

CHALLENGES IN THE OPERATIONALIZATION OF SINGULAR THERAPEUTIC PROJECTS IN PSYCHOSOCIAL CARE CENTERS¹

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ABSTRACT. This work aimed to describe how professionals operate Singular Therapeutic Projects (STP) in Psychosocial Care Centers. For this, qualitative research with a descriptive and exploratory nature was developed with 58 professionals from seven Psychosocial Care Centers located in three municipalities in the State of Goiás, Brazil. Data collection was carried out through focus groups and field diary records submitted to thematic content analysis. Data analysis revealed the following thematic categories: Work processes related to the Singular Therapeutic Project; Influence of ambulatory logic on the Singular Therapeutic Project. Thus, the perception of the importance of STP for professionals was revealed. However, their lack of organization and systematization, and the STP elaboration did not even exist in some of the services surveyed. We conclude that professionals recognize the logic of Singular Therapeutic Projects as important to reflect psychosocial care, even though the elaboration is still precarious, medically-centered, and the offer of therapeutic activities restricted to the interior of Psychosocial Care Centers (known in Brazil as Centros de Atenção Psicossociais – CAPS). The evidenced reality points to the need for investment in Permanent Education in Health to qualify the work processes developed in the CAPS by the various professionals who work in them, through the systematization of STP, in order to guarantee psychosocial care as a promoter of care in freedom. This will enable greater effectiveness of social reintegration and also the evaluation of the results obtained.

Keywords: Psychosocial Care Centers; professional competence; psychosocial intervention.

DESAFIOS NA OPERACIONALIZAÇÃO DOS PROJETOS TERAPÊUTICOS SINGULARES NOS CENTROS DE ATENÇÃO PSICOSSOCIAL

RESUMO. O objetivo deste trabalho foi descrever como os profissionais operacionalizam os projetos terapêuticos singulares (PTS) em Centros de Atenção Psicossocial. Para isso, foi desenvolvida uma pesquisa de abordagem qualitativa de caráter descritivo e exploratório com 58 profissionais de sete Centros de Atenção Psicossocial situados em três municípios do

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Estado de Goiás, Brasil. A coleta de dados foi feita por meio de grupos focais e registros em diário de campo submetidos à análise temática de conteúdo. A análise dos dados revelou as seguintes categorias temáticas: processos de trabalho relacionados ao Projeto Terapêutico Singular; Influência da lógica ambulatorial no Projeto Terapêutico Singular. Sendo assim, foi revelada a percepção da importância dos PTS para os profissionais, mas a falta de organização e sistematização dos mesmos, sendo a sua realização sequer existia em alguns dos serviços pesquisados. Concluímos que os profissionais reconhecem a lógica dos projetos terapêuticos singulares como importante para refletir cuidado psicossocial, entretanto a elaboração ainda é precária, médico-centrada e as ofertas de atividades terapêuticas restritas ao interior dos Centros de Atenção Psicossociais. A realidade evidenciada aponta para a necessidade de investimento em Educação Permanente em Saúde para qualificar os processos de trabalho nos CAPS desenvolvidos pelos diversos profissionais que neles atuam, por meio da sistematização dos PTS, de modo a garantir cuidado psicossocial como promotor de cuidado em liberdade. Isso possibilitará maior efetividade de reinserção social e, ainda, a avaliação dos resultados obtidos.

Palavras-chave: Centros de Atenção Psicossocial; competência profissional; intervenção psicossocial.

DESAFÍOS EN LA OPERACIONALIZACIÓN DE PROYECTOS TERAPÉUTICOS EN CENTROS DE ATENCIÓN PSICOSOCIAL

RESUMEN. El objetivo de este trabajo fue describir cómo los profesionales operan proyectos terapéuticos singulares (STP) en los Centros de Atención Psicosocial. Para ello, se desarrolló una investigación cualitativa de carácter descriptivo y exploratorio con 58 profesionales de siete Centros de Atención Psicosocial ubicados en tres municipios del Estado de Goiás, Brasil. La recolección de datos se llevó a cabo por intermedio de grupos focales y registros de diarios de campo sometidos a análisis de contenido temático. El análisis de datos reveló las siguientes categorías temáticas: procesos de trabajo relacionados con el Proyecto Terapéutico Singular; Influencia de la lógica ambulatoria en el Proyecto Terapéutico Singular. Así, se reveló la percepción de la importancia del STP para los profesionales, pero la falta de organización y sistematización de los mismos, y su realización ni siquiera existía en algunos de los servicios encuestados. Llegamos a la conclusión de que los profesionales reconocen la lógica de proyectos terapéuticos singulares como importantes para reflejar la atención psicossocial, sin embargo, la preparación aún es precaria, centrada en lo médico y la oferta de actividades terapéuticas restringidas al interior de los Centros de Atención Psicosocial. La realidad evidenciada apunta a la necesidad de invertir en Educación Permanente en Salud para calificar los procesos de trabajo en los CAPS desarrollados por los diversos profesionales que trabajan en ellos, por intermedio de la sistematización de STP, para garantizar la atención psicossocial como promotor de la atención en libertad. Esto permitirá más efectividad de la reintegración social y también la evaluación de los resultados obtenidos.

Palabras clave: Centro de atención psicossocial; competencia profesional; intervención psicossocial.

Introduction

In Brazil, Psychosocial Care Centers (CAPS) are community/territorial-based-devices for health care to people with severe and persistent mental disorders and or with problems resulting from the abuse of alcohol and other drugs. These services represent the specialized and strategic component of the Psychosocial Care Network (Known in Brazil as Rede de Atenção Psicossocial - RAPS), and they are, therefore, the articulators of comprehensive care for those people and their families. At CAPS, care is based on the psychosocial care model that is opposite to the traditional psychiatric model, known for being hospital-centered, biomedical and segregating. The change from one model to the other is complex and seeks changes in several spheres: political, institutional, educational, assistance, social and cultural (Vargas & Campos, 2019).

The psychosocial care model supports the changes that have taken place in the field of mental health care considering the following dimensions: theoretical-care that is related to the construction of the concept of existence-suffering as opposed to the binomial disease-cure; legal-political, which involves social control and legal apparatus that regulate substitute services and reorient mental health assistance in the country; technical-assistance, which is evidenced by the construction of a network of articulated services as spaces for care, dialogue and interlocution and have a multidisciplinary team whose practice must be based on the integrality concept and considers the needs to develop singular therapeutic proposals; and sociocultural, whose activities are related to transforming the collective imagination about madness (Amarante, 2015).

The CAPS care process includes activities such as reception; individual and group assistance; family assistance; home visits; health education actions; therapeutic and breeding workshops; physical activities; medication prescription and dispensing; handling in crises; reinsertion through work; offer of matrix support to other points of health care; assemblies, coordination and participation in inclusive and inter-and extra walls coexistence activities; aside from actions to articulate the service and people network (Pinho, Souza, & Esperidião, 2018).

Aiming to systematize the care of users in CAPS, mental health teams must develop the Singular Therapeutic Project (STP) that can be understood as a care management tool that seeks to collect, organize and record various therapeutic possibilities, in the multiple dimensions of health-disease-process. It is suggested that the construction of the STP occurs through dialogue among professionals from different areas of training and performance, intending to achieve the singularity of an individual, his family and or social group, and should have matrix support, if necessary (Deschamps & Rodrigues, 2016; Rocha & Lucena, 2018), favoring the promotion of users' autonomy, citizenship and social participation (Deschamps & Rodrigues, 2016).

Thus, the STP requires an organic, psychological and social assessment in order to identify elements of the user's vulnerability; a definition of therapeutic goals and redefinition of therapeutic intervention lines; a definition of tasks and responsibilities of the various specialists, when the attributions of each one of those involved in care are made explicit; and, finally, the re-assessment of therapeutic goals to ascertain the user's progress and establish changes that will have to be carried out (Deschamps & Rodrigues, 2016; Rodovalho & Pegoraro, 2016).

However, although STP is a potent strategy for the care of the psychosocial care model, some challenges related to the systematization of elaboration and monitoring process and assessment of therapeutic proposals have been highlighted (Lockley, Soares, Pereira, Domanico, & Oliveira, 2019; Mororó, Colvero, & Machado, 2011; Pinho et al., 2018; Rocha & Lucena, 2018; Santos, Pessoa Júnior, & Miranda, 2018).

Thus, this work aimed to describe how the professionals operate the Singular Therapeutic Projects in the Psychosocial Care Centers surveyed. This study is based on both the expanded clinic references and psychosocial care model in mental health. The expanded clinic considers the singularization of health care through the efforts of professionals in each specific case. Moreover, it considers fundamental to expand the degree of users' autonomy and values therapeutic resources such as listening, health education and psychosocial support (Campos & Amaral, 2007).

Method

This is a qualitative approach research with a descriptive and exploratory nature. The study scenario included seven CAPS located in three different municipalities in the state of Goiás, qualified for more than two years, which are characterized as II, III, AD, Infantele, and AD III.

The choice of services was made at random, seeking to find distinct and peculiar issues, considering the different types of CAPS, the availability of services to participate in the research and the population and territorial characteristics of the municipalities in which they were inserted. The study included 58 professionals from different professional categories who had been providing some type of care for at least six months at the CAPS and who were in professional practice at the time of data collection, thus excluding those who were on official leave from the service, due to vacation and license; and professionals who did not have time to participate in the groups.

Data collection was performed through focus groups, lasting approximately 45 minutes each meeting. The discussions were recorded through digital audio recording. The groups were carried out at the CAPS, in a reserved environment, which allowed the circular arrangement of the chairs. Participants sat in a circle to facilitate eye contact and encourage verbal interaction among everyone. At the beginning of the group activity, the context of the study, the presentation of the objectives and ethical questions for the participants were verbalized. Subsequently, a script was used with the following triggering questions: 1 - How do you build each user's STP? 2 - Share a case and the actions carried out and or planned in this user's STP? 3 - How do you register the STP planning and the developed activities?

Two facilitators led the focus groups: a nurse, a master's in nursing, responsible for leading the group and a psychologist specialized in Permanent Education in Health (PEH) in the role of observer. Both recorded the most relevant phenomena that emerged from group interaction in a field diary.

After data collection, the transcribed audios and the notes in the field diary were included in the thematic content analysis process carried out in four stages: pre-analysis, material exploration, results treatment and interpretation (Bardin, 2018) with the help of ATLAS.ti 6.2 software.

The pre-analysis phase consisted of organizing and reading the interview transcriptions. To follow the stage of material exploration, we tried to identify words and phrases that had a higher frequency of citation and that could be grouped by similarities of

meaning, which gave rise to the registration units. The interviews were coded with the recording units in order to discover the context units that make up the communication, excerpt of speeches, reports and whose frequency of appearance may have some meanings with the chosen analytical objective (Bardin, 2018).

After coding, and with the help of the building of relationships networks among the record units, in Atlas.ti, it was possible to categorize the record units into two thematic categories: Work processes related to the Singular Therapeutic Project and Influence of ambulatory logic on the Singular Therapeutic Project. The context units that made up the communication (speeches excerpts, reports) were illustrated to favor the understanding and interpretation.

The study was approved by the Research Ethics Committee of Clinic Hospital of Goiás Federal University (known in Brazil as Hospital das Clínicas da Universidade Federal de Goiás), under opinion number 1,502,429 / 2016, aiming to meet the ethical and legal requirements regarding research carried out with human beings, considering the requirements of *Resolução nº 466* (2012) of the CNS/MS. All participants involved in the study signed the Written Informed Consent (WIC), having their identity preserved through the anonymity of the participants' reports that were identified by the CAPS coding and the participating professional in question.

Results and discussion

Category 1 - Work processes related to the Singular Therapeutic Project

When questioning about the STP, the professionals expressed understanding it as a fundamental tool for planning the user care, according to the psychosocial care model, and they considered some of the expanded clinic principles, such as comprehensive assessment and multidisciplinary involvement. As we can see in the following statement, “[...] in this integration group, we have the opportunity to ask about their family, if they can participate and what their life is like outside. How can we help them? What do they want to do again?” (CAPS4 P2).

The subject's psychosocial assessment involves identifying the demand presented when the user accesses the service, the presence of evident signs and symptoms and a broad look at the user in the territory with his support networks. In order to carry out this assessment, it is necessary to work closely with various professionals and services to identify the real needs, desires and wants of the person, the family and the territory.

Therefore, the importance of qualified listening is emphasized to favor the bond and, thus, for the understanding of the trajectory and meanings present in the paths taken by users to meet their demands and enrich the construction of STPs (Deschamps & Rodrigues, 2016). By qualified listening is understood as the exercise of listening to the other in an interactive relationship, being conceived as an essential tool for comprehensive care that enables the construction of bonds and respect for the singularity in the encounter between those who care and those who receive care (Maynard, Albuquerque, Brêda, & Jorge, 2014).

If the therapeutic project relates a dynamic between the past and present, to design a possibility for the future, the knowledge about therapeutic itineraries can bring rich contributions to both the planning and the development of lines of care (Deschamps & Rodrigues, 2016; Rocha & Lucena, 2018; Silva, Sancho, & Figueiredo, 2016).

However, despite understanding STP as a care planning strategy, it was possible to identify that in five services of the researched services the elaboration of STP has been made, although it was evident that it was not made collectively and systematically, much illustrated by the record absence, the establishment of therapeutic goals and periodic assessments. In two other CAPS, STP was not performed. As we see in the speeches of the participants below, "The STP happens very informally" (CAPS3 P6), "Because it is sometimes just to spend time" (CAPS7 P5).

During the focus groups, when asked about the actions performed and planned in STP of service users, as the participants presented the interventions performed for each case, they were questioned about the therapeutic purpose that determined the care needs identified to do the interventions. Most workers were unable to answer clearly about the alignment between the therapeutic goals and the planned activities, and it became evident that many interventions made did not correspond to the user's demands, but rather the team's and or health unit's conveniences. Besides, the affirmation of scheduling activities 'just to spend time' surprises us.

Still, it was possible to infer that the STP is thought from a 'menu' of activities that CAPS offers and not from the user/family therapeutic needs. As we see in the words of the collaborators, "According to the framework of activities that we have, we insert the user. If he is a user that does not fit into any of them, we try to think of other possibilities" (CAPS1 P8).

We end up not doing the project the way we want because, sometimes, the workshops are very crowded! On Wednesday, there is no chair for people to sit as the meetings are so crowded. Then, we sometimes avoid scheduling the user on some days of the week even though we know it will bring some benefit, but facing this situation CAPS3 P1).

We present what CAPS has to offer, what activities we have. Therefore, we tell them to try to choose an activity that they understand it will bring benefits and well-being. Something that addresses the demands they have (CAPS2 P11).

One of the consequences of the professionals' practice in planning activities for users without defining therapeutic goals is the proposition of actions and activities for users who do not address their demands and needs. An example of this is the proposition in the user STP about the continuous participation in several groups and workshops offered within the CAPS, without real issues of daily life, which involve relations with actors in their territory of existence, being inserted in the assistance plan. The statements of some participants portray this reality, as we can see, "I realize that much mental illness is based on organic illness and this is not assessed with discipline. They have many diseases that pass by. So, this patient has to be seen as a whole" (CAPS7 P5). And also,

His main current complaint is that he has no friends, that he cannot have these ties. Then, in this case, the first thing we thought about was hygiene that is precarious and keeps people away. He needs self-care and hygiene (CAPS4 P6).

The results of this study corroborate with those reported in a literature review, pointing to the absence of critical debate for the elaboration of the STP and that in some services, the STP 'exists' in an idealized way (Rodvalho & Pegoraro, 2016).

Regarding the STP assessment, it was possible to notice that it only occurs if there is adherence or not to the proposed activity and not because of a therapeutic goal or evolution of the case. Non-adherence to the activities proposed in the STP is closely related to this lack of planning and inclusion of the user in the STP elaboration. Often, the activity does not

meet the user's demand or needs, or he is unaware of the therapeutic purpose of the STP activity he is doing and, therefore, he thinks his participation does not make sense.

In addition, there is her relationship with this boyfriend that she always brings here for us to solve. Then we say that here is not the place to resolve these conflicts with a boyfriend and that the two of them have to sit down and talk, but she brings a lot to us, many demands on personal relationships (CAPS1 P1).

She (the user) said that it was the extension of her house, the conversation round was happening and she sat there; afterward, she left. Then at the other workshop, she came again. Therefore, she went in, she took everyone out of focus and left, nobody knew for sure which workshop she really took part (CAPS4 P6).

Favoring the elaboration of the STP, it is suggested the use of some script or guide because these instruments can direct the necessary actions both from the team and the user, in order to achieve the goals (Boccardo, Zane, Rodrigues, & Mângia, 2011), to present a programming dimension for the future, where users' social inclusion actions are priorities (Rodvalho & Pegoraro, 2016) and to facilitate the action records (Silva, Camargo, & Bezerra, 2018).

Anyhow, STP does not fit in simple forms due to its immensity and power (Kinker, 2016). Still, health care flowcharts and protocols can be limiting for the possibilities of professional's dialogue and accountability and territory services, if they are not sufficiently clear or permeable to the different logics that permeate the health care process (Silva et al., 2016).

Profession does not separate this instrument, and each one had his look at the instrument to see if it had an answer to what we needed to see in general (CAPS3 P6).

The STP record can help with the process organization, but it does not represent the process in its entirety. This is because it needs to consider the dynamics of the therapeutic project (Silva et al., 2016) and the flow of transformations that occurs in the life and context of users, family members and teams (Kinker, 2016).

Thus, when it comes to the need for systematization and planning of care, the need to use mechanisms of record-memory can be considered (Kinker, 2016). This record, considered potent, enables the management of expanded care with information sharing and co-responsibility of those involved, favoring inventive and creative actions for the production of care (Grigolo, Peres, Garcia Junior, & Rodrigues, 2015).

The lack of establishing therapeutic goals, before the proposal of interventions, makes it difficult for users to link and adhere to activities. Moreover, there is still a loss in the assessment of therapeutic results and the evolution of the medical record because the therapeutic goal was not clear, and the proposed activity does not meet the user's demand or needs.

Therapeutic workshops at CAPS have been instituted as intervention practices, sometimes as multiple experiences connected to the territory, sometimes as interventions to be applied as remedies for users. Once again, there is an epistemological impasse in the understanding of the psychosocial way of care by professionals. The way of conceiving the workshops is linked to a certain way of understanding the phenomenon of life and psychic suffering (Kinker & Imbrizi, 2015).

Category 2 - Influence of ambulatory logic on the Singular Therapeutic Project

User reception is one of the main work processes of CAPS. It permeates all therapeutics and it must be an action of qualified listening that is fundamental for the connection of the user to the service. However, the professionals' reports reflect welcoming actions more similar to triage. Professionals seem to be more attentive in assessing the referral to another service than to do qualified listening and care with the user connection.

In the shared consultation, with the presence of all professionals, the reference professional explains the whole case. Then they discuss and ask questions. If he is not a CAPS patient, we already make a referral; if he is a patient of ours, we already do his singular project with the professional who provided his reception (CAPS2 P2).

Then the technician already sits down with the user and, while asking questions, fills in the instrument. If he verifies that the user is not a CAPS user, he makes the referral (CAPS3 P6).

The aim of welcoming should be the therapeutic link, presentation of the service, sketching a diagnostic hypothesis and starting the process of co-responsibility for care (Deschamps & Rodrigues, 2016; Diniz, 2017; Jalles, Santos, & Reinaldo, 2017). Favoring the performance of the STP and the link between the user and the service, it is recommended to define the reference technician or technicians for the user and family members to accompany them in their STP. The choice must be based on possible linkages established in the therapeutic process (Boccardo et al., 2011).

However, in the CAPS where the research was carried out, the reference professional is indicated at the moment of the first contact, that is, the reference professional is the one who first listens to the user or is systematically indicated so that there is an equal division of users by professional. These strategies may not consider the greater proximity of dialogue with the user, but rather an organization to facilitate the service.

The referring professional must fill out the script on the chart, so there is space for him to put all the observations made. When this point comes, three professionals have already listened to the user and we are better able to close the singular therapeutic project. Then, the referent makes the return to the user (CAPS4 P7).

Welcoming is important to establish a bond with the user, but it may be that, during the follow-up, the connection is better with another professional on the team, different from the one who made the first contact or the one designated because of the division of labor.

The professional made the reception and marked the welcome and, there, we build the therapeutic project together with the user and the family (CAPS7 P11).

After passing through the reception, he comes to the integration group. This group is where the bureaucratic part of the thing happens because we make the record of the action with defined locations. We carry out the STP that has already started at the reception and discussed it with the team and with the user, and we handed him a card and scheduled his treatment with the reference professional (CAPS5 P5).

The report of CAPS5 P5 illustrates a bureaucratic process for preparing the STP, evidencing the absence of user participation and the definition of the reference professional depending on the organization of the services and not on the link between professional and user. It was not possible to perceive effective involvement of users and family members in the dialogical construction, negotiation and co-responsibility of the STP among team/user/family. In the studied context, their participation is restricted to the knowledge of what the

professional or reference team planned. Similar behavior was noticed by researchers who warn that the insufficient participation of users and their families in the negotiation of therapeutic activities at CAPS has been an obstacle to the realization of STP (Vasconcelos, Jorge, Catrib, Bezerra, & Franco, 2016) besides interfering with the users' commitment to the services and their treatment (Diniz, 2017).

Psychosocial care does not presuppose rigid and closed practices in a care model, but rather, a complex social process that undergoes changes due to several factors and is transformed, assuming other conformations different from those idealized (Vasconcelos et al., 2016), therefore, the need for constant therapeutic assessment. However, the literature points to the absence of records by the reference technician on the STP that is on his responsibility, making it difficult to reassess it. Still, the team has difficulty in visualizing the STP, as there is a lack of systematic conversations about it beyond the specificities of each professional (Rodovalho & Pegoraro, 2016).

In the studied reality, professionals understand the importance of STP elaboration to guarantee expanded care in such complex contexts. However, they are unable to systematize the elaboration based on the identification of health needs, and the practice is still medically centered, with a focus on the medical diagnosis and symptom remission.

There was a recurring need that many CAPS professionals surveyed have to know the medical diagnosis that was established to build the STP later. Still, there were reports of the existence of a link between users and the CAPS, only for the exchange of medical prescriptions, as we can see in the statements below, "As I have an empty agenda, I am in charge of going after these patients who are not going or who are just going to renew the prescription, and I started to rethink, together with him the STP" (CAPS7 P5).

You know that you should not link the user to a medical appointment, but you also know that society and the family think that they should leave with a scheduled appointment. If he does not leave with a scheduled appointment, the social assistance will call you, asking you about this (CAPS 5 P8).

Many professionals find it difficult to understand that welcoming is not limited to a single meeting to evaluate signs and symptoms of mental disorders. How the professionals referred to an instrument used to perform the reception refers to a traditional anamnesis protocol where the main focus is the gathering of information in detriment to the creation of bonds, and the construction of therapeutic empathy. Considering this, the dependency on the establishment of a medical diagnosis for the elaboration of STP was recurrent. Still, there were repetitive reports of the existence of a link between users and the CAPS, only for the exchange of medical prescriptions, denouncing medical-centered practices for both users and services.

The expanded understanding of people's needs is still under construction in the actions of health professionals and the intra and intersectoral network because some reports reveal psychiatric assessments, focusing on signs and symptoms and medical diagnosis. The practice of developing an STP based on medical diagnosis undermines a global assessment considering the psychosocial aspects of the user's demands and his potentialities, in addition to the fact that interventions can be established from 'a label' and not to meet the needs.

Despite the institution of a National Mental Health Policy legitimized by law (Lei nº 10.216, 2001), which considers the psychosocial care model, the biomedical paradigm persists and, many times, the actors who question this paradigm demand intervention based on it (Kinker, 2016). The forms of care still reflect a clinic centered on the doctor, on the medication, of a strictly biological and curative nature, without an extensive assessment of

the health-mental illness process, thus devaluing the psychosocial rehabilitation actions and approaching the ambulatory logic (Boccardo et al., 2011; Fiorati & Saeki, 2013; Jorge, Diniz, Lima, & Penha, 2015; Silva et al., 2016).

The centrality in medical work, not very porous to the exchange of knowledge and actions with other team workers, and even less willing to work in harmonic care networks, derails the construction of therapeutic projects integrated with the knowledge centers of the various professionals that make up the teams, disregarding the fact that other workers are decisive in monitoring users with mental disorders (Jorge et al., 2015; Vasconcelos et al., 2016).

An issue that appeared and that weakens the user's bonding and the effectiveness of care is not to consider the territory to propose activities. The occupation and production of other existential territories and new social relationships are not considered, even though many demands and needs of users involve people, places beyond CAPS, as we see in the speech of a collaborator,

Thinking here, I see that we do the therapeutic project, but with the name of report. We are in the process of reorganizing. So, in that first moment, we go after service documents on the network, gyms. Today he already manages to bring to us what we want. It is a job that we have done daily so that they can get out of the walls, but some still have a lot of resistance (CAPS6 P2).

Most of the time, the activities proposed to users are the CAPS 'intramurals' and do not have established therapeutic goals, nor planning and systematic assessment of the achieved results. The actions are offered as a 'menu' because there is no psychosocial assessment, therefore, without considering the uniqueness of each user.

This 'menu' is also understood as a 'grid of activities' and the authors point out that it can become a control device as rigid as the prison bars and asylum cells are. The bars are set when professionals have difficulty or limited availability to identify possibilities of existence in the users' life territories as well as to deal with the anguish that the experience of mental suffering produces (Kinker & Imbrizi, 2015). The STP understood as a menu, grid or schedule exposed to the user, pointing out the days and time of the week when he should go to the CAPS to do activities, does not work as an instrument that can help the user to think about other life possibilities (Rodvalho & Pegoraro, 2016). The STP is potent when it ceases to be a set of procedures to seek the normalization of subjects, and begins to operationalize practices that mediate in the territories of life based on the real and daily needs of users and services (Kinker & Imbrizi, 2015).

To ensure comprehensive care, user access to other RAPS services must also be considered in the construction of the STP, which implies the recognition that existing points of care in the health network must be articulated for the promotion, protection and recovery of health (Rodvalho & Pegoraro, 2016), besides being part of a social intervention project (Kinker & Imbrizi, 2015). Thus, the STP is effective only if there are incorporation and appreciation of the users' singularities in the way they deal with the different situations involving their health and disease, and not only perform in the form of protocol prescriptions and little sensibility to these particularities (Silva et al., 2016).

The psychosocial rehabilitation component is included in the RAPS, understood as powerful strategies to promote deinstitutionalization and social reintegration, even though it was possible to identify incipient actions related to this direction in the STP. That said, it is considered important to note that, for the activities of culture and work and income generation, budget resources have not been defined, which indicates little strategic significance attributed to such initiatives (Amarante & Nunes, 2018).

The challenge of elaborating STP committed to the dimensions of psychosocial care and the ideal of the integrality of SUS goes beyond the CAPS institution. They need to cover the eye and establish solid relationships with the community, with the social assistance and social support network, aiming to consider the subjects' singularities (Vasconcelos et al., 2016), and considering the territory and its social and cultural devices.

Thus, many challenges are still faced by health professionals to carry out the STP, such as the difficulty in communication, articulation and integration among the multidisciplinary team of different work shifts at CAPS; difficulty in building a moment for the development and re-assessment of projects among all components of the interdisciplinary health team and deficiencies in the notes, in the medical records collectively, making it difficult for the service team to access information about the users' therapeutic process proposed by the other professional categories, causing damage to the integrality of assistance (Lockley et al., 2019; Mororó et al., 2011; Rocha & Lucena, 2018; Silva et al., 2018).

Despite all the challenges, the professionals recognize the importance of developing the STP according to the principles of psychosocial care, having the perception of the factors that restrict this practice according to the reality of each service. This consideration is fundamental for the transformation of work processes through a critical and reflective process of professional practice. The results of this study support the planning of strategies for Permanent Education in Health (PEH) aiming to overcome weaknesses for more effective construction of the STP in the CAPS by pointing out, among other aspects, the absence of proposition of care goals and the systematic registration of the STP.

It is worth clarifying that this is an education process that overcomes specific, fragmented actions, with little or no connection with the reality of the places. The PEH understood here proposes a daily update of practices being inserted in a necessary construction of relationships among its agents, organizational practices, and interinstitutional and or intersectoral practices (Campos, Cunha, & Figueiredo, 2013; Ceccim, 2004/2005).

The limitation of the study is related to the impossibility of generalizing about the results, given the qualitative characteristic of the research. It is also worth mentioning that it was not possible to mobilize all CAPS professionals to participate in the focus groups, as they were working in other places, were welcoming or were away from work, factors that did not allow for the joint reflection of all service professionals.

Final considerations

The professionals who work at the CAPS surveyed recognize the STP as important to reflect on psychosocial care and overcome the ambulatory logic; however, the elaboration is still precarious, medically-centered and based on a 'menu' of activities offered within the CAPS. Despite this, the few initiatives of expanded care and in the territory are extremely potent.

The birth of the psychosocial care model, as well as its working tools, is considered to be recent. There is no doubt how beneficial care can be collectively built through STP and the intra-team, intrasectoral and intersectoral articulations that result from it.

The evidenced reality points to the need for investment in Permanent Education in Health, as a possibility of significant training that considers the context of work. It is

necessary to qualify the work processes developed in the CAPS by the various professionals who work there, through the systematization of the STP. Thus, it will be possible to guarantee psychosocial care and promote freedom. Add to this the achievement of greater effectiveness of social reintegration and creation of evidence to assess the results obtained.

It is suggested that new studies be implemented to highlight the impact of PEH for the effective elaboration of STP by CAPS teams, as well as investigating other reasons that may lead professionals not to perform STP.

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