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POWERS AND CHALLENGES IN THE CONSTRUCTION AND CONDUCTION OF THE SINGULAR THERAPEUTIC PROJECT IN MENTAL HEALTH

POTÊNCIAS E DESAFIOS NA CONSTRUÇÃO E CONDUÇÃO DO PROJETO TERAPÊUTICO SINGULAR EM SAÚDE MENTAL

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ABSTRACT: Aim: To identify strengths and challenges in the development and implementation of STP. **Methodology:** This is a qualitative and exploratory study, utilizing two data collection tools: a semi-structured interview guide and an information protocol, composed of personal and professional data from the participants and the services to which they were linked. A total of 21 semi-structured interviews were conducted, subsequently transcribed, validated, and thematically analyzed. **Results:** A characterization of STP consistent with the proposals of Psychosocial Rehabilitation was highlighted. The reference professional was identified as the primary coordinator of STP. The main challenge in implementing STP was COVID-19, along with social vulnerability, stigmatization, and difficulties within work dynamics. Interdisciplinarity was emphasized by participants. **Conclusions:** The study provides important contributions to current discussions in the field of Psychosocial Care.

KEYWORDS: Interdisciplinary Placement. Mental Health. Psychosocial Care. Singular Therapeutic Project.

RESUMO: Objetivo: Identificar potências e desafios na construção e implementação dos PTS. **Metodologia:** Trata-se de uma pesquisa qualitativa e exploratória, na qual foram utilizados dois instrumentos de coleta de dados: um roteiro de entrevista semiestruturado e um protocolo de informações, composto por dados pessoais e profissionais dos participantes e dos serviços aos quais estavam vinculados. Foram realizadas 21 entrevistas semiestruturadas, sendo posteriormente transcritas, validadas e analisadas tematicamente. **Resultados:** Foi evidenciada uma caracterização do PTS coerente com as propostas da Reabilitação Psicossocial. O profissional de referência foi apontado como principal articulador do PTS. O maior desafio para operacionalização do PTS foi da pandemia de Covid -19, além da vulnerabilidade social, da estigmatização e das dificuldades nas dinâmicas de trabalho. A interdisciplinaridade foi ressaltada pelos participantes. **Conclusões:** Este estudo apresenta contribuições importantes para os debates atuais em torno do campo da Atenção Psicossocial.

PALAVRAS-CHAVE: Centro de Atenção Psicossocial. Práticas Interdisciplinares. Projeto Terapêutico Singular. Saúde Mental.

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INTRODUCTION

The World Health Organization (WHO) emphasizes the need to promote mental health on a global scale, highlighting its importance as an essential component of health and well-being, as well as being a basic human right. In 2022, the WHO's World Mental Health Report pointed to a high prevalence of mental health conditions, affecting approximately one in eight people worldwide. This report highlighted the need for changes in mental health policies and practices, promoting a community and human rights-based approach[1].

Italy, a pioneer in deinstitutionalization and the territorial mental health care model, is cited as an example in the WHO report, along with Colombia, which developed a personalized care project; Peru, with the creation of Community Mental Health Centers; and Brazil, with the expansion of Psychosocial Care Centers (CAPS in the Portuguese acronym) and the Back Home Program[1]. Other initiatives in low-income countries investing in the transformation and reorganization of mental health care integrated into the territory point to a possible way forward[2].

However, there is a significant gap between the demand for and supply of mental health care, especially in countries in the southern hemisphere, where around three out of four people suffering from mental illness do not have adequate access to health services. Although the WHO guidelines are explicit about the need to expand mental health care, the effectiveness of these actions varies according to the particularities of each territory[1,2,3].

In Brazil, since the late 1980s, the Singular Therapeutic Project (STP) has been developed in conjunction with the history of the Unified Health System (SUS), the health movement and the anti-asylum movement. The STP, widely used in mental health services and primary care, brings a proposal with fewer certainties and greater openness to negotiations between those involved, considering their perceptions of illness and health production[4,5,6].

Initially presented in the proposals of the National Humanization Policies, the STP values the health production process, promoting autonomy, protagonism and co-responsibility between the user and the technical reference team in the collective construction and management of a health project[4,5]. Essential aspects of the mental health field, such as desire, the meaning attributed to illness, singularity and the subjects' life history, are strongly considered in the elaboration and development of this instrument, regardless of the field in which it is applied[5,6].

The STP reaffirms the need for comprehensive health care, covering different dimensions and recognizing that promoting health goes beyond treating illnesses - it involves thinking about and developing care practices that promote life and well-being[6]. In addition, the STP acts as a management device, allowing professionals to reflect on the coherence and effectiveness of the practices developed in the services where they work, triggering reorganizations in work relationships and dynamics[4] to collectively build actions and solutions to everyday problems identified with users and their families[6,7].

The STP can be developed with collectives, unique population groups at risk and vulnerable or territorial groups experiencing a problem situation, through a set of actions organized and agreed collectively between those involved and their support networks[5,7]. It is presented as a strategy that organizes care in services and promotes actions in search of health and new life possibilities[6,7,8].

It is understood that, in order to build and implement the STP, it is essential to have an interdisciplinary team that shares and integrates its knowledge. This team must be linked to an intersectoral network, involving services, users and family members at all stages of the process, with ongoing negotiations and reassessments of the goals set, taking responsibility and welcoming the daily

demands of everyone involved[5,6,7] in order to develop a practice that is committed to comprehensive health care[6,7].

Thus, the interdisciplinary approach is necessary, with the establishment of horizontal and democratic relationships within the team, in which the various professional nuclei, each with their own characteristic knowledge, influence each other and organize themselves to develop theoretical and practical actions in response to the needs of the field[9].

In the field of mental health, the CAPS offer a favorable environment for the development of this approach. They are specialized services that care for people suffering from mental illness and are part of the Psychosocial Care Network (RAPS in the Portuguese acronym). Regulated more than 20 years ago by Ordinance 336/2002, CAPS are classified according to their complexity and population coverage[10]. In these services, each user must have their STP[10] drawn up collectively, following the psychosocial paradigm[11].

Psychosocial Rehabilitation is still new compared to the centuries of confronting a model of alienation and exclusion of people suffering from mental illness; consequently, the implementation of its precepts represents a challenge in various territories. However, the psychosocial model has become a benchmark for structuring care for users in CAPS, guiding practices in the field of mental health[11,12].

Occupational Therapy, one of the professions that make up the interdisciplinary team at CAPS, works significantly in the field of Mental Health. Its theoretical framework, focused on human activities and daily life, enables the re-signification of social and affective exchanges, promoting the establishment of new relationships - a fundamental principle of Psychosocial Rehabilitation[11]. The objectives of Occupational Therapy converge with the assumptions of Psychosocial Rehabilitation, reaffirming the profession's potential for implementing practices such as STP in services guided by Psychosocial Care policies[11].

It is argued that all professionals in the CAPS team contribute significantly to the development of STP; however, in this article, the aim was to identify the strengths and challenges in the construction and implementation of STP from the perspective of occupational therapists.

This article is structured in five main sections. The Introduction presents the context and justification for the study, outlining the research problem and the proposed objectives. The Methodology describes the study design, the data collection and analysis methods, as well as the participants involved. The Results present the main findings, which are presented and discussed in the light of the objectives and the existing literature, pointing out the practical implications of the study. In the end, the Final Considerations summarize the study's contributions, indicate limitations and suggest directions for future research.

METHODOLOGY

TYPE OF STUDY

This study has a qualitative and exploratory approach, developed in the field[13], with the purpose of identifying strengths and challenges in the construction and implementation of STP from the perspective of occupational therapists working in CAPS[1].

[1] This article comes from an excerpt of the master's thesis entitled: “Projeto terapêutico singular em saúde mental: contribuições da Terapia Ocupacional”, which aimed to analyze how Occupational Therapy contributes to the construction of the STP in CAPS.

RESEARCH PARTICIPANTS

The research included 21 participants linked to different types of CAPS[10] in the defined region, all of whom had been working in the service for at least six months.

RESEARCH CONTEXT

The study was carried out in the Southeast region of Brazil, in the interior of the state of São Paulo, in the region demarcated by the Regional Health Department VII, with headquarters in the municipality of Campinas**.** Five municipalities took part, making up a total of 16 services: two CAPS I, one CAPS II, five CAPS III, which are respectively in increasing order of complexity of care for people in psychological distress; five CAPS AD, with specialized care for people with problematic use of alcohol and other drugs; as well as three CAPS IJ, which care for children and adolescents.

ETHICAL ASPECTS

The project was submitted to Universidade Federal de São Carlos' Human Research Ethics Committee and was cleared under opinion No. 4.497.581/2021, respecting the fundamental ethical principles applicable to all those involved in this research. The participants presented in this study are identified by the letter “P” followed by the interview number, in order to preserve their identities.

DATA PRODUCTION

Data was collected through semi-structured interviews, using two different instruments: an information protocol, comprising personal and professional data on the interviewees and the CAPS to which they are linked; and an interview script[14].

The instruments were previously sent for analysis by twelve researchers and occupational therapists with relevant experience in the subject, in order to better adapt[14] them to the target audience. After feedback from seven collaborators, the necessary adjustments were made, resulting in the final versions of the instruments for this research.

The interviews were carried out remotely, via *Google Meet*, following the social distancing guidelines due to Covid-19[15], and lasted between 40 minutes and 1 hour and 50 minutes.

DATA ANALYSIS

The data collected through the information protocol was analyzed descriptively. The data from the semi-structured interviews was subjected to thematic analysis, a content analysis technique that involves finding the nuclei of meaning and the main themes contained in the communications and speeches, based on an exhaustive reading of the material collected in the research[16].

Themes are made up of units of meaning that appear in the text and are systematically organized, giving rise to categories of analysis[16]. Thematic analysis is structured through the following stages: pre-analysis; exploration of the material; treatment of the results obtained and interpretation, with analysis of the significant data - allowing the researcher to propose inferences and make interpretations that are consistent with the planned objectives[16].

RESULTS AND DISCUSSION

With regard to the participants, 12 of them had been working as occupational therapists in the service for less than 5 years; 6 of them between 5 and 10 years, and only 3 of them had been working for more than 10 years. All the participants had one or more complementary qualifications, 15 of them in the field of mental health, which shows a high level of engagement and qualification among the group surveyed. Fifteen participants had previously worked in other mental health services. Other aspects of the participants' characterization can be seen in Figure 01 below.

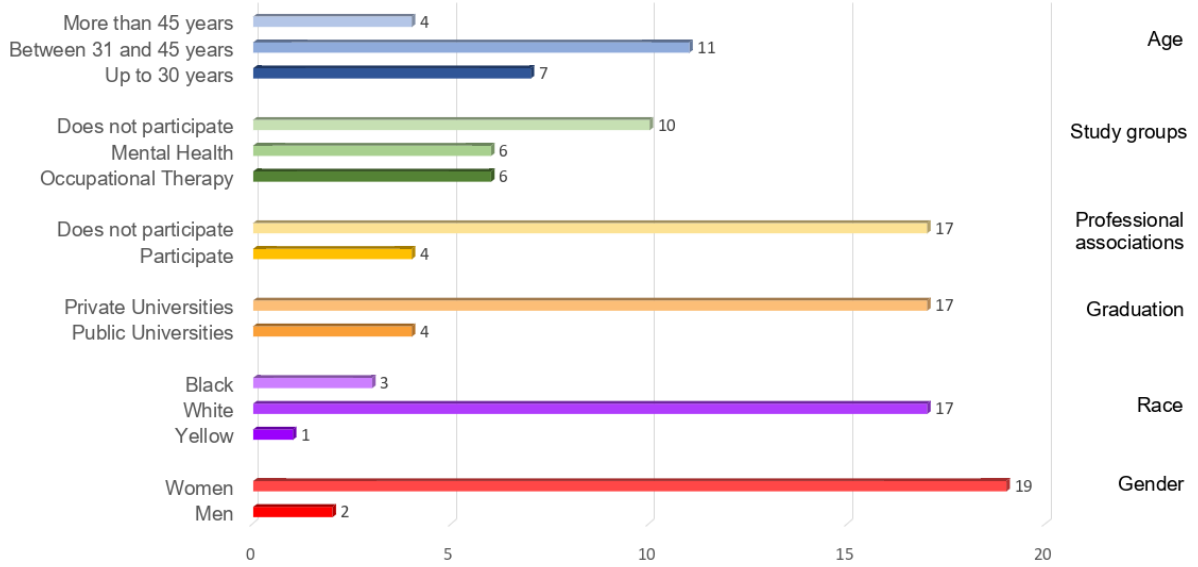

Figure 1: Characterization of participants following gender, age, race, schooling and political participation
Source: Authors of the study.

The opening hours of the services and the age range of the users varied according to the type of CAPS, in accordance with the RAPS regulations. The number of active users ranged from 160 to 650; men represented the majority of the population assisted, while the LGBTQIA+ population was identified as the minority.

According to the majority of the participants, the STP has been used by all users in the services since their inauguration. However, we identified three ways of incorporating the STP: 1) Following the RAPS[10] guidelines, using the tool for all users (10 services); 2) Using the STP as recommended for Primary Care, only in serious and complex cases (3 services); and 3) Using it in times of urgency for crisis management (3 services).

However, in the services that deviate from the RAPS guidelines regarding the need to build a STP for all CAPS users, the professionals agree that following these regulations would be ideal. There is no lack of knowledge about this need, but rather difficulties in operationalizing it. In these cases, where the project is not built collectively, outpatient care predominates, focused on specialties, with little exploration of the territory.

Other services in the health network and the intersectoral network with which CAPS maintains links in order to build and run the STP were mainly Primary Health Care services and the services of the Unified Social Assistance System.

It is understood that, in addition to the possibilities of operationalizing the STP considering RAPS services and the intersectoral network available, vulnerabilities and social determinants significantly

influence people's access to these services[6,17] and, consequently, the establishment and articulation of a more or less shared STP.

Data analysis enabled the identification of six thematic categories, four of which will be covered in this article: Professionals' understanding of the STP, Composition of the family and users in the STP, Team of professionals that make up the STP and Challenges in building and conducting the STP.

The participants defined the STP, from their perspective, as a project built with users, involving strategies and the articulation of resources between health services and the intersectoral network, considering the expectations, perspective and uniqueness of the user, as shown in the following excerpt[2]:

> The STP is a procedure built together with the user, we think about how heir life is at that moment and build strategies to work on their problems, such as the use of psychoactive substances. We think about the strategies together and the user orchestrates and sets the tone for the interventions (P 01).

The definitions of STP are complementary, and most of them emphasize the need for the user to play a leading role in this construction, reinforcing the importance of their life story, highlighting Cunha's assumptions[5,7] about valuing the singularity of the subject and their social, family and territorial context in the construction of a health project, as the following excerpt shows:

> It's a methodology, a very important tool that we use to evaluate and construct meanings for a health monitoring project in a very democratic way, according to that person's history. It brings the issue of the singular, of individuality, of each person's context and the whole foundation of collective health to the field of mental health... (P 19).

The STP was described as a project built with the aim of organizing the user's life through care management, considering health care, community resources and possible links with services in the intersectoral network.

> The STP guides care, is built on the user's wishes, involves possibilities for providing care inside and outside the CAPS, leads us to think about what is possible at that moment, considering the demand that the user brings us and their uniqueness (P 18).

The characterizations of the STP presented by the participants show that the instrument is aimed at the individual, without being applied to population groups or collectives. They reaffirm the singular dimension as the essence of the therapeutic project, valuing the subject's experience and the meaning attributed to this experience. With actions based on the needs of each user, respecting singularity requires looking at and listening to people in psychological distress, considering their social and territorial context[6,18,19].

In addition, the STP was pointed out as an instrument that democratizes and humanizes care, directing practices considering the individual's unique context. Systematized so that it can solve the proposed objectives and everyday problems, it is in line with the findings of Oliveira[4] and Depole *et al*[7].

The characterizations observed in this study are also in line with Junior *et al*[6], highlighting the importance of agreed actions aimed at social emancipation, designed and built together with users. This

[2] The discursive excerpts have been edited to the standard norm, without modifying their content, in order to improve comprehension and reduce language vices

process values the transformative potential and uniqueness of each person, rather than simply imposing interventions or communicating them unilaterally.

In most services, there are no pre-established deadlines for discussions and reassessments of the STP, as indicated in the following excerpt. However, the literature suggests that re-evaluations should take place at sufficient intervals to assess the initial actions and goals, without becoming so spaced out that the team loses familiarity with the users' problems[4].

> The STP changes, it's dynamic, we analyze whether the interventions and plans initially drawn up were assertive or not. And if the objectives have not been achieved, we restructure and redesign this STP together with the user (P 01).

The operationalization of the STP should include four stages: the identification of the problem with a biopsychosocial assessment; the definition of goals with an estimated time for execution; the division of responsibilities between users and teams; and reassessments, carried out as necessary[5,7]. In the participating services, reassessments take place when the team or the user themselves realize that the project is not being effective or when new demands arise in their daily lives.

> STP points out a direction to be followed in order to organize both the user's life and the functioning of the service, taking into account the number and profile of the people served, so that we can provide the minimum assistance to all those who come to us! (P 06).

The STP can be used as a management resource to reorganize working practices, taking into account the teams, the dynamics and institutional resources, as shown in the previous excerpt, however, this aspect was little highlighted by the participants. However, the development of the STP is relevant to the exchange of knowledge between professionals; it enables re-evaluations of established practices and promotes a space in which the different team members can explore their creativity in developing unconventional activities[5,7] that take into account the different ways of life of users[7].

Participants mentioned the importance of families in the process of building and conducting the STP, as they help to ensure continuity of care in everyday actions and bring relevant aspects to the composition of users' life histories. However, most of the time, participants point out that families are not very participative.

> We try to include the family in the STP, but some cases are very difficult. We can't get in touch with the family, there's resistance, they're fragile, they don't have a support network [...], but we try to call them in because we can't manage the project on our own, so we ask the families for help (P 05).

The participants present family members as a possible support network for the user, but recognize that they are also suffering, fragile, tired and ill, which compromises their participation in the STP. And when they do participate, their work is limited to the care offered to the user, and not directed at the demands of the family members themselves.

The participants' reports are in line with studies on the inclusion of family members in mental health services, which point to the lack of a specific listening space to hear and meet their needs[20,21,22,23]. There is a disparity in these services between what professionals see as possibilities for family members

to participate and the real demands they present[20,21,23]. In this context, the STP is an alternative for aligning perspectives between family members and health teams.

Users are presented as active players in the process of building and conducting the STP; their protagonism is valued - they even request re-evaluations of the STP and offer their perspectives on the effectiveness of this project in their daily lives.

> [Users] take an active part from the start, they give direction while we present possibilities, and as this process develops, they tell us whether they would like it or not and whether the project makes sense to them. They are the protagonists; we offer tools, support and assistance (P 19).

The above excerpt illustrates the user's participation as the protagonist of their STP, valuing their choices and decisions, strengthening their autonomy and bringing relationships and affections closer together between the user and the interdisciplinary team, in line with the propositions of Depole *et al*[7].

Therefore, users should construct and discuss the proposed actions with the interdisciplinary team and their families, as well as re-evaluate them when there is a need for new actions suited to their daily lives. It is important to emphasize that the proposals should be drawn up with the user and not for them[19,24]. User participation can be seen in Figure 02 below.

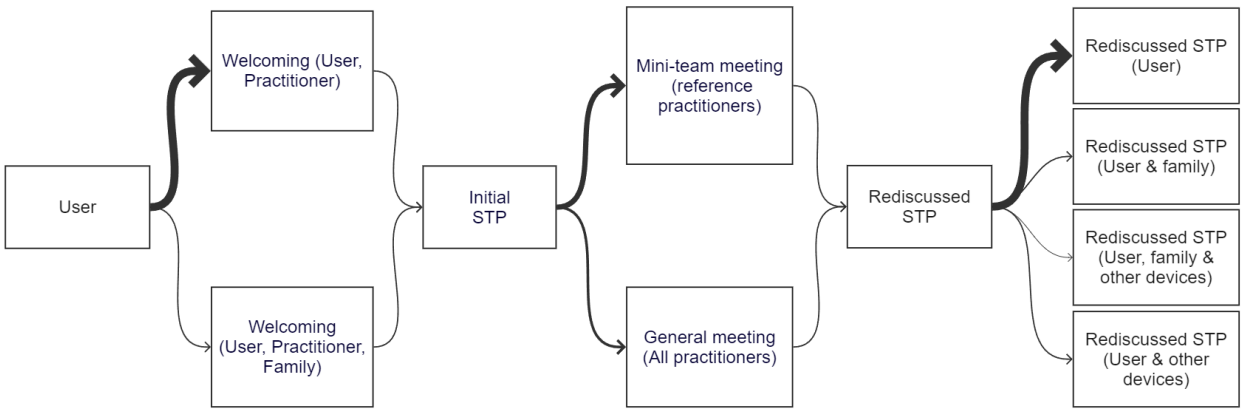

Figure 2. Flowchart of STP organization within services and points of users, family members, practitioners and other health devices' participation, as well as the intersectoral network
Source: Authors of the study.

However, we found a discrepancy in the participants' reports: between the discourse of valuing the family and the user in the STP and the actions and decisions in which these actors actually participate. This finding is in line with that of Vasconcelos *et al*[23], who show that there is a lack of discussion and protagonism on the part of users and their families in the construction of the STP, as well as actions that do not take into account the various social actors that should make up a collective construction[20]. The perspective put forward by two participants is that, usually, neither family members nor users actively participate in the construction of the STP, as described below:

> We the practitioners build the STP and present the project, then they [users and family members] tell us whether they agree or not, but as for actively participating in this construction or discussing it together, it only happens in one case or another (P15).

In view of this, we believe it is essential to promote more spaces for listening, exchanging knowledge and bringing these actors closer together, both inside and outside institutional spaces. One

viable possibility would be to occupy the territories more effectively, developing intersectoral and/or health-promoting activities, which would bring users, family members and other actors who may arise into the development of the STP.

However, according to Silva *et al*[22], in the speeches of CAPS professionals, despite the provision for valuing and contextualizing the territory in the formulation of the STP, the actions and practices referred to are mostly restricted to the institutional spaces of the services.

The territory is a space for action and resistance, which promotes both social inclusion and exclusion. It is the stage where social changes take place and routine scenes develop, in terms of its geography, relationships and institutional structures. In order to reconstruct and give new meaning to everyday life, it is important that the professionals who work in CAPS occupy the territory, especially the occupational therapist, due to their knowledge and ability to explore the activities carried out by people in their daily lives[11,12].

According to the research participants, Occupational Therapy was presented in two dimensions: clinical and methodological. In the clinical dimension, the occupational therapist contributes to the construction and conduct of the STP, inserting components from the core of their profession in the development of assessments on autonomy and daily life, as well as highlighting these aspects in the proposition of activities and in the planning of the STP. In the methodological dimension, the occupational therapist sees the STP as an activity in development that must be carried out, also demonstrating the way of doing things and the pragmatic nature of the profession.

There was evidence of the participation of all the professionals in the service teams in the composition of the STP, including occupational therapists. This composition varies according to the CAPS, since each service has different professional categories. Transdisciplinarity and interdisciplinarity were used to explain the need for a diversity of professional groups in the STP.

> I can't see a STP being built without the team as a whole; we feel the contribution of psychology, medicine, nursing, occupational therapy, sometimes we miss social work - because she [the social worker] is here once a week, she doesn't take part in the mini-team meetings (P 05).

These reports are in line with Campos' presentations[9] on the need for the organization of work and democratic management, which values the different professional roles in the field of mental health, understanding health in its various dimensions, with sharing and shared guidelines for practices. It is a space in which different types of knowledge are respected and the professional groups work in a collaborative and articulated manner.

In CAPS' work practices, practitioners develop workshops, therapeutic groups, home visits, family guidance and activities in the community, regardless of their professional category, which shows the establishment of transdisciplinarity and interdisciplinarity[25].

However, as in any Psychosocial Rehabilitation process, the development of shared working practices is still a process under daily construction. Continuous investment by the team is needed so that the STP is not organized with actions centralized in a specific professional nucleus or considers psychosocial and territorial actions to be less relevant[22].

It's worth noting that the reference professionals, regardless of their professional category, were pointed out as the ones who are closest to the users when it comes to building, re-evaluating, conducting and articulating the STP, as well as participating more actively in the planned actions. This is illustrated in the following statement:

> The practitioner closest to the users is their reference, who builds their STP together [...] then takes it to be discussed at the general meeting, especially the STP of the user who will stay in the unit longer, or who will attend daily, or who will require actions from other professions, in addition to the reference (P 12).

The reference professionals end up taking on the management of care within the STP in progress. As this professional is more closely linked to the user, they take responsibility for the case within the team, enabling continuity of care and day-to-day decision-making with users and their families, reducing bureaucratization. However, their proximity to the user does not exempt the rest of the interdisciplinary team from their commitment to shared care[6,25].

> We discuss the STP in a general meeting with all the professionals in the service, especially those users who demand more and are more serious. Normally, we discuss the other projects at mini-team meetings, with the professionals who work in the area where the user lives (P 04).

In some services, professionals are organized into trios or mini reference teams, playing a role similar to that of the reference professional, but in a more collective context, reorganized into smaller groups within the general team. This structure allows for more frequent and quicker discussions and exchanges when faced with users' daily demands[25].

The participants explained that the composition of these reference groups depends on the human resources available, the characteristics of the population group and the emerging demands of the region in which these professionals are references.

The various professional groups make a significant contribution to the therapeutic projects, with the aim of taking full account of the user's uniqueness, needs and life story. In this way, the participation of all professionals is fundamental to building a STP that promotes health and people's social emancipation[4,7].

For the STP to achieve its objectives, in addition to interdisciplinarity, it is essential to consider the knowledge acquired through the user's lived experience[6,7]. Occupational Therapy, with the assumption of doing activities with the user in a space with an exchange of knowledge and experiences, where the user's autonomy and knowledge are valued, traces paths alongside them to establish their leading role in this collective construction[24].

At the time of the research, the biggest challenge in building and conducting the STP pointed out by the participants was the pandemic, which had a negative impact on the functioning of the services. It prevented the development of collective practices aimed at socialization; it limited users' access to other services in the intersectoral network, including CAPS itself; and it limited therapeutic and territorial actions.

We argue that situations with a high degree of emergency, such as the pandemic, cause major transformations in people's dynamics and daily lives[14]. We point out the importance of analyzing these transformations so that they can be used in a pedagogical way in the services, with a view to improving their qualification and effectiveness in similar situations in the future.

However, despite the seriousness of the pandemic's repercussions on professionals' day-to-day work, it is important to take them as analyzing a pre-existing dynamic whose challenges and potential are highlighted in this article.

Other challenges related to users' daily lives were identified and have a negative impact on health care, such as social and territorial vulnerabilities; little family participation; lack of a support network; difficulty accessing services; racism and stigmatization of users in the territory and in other care services.

According to Cunha[5], issues relating to the territory or people's conditions of survival involving housing, food, sanitation, financial conditions, vulnerabilities, participation in groups - such as trafficking, church, work - and their life history, are among the determinants that directly influence the STP.

People who are more vulnerable have greater social and health needs due to the many shortcomings they experience in their daily lives. However, paradoxically, these people find it more difficult to access health services and intersectoral links, such as education, culture, leisure and work[17].

This difficulty of access is directly related to the social determinants of health, which are unfavorable in the case of people in psychological distress, as socio-economic, behavioral, ethnic, racial and territorial factors have a negative impact on their daily lives, reinforcing social inequalities and further limiting access to services and the right to health[17,18].

Thus, when STP participants dedicate themselves to creating a shared instrument between different intersectoral bodies, with common objectives and integrated resources, they contribute to this population having more effective access to the minimum conditions of existence and strengthening the exercise of their citizenship[17]. In this context, occupational therapists, due to their pragmatic nature and knowledge of daily life, play an essential role in articulating the intersectoral network with users in the territory[12].

Stigmatization, understood as an erroneous, discriminatory and limiting belief, creates barriers that deny rights and citizenship to people in psychological distress. It hinders access and adherence to health services, school and work; it can cause more harm than the primary condition of the illness itself. It also creates difficulties in social and emotional relationships, promoting and fueling social exclusion[26].

For this reason, collectively developing an articulated and territorial STP, which promotes social emancipation, is a strategy for confronting discrimination and stigmatization among people suffering from mental illness.

Other challenges related to the organization and logic of work in the CAPS were pointed out, such as reduced human resources; an increase in the number of users (in relation to the professionals available to attend to them); difficulties in communication and sharing projects with other intersectoral services; bureaucratization of work processes and difficulties in interprofessional relations and/or the lack of continuity in the execution of the STP by the CAPS team itself. The same challenges were pointed out for both the construction and implementation of the STP.

> The bureaucratization of access is a major difficulty, as are the team relationships themselves, because we know how much we disagree [...]. Sometimes we encounter barriers when it comes to coordinating with other services. And I'm not going to say that CAPS doesn't put up barriers, because we do too (P 03).

Practices of objectification and bureaucratization in the production of health services are incompatible with the development of a STP, given that its assumptions prioritize and encourage creative and innovative practices to solve everyday problems[7].

Other difficulties in operationalizing the STP include the failure to exchange knowledge between professionals, the overload of teams due to their responsibility for caring for a large number of users and the lack of collective spaces for discussing the STP with all those involved[8].

Therefore, in order for the STP to be more effective, in addition to negotiations between those involved that take into account their needs, perspectives, affections, desires and conflicts[4], changes are needed in the organization of services and teams with sufficient resources to enable this device to be put into practice[6,8].

In this context, it is crucial to remember the frequent attacks on the SUS and the dismantling of the advances of the last 30 years, instituted by the psychiatric reform, made official in Technical Note 11/2019[27] known as the New National Mental Health Policy, which brought setbacks and negative repercussions to the functioning of services.

Between 2016 and 2019, around 15 documents were issued, giving rise to the questionable technical note, contrary to Law 10.216/2001[28], the Federal Constitution, the International Covenant on Civil Rights and specific recommendations from both the National Health Council and the National Human Rights Council. This note was widely contested by various organizations such as the Brazilian Association of Collective Health, the Brazilian Association of Mental Health and the Councils of various professional categories involved in caring for people in psychological distress[28].

The dismantling began in 2016 with Constitutional Amendment 95/2016[28], which ordered the freezing of resources for social policies, including the SUS, for 20 years. In 2017, changes to the National Primary Care Policy[28] had repercussions in the reduction of community agents and matrix support actions, limiting community and territorial actions such as the STP.

In the same year, Ordinance MS 3.992/2017[28] allowed public funds to be allocated to therapeutic communities and psychiatric hospitals, signaling a de-funding of CAPS and a violent attack on policies on drug use. In 2018, the Ministry of Health, based on CIT Resolution 36/2018[28], suspended funding for 319 mental health services, including 72 CAPS, alleging low productivity.

In short, Technical Note 11/2019[27] came about in continuity with the regulations, ordinances, resolutions and decrees that began a process of devaluing community-based services, reducing budgets and resources, financially prioritizing exclusionary institutions, despite having been created under the justification of strengthening RAPS[28].

Unfortunately, in addition to the attacks on the National Mental Health Policy, the National Humanization Policy[29], whose assumptions strongly influence and instrumentalize care technologies such as the STP, has also suffered continuous disinvestment, resulting in a lack of political inducement for humanizing health practices.

In this scenario, it is possible to understand the difficulties faced by the participants, such as the reduction in material and human resources, the excessive demand from users and the difficulty of investing in tools such as the STP, which require more time and staff availability. The STP, being a political-clinical-institutional project, requires trained teams, organized work processes and sufficient resources for its operationalization in the territory[6,18]. Otherwise, you run the risk of planning projects that don't get off the ground, or worse, reproducing the STP in a prescriptive and life-normatizing way[7].

However, the STP stands out as a device for humanizing care, which makes it possible to create innovative practices even in unfavourable scenarios, which encourages professionals to develop unconventional actions in unique and complex situations. It values people's protagonism, reaffirming the need to create public policies that enable and strengthen democratic devices for care and health promotion.

The results of the study on the use of the Singular Therapeutic Project (STP) in CAPS have significant practical implications for improving mental health care. Firstly, by identifying the challenges related to the STP, CAPS professionals will be able to talk to management about the need for resources and infrastructure to make this care practice effective.

In addition, knowledge of these challenges allows professionals to anticipate and adapt actions during the planning and implementation of the STP, making interventions more efficient. The analysis of the potential and limitations of intersectoral links favours the use of the STP as an organizing tool, systematizing support networks and strengthening joint work between different sectors to ensure comprehensive care.

Finally, by highlighting the potential of the STP, it promotes greater adherence and engagement by users in their care projects, since the instrument enables a space for negotiating actions, desires and priorities, valuing the user's protagonism.

CONCLUSION

The findings of this study, the aim of which was to identify strengths and challenges in the construction and implementation of the STP, revealed the perspective and characterization of the STP as a humanization device and a powerful instrument, widely disseminated in the field of Mental Health.

Families and users are considered important players in the composition of the STP, but we found discrepancies between this professional discourse and their actual participation in the practical actions of the service.

Interdisciplinarity was highlighted by the participants as an organizing assumption of work practices, and Occupational Therapy was pointed out as a significant component of the interdisciplinary team, alongside the other professional categories. However, the reference professional, regardless of their training, was pointed out as the one who is closest to the user and the greatest articulator of the STP.

The biggest challenge to building and running the STP during the research period was the Covid-19 pandemic, coupled with social vulnerability, the stigmatization of people in psychological distress and difficulties in working dynamics.

The research demonstrated the power of health professionals and the STP within the SUS, which is very significant in the current moment of reconstruction of public policies; in addition to the viability of using the STP as a device that reaffirms and values the autonomy of the user in the construction of their care project.

A limitation of the study was the absence of the perspective of other actors involved in the STP, such as families, the users themselves or other professional categories. Future research could enrich the debate by including more players, allowing different perspectives on the use of this tool to be analyzed.

Finally, we believe that this research can make important contributions to the debates that are heating up in the field of psychosocial care.

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