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Singular therapeutic project in mental health: an integrative review

Projeto terapêutico singular na saúde mental: uma revisão integrativa

Proyecto terapéutico singular en salud mental: una revisión integrativa

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ABSTRACT

Objectives: to analyze the Singular Therapeutic Projects' characteristics in mental health care used to assist the subject with psychological distress. **Methods:** it is an Integrative Literature Review study conducted in July 2017. The following databases used to collect the data were LILACS, MEDLINE and BDENF. After applying the inclusion and exclusion criteria, 12 articles were selected. **Results:** there was divergence between what was recommended by the Ministry of Health for PTS elaboration with that described in the studies analyzed. Emphasis is placed on the low participation and co-responsibility between team/user in PTS elaboration, excessive referrals to specialized mental health services, fragmentation of knowledge within the multidisciplinary team, and difficulty sharing and discussing information about cases. **Final considerations:** it is pointed out the need to adapt PTS elaboration, and its respective steps, to the needs of each individual.

Descriptors: Mental Health; Primary Health Care; Mental Health Services; Patient Care Planning; Integrality in Health.

RESUMO

Objetivos: analisar as características de Projetos Terapêuticos Singulares (PTS) utilizados na assistência ao sujeito em sofrimento psíquico na atenção à saúde mental. **Métodos:** trata-se de um estudo de Revisão Integrativa da Literatura, realizada em julho de 2017. Foram utilizadas, para a coleta dos dados, as seguintes bases: LILACS, MEDLINE e BDENF. Após a aplicação dos critérios de inclusão e exclusão, foram selecionados 12 artigos. **Resultados:** evidenciou-se divergência entre o preconizado pelo Ministério da Saúde para a elaboração de um PTS com o descrito nos estudos analisados. Destaca-se a pouca participação e corresponsabilidade entre equipe/usuário na elaboração dos PTS, o excesso de encaminhamentos para serviços especializados de saúde mental, a fragmentação do saber dentro da equipe multidisciplinar e a dificuldade de compartilhar e discutir informações acerca dos casos. **Considerações finais:** aponta-se a necessidade de adequar a elaboração do PTS, e suas respectivas etapas, às necessidades de cada indivíduo.

Descritores: Saúde Mental; Atenção Primária à Saúde; Serviços de Saúde Mental; Planejamento de Assistência ao Paciente; Integralidade em Saúde.

RESUMEN

Objetivos: para analizar las características de los Proyectos Terapéuticos Singular utilizados para asistir al sujeto en el sufrimiento psicológico en la atención de salud mental. **Métodos:** es un estudio de Revisión Integrativa de Literatura, realizado en julio de 2017. Las siguientes bases de datos se utilizaron para recopilar los datos: LILACS, MEDLINE y BDENF. Luego de aplicar los criterios de inclusión y exclusión, seleccionamos 12 artículos. **Resultados:** hubo una divergencia entre lo recomendado por el Ministerio de Salud para la elaboración de una PTS con la descrita en los estudios analizados. Se hace hincapié en la baja participación y la corresponsabilidad entre el equipo / usuario en la elaboración de PTS, las referencias excesivas a servicios especializados de salud mental, la fragmentación del conocimiento dentro del equipo multidisciplinario y la dificultad de compartir y discutir información sobre los casos. **Consideraciones finales:** se señala la necesidad de adaptar la elaboración del PTS, y sus respectivas etapas, a las necesidades de cada individuo.

Descriptores: Salud Mental; Atención Primaria de Salud; Servicios de Salud Mental; Planificación de Atención al Paciente; Integralidad en Salud.

INTRODUCTION

The Singular Therapeutic Project (PTS – *Projeto Terapêutico Singular*) is an important strategy in mental health care, especially in the face of achievements and guidelines defended in public health policies such as humanization, comprehensiveness, and equity in the Brazilian context, helping to discover new paths for deal with "madness". However, it is important to highlight some historical aspects that bring to the surface the need to implement tools such as PTS.

In 1948, its founding year, the World Health Organization (WHO) now defends a new, more comprehensive and not restricted to the absence of clinical problems health concept. This new proposal brings health as "being a state of complete, physical, mental and social wellness". The WHO initiative to establish a broad definition of health has had very rapid consequences in medicine: the concept of mental health arises at that time, and the "mental hygiene" old concept goes is not used anymore. The Universal Declaration of Human Rights was created in 1948, defending equal rights and dignity for all human beings and condemning acts of torture, cruelty, exile. These two historical facts in the late 1940s began the great and revolutionary subsequent changes in mental health[1].

In Brazil, great transformations were established in the late 1970s, with initiatives against asylums, and the beginning of a model that aims to uncover madness, rescuing its complexity and subjectivity. The Brazilian Psychiatric Reform pillars emerge. Over the years, new thoughts and plans for changes in mental health care have been proposed, including the process of humanizing health in the 1980s up to the 1988 Constitution and the Brazilian Unified Health System (*Sistema* Único *de Saúde*) structuring[1-2].

The Brazilian Psychiatric Reform Law (Law 10.216/2001) seeks to ensure the change of the asylum model of care by a more inclusive and participatory model of psychosocial care. These characteristics aim to ensure the rights and protection of people with mental disorders[3], demonstrating the importance of creating new devices (services and technologies) for mental health care.

Psychiatric reform has brought a paradigm shift in mental health care. Among the challenges and needs launched from this movement, there is the implementation of multidisciplinary therapeutic strategies that foster interaction among professionals of a team, articulating actions to provide maximum autonomy and dignity possible for patients[4].

In view of humanization of health care, within the principles of comprehensiveness and equity established by SUS, PTS was born in the early 1990s. It is a care strategy, that is, a set of therapeutic proposals that are discussed and constructed collectively by a multidisciplinary team. É elaborado especificamente para uma pessoa, uma família ou um grupo, com intuito de promover a integralidade e a equidade do cuidado, princípios básicos do SUS[5]. PTS construction presupposes a greater participation of the subject in the elaboration, application and assessment of its therapeutic project, encouraging family participation in the process of care aiming to facilitate social reinsertion of the individual in their environment.

In this way, a PTS aims to contemplate the needs of the individual in a unique way because it is personalized in a broad way and its actions are not restricted only to the fulfillment of demands related to clinical problems and pharmacological therapies[5].

PTS also takes into account the subject vulnerabilities[5], which, in addition to contemplating individual, cultural, economic and social dimensions, has a programmatic dimension, which concerns strategies and programs that aim at the care of a certain individual's need[6]. This understanding points to it as a tool capable of subsidizing the construction of interventions to face situations of vulnerability based on the problematization of the situation under analysis, adjusting the proposals of action according to reality[5].

PTS is a tool that makes health actions easier, since it establishes and organizes care, promotes autonomy and contributes to the notion of co-responsibility, since it is through a dialogue between a multidisciplinary team and user, considering the particularities of the subject and the characteristics of each case[7]. PTS is therefore "a movement of co-production and co-management of the therapeutic process of individuals or groups, in situations of vulnerability"[8].

In the Brazilian context, PTS is often used at the primary level of health care, with the support of the Family Health Support Cores (NASF – *Núcleos de Apoio à Saúde da Família*) team or other matrix team[7-9]. Matrix Support is a complementary and often essential tool in Primary Health Care (PHC) that often requires specialized support that allows an interdisciplinary discussion to elaborate a PTS, increasing the possibilities of action[10-11].

The Ministry of Health[5] assumes that PTS construction is divided into four steps: 1) The first step is based on the diagnosis and situational analysis of the subject or collective in question, assessing its comprehensiveness, its physical, psychic and social aspects. The objective is to enable a conclusion regarding the risks, vulnerabilities, resiliency and potentialities of the subject, their beliefs, desires and interests, their work, culture and family and social support network; 2) The second step defines actions and goals in the short, medium and long term that will be discussed and negotiated with the subject or group in question, involving a shared decision-making process; 3) The third step is the division of responsibilities that is given to each of PTS participants (user, primary care team, NASF or other parenting team). It is time to define the reference professional for the case. This should be the person of the team with whom the individual has formed the largest bond, to facilitate the care process and may, preferably, be the manager of PTS; 4) The fourth and final step is reassessment, which discusses the evolution of the case, directions, changes, new goals and changes (if needed). That is, it is the step of realizing the inventory of PTS.

Thus, it is observed that PTS is an important tool for mental health professionals in the areas of planning, implementation and assessment of actions to assist the subject in psychological distress. Thus, this study becomes relevant insofar as it seeks to analyze the PTS performed in the daily life of health services that attend individuals in psychological distress, allowing a greater visibility of the potential of this tool in health care. The purpose of this Integrative Literature Review is to analyze the characteristics of therapeutic projects used to assist the subject in psychological distress.

OBJECTIVES

To analyze the Singular Therapeutic Projects' characteristics in mental health care used to assist the subject with psychological distress.

METHODS

Ethical aspects

Since this was a review study, there was no need to submit the project to the Research Ethics Committee. However, this review respected the ideas, concepts and definitions of the authors of the articles that composed this study, being the same registered and approved by the Research Committee of *Universidade Federal do Rio Grande do Sul*'s School of Nursing.

Type of study

This is an Integrative Literature Review (ILR). It is an Evidence-Based Research method that makes it possible to synthesize research results on a given issue or subject, performed in an orderly and systematic manner, and following a pre-established protocol that guides its execution from the definition of the problem to be investigated until the presentation of the final results[12].

Data collection

Data collection for Integrative Review used the Cooper method[13], which aims to gather and analyze the results obtained in the research of the primary studies on a certain subject. Finally, the results serve as a basis, as they allow for greater clarification on a specific subject. This study is divided into five steps: 1) Problem formulation; 2) Data collection; 3) Data assessment; 4) Analysis and interpretation of the data collected and 5) Results presentation.

In view of the objective of this RIL, problem formulation was given by the following guiding question: what are the characteristics of therapeutic projects used to assist the subject in psychological suffering? The survey of scientific productions was carried out in July 2017 in the following electronic databases: Latin American & Caribbean Literature in Health Sciences (LILACS), Medical Literature Analysis and Retrieval System Online (MEDLINE) and Nursing Database (BDENF - *Base de Dados de Enfermagem*). The choice of the first two bases was due to incorporate a large volume of studies on the proposed theme. The third presents the theme of interest of this study in the productions inserted in the nursing context.

Access to the selected electronic databases was carried out through the Regional Portal of the Virtual Health Library (VHL). The following subjects were used: "Mental health" AND "Therapeutic Project", in the field destined to the research in "Title, abstract, subject". The study was chosen because of the lack of specific descriptors for the subject, thus allowing the capture of studies on the proposed theme. Figure 1 shows the flowchart of the steps followed until the final sample was obtained.

The inclusion criteria adopted for the sample of this study were: experience-type studies; case study and original articles; published in national and international journals; that have used qualitative, quantitative and quantitative approaches; published between the years 2002 and 2016; in Portuguese, Spanish and English; available online; and with full text. The exclusion criteria were: studies that dealt with institutional (service) therapeutic projects; and other articles that did not address the research topic or did not answer the guiding question.

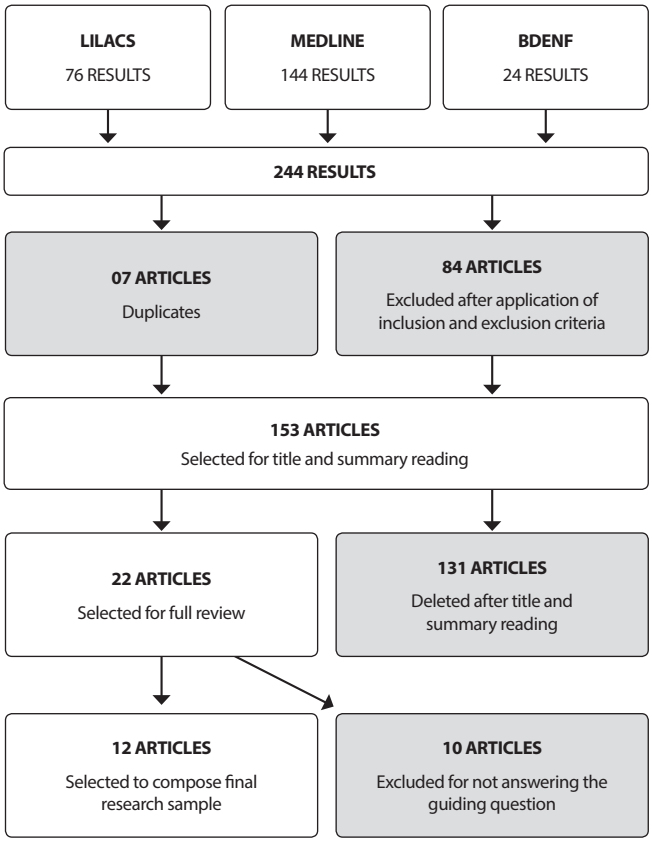

Figure 1 – Flowchart of the research steps, 2017

Data analysis

After applying the inclusion and exclusion criteria, there were 12 articles that composed the final sample of this ILR, as shown in Chart 1, highlighting the title, place of study, year of publication and main results of each selected article. At this step, the data were assessed, in order to verify their adequacy to the research theme[14]. Triage was carried out by critical reading of the selected studies, which answered the guiding question of this RIL. A data collection tool previously developed for this purpose was used, containing identification data (authors, journal in which it was published, year of publication), objectives, methods used (type of study, participants, location where it was developed and collection techniques) and results.

Chart 1 – Title, place, year of publication and main results found

A*	Title	Year/place of publication**	Main Results
01	*A construção de um projeto terapêutico singular com usuário e família: potencialidades e limitações*	2012 Mato Grosso	• Embracement as a way of approaching users aiming at link building; • Importance of home visit to include family members in care.

To be continued

Chart 1

A*	Title	Year/place of publication**	Main Results
02	*A prática do apoio matricial e os seus efeitos na Atenção Primária à Saúde*	2016 Espírito Santo	• Search for immediate answers aimed at healing, referring to the biomedical model; • Difficulty creating links with users; • Matrix support as a facilitator of qualified listening, co-responsibility for care, and reduction of unnecessary referrals.
03	*Apoio matricial: dispositivo para resolução de casos clínicos de saúde mental na Atenção Primária à Saúde*	2013 Ceará	• Team stigma in seeing mental health demands; • Importance of the link to the discussion of issues little explored; • Need to expand the therapeutic offer; • Team search in broadening the dialogue and listening; • Importance of matrix support for mental health care; • Importance of light technologies, affection clinics and co-responsibility.
04	*Apoio matricial, projeto terapêutico singular e produção do cuidado em saúde mental*	2015 Ceará	• Centered-medical work and intense influence of classical psychiatry geared towards medicalization, but difficulty of physicians in prescribing psychotropics; • Articulation with devices of the territory to compose PTS and punctual attempts of articulation in network; • Unpreparedness and impotence of professionals in dealing with clinical cases of mental health; • Lack of user participation in the elaboration of their PTS; • Need for permanent education for the Family Health Strategy (FHS) team; • Encouraging interdisciplinary work at FHS.
05	*O projeto terapêutico nos CAPSs de Mato Grosso: uma análise documental*	2009 Mato Grosso	• Performances on an authoritarian, repressive and punitive basis with emphasis on pre-established rules and norms; • User has the possibility of disconnection or suspension of the service if it exceeds the number of allowed faults; • Lack of family support; • Concern about identifying those responsible for users; • Lack of linkage and participation of users in PTS construction, considering that only one document brought the participation of users in the decisions of its therapeutic project.
06	*O Projeto Terapêutico Singular e as práticas de saúde mental nos Núcleos de Apoio à Saúde da Família (NASF) em Guarulhos (SP), Brasil*	2013 São Paulo	• Lack of physical space for extended meetings and basic communication technologies such as telephone and computer; • Lack of capacity to perform primary health care and mint health; • Absence of PHC physicians at meetings with the NASF; • Meetings guided by referral guides, without information from users and without preparation of the team to discuss the cases taken to the matriciamento; • Embarrassment, distrust and detachment between teams; • NASF team work overloads; • Lack of intersectoral involvement and networking; • Feeling of professional dassessment.
07	*Os desafios da integralidade em um Centro de Atenção Psicossocial e a produção de projetos terapêuticos*	2011 São Paulo	• Deficiency of records in medical records; • Lack of sharing of PTS information among team members; • Difficulty of night shift being present at case discussion meetings; • Need for interventions with family members and home visits; • Need for a less compartmentalized practice.
08	*Projeto terapêutico de usuários de crack e álcool atendidos no centro de atenção psicossocial*	2015 Ceará	• Individual and group approaches; • Performance of multidisciplinary team in the development of activities; • Risk of fragmentation of care and need for interdisciplinary action; • Assessment of therapeutic projects through consultations with the medical clinic; • Active search through home visits to redeem the link; • Incomplete information in records, with inadequate filling and unreadable letter.
09	*Projeto terapêutico em Saúde Mental: práticas e processos nas dimensões constituintes da atenção psicossocial*	2016 Ceará	• Participation of the team in decisions and planning of actions from the political guidelines of the Psychosocial Care Center (CAPS - *Centro de Atenção Psicossocial*); • Underestimation of sociocultural aspects; • Fragmentation of care evidenced by specialization in action organization and lack of knowledge interlocution; • Lack of user participation in the process of discussion and elaboration of its therapeutic project; • Lack of linkage and co-responsibility, evidencing the lack of interventions in the socio-affective field; • Preponderance of the biomedical model evidenced by the formatting of the supply of care strategies; • Challenge to ensure the construction of PTS that promotes psychosocial care and can cover the affective dimension.

To be continued

Chart 1 (concluded)

A*	Title	Year/place of publication**	Main Results
10	*Projeto terapêutico singular na produção do cuidado integral: uma construção coletiva*	2011 Ceará	• PTS is based on the mutual effort between health-user-family worker; • Users interact at any moment in the process; • Prioritization of networking; • There are meetings to discuss the work process; • Consideration of the social spaces of users; • Hosting based on active listening and bonding; • Interconnection between ESF and CAPS to identify care needs of users; • PTS considers the opinions, dreams and purposes of the user's life, establishing a horizontal relationship between worker-user-family; • Responsibility for monitoring PTS does not lie solely with the Reference Technician (RT).
11	*Projeto terapêutico singular no âmbito da saúde mental: uma experiência no curso de graduação em medicina*	2014 São Paulo	• Semi-structured interview for bonding; • Follow-up of the case through meetings with sequential themes; • Challenge in enabling users a moment of listening and therapeutic orientation according to their own demands.
12	*Projeto terapêutico singular para profissionais da estratégia de saúde da família*	2016 Santa Catarina	• Difficulty organizing teamwork as an obstacle in the elaboration of PTS as routine; • Non-standardized records and parallel information hampering communication; • Lack of joint organization and planning of care actions for users and family; • Excess demand from users; • The need for a computerized interconnected system for recording information shared between CAPS and FHS.

*Note: * Article; ** Brazil's Federation Unit.*

RESULTS

Based on the analysis of study objectives, the importance of Matrix Support on the development of PTS is made evident, showing the clear necessity that PHC services have towards specialized care in Mental Health, as it happens with Family Health Support Cores (NASF – *Núcleos de Apoio à Saúde da Família*) and mental health teams in municipalities.

Regarding the research approach herein used, all the selected articles are qualitative studies. As a data collection technique, semi-structured interview was used on five of the 13 selected articles (which do not specify the kind of study performed): three articles were experience reports, two used document analysis method, one article was a cartography research, and another one was a case study.

Regarding the study location, six out of 12 articles had the Psychosocial Care Center (CAPS – *Centro de Atenção Psicossocial*) as their exclusive research location, three articles had basic health care units as study locations, two articles were made with data collected both in CAPS and in basic health care units, and a single article had a Primary Care Support Core (NAAB - *Núcleo de Apoio à Atenção Básica*) and a NASF as basis.

Among the research locations for the selected articles, two components of the Psychosocial Care Network (RAPS – *Rede de Atenção Psicossocial*) are highlighted: Primary Health Care, including Family Health Strategy (FHS - *Estratégia Saúde da Família*), since NAAB and NASF appear as research fields of at least 40% (five articles) of the selected studies; and Strategic Psychosocial Care, which refers to different CAPS models, portrays approximately 60% (eight articles) of the research papers sampled in this review.

It must be made clear that all articles had, as their research field or data source, services that are part of RAPS, which was sanctioned by Ordinance n. 3088/2011 and republished in 2013, aiming mainly at broadening access to psychosocial care, regarding people in psychological suffering, with mental disorders and with necessities arising from substance abuse (crack, alcohol and other drugs), at SUS level[15].

Chart 2 – Categorization of selected articles according to Singular Therapeutic Project steps

	CHARACTERISTICS	ARTICLES											
		A1	A2	A3	A4	A5	A6	A7	A8	A9	A10	A11	A12
1st STEP	Embracement and situational analysis of the case	X	X	X	X	X	X	X	X	X	X	X	X
	Comprehensiveness (physical, psychic and social aspects)	X	X	X	-	-	-	X	X	-	X	X	-
2nd STEP	Actions	X	X	X	X	X	X	X	X	-	X	X	X
	Goals	-	X	-	-	-	-	-	X	-	X	X	X
	Discussion with subject about actions and/or goals	X	X	X	-	-	-	X	X	-	X	X	X
	Discussion with team about the PTS under study	X	X	X	-	-	-	X	X	X	X	X	X
3rd STEP	Sharing responsibility in the teams	-	X	X	-	-	-	X	X	X	X	X	-
	Co-responsibility (team/user)	X	X	X	-	-	-	X	X	-	X	X	X
	Definition of PTS by RT	-	X	-	-	-	-	X	X	-	X	-	-
4th STEP	PTS reassessment with subject and team	-	X	-	-	-	-	X	X	-	X	X	X

Note: RT (Reference Technician); PTS (Singular Therapeutic Project).

Considering the participants of the selected research papers, two articles used available institutional documents as data collection sources, such as medical records and other data logs; five articles had health care professionals as research subjects, exclusively; two articles were based on spoken accounts, both from health care professionals and from service users; one article, besides health care professionals, also counted on the participation of family members from service users; another study had only users as participants; and the last article brought data from service users and their family members.

Concerning the place where the studies were carried out, the state of Ceará must be highlighted, as it was the scenario of five out of the 12 selected articles, followed by the states of São Paulo and Mato Grosso, with three and two articles, respectively. The states of Espírito Santo and Santa Catarina produced a study each. All articles were published in Portuguese, in 11 Brazilian journals. It must be informed that, even though article search was carried out in Portuguese, English and Spanish, because the theme is particularly Brazilian, findings were limited to the national scope.

In order to carry out the analysis of PTS, the chosen concept reference was the Health Ministry recommended steps (moments) for the development of a PTS: Step 1 – Diagnosis and analysis; Step 2 – Action definition and goals; Step 3 – Sharing responsibilities; and Step 4 – Reassessment. Thus, articles were categorized according to PTS steps, as shown in Chart 2.

DISCUSSION

The first PTS step consists of diagnostic and situational analysis of the case, assessing the subjects' potentialities, beliefs, values, risks, vulnerabilities and social, family, cultural, psychic, and physical aspects. It is on that occasion that the initial bond with the patient is established, and professionals must act in an empathetic manner, guiding embracement as to guarantee the comprehensiveness of the matters that involve each individual[5].

The 12 studied articles brought, as the initial part of a PTS development, the creation of a bond and embracement of subjects, however, it is noticeable how greatly divergent is the way this initial contact is performed and carried out.

It is made evident, at times, the lacking of an adequate embracement due to professionals' difficulty to perform empathetic and qualified listening, since there is a lack of use of lighter health care technologies (relational technologies), causing an impotence sensation on professionals who, oftentimes, fear to be harmed by individuals in psychic suffering[16].

An initial approach based on qualified listening is essential for establishing the bond and for the detection of situations to be discussed and worked throughout PTS planning. Understanding the subject in the physical, social, cultural and emotional aspects is the first step for a singular care that values comprehensiveness[17]. One of the interventions mentioned in a study made in an ESF was the mapping of available resources in the community, such as health care equipment and services, schools, and cultural/sports activities, so they could be added to actions and PTS development possibilities, favoring the comprehensiveness of care so it is not restricted to a single dimension of the individual's life[16].

However, it is observed that the difficulty or even absence of intersectional articulation and network treatment, mainly in matters related to violence and social ruptures throughout the development of a PTS, even with matrix support in NAAB and NASF teams[18]. Neglect towards subjective issues of the environment where users are inserted can be noticed from the speech of some patients (individuals) as they complain about the treatment they received in certain health services, criticizing objective therapeutic approaches that are restricted to the indication and use of medication and the reissue of prescriptions[19].

In the second step of PTS development, the actions and goals are defined for the long, medium and long term, to be reached through treatment, so making sure that the importance of this moment lies in the participation of users on decisions to be taken and intended goals, since that is a shared process between team and user[5].

Given data analysis, it is noticeable that actions proposed in PTS are established in at least seven of the 12 articles (A1, A2, A3, A7, A8, A10 e A11). However, the way that step is carried out varies a lot in the different described health care services.

The difficulty to program actions in a joint effort (team/user/family) is made evident since users are, many times, not allowed to take part in this step, being asked to leave the case discussion place[20]. Nevertheless, actions established in a PTS must be flexible, so they may be modified by the professionals who follow-up the case, always considering the opinions of users, his perspective, preferences, particularities and possibilities[16,21-22].

Situations were observed where actions were restricted to referring patients to specialized mental health services, although in many cases there was no need for that, since the subject could be treated at the original health care unit[16]. In this context, diverging from the Health Ministry recommendations for establishing goals in PTS, seven articles did not mention the existence of goals in PTSs, and those which mentioned them, did not clearly present goals for the short, medium and long term.

There are challenges to be overcome in the field of communication between team and user, since it is not rare to observe a user being adamant on not accepting some proposals made by the team during the development of his PTS. In some cases, this situation causes discomfort among professionals to offer alternatives that embrace the user's expectations[20]. On the other hand, users frequently lacks critical judgement in relation to his health condition and it is up to the professionals who treat him to create discussion and reflection spaces about his needs[23].

Another aspect of communication refers to sharing information about PTS, thus, case discussion with the team that offers care to each user is indispensable for the development and evolution of PTS. However, it is evident that information is not always shared satisfactorily. One of the highlighted hindering issues is the scheduled time of meetings for case discussion, making participation impossible for all work shifts involved in patient care, especially in health care services that also open at night, for example[24].

Moreover, important communication problems were detected, such as the lack of records of interventions made by other professionals, what raises another obstacle for the adequate continuity of care, as well as lacking infrastructure and places to hold team meetings, which oftentimes need to be held in venues offered by the community, usually of difficult access or far from the health

care unit[17-18,24]. Those situations show the difficulty to share information and harm the interdisciplinary action that must be aimed at integral and continuous care.

The third step must be responsibility sharing among all PTS-involved parties (user, family, teams, etc.). In this moment, the PTS reference technician (TR – *técnico de referência*) is defined, i.e., the professional who shall more actively follow the case, where it can be the manager of the therapeutic project. It is advisable that the choice of this professional be based on the bond he developed with users, because it facilitates care and the idea of co-responsibility, which sums up the third step[5].

The necessity to define a RT to facilitate management and follow-up of PTS must be emphasized, where this professional is, preferentially, somebody who has a good bond with users and knows the case in as much detail as possible, since the RT shall be an important link between team and user. It is highlighted that the RT of PTS must follow up the project actions and establish partnership relations with available support networks[16-17]. However, it is observed that the choice of this professional is rarely based on the bond, but rather in the organizational logistics of services, since the professional who carries out the initial embracement of users, in most studies, is automatically appointed as the RT for the follow-up of the individual under care[20,24].

It is important that each PTS development step be shared with the subject, who shall be the protagonist of the project, so since the beginning the concept of co-responsibility be made evident, thus both the reference team and the individual participate on PTS planning and execution. In this moment, it is the PTS development team's duty to identify, alongside users, how they intend to carry out his treatment and whether, at that point in time, he is able to manage his actions and decision-making by himself[20]. This posture allows better results and accession to established actions and goals, since they were thought together rather than imposed as a therapeutic plan driven by the professional (inflexible).

Nevertheless, during PTS construction process, a lack of dialog and negotiation between involved parties is frequently observed, because the protagonism of users and their families is not taken into account in this process[25-26]. The participation of teams in users' PTS is intrinsic to the co-responsibility process. However, in some health care units, a repressive health care model is still in force, which threatens to abandon and "punish" patients who do not rigorously follow the rules imposed by the service, what echoes on the team's abstention to provide medication, to treat urgencies and to make house calls. There is a lack of identification of the team with the service they provide, what makes evident the technical neglect that denies users' their basic rights, demanding the individual in psychic suffering to have full responsibility for his treatment[27].

Besides matters related to responsibility sharing within a single PTS management team, the lack of definition for the role of specialized service teams is noticeable when they are articulated with primary care units through matrixing, especially those provided by the Family Health Support Cores. That is to say, at times it is not clearly defined who shall be responsible for decision-making and PTS execution, so a doubt prevails in relation to whom users "belong" and whose is the responsibility for his health care[18].

Another aspect that was made evident is the fragmentation of care due to specialization in action definition, what betakes an exclusionary assistance model where each knowledge core closes up in its own activities, turning a process that should be interdisciplinary, subjective, and shared, into a worked that is based on protocolized techniques, exclusive to the knowledge field of each profession that takes part in the multidisciplinary team. This team work model, however well-meaning and somewhat practical it intends to be, makes the sharing of knowledge impossible, yet that is essential to the development of a PTS that is truly singular and directed to several multicentric matters of the individual's life[26].

The fourth and last PTS step is the moment of reassessment. In this occasion, which must be periodic, the evolution of treatment is discussed with users, as well as the advances and difficulties faced until that moment, recombination is made, new actions are incorporated (if necessary) and new goals are set. Thus, this step can be summed up as a PTS inventory[5].

Perhaps the biggest fragility found in the studies is the difficulty of PTS reassessment, because such difficulties derive from multiple sources, from the lack of physical structure to gather team and user to assess the progress of his treatment, to the lack of communication within the team[17-18]. Moreover, when PTS reassessment is made, it is evident that there is an effort so it is carried out and discussed only among team professionals, excluding the patient from this step, thus restricting his protagonism and offering only a notification to wait for instructions on the next steps of his treatment[23]. In the analyzed studies, the establishment of periodical PTS reassessment is not observed, similarly to the observation of frequent inexistence of goals with defined deadlines.

Study limitations

As a limitation of the study, the absence of foreign articles about the theme is noticed, since PTS with prerogatives proposed by the Health Ministry is an intimately Brazilian tool, what makes it difficult to draw comparisons of this kind of mental health care tool in international scope. Furthermore, the heterogeneity of studies does not make it possible to assess all aspects involved in PTS development, due to superficial information provided, and due to the fact that objectives and research methods of the studies were very varied, what consists of a limitation in this integrative review. Nonetheless, the findings revealed by this study show the necessity to problematize the configuration (structure) and the use of PTS in mental health services, since it is an important tool for the integral care of users (subjects in psychic suffering).

Contribution to Health

This study contributes to better understand how PTS is used in the scope of mental health care in Brazil so that, from that knowledge, it is possible to problematize the use of PTS as a (personalized and integral) care tool for individuals in psychic suffering.

This study reinforces, moreover, the necessity of a paradigm shift in mental health care, contributing for the strengthening and

empowerment of health care professionals on the importance of a versatile multi-professional therapeutic strategy, such as PTS. It is expected that the knowledge obtained with this integrative review may promote critical and reflective thinking that results in better applicability and use of PTS potential.

FINAL CONSIDERATIONS

Critical analysis of the selected articles in this integrative review made it possible to highlight different ways of how PTSs are configured and carried out in the studied scenarios. There is great dissociation, in most studies, between what is recommended by the Health Ministry and what is performed in care practice in mental health services.

The importance of the bond with users is acknowledged, as well as the use of other light technologies in health care to facilitate this process. However, it is observed that there is a certain difficulty in performing active listening and to make the bond effective, due to fear of aggression from users and to little autonomy, as made evident by the dependency of support from specialized mental health care services.

There is some deficit related to the situational diagnostic of cases which, oftentimes, leads to unnecessary referrals to specialized mental health care services and to great difficulty to integrate the resources of the psychosocial network, as well as to incorporate territorial resources of therapeutic nature, such as schools and cultural centers, in the subject's action plan.

Regarding the establishment of actions and goals, it is indispensable, as to act in a joint and even fair manner, to take into consideration the implication of users (their anxieties, wishes, interests and involvement), because it is the path of his treatment that is discussed at that moment, aiming at an improvement of his quality of life and health, within his possibilities. Those aspects are not clearly mentioned in a large part of the analyzed studies, where many times actions are preestablished as a singular care plan. Furthermore, there are not enough data about the definition of goals, nor about the establishment of deadlines for set objectives.

Another point to be emphasized is the importance of co-responsibility and user protagonism, since it can be noticed that some health care services value those aspects, establishing shared actions and moments of greater interaction with users. However, other services impose rules (services of high demand), making the subject's protagonism impossible and any shared decision-making inviable. Such dissonance takes us to the fact that PTS may still be an underused tool in its comprehensiveness, and which is still in an adaptation process to routine use in services.

Results suggest wide divergence between Ministry of Health recommendations for PTS development and how that care tool is truly carried out, with highlight to the little participation and co-responsibility of team/user in the development of projects, the excess of unnecessary referrals to specialized mental health care services, the fragmentation of knowledge within the multidisciplinary team, and the difficulty to share and discuss information about cases.

PTS is doubtlessly a tool with great potential in mental health care. This research makes evident that there is a long path to be traversed until services can adequate the pertinent systematization to a tool that proposes a certain level of standardization in its development, to singularity and the needs of each individual.

A suggestion for future studies is a more detailed follow-up of the PTS development steps in health services, as well as establishing a comparison between PTS used in different Brazilian experiences with other tools (care projects and plans) used internationally. Another point to be explored is the identification of dimensions where PTS can be useful, such as studies that aim to introduce it on mental health care beyond PHC and CAPS, contributing to a better understanding of its therapeutic potential.

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