RESEARCH

PROFILE OF HOSPITALIZATIONS IN THE PSYCHIATRIC UNIT OF A GENERAL HOSPITAL

PERFIL DE INTERNAÇÕES HOSPITALARES EM UNIDADE PSIQUIÁTRICA DE UM HOSPITAL GERAL

PERFIL DE INTERNACIONES EN LA UNIDAD PSIQUIÁTRICA DE UN HOSPITAL GENERAL

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ABSTRACT

This is a cross-sectional, descriptive study aimed at describing the hospitalization profile in the psychiatric unit of a general hospital in the state of Paraná. Data was collected from January to July, 2011 using a structured questionnaire with information on 240 hospitalizations. Demographic and hospitalization data were analyzed and expressed as frequencies and percentages. The results show a profile of voluntary admissions by individuals struggling with psychoactive substance abuse and who come from primary healthcare. A family member was usually responsible for hospitalization. We found that in 47.5% of cases the diagnosis was related substance abuse and clinical improvement at discharge was observed in 75.5% of admissions. Average length of hospitalization was 26.2 days. These results can help nurses in planning care and assistance actions that seek effective treatments with more positive outcomes.
Keywords: Nursing; Mental Health; Mental Health Services; Deinstitutionalization; Hospitalization.

RESUMO

Pesquisa descritiva, transversal que teve por objetivo descrever o perfil das internações em unidade psiquiátrica de um hospital geral do estado do Paraná. Os dados foram coletados de janeiro a junho de 2011, por meio de um questionário estruturado com informações de 240 internações. Foram analisados os dados sociodemográficos e da internação, expressos em frequências e percentuais. Os resultados revelam perfil de internações voluntárias de indivíduos com problemas de utilização abusiva de substâncias psicoativas, advindos da atenção primária de saúde, sendo um familiar o responsável pela internação. Evidenciou-se em 47,5% do total o diagnóstico de transtornos relacionados ao uso/abuso de álcool e drogas e em 75,5% foi observada a melhora do quadro na alta. O tempo médio de internação foi de 26,2 dias. Para o enfermeiro, estes resultados podem contribuir para planejar o cuidado de enfermagem e ações assistenciais que visem ao tratamento eficaz, com desfecho positivo.
Palavras-chave: *Enfermagem; Saúde Mental; Serviços de Saúde Mental; Desinstitucionalização; Hospitalização.*

RESUMEN

Se trata de una investigación descriptiva transversal que tuvo como objetivo describir el perfil de las internaciones en la unidad psiquiátrica de un hospital general del Estado de Paraná. Los datos fueron recogidos entre enero y julio de 2011, a través de un cuestionario estructurado con información de 240 internaciones. Fueron analizados los datos sociodemográficos y de internación, expresados como frecuencias y porcentajes. Los resultados muestran un perfil de internación voluntaria de personas con problemas de abuso de sustancias psicoactivas, derivadas de la atención primaria de salud y que un familiar es responsable de la hospitalización. Es evidente que en el 47,5% del total el diagnóstico fue de trastornos relacionados con abuso de alcohol y drogas y que hubo mejoría clínica en el alta en el 75,5% de los casos. El promedio de estadía hospitalaria fue de 26,2 días. Para las enfermeras, estos resultados pueden ayudar a planificar los cuidados de enfermería y las medidas de asistencia con miras a un tratamiento eficaz con resultados positivos.
Palabras clave*: Enfermería; Salud Mental; Servicios de Salud Mental; Desinstitucionalización; Hospitalización.*

INTRODUCTION

The ongoing process of Psychiatric Reform (PR) in Brazil criticizes the hospital-centered model that has existed for centuries around the world and which was widespread spread in the country until the 1970s. This model focuses on individual treatment of persons with mental disorders based on inpatient treatment in large hospitals specializing in Psychiatry, usually located far away from urban centers.

The principles advocated by the PR include the reintegrating the person with mental disorders in the family and society, restructuring all mental health services, following new approaches to substitute psychiatric inpatient treatment and focusing on Primary Care. Psychosocial Community Centers (Centro de Atenção Psicossocial – CAPS) have emerged as open community-based services.[1]

The current organization of mental health assistance in Brazil resulting from the Psychiatric Reform comprises a network of services called Psychosocial Care Network (Rede de Atenção Psicossocial - RAPS), including basic health care units, community centers and basic care teams care for specific populations, such as street clinic teams and support teams to run the services in the "Return Home" Program, such as inpatient units and home health care.[2]

This service network also comprises the CAPS, Urgency and Emergency Care, Therapeutic Home Services and Hospital Care. The latter is composed of wards in general hospitals and reference hospitals providing care for people with mental disorders caused by alcohol and other drugs.[2]

These services must be strengthened by a social support network composed of various sections of society, such as the associations of patients with mental disorders and their families, mutual aid groups, neighborhood associations, religious leadership, and schools.[1]

Data from the last Report on Mental Health Care in the Public Health System (SUS) show 72% coverage in access to mental health services as substitutes to full-time hospitalization. Such a result can be seen mainly in the expenses on extra-hospital services, which exceed 71.20% of the total resources allocated to this area. This reveals the inversion of the hospital-centered model since, until 1997, only 8% of the funds were intended for mental health outpatient services, while the other 92% were used to finance hospitalizations.[2-4]

The psychiatric hospital can still be considered to be a treatment option in regions where the creation or expansion of the RAPS is not sufficient. However, replacing the psychiatric beds should be a priority for the cities.[2] At the moment, hospitalization is an important therapeutic resource for people who need urgent and emergency care at time when the disorder aggravates.[2]

The Federal Mental Health Act 10.216 /01 recommends hospitalization only when extra-hospital resources prove insufficient. In these cases, admission must be full and all the necessary services must be provided to rehabilitate the person in need.[1,5]

Hospitalization in the Psychiatric Unit in a General Hospital (PUGH), the object of this study, was regulated by the Ministerial Decree SNAS 224, January 29, 1992, which establishes its constitution with regard to the number of beds, services offered, human resources and payment of hospital admissions according the Hospital Information System of the Unified Health System (SUS).[6] Brazil currently has 3,910 psychiatry beds in general hospitals distributed in 646 hospitals, with emphasis on the state of Rio Grande do Sul, which has 1,086 beds distributed in 199 general hospitals. The lowest number of available beds is in the state of Amapá, which has one general hospital with only one psychiatry bed.[3]

Full-time hospitalization, whether in a general or psychiatric hospital, can be voluntary, when the patient gives explicit consent; involuntary, when the patient does not give consent; and compulsory, determined by judicial order. Decree 2,391/2002 also describes voluntary admission that becomes involuntary, when subjects oppose continued hospitalization.[6]

Much has been discussed about the types of hospitalization that result from actions that have taken place in some Brazilian states, in the so-called cracktowns, where drug users, especially of crack cocaine, are approached and admitted compulsorily and also involuntarily for treatment. Involuntary treatments often raise ethical issues regarding deprivation of liberty of the hospitalized person, and the conflict among health professionals whose vacillate between a charitable action and patient autonomy.[7]

If the admission criteria are followed, there are some services which are mandatory in order to proceed with mental healthcare in the PUGHs: medical/psychological and social assessment, individual care, group care, family approach, preparing the patient for discharge and assured continuity of treatment in a health unit or via a program compatible with the patient's needs as available in the healthcare network.[2]

The purpose of psychiatric hospitalization in general hospitals is to offer a wider and more humanized approach to patients and family members who seek an extended treatment by side-by-side with other medical specialties, therefore leading to a humanized therapeutic plan. It also contributes to reduce the stigma and prejudices that have historically befallen persons with mental disorders.[8]

The PUGHs are important because their health care purpose is to prevent long-term hospitalizations, which in their turn cause loss of identity, as well as disruptions in family and social relationships, reducing the isolation caused to individuals. Despite the benefits, creation of these units is still a challenge for the Brazilian State since there are few beds available as a result of the precarious political and financial support for psychosocial care policies.[8]

The relevance of this study is justified by the importance of knowing the reality of psychiatric admissions in general hospitals in light of the Psychiatric Reform. Considering that the general hospital is an important device for RAPS treatments. Describing the hospitalizations in this service becomes relevant as it broadens the discussions and can inform the development of therapeutic strategies, thereby contributing to a practice that strengthens multidisciplinary and interdisciplinary approaches. The guiding question is as follows: what is the profile of admissions in a general hospital's psychiatric unit?

To answer this question, we describe the profile of admissions in the psychiatric unit of a general hospital in the state of Paraná.

METHOD

This is a descriptive, cross-sectional study with a quantitative approach carried out in a PUGH in a town of Paraná, which is subdivided into two sections: one for males and one for females, with 30 beds each.

The data were collected from medical records, except when the information was incomplete, in which case the patient was approached so that this information could be obtained. The data collection period was from January to June 2011. The variables used were: sex, age, reason for admission (use of psychoactive substance, behavior, others), formal referral, place of referral (ignored, public health services, psychiatry offices, CAPS, and others), type of hospitalization (voluntary, involuntary and compulsory), person responsible for hospitalization (family, health professional, the patient, a friend), diagnosis at admission, length of hospital stay, condition upon discharge (improvement, stabilization and lack of improvement), family accompaniment, rehospitalization (during the data collection period) and medication prescribed upon discharge.

In the period comprised by this study, 461 patients were admitted in PUGH, but only 240 records were analyzed, given the inclusion criteria, namely: 18 years old or more, completing the treatment with scheduled hospital discharge, being cognitively able to understand the objective of the study, and giving consent to the use of the medical records (Free and Informed Consent).

Considering these criteria, 221 records were excluded: three users under 18, three indigenous persons (regarded as a special theme area by Resolutions CNS 196/96 and 304/00), 13 non-communicative, 31 unable to answer due to a crisis during the hospitalization or unable to sustain structured speech to agree with their participation in the research, 49 refused to participate in three consecutive attempts at different times, 66 did not complete the treatment and 56 had non-scheduled discharges, making the approach infeasible.

The collected information was recorded as a Google Docs® form created for this purpose. For the statistical analysis, the data were transported to Excel for Windows® and subsequently submitted to a descriptive analysis (absolute and percentage frequency).

The data in this article were taken from the Master's thesis entitled "Demographic, Clinical and Hospital Admission Profile of Patients Treated in the Psychiatric Unit of a General Hospital", a study approved by the Committee for Ethics in Research Concerning Human Beings of Universidade Federal do Paraná, under protocol CEP/SD: 1016.141.10.09; CAAE:4581.0.000.091-10.

RESULTS

In order to describe the admissions of 240 participants, we used variables regarding the time of admission, type of admission, updated diagnosis, as well as the outcome of hospitalization, as shown in Tables 1 and 2.

Table 1 - Description of participants according to reason for admission, place of referral, type of admission, person responsible for admission, diagnosis, and outcome of hospitalization, 2011

	Female		Male		Total	
	n(84)	%	n(156)	%	n(240)	%
Reason for Admission						
Substance-related	15	17,8	102	65,4	117	48,8
Behavior-related	67	79,8	29	18,6	96	40
Others	2	2,4	25	16	27	11,2
Formal Referral						
No referral	51	60,7	89	57,1	140	58,5
With referral	33	39,3	67	42,9	100	41,5
Place of referral						
Ignored	32	38,1	52	33,3	84	35
Non-specialized public health services	14	16,7	43	27,6	57	23,7
Psychiatry Clinic	18	21,4	29	18,6	47	19,6
CAPS	13	15,5	28	17,9	41	17,1
Others	7	8,3	4	2,6	11	4,6
Type of hospitalization						
Voluntary	51	60,7	101	64,7	152	63,3
Involuntary	33	39,3	55	35,3	88	36,7
Compulsory	0	0	0	0	0	0
Person responsible for hospitalization						
Family member	73	86,9	112	71,7	185	77,2
Health professional	9	10,7	21	13,5	30	12,5
The patient herself	2	2,4	19	12,2	21	8,7
Friend	0	0	4	2,6	4	1,6

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Table 1 - Description of participants according to reason for admission, place of referral, type of admission, person responsible for admission, diagnosis, and outcome of hospitalization, 2011

	Female		Male		Total	
	n(84)	%	n(156)	%	n(240)	%
Diagnosis						
F10 – F19*	15	17,8	99	63,5	114	47,5
F20 – F29	50	59,5	49	31,4	99	41,3
F30 – F39	15	17,9	5	3,2	20	8,3
Others	2	2,4	2	1,3	4	1,6
No diagnosis	2	2,4	1	0,6	3	1,3
Length of hospital stay (days)						
0 – 15	5	6	31	19,8	36	15
16 – 30	30	35,7	99	63,5	129	53,7
31 or more	49	58,3	26	16,7	75	31,3
Condition upon discharge						
Improvement	57	67,8	124	79,5	181	75,5
Stabilization of clinical condition	23	27,4	25	16	48	20
Lack of improvement	4	4,8	7	4,5	11	4,5
Family involvement in discharge						
Yes	25	29,8	56	35,9	81	33,8
No	59	70,2	100	64,1	159	66,2
Readmission						
Yes	13	15,5	15	9,6	28	11,7
No	71	84,5	141	90,4	212	88,3
Medication prescribed upon discharge						
Yes	79	94	149	95,5	228	95
No	5	6	7	4,5	12	5

* F10 – F19: mental and behavioral disorders due to use of psychoactive substance; F20-F29: schizophrenia, schizotypal disorder and delusional disorders; F30-F39: mood disorders (affective).

The participants in the survey (Table 1) were patients with mental disorders aged 18 to 80 years, with an average age of 41.5 years, standard deviation of 12.8 and median of 41, an age group predominantly between 30 and 49 years of age. We found that 48.8% of hospitalizations were due to problems related to use of psychoactive substances, with men accounting for 65.4%. Public health services were responsible for referral to hospitalization in 40.8% of cases, and 63.3% of them were voluntary. The persons legally responsible for hospitalization were relatives (77.2 %) and the length of hospital stay was 16 to 30 days (53.7 %). Discharge was due to improvement (75.5 %). As regards referral, 58.5% of the patients were not referred to a reference service and 66.2% did not have a family member present upon discharge. Medication prescription upon discharge happened in 95% of the cases.

Table 2 - Profile of hospitalizations according to type hospitalization, 2011

	Voluntary		Involuntary		Total	
	n(152)	%	n(88)	%	n(240)	%
Reason for admission						
Substance-related	85	55,9	32	36,4	117	48,8
Behavior-related	43	28,3	53	60,2	96	40
Others	24	15,8	3	3,4	27	11,2
Formal referral						
No referral	84	55,3	56	63,6	140	58,3
With referral	68	44,7	32	36,4	100	41,7
Place of referral						
Not included	46	30,3	38	43,2	84	35
Non-specialized public health services	38	25	19	21,6	57	23,7
Psychiatry Clinic	34	22,3	13	14,8	47	19,6
CAPS	29	19,1	12	13,6	41	17,1
Others	5	3,3	6	6,8	11	4,6
Responsible for hospitalization						
Family member	116	76,3	69	78,4	185	77,1
Health professional	19	12,5	11	12,5	30	12,5
The patient	16	10,5	5	5,7	21	8,7
Friend	1	0,7	3	3,4	4	1,7
Diagnosis						
F10 – F19*	78	51,3	36	40,9	114	47,4
F20 – F29	51	33,6	48	54,5	99	41,3
F30 – F39	18	11,8	2	2,3	20	8,3
Others	4	2,6	0	0	4	1,7
Without diagnosis	1	0,7	2	2,3	3	1,3
Length of hospital stay						
0 – 15	25	16,4	11	12,5	36	15
16 – 30	90	59,2	39	44,3	129	53,7
31 or more	37	24,4	38	43,2	75	31,3
Condition on discharge						
Improvement	124	81,6	57	64,7	181	75,4
Stabilization of clinical condition	19	12,5	29	33	48	20
Lack of improvement	9	5,9	2	2,3	11	4,6
Family involvement in discharge						
Yes	51	33,6	30	34,1	81	33,8
No	101	66,4	58	65,9	159	66,2
Readmission						
Yes	13	8,6	15	17	28	11,7
No	139	91,4	73	83	212	88,3

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Table 2 - Profile of hospitalizations according to type hospitalization, 2011

	Voluntary		Involuntary		Total	
	n(152)	%	n(88)	%	n(240)	%
Medication prescribed upon discharge						
Yes	141	92,8	87	98,9	228	95
No	11	7,2	1	1,1	12	5

* F10 – F19: mental and behavioral disorders due to use of psychoactive substance; F20-F29: schizophrenia, schizotypal disorders and delusional disorders; F30-F39: mood disorders (affective).

The analysis of the data in Table 2, by type of hospitalization, shows that those related to use of psychoactive substances accounted for 55.9% of voluntary admissions and those related to behavior amounted to 60.2% of involuntary admissions. In 5.7% of cases the patients declared themselves legally responsible for their admission, although it was involuntary. Hospitalizations that lasted 31 days or more differ considerably in voluntary (24.4%) and involuntary admissions (43.2). In the outcome of the discharge conditions, stabilization of the clinical condition occurred in 33% of involuntary admissions, whereas the figure was 12.5 % for involuntary admissions. Rehospitalization occurred for 17% of patients involuntarily hospitalized and for 8.6% of those who were voluntarily hospitalized.

DISCUSSION

The main reason for hospitalization, as shown in Table 1, is related to use of psychoactive substances (48.8% of the patients). In general, regardless of the diagnosis of mental disorder, one of the most commonly mentioned problems leading to a demand for mental health services is the use of alcohol or other drugs. The study that outlined the profile of 233 users of a CAPS showed that 17.5% of users had reported problems with alcohol and drugs before seeking the service and that 16.7% of the health problems were also related to psychoactive substances.[7]

The differences between men and women are mainly related to the type of disorder. It was found that 65.4% of men required hospitalization due to problems related to use of psychoactive substances, while among women 79.8% had behavior-related issues arising from the typical signs and symptoms, such as, for example, mood, schizotypal and delusional disorders.

The prevalence of men who use drugs over women is addressed by other studies. This characteristic may be related to the fact that women who use drugs are less prone to seek treatment services due to the social stigma they face, as they find it easier to hide the problem for longer.[9] Another study that assesses the health conditions of women with mental disorders in treatment in a CAPS III emphasizes that women are more vulnerable compared to men when it comes to mood disorders and anxiety.[10]

The studies found in the literature on this topic are very different because they take into consideration the location of hospitalization. In a study with 600 patients in an emergency department of a general university hospital, the main reasons of demand for the services of psychiatric emergencies were: psychomotor agitation or aggressive behavior (23.9%) and suicidal attempt or ideation (15.7%).[11] Another study, conducted in psychiatric hospitals in Fortaleza with 393 patients, showed that 27.6% of the patients who sought the services showed symptoms caused by use/abuse of psychoactive substances.[12]

Regarding the referral for treatment, Table 1 shows that in 41.5% of the cases there were no formal referrals from a health service or health professional. The question of referral for psychiatric hospitalization is noteworthy because Federal Law 10,216 /2001 admits that "any kind of hospitalization is only suggest when the extra-hospital resources prove insufficient". [5]

The law does not mention the need for formal referral specifically. However, the Psychiatric Reform advocates the organization of Mental Healthcare in a network composed mainly of community-based and Primary Care services.[5] Thus, we understand that patients should have been treated in extra-hospital resources and, as a last resort, were referred to full-time hospitalization in the PUGH, which is the reference service in the studied location. In its turn, referral should contain information on the therapeutic plan established for the patient, such as, for example, the psychotherapeutic, pharmacological and alternative resources received, in order to justify the need for hospitalization.

Regarding referral, according to a study conducted in a psychiatric emergency unit in 2007, out of 191 patients surveyed 66.5% were walk-ins and the others were referred by General Hospital, Mobile Emergency Care Service (SAMU), the Family Health Strategy (ESF) and CAPS, respectively.[13]

77.1 % of patients were accompanied by at least one family member at the time of admission and who were legally responsible for hospitalization. Historically, families are excluded from the treatment of the person with mental disorders. The current policy, however, calls for the strengthening of family ties in order to help promote rehabilitation. On the other hand, families usually find it difficult to establish bonds with patients because the relationship with the person in crisis is often permeated by stress, insecurity and instability. Consequently, the admission is a way to relieve the emotional, physical, economic and social overload.[14] We can also speculate from fact that 22.8% of the patients had no relative with them at the time of admission that families have issues dealing with psychological distress and are part of a culture of non-participation of the family perpetuated in the mental healthcare mentality. This condition is reflected also in the presence of a family member

at the time of discharge, which happened with only 33.8% of the patients. There was a marked difference between presence of family members at the time of admission and of discharge, since during admission 77.2% patients were accompanied by a relative and during discharge, only 33.7% were.

Considering the reformulation of psychiatric care, the family starts to play a crucial part in the treatment of mental patients as well as in their care and rehabilitation. However, we must understand that living with a person with mental disorder and its chronicity offers various challenges, changing the habits and customs of the family nucleus, which may reflect in interpersonal relations. This reality shows the need for interventions with the family members in order to provide support to cope with these difficulties.[14]

We noted that 97.1% of the subjects in the service received an initial diagnosis according to the criteria of the International Classification of Diseases (ICD-10). The prevalent group was presented mental and behavioral disorders due to substance abuse (47.5%), followed by schizophrenia, schizotypal disorders and delusional disorders (41.3%), and mood disorders (8.3 %).

From a mental health standpoint it can often be difficult to accurately establish a diagnosis for patients. Defining a diagnosis can be a complex task due to variations in symptoms and the manifestation of behavior that occurs in each crisis. Thus, the high number of people with initial diagnosis with criteria defined by the ICD-10 may be due to the fact that the unit provides services to the SUS, for which the filling out of documents ensures the transfer of resources. Among these documents we find the Authorization for Hospitalization (AIH), which contains a required field to be filled with the initial diagnosis according to the ICD-10.[1]

The bibliographic research gathered studies on the occurrence of mental disorders in adults between the years of 1997 and 2009 and concluded that mood disorders are the most common diagnosis, mainly unipolar depression resulting from the use of substances, and schizophrenia.[15] This information is confirmed by comparing the data found in the present study.

Study conducted in a PUGH in the city of Campinas (São Paulo) with individuals with mental disorders aimed to verify the sociodemographic and clinical variables related to the process of admission. The data collected therein differ from the findings of Table 1 because it shows that among the people who benefited from psychiatric hospitalization in general hospital 30% had mood disorders, 19.1% schizophrenia and 7.3% were hospitalized due to the use of psychoactive substances.[16]

The data in Table 1 are in line with the information of the Ministry of Health regarding the expansion in alcohol and cocaine use, mainly in impure forms such as crack. For this reason, the Emergency Plan to expand access to treatment and prevention of alcohol and other drugs highlights the importance of expanding and intensifying the actions of prevention, promotion and treatment of vulnerable people and drug users. [17]

The average duration of hospitalization was 26.2 days, with a standard deviation of 12.2 and median 22. Table 2 shows that 53.7% of patients completed the treatment between 16 and 30 days. The duration of hospitalization for men and women were different, since 63.5% of men remained in hospital for up to 30 days and 58.3% of women, 30 days or more.

A research conducted on the length of stay in psychiatric hospitals with 114 patients showed that those who suffered from chemical dependence were, on average, 14.5 days in hospital, while the patients in crisis with other disorders spent more time (33.5 days), similar to the data found in the present study.[18]

In their analysis of 1,463 psychiatric hospitalizations in a general university hospital in the city of Campinas-SP, the authors found that patients showed improvement of symptoms within the relatively short period of up to three weeks, which meets the expectations of the role of the PUGH in the current model for psychiatric care, highlighting full-time hospitalization of short duration until clinical stability.[2,18]

The average length of hospital stay of the present study was lower than the average duration of hospital stay in psychiatric hospitals.[18] This aspect associated with other factors, such as the preference for a model of community-based care in detriment of the hospital-centered model, has been considered an important metric for the evaluation of the quality of care in the context of mental health.[18]

Among the conditions for discharge shown in the medical records, 75.5% of the participants showed an improvement in clinical condition. It is worth noting that the evaluation parameters for discharge are subjective and depend on the clinical impression of the physician who provides the report for discharge. Thus, in this research there was no quantitative and clinical method that allowed the researchers to express their views. On the other hand, we understand that, in addition to the patient's psychiatric condition, we must also consider social support and the more appropriate extra-hospital service that the patient will attend, which results in different evaluations according to the discussion of the multi-professional team and not only the doctor's.[18]

The formal referral to a reference service upon discharge happened in only 41.5% of the cases. However, the National Mental Health Policy[1] advocates, as previously mentioned, that the services be integrated into care networks, allowing a dialogue between the institutions with a view to promote the rehabilitation and social reintegration of these patients and their families, and in this way comply with the precepts of integrality standardized by SUS. However, this is still a distant reality for the place where the research was carried out, where 58.5% of patients were discharged without formal referral to basic services, which would ensure the continuity of treatment.

A research conducted in a service for recovery of chemical dependents also detected that flaw, out of the 203 participants 14.3% received no formal referral.[13] Structuring care networks so that professionals who constitute this network can focus on these patients is crucial, since their issues can manifest itself in symptoms and on the psychological health needs that permeate family and other social relations.

The RAPS emphasize the need to guarantee access to activities in their coverage area, fostering social inclusion as part of autonomy promotion and the exercise of citizenship. Therefore, PUGH should strive to articulate and integrate with the CAPS or refer users to basic health unit because they are the ones responsible for the post-discharge follow-up.[2] Regarding drug treatments, 95% of patients were discharged with a prescription for at least one class of psychotropic medication. Psychopharmacological treatment plays an important role in the control of psychiatric symptoms, better management of ADHD and risk of relapse, which, in its turn, consequently may lead to the recurrence of psychiatric hospitalization.[19]

Although the sample showed 95% of the cases as having prescription medications at the time of discharge, it is known that this action alone does not guarantee adherence to therapy. Adherence is a complex and difficult issue to control, requiring family support, guidance and supervision of health professionals and issues related to the patient, such as an understanding of the importance and need for medication for improving the clinical condition.

Among the difficulties faced by people with mental disorders that can interfere with the adherence to medication treatment are the adverse reactions, drug interactions, costs, not understanding the posology, among others. Therefore, there must be a continuity of treatment in the primary network after the discharge from the full-time psychiatric hospitalization, in order to make supervision and guidance from the health professionals available.[19]

The rate of hospital readmission of participants in the studied period was 11.7%, and the patients that had the highest rate of rehospitalization were the ones affected by schizophrenia, schizotypal disorders and delusional disorders. These data refer to a survey carried out in an outpatient mental health unit with 48 patients discharged from psychiatric hospitalization, where the rate of rehospitalization was 12.5%.[20]

In a study conducted with 54 patients from psychiatric hospitalization in the mental health service in Ribeirão Preto, São Paulo, the authors state that patient adherence is low; 70.8% of people surveyed have a low degree of adherence to treatment and this is due, among other things, to adverse reactions to the medication prescribed.[21]

Thus, the readmission of persons with mental disorders in psychiatric institutions is being studied and is known as the "revolving door", an expression that refers to the model of repeated admissions and discharges. Authors emphasize that one of the reasons for recurrence of hospitalization is the lack of efficient extra-hospital services that are focused on psychosocial rehabilitation.[21]

We should point out that the possibility of opting for admission and request discharge of treatment represent a victory for patients with mental disorders, as a result of the current model of Mental Health Care. However, one wonders how much improvement has taken place at this point when it comes to institutional respect for patients and the criteria used to determine admissions.[5]

In Table 2, the data were further analyzed according to the type of hospitalization. Hospital admissions related to the use of psychoactive substances represent 55.9% of voluntary admissions, while admissions related to behavior represent 60.2% of involuntary admissions. Historically, the proportion of involuntary hospitalization is higher in cases where there is a change of behavior. Current literature, however, reveals that involuntary admissions have been directed at users of alcohol and other drugs, related to an increase in the consumption of such substances and the surrounding legal issues.[12,22]

Another important data found in this research is related to the length of hospital stay (Table 2). The hospitalizations of 31 days or more differ considerably for voluntary (24.4%) and involuntary admissions (43.2%). This differs from the findings of a study on sociodemographic and clinical factors of voluntary and involuntary psychiatric admissions held in Fortaleza-CE, which identified that involuntary admissions had an average duration of 15 to 30 days in 65% of cases.[12]

Rehospitalization occurred in 17% of cases of persons involuntarily hospitalized and in 8.6% of people voluntarily hospitalized. We found no data in literature that could corroborate or that was similar to these findings. We believe that the acceptability and participation of patients in their treatment are important ways to prevent rehospitalization.

CONCLUSIONS

The aim of this article was to delineate the profile of admissions in a psychiatric unit for patients with mental disorder requiring institutional treatment. The hospitalization characteristics showed that most occurred due to problems arising from the use of psychoactive substances, with the family being responsible for hospitalization. On the other hand, we question family participation and involvement in the treatment, since for most hospital admissions there were no family members present at the time of discharge. The moment of discharge showed that hospitalizations are feasible, given the improvement in the patients' condition.

An important outcome that is contrary to the precepts of the PR was the fact that, in most cases, there is no formal referral for an extra-hospital service, which may have reflected in the rate of rehospitalization. In the case of involuntary admissions, the study shows that this type of hospitalization happened mostly for patients with psychotic disorders, contrary to the current literature on the subject.

Among the limitations to this study are institutional issues related to the filling out of medical records, as well as the lack of standards in the service for scheduling patient discharge, which resulted in the loss of 56 subjects who could have participated in the study.

New studies qualitatively exploring the difficulties and needs of persons with mental disorder with regard to assistance are sorely needed, as well as more research detailing the reality of mental healthcare services and of professionals working in this area.

This study offered an important insight into the process of psychiatric hospitalization in the wards of general hospital, possibly contributing to the creation of working strategies aiming to improve patient care, to include the family and to enlarge the care network.

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