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Analysis of reference work in Psychosocial Care Centers

ABSTRACT

OBJECTIVE: To analyze how psychosocial care center users, family members and workers assess related work by reference team and professionals.

METHODS: Qualitative research based on Constructivist Paradigm and Gadamerian Hermeneutics. Two cycles of focus groups consisting of professionals, users and users' family members from all psychosocial care centers in the city of Campinas (Southeastern Brazil), in 2006, were analyzed.

RESULTS: Reference work was assessed as an arrangement that has therapeutic effects and contributes to the work organization efficacy. However, risks related to power centralized by reference professionals and to workers' suffering, as these may feel overly responsible for the case they are reference for, were reported.

CONCLUSIONS: The effects of the "reference team/professionals" arrangement on patients are based on emotional aspects associated with reliability, constancy and integrality of care. In contrast, such aspects also show relationship problems, especially as regards omnipotence, which may involve the worker.

DESCRIPTORS: Patient Care Team. Institutional Management Teams. Patient-Centered Care. Professional-Patient Relations. Mental Health Services, manpower. Qualitative Research.

INTRODUCTION

Current Brazilian mental health policies invest in country and community services, such as the *Centros de Atenção Psicossocial* – CAPS (Psychosocial Care Centers).^a These are instruments that promote complete care to people with severe and persistent mental disorders by developing clinical practices that enable them to live in a community, and to have access to work, leisure and civil rights.^b

CAPS require that new forms of clinical work and institutional organization be designed for their implementation and qualification.^c Among these, reference teams/professionals³ stand out, an arrangement that is based on interdisciplinarity and the bond between professional and user to provide patients with unique, complete care. Every professional or group of workers from distinct categories must be reference for a certain number of users to put this arrangement into practice. They achieve this by being responsible for the designing, application and assessment of a therapeutic project, with objectives that are prepared together

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^a Ministério da Saúde. Secretaria de Atenção à Saúde. Departamento de Ações Programáticas Estratégicas. Saúde mental no SUS: os centros de atenção psicossocial. Brasília; 2004.

^b Ministério da Saúde. Coordenação Geral de Saúde Mental. Saúde mental no SUS. *Bol Inf Saude Mental*. 2005;4(8).

^c Ministério da Saúde. Coordenação Geral de Saúde Mental. Relatório da gestão 2003-2006. Saúde mental no SUS: acesso ao tratamento e mudança do modelo de atenção. Brasília; 2007.

and satisfactorily pursued. The key feature is the fact that the professional, by means of a shared plan, becomes responsible for following the patient, considering social, familial, political, and psychological aspects.^{8,9} The reference teams/professionals arrangement seeks to maximize the effects of shared management of interdisciplinary services, overcoming hierarchical, fragmented and authoritarian organization models.⁴

In other countries, mental health policies adopt a type of work which is closer to reference Brazilian professional teams, called case management. In this process, a professional or team takes responsibility for maintaining a supportive relationship with a patient, regardless of where this patient is and the number of health, educational, social, or cultural institutions involved. The purpose of case management is to identify and guarantee internal and external resources that are essential for life in society. One of the contributions of this type of work was the substantial decrease in the number of psychiatric hospitalizations and re-hospitalizations and the improvement in patients' quality of life.¹⁸

In Brazil, work with reference professionals is recommended in material on CAPS prepared by the Ministry of Health in 2004.^a According to this document, it is the reference professional, through dialogue with the technical team and the user, who is in charge of monitoring the individual therapeutic project, making contact with the patient's family, and regularly assessing the target goals.

However, there are no scientific studies that assess the implementation and impact of the reference arrangement. Few publications on the reference work clinic aimed at psychotic patients, their functions and specificities can be found.⁸

Given the official recommendation for its use, this study aimed to analyze how workers, users and family members assess reference teams from psychosocial care centers. The purpose is to understand if this arrangement has therapeutic effects, what theoretical conceptions its practice has been based on, and what its result is in the work organization and workers' psychic life.

METHODS

This study is part of the research on CAPS network assessment in the city of Campinas, Southeastern Brazil.^b It is qualitative, evaluating and participatory in nature, based on Gadamerian Hermeneutics¹⁰ and the constructivist paradigm. According to this paradigm, there are multiple, socially-constructed realities, not governed by natural laws. The truth is defined by consensus,

and the epistemology is subjectivist, once it considers interaction and mutual re-construction among object, observer and reality.¹⁴ Such re-construction is made possible through what Gadamer calls tradition, as well as through the possibility of considering objects under distinct forms in which they present themselves and in different ways people can see them.

CAPS that care for adults were the ones studied: five CAPS III (which operate 24 hours a day and have night shelter beds) and one CAPS II (which operate 12 hours a day, everyday). The arrangement studied was used by all these CAPS, whose teams were free to choose how to organize it (in teams, pairs, groups of three or reference professionals).

Data were gathered through two cycles of focus groups¹⁵ comprised of professionals, users and family members. In each cycle, one group with family members (two from each service), one group with users (two from each service), and six groups consisting of 12 workers from each CAPS, respectively, were formed, thus totaling ten groups in the first cycle of research and ten in the second cycle. The questions discussed were related to the whole CAPS work structure. Among the topics discussed, that which refers to reference work is presented here.

An intentional sample was used to form the groups¹⁵ and the inclusion criterion was that participants had to be enrolled for more than six months in the service. As regards the group of professionals, representatives from the university and high-school categories who worked directly with care were requested to be present. The guest users should have had experience using the CAPS night bed, thus being aware of the reference care during crises. There was no loss of people between the two cycles of groups.

Understanding discourses on the participants' practices was achieved by narrative construction.^{7,17} After transcription of focus groups, a narrative was constructed for each group, formalizing the contents discussed.¹⁷ These narratives were read to their respective participants in the second cycle of groups and could be deepened, reviewed and validated.

After this review, the groups' narratives and transcriptions were used again to make an analysis that involved their contents and discourses, emphasizing the key issues and the tradition they are based on, as suggested by Gadamer. For this reason, all transcriptions and narratives were read, followed by the identification of the most problematic aspects raised by participants and the identification of each group's inner logic. A total of three

^a Ministério da Saúde. Secretaria de Atenção à Saúde. Departamento de Ações Programáticas Estratégicas. Saúde mental no SUS: os centros de atenção psicossocial. Brasília; 2004.

^b Onocko Campos RT, Furtado JP. Pesquisa avaliativa de uma rede de centros de atenção psicossocial: entre a saúde coletiva e a saúde mental. Campinas: Unicamp; 2005.

analysis categories were established: work organization, therapeutic function, and suffering at work. Reflections were compared among groups and results were contrasted with the existing literature on the analysis.¹⁴

This research was approved by the Ethics Committees of the Department of Health from the city of Campinas and of the *Faculdade de Ciências Médicas da Unicamp* (State University of Campinas School of Medical Sciences) (report n° 396/2004). Participants signed an informed consent form, in accordance with the Resolution 196/1996 from the *Conselho Nacional de Saúde* (National Health Council).

RESULTS

Users, family members and professionals reported that the reference work was used in all services, produced therapeutic effects and contributed to the effectiveness of the work organization. However, they revealed that the clinical work of reference teams required further clarification as regards its functions.

CAPS users reported that they had a reference team comprised of a group of professionals who, along with the doctor, shared patients and gave more attention to those from their team. For users, “each doctor has his/her reference” and professionals from several other categories helped him/her. They reported that they form a group with reference patients and professionals – the reference group – a mechanism through which “life is straightened out and one learns about how another’s life is going”. At the same time, they explained that “the reference professional is the one employee” they most usually sought to talk to, the one with whom they decided when they would go to the CAPS, and who looked after them, giving more attention when they were not well and feeling concerned when they did not go to the service. In addition, they mentioned that the reference professional was the one who received them at the CAPS or went to pick them up where they live, the one they really trusted in. They also reported feeling they had been really helped, given the terrible suffering which causes them not to wish to live, to become aggressive, or “to carry a head that does not belong to them”.

Family members explained that the reference team was necessary as it was impossible to care for all the patients at the same time. Thus, they were divided into groups of professionals who cared for specific patients. The reference professional was the person closest to the patient and whom family members sought to know “everything that had been going on”, once he/she “knew best about the patient, followed them directly and made note of everything”.

The focus groups with workers revealed that some CAPS concentrated therapeutic projects on one reference professional and used the reference team as a way to share experiences related to the follow-up of cases.

Others considered it to be a patient’s follow-up unit, yet others used both ways of working and emphasized that, sometimes, team members needed to divide the functions in the patient’s treatment, even though the reference professional was “always the key member, the center”.

According to workers, the reference professional of each patient who arrived at the service was usually the one who first saw them in the screening process. There were no criteria to qualify the professional who would serve as reference for each patient, but doctors would not usually do this directly, even though they belonged to a reference team. Moreover, the number of patients per professional was not limited.

At some CAPS, workers viewed concentrating functions on one professional as a necessity, once they argued that, when many were responsible for one patient, perhaps nobody would take responsibility for the required tasks. Other groups pointed out that the organization in the reference team would allow cases to be shared, reducing the discomfort of solitary work, such as the clinical reception, and minimizing the risk of unchanging behavior. These groups reported that the reference team enabled patient’s transference to occur with more than one worker, decreasing the potential “weight of strong transference” with their reference professional. In addition, the reference team enabled to manage problems caused by high turnover of doctors and to encourage them to share their practice.

When asked about the purpose of the reference team, workers mentioned its organizational use for the service and for contacting the network. However, groups spent more time discussing the functions related to the reference professional: articulation of the treatment with the patient, identifying needs, wishes, possibilities and limitations. It means to be responsible for updating medical records, making contact with the family, articulating the treatment and assessing the therapeutic project.

The reference work was, according to some professionals, an “operational function that seeks what the patient needs”. Reference was also associated with a task, bureaucratic at times, even though it always implied important closeness to the patient. The reference professional was described as the first one who saw the user, mediated their relationship with the institution, and was available when there were problems, being characterized as “emotional reference”. “They bring with them a little of the patient’s actual story” and are eventually called on by the team to explain about the well-being, or the lack thereof, of the one they are reference for, once they are “held responsible” for this patient. At the same time, they were involved with emotional issues that were intrinsic to a profound therapeutic relationship with the user. They also tend to have difficulty sharing the case with colleagues, once they believe they can “manage to do everything”.

Another difficulty identified in the reference work regards the nature of the tasks, which are usually distant from each worker's field of knowledge, and to which there was no specific qualification at all. Thus, inter-disciplinarity was viewed as essential, yet difficult to achieve.

During the validation of narratives, there was a debate, in some groups, about the possible dangers involved with reference work. Some workers observed the risk that, due to excessive responsibility for the patient, the work would be focused on the reference professional, comparable to the focus on doctors in institutions for the elderly. In contrast, another group pointed out that the reference was more of a function associated with reliability, rather than someone with specific qualities.

When asked about the theoretical parameter the reference work is based on, some groups explained that this does not exist. Others said that the professional uses that with which they have more affinity with. Yet others mentioned two modern authors of Collective Health, and were not restricted by the topic.

DISCUSSION

Reference function and the service organization

Workers, family members and users were unanimous when assessing that the arrangement under study is useful for the work organization. However, the choice between work with a professional and with a reference team could not be made; both exist in practice and are acknowledged in terms of their therapeutic functions. In the present study, the reference work was analyzed as a whole, and was not associated with specific characteristics of each service.

Among users and family members, the arrangement seems to respond to the recommended functions of forming bonds and being responsible for the case. In contrast, workers emphasized that the reference work increases the exchange of knowledge, decentralizes power and promotes sharing of practical tasks and affective experiences. However, it frequently leads to problems in the work process and ends up creating new forms of power centralization and suffering associated with the feeling of responsibility for the patient's life.³

As regards power decentralization, even though it is not the doctor's responsibility to make all decisions on a certain treatment, according to users, he/she has a key role in the make-up of teams. Workers, however, identified the reference team as a protection against high turnover of doctors and the difficulty they have to share their actions. Nonetheless, workers paradoxically pointed to the risk that the reference professional may centralize power on the patient. Thus, even though the

reference team can be used to form bonds that surpass the doctor's power centralization, without diminishing their importance to patients, it has not been able to prevent a tendency towards knowledge monopolization of a case. However, according to workers, the team is useful for the development of transference with more than one professional, that is, it does not prevent complete knowledge centralization, but enables the establishment of other emotional bonds.

A study on reference teams at *Unidades Básicas de Saúde* (Basic Health Units) shows that this arrangement faces obstacles to maintain its objectives, due to high competitiveness among professionals. This creates reactive and paranoid subjective patterns, leading professionals to be unwilling to change their own knowledge and attack whatever seems to differ from this.³ Thus, the difficulty pointed out by workers about the nature of the tasks of the reference professional is understandable: they are connected to the field of mental health, rather than the specific core of a given profession. As a result, these tasks demand a context of inter-subjective relationships in a multi-professional team that enables some level of interaction.

International research shows a decrease in problem-solving capacity by case management due to the following factors: an excessive number of patients, the stigma that surrounds them, inadequate living conditions, poverty and unemployment. They suggest that professionals, when overburdened, cannot identify the patients' needs and perform flexible and creative jobs.¹⁸

Reference function and the clinic

As regards the therapeutic effects of the reference professional's work, there are differences between the users' and the workers' discourses. Among users, an intimate relationship with the reference professional is identified, in which they create a type of emotional support, based on the acquisition of trust and the possibility of finding a measure of existence, once they constantly feel they are noticed in their singularity. This support enables them to continue to live in the social world, despite their terrible psychic suffering.²⁰

In general, workers emphasized that the reference work allows them to articulate the treatment and associate it with bureaucratic and organizational tasks, without revealing their clinical nature. However, they reported the reference professional should be in charge of identifying the patient's needs, wishes, possibilities and limitations, thus placing them as emotional reference. Nonetheless, there was no allusion to the interpersonal relationship between the reference team and the professional as the core of the clinic to be developed. The articulation of the treatment and identification of patients' needs are mentioned as actions centered on the reference professional, rather than a relationship process.

As regards the clinic, it is necessary to consider that, by dismissing the proposal to analyze the disease as separate from the person who has it,¹ health care constantly takes into consideration the worker's own subjectivity, once it requires them to truly make contact with the other and let themselves be influenced. In this sense, some policies from the *Sistema Único de Saúde* – SUS (Unified Health System) affirm that the clinic is a practice of destabilization and movement, which affects both users and workers.¹⁶

The type of clinic CAPS patients need is the one that enables them to experience emotional issues, even though they may be involved with crises, and also provides conditions for the establishment of inter-personal relationships that allow them to be in contact with other than themselves and to share a social world. For these relationships, the professional team is reliable, constant and available to share experiences of suffering.²⁰ As a result, it is expected that reflections on the reference professionals'/teams' clinical work be based on the relationship process that involves workers and patient, so that the therapeutic project is designed from this process, rather than the reference professional's knowledge.

Authors point out that Collective Health has considered the clinic only partially, in fragments. Another problem is that workers incorporated some ideological debates over the *Luta Antimanicomial* (Anti-Asylum Struggle), disregarding the fact that the disease continues to exist, even though it should be "put in quotes".⁵ Thus, the reference function is supposedly separate from its clinical dimension. To be separate does not mean to be inexistent, but rather that it is not integrated to its objective, practice and results.¹²

Other studies show that the formal characterization of mental health equipment reveals substantial restriction on investments in the clinical area. Concomitantly, workers only recognize the clinical dimension of their practices in psychotherapy care, groups and therapeutic follow-up. Narrowly associated with the assessment that it would be a "good clinic", psychoanalysis is restricted to the field of theory and to what the professional could do if there were proper settings.^{6,13} Once they cannot count on such settings, the service organization, work division and bureaucracy are what remain to the reference teams/professionals.

Some authors suggest that university course curricula do not follow the changes in public health and professionals who graduate are not qualified for clinical work beyond old-fashioned models of private practices.^{2,4} This could contribute to some of the difficulties, as mentioned by workers, in relation to mental health practices that are distant from their area of qualification.

The vague allusion to theoretical reference points, which would probably support the reference team/professional arrangement, indicates that the work has been conceived in terms of its apparently bureaucratic

aspects. In spite of this, in the field of relationships between workers and users, therapeutic processes take place, as acknowledged by the latter. However, there are few academic studies on the reference work clinic, in the particular context of mental health,⁸ thus limiting professionals to a more theoretical basis and also the possibilities of associating this work with the clinic.

As part of this problem, there are family members reflecting on the function under study, pointing out that the reference professional cares for some of the patients exclusively. However, he/she cares for them completely, doing all that is necessary, and responding to all dimensions of the treatment. This situation leads one to question whether the function is being understood as complete or omnipotent.

Reference function and the worker's psychic suffering

Workers argue that the team attributes great power to the reference professional, though demanding from him/her the responsibility for the users' several life dimensions. At the same time, they recognize they also choose to be the ones who "own the case". Such contradiction seems to be felt as a paradox inherent to the work dynamics and to be associated with defense mechanisms against psychological sufferings that working with psychosis tends to cause. It is possible that by delving into the idea that links reference to a "function", as pointed out in one of the groups, this debate can be broadened.

A study performed in the city of Rio de Janeiro shows workers are uncertain about the role of the reference professional, but clearly identify him/her with a higher level of responsibility for the patient than that expected from the psychotherapist or doctor. This responsibility leads professionals to suffer due to the sensation of being, concomitantly, omitting themselves and giving too much care.¹⁹

This type of suffering may lead the team to create unconscious psychological defenses, such as standard, hardened, collective emotional reactions, which protect the group of workers from the anguish caused by the contact with sensations of almost complete omnipotence and impotence, typical of psychosis. One of these defenses is named narcissistic identification with the patient, one type of relationship in which, unconsciously, the therapist identifies with the patient's mode of psychological functioning, thus acquiring, momentarily, his/her patterns of sensation and emotional reaction.^{11,12} This defense can be interpreted as the sensation of omnipotence, when someone feels they "own the case" and can "manage to do everything". Another aspect of omnipotence is the desire to do everything one can for the patient.¹¹

As regards the weight of responsibility, there are studies which relate the theme to public health policies.

They argue that the SUS institutionalized discourse, by inviting user and worker to participate in the management of institutions, may also place responsibilities on these people individually, thus exempting services and the State itself from their responsibility functions.¹⁹ In this sense, the reference professional would be the focus of several responsibilities and problems that the institutional system as a whole should be in charge of.

In terms of limitations, there was bias caused by a greater number of groups of workers than users and family members, thus reducing the possibility of contribution by the latter, with more diversified reports, and of comparison of distinct assessments. However, the second step of the investigation, which is being

processed yet, may deepen the analysis of the study arrangement assessments users make.

In conclusion, the effects of the reference teams/professionals arrangement on patients is based on emotional aspects associated with trust, constancy, and complete care. Nonetheless, these aspects have not been sufficiently analyzed and conceptualized, thus causing relationship problems and confusion which are primarily associated with omnipotence and its results. It is recommended that this analysis be based on what users view as significant for their treatments. Finally, it is suggested that CAPS workers be able to count on supervision and institutional support so they can deal with problems that are inherent to inter-subjective contact.

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