concerns about not being able to fulfill their role and responsibilities as an educator. These were described as unpleasant feelings, of frustration, fear, worry, despair and helplessness.

> *So, at the beginning it was very [...] The child was quite aloof. He had his own little world. So, it was very difficult to work with him. I had a lot of difficulty* (P6).

> *What do I do? "Teacher, I want it!" referring to the child's/adolescent's statements]. I go according to him, I get his attention, but with caution, with fear, do you understand? I am not prepared [...] So, if I make a mistake, I am ready to start over. Ah, but it is complicated, I feel very helpless* (P7).

However, love, satisfaction and gratification in being able, in some way, to fulfill his/her role as an educator were also mentioned:

> *Each day you have a new learning, very different. It is rewarding for those who work. But it is a work of patience, love, dedication [...] He has already read the syllabary to say: "Ah, that is the word" (referring to the child's/adolescent's speech). It is interesting as a child who has five reports, so much. Each time I get happier! I say that money is not everything. Satisfaction, the one you pass, is everything for us* (P1).

Regarding the difficulties experienced to teach, the scarce knowledge in relation to the theme was highlighted as main:

> *I have no knowledge (about mental disorder) my knowledge about it is very little. So, that basic for you to manage* (P7).

> *When you finish college, you have almost no knowledge (about mental disorder)* (P3).

For those who demonstrated to have some kind of knowledge on the subject, they mentioned that it had been acquired only through the support teacher, present at the school.

> *To tell you the truth, what I have knowledge was with this teacher who, this autistic's first companion* (P6).

> *The support teacher who is guiding me. I tell her like this, she tells me more or less what the student has, what is happening, what is his/her difficulty* (P8).

In this context, the participants reported that teaching to these children and adolescents are situations determined by public policies. However, they reported that there is no preparation and professional training to meet these policies, emphasizing the need to acquire knowledge on the subject.

> *I think we have to be more prepared, have more courses offered by outsiders. Because, thus, they* [government] *impose. They do not give you a course "Oh, we're going to work with that child, so we're going to prepare you". We did not have this preparation* (P1).

> *Therefore, the first thing is to invest in teacher training. If he/she did not have it at the beginning, there must be continuous training, so that the teacher has knowledge and can deal with these students with mental disorders* (P11).

> *I think we had to have more courses within the unit, aimed at the reality of our students* (P10).

Finally, another difficulty mentioned was the overcrowding of the classroom, which makes it difficult to offer the attention spent by the teacher who meets the students' specificities.

> *It is a little complicated because, sometimes, you have to pay more attention to this student, more close attention and, in an overcrowded classroom, sometimes it is not possible* (P11).

> *We need to pay more attention to this student and, sometimes, overcrowding prevents this* (P2).

However, it was observed that from the experiences and knowledge acquired, teachers create strategies to better serve this student, even with all existing limitations. One of the strategies in the teaching-learning process was the use of technological resources, games, images, differentiated assessment and activities.

> *How are you going to make him/her understand what you are talking about? It is orally, it is with image, it is with slide, it is with video, we work a lot on video, image* (P1).

> *So, like that, and the activity too, it has to be differentiated. It is the same content, but the activity has to be different from the class. You have to get involved with games for him/her to pay attention. Games that will develop this, attention, concentration, logical thinking. [...]As I said, games are a gift, a good strategy for you to be working on. It is through games that you will encourage him/her to develop his/her oral language* (P2).

The use of other resources was also described as important, because in their experiences, a large part of students with mental disorders need these resources.

> *We work a lot with the concrete, with the playful, concrete, music, everything, with image; because he/she does not write, he/she does not register, but he/she keeps the images in his/her head* (P1).

> *Just like when you are going to work addition and subtraction, you always have to be working with golden beads, concrete material, so they can carry out the activities* (P10).

In addition to technological and recreational resources, didactic, teaching and adapted assessment materials, they were also reported as strategies for teaching.

> *So, you are already working with material. Not with suitable material, but, at least, different teaching material for him/her. Regarding the tests, yes, I was always looking for a differentiated test* (P6).

> *It is very different; it is not the same as other students. It is the way of dealing with them, the way of teaching the same content, it is also a little different, the assessment is also different, always respecting the limit of the students* (P9).

The challenges of mainstreaming

In this category, the main challenges involving the process of inclusion (mainstreaming) of children and adolescents with mental disorders at school were listed. Educators reported that the school proposes inclusion without them being prepared and trained to receive students with mental disorders.

> *They do not prepare conducting teachers to receive. Then they get a little lost [...]they talk about inclusion, but did they prepare, did they equip the school? Accessibility, adequate bathrooms, ramp, does the school have this? There is not, they just joined* (P1).

> *I say: "The government wants to make this inclusion, but there is no inclusion". Just you stop to think. I think like this: This poor guy has been thrown here, and I have to take care of him* (P7).

Furthermore, in addition to the lack of investment in training and infrastructure, there is a lack of technological and recreational resources that, in most cases, are not sufficiently available, which is a barrier to the inclusion.

> *But the Datashow was very, very requested, I had to wait a lot* (P4).

> *And, within the difficulties, we, as teachers, need to make available time, resources. And, sometimes, resources are limited* (P11).

The investment in the organization of adapted teaching materials is also low, which means that teachers are unable, due to the limited time available, to adapt the existing material in an appropriate way.

> *You have little time to prepare specific material, to dedicate yourself specifically to this student* (P7).

> *And material, pedagogical material that sometimes comes the same for all students, and the teacher has to prepare the pedagogical material, however, many times he/she does not have that time* (P11).

Another challenge reported in the inclusion process was that the learning of the child/adolescent with mental disorder was limited due to the medical report, because, when absent, there is no justification for resorting to rights.

> *You receive a child, you will see the report first, what it has. There is this report. So, let us see what it is, what he/she learns, what he/she doesn't learn, what I can build, what I can do, what material to use* (P1).

> *So, if he/she doesn't have a report, he/she doesn't have a support teacher* [...] *So, we need these reports to, from then on, get a support teacher* (P5).

To get the medical report, there is a waiting time, making it even more difficult for the child to learn. Thus, the fragile articulation of the school with the health services becomes an important factor in making inclusion effective.

> *He/she really needs a psychiatrist. And then, what happens, I'm trying to book at the health center. So, it is between detecting a problem and taking it to the appropriate authorities, it takes a long time, it takes too long* (P3).

> *Now, we have families who are also very, very responsible, they go, they try to book and sometimes they cannot. The consultation is scheduled for two, three months later. Meanwhile, the student is in the classroom unable to learn* (P5).

However, when this articulation occurs, the teaching-learning and inclusion process is favored.

> *And when the child is being medicated or sometimes going to the psychologist, we can already work better with them* (P5).

DISCUSSION

The results of the present study showed the feelings, difficulties and strategies adopted when teaching children and adolescents with mental disorders, which corroborates other studies, especially with regard to the lack of knowledge of teachers about the disorders and the needs generated. It should be noted that the lack of knowledge and training implies unpreparedness to deal with students and difficulties in establishing a relationship of social interaction with them or encouraging them to interact with other students.[10,14]

In view of that, teachers can sometimes feel dissatisfied and frustrated for not being able to identify and meet the needs of their students and, with this, perform their work efficiently. These feelings generate internal conflict, as failure, as well as success, is linked to the difficulties encountered when teaching, such as overcrowded classrooms, lack of preparation and even the efficiency of the teacher in the classroom.[10,14]

It was found that the knowledge acquired about mental disorders, considered by the participants as scarce, was through the support teacher, whose performance was highlighted in the present study as a factor that contributes to the success of the teaching-learning process. It is noteworthy that this professional has the function of assisting this process, facilitating the student's communication with other colleagues and conducting teachers, and ensuring educational services to students at risk of academic failure.[15]

However, there are contradictions regarding the presence of the support teacher, because that professional, when assisting and guiding exclusively a student, can make it difficult for the student to communicate with classmates and, especially, with the conducting teacher. This is because the student will have more confidence in the support teacher, which can strengthen the dependency relationship and constitute an inclusion barrier. Furthermore, the conducting teacher begins to consider the teaching-learning process for this student as impossible without the support professional in the classroom, which leads the conducting teacher to believe that he/she is unable to teach a child/adolescent with a mental disorder.[15]

Continuing education was mentioned as an important device to help them improve the teaching-learning process. It is noteworthy that this resource can offer the teacher the necessary knowledge about mental disorders and, thus, provide the use of appropriate strategies and adaptation of the methodology according to the needs of the student. However, it is necessary that all actors involved in the teaching process also have training and continuing education, because they become an educational support for teachers, being multipliers of knowledge.

Another difficulty mentioned is overcrowding in classrooms, which makes the teaching-learning process more difficult, because it favors indiscipline and excessive conversations. Furthermore, it

represents a delimitation factor in relation to the development of differentiated activities, because the teacher is unable to supervise all children. In addition, that can make teaching practice less effective. This can interfere even more in the students' learning process, as they need assistance and an environment that meets their limitations in attention and cognition.[16]

However, even with the existing limitations and difficulties, the teachers of the study, from the experience in the classroom, reported creating strategies to favor learning, such as the use of technological resources, games and other recreational activities and different didactic activities. These strategies were also described in a study with children and adolescents withattention deficit disorder and hyperactivity and used with the main objective of breaking the barriers and difficulties encountered, to achieve the best performance of students in the stages of learning.[17]This makes them important tools when teaching children and adolescents with mental disorders.

Therefore, the importance of preparing the school to receive these students and their diversities with an adapted structure, changes in teachers' attitudes and perceptions and curricular adaptations is reiterated.[18]In addition, intersectoral partnerships, such as, with the health network, become essential, because depending on the disorder, the use of medication and therapies is necessary for the remission of some symptoms such as impulsiveness, anxiety and reorganization of the thinking process, promoting appropriate learning conditions.[19]

Although the Ministry of Health (*Ministério da Saúde* (BR)) advises that the diagnosis cannot be considered essential to fulfill the needs, even so, the educational institutions request the report to make sure that the student is part of the target audience to enjoy the legal rights. This fact can sometimes contribute to the limitation of learning and the inclusion process, mainly because the health care network is not prepared to meet the increase in this demand.[20,21]

This is explained because there are not enough specialists and services, causing the difficulty of serving this population, in addition to the difficulties still encountered in making the diagnosis, especially in childhood.[20,21]It is in this scenario that intersectoral and co-responsibility actions must be articulated, to favor the early screening of children/adolescents who present alterations in cognition and learning and to direct the conduct as soon as possible, so that the learning is not conditioned to the medical report.

In this study, it was noticed that the school often has difficulty in accessing or establishing an articulation with the health services, interfering in the attention and in the integral development of the student. Thus, the professionals working in the Family Health Strategy, sometimes represented by the nurse as the team manager, occupy a privileged space in the development of intersectoral actions, as these are developed in different spaces, such as, for example, in the school environment.[15]In addition, professionals working in primary health care can favor access to different information related to mental disorders and psychic needs and enable joint actions that culminate in effective and resolving health care strategies that favor learning and that can also be developed in the school environment.[22]

For these strategies to contemplate the rights, education and comprehensive care of the child/adolescent, the development of public policies and programs is essential. Among them, the School Health Program (Portuguese acronym: PSE) stands out, which proposes the union of health and education policies.[10] A study carried out with professionals working in the teams of the Family Health Strategy and teachers in a municipality located in the interior of *Rio Grande do Sul* found that, although there are challenges in the execution of the PSE, it was highlighted as relevant for the promotion of the health of children/adolescents and for comprehensive care.[23]

Participants also highlighted, in the present study, that the difficulties and strategies presented are related to the inclusion process. This, in turn, comes from political, cultural, social and pedagogical actions, whose objective is to defend the right of all students to be able to go through the learning process together. However, there is sometimes a lack of intersectoral actions that favor the school organization to receive students with mental disorders[18]and develop actions that make inclusion possible.

With regard specifically to education, studies reveal the need for new proposals in methodology, in teaching strategies and in actions that favor social inclusion, in the political pedagogical project.[18-19]It is understood that an inclusive school is not just the one that allows the student to enroll in regular education. But the one that is able to favor access to quality education, with trained human resources to deal with this scope.[18,19]

To this end, there is a need for the school environment to eliminate barriers that hinder the inclusion process, such as architectural, curricular and investment barriers for financial resources. When these barriers and factors are not adequate, the exclusion process can be increased.[24]Thus, it is shown that inclusion is not done alone in the school environment, intersectoriality between school, health and family professionals is necessary. It can favor the exchange of information about the child, resources to support family members and the school, as well as better management in these different environments.

Therefore, it is expected that the results of this study can support intersectoral actions in the search for strategies that favor comprehensive care for children/adolescents with mental disorders, as well as their inclusion in the teaching-learning process beyond the sharing of the school space. More than the need for organizational, structural and resource investments, it is reiterated the importance of teacher training and guidance by health professionals, on the management of children and adolescents with psychological problems.

FINAL CONSIDERATIONS

The results of the present study revealed that the experience of the participating teachers, when teaching children/adolescents with mental disorders, is characterized by feelings of frustration, fear, helplessness and, sometimes, of love and gratification. In addition, difficulties were identified in the teaching process as a result of unpreparedness to deal with the specificities of these students.

It is believed that this study may contribute to interprofessional and intersectoral discussions in the planning of comprehensive care actions and access to the rights of children/adolescents with psychological needs. This is because it reiterates the need for a solid care network, with articulation between school and health services, which can assist the co-responsible planning of strategies that favor the teaching-learning process of children and adolescents with mental disorders, health promotion in primary care and, consequently, their inclusion.

The limitation of this study is related to the fact that the results are not subject to generalization, given that the information obtained by the participants may not be applied in other frameworks nor extend the results to other Brazilian states. However, it presents information that can support discussions about the process of school inclusion and the importance of intersectoriality and interdisciplinarity in assisting this population. In addition, it is suggested to carry out intervention studies that compare strategies that can favor the articulation of actions between health services and the school that impact the inclusion of children/adolescents with mental disorders in their social context.

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