

Who are the patients who have been discharged from psychiatric hospital care recently?*

Quem são os egressos de internação psiquiátrica?

¿Quiénes son los pacientes que obtuvieron el alta de la internación psiquiátrica?

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ABSTRACT

Objective: To describe the characteristics of persons with mental illnesses who have been discharged from psychiatric hospital care recently. **Methods:** Descriptive study conducted with a sample of 48 patients between December 17 2007 and April 17 2008. Data were collected through the economic and social questionnaire that gathers socio-demographic information including psychiatric hospitalizations and patient's knowledge of diagnosis and psychopharmacological treatment. **Results:** The mean age of the participants was 39 years. The majority were women (n = 39), had at least one previous hospitalization (62.5%), and did not know the diagnosis of their mental illness. Schizophrenia and/or Schizotypic Disorders were the most common types of mental illnesses (33.3%). Less than half of participants (43.8%) were able to verbalize the name and dosage of their medications correctly. **Conclusion:** Knowing those patients characteristics may be helpful in planning and implementing the best mental health treatment that includes professional support and effective psycho educational intervention.

Keywords: Psychiatric nursing; Rehabilitation nursing; Mentally ill persons; Hospitals, psychiatric; Mental health.

RESUMO

Objetivo: Conhecer quem são, hoje, as pessoas com transtornos mentais que tiveram alta hospitalar de internação psiquiátrica recente, e quais suas características comuns. **Método:** Pesquisa quantitativa descritiva realizada no período: 17/12/2007 a 17/04/08, através de questionário acerca das variáveis sociodemográficas, internações anteriores e conhecimento de 48 pacientes quanto ao diagnóstico e tratamento psicofarmacológico. **Resultados:** A média de idade foi 39 anos e 30 pacientes eram mulheres. Diagnósticos de Esquizofrenia e Transtornos Esquizotípicos foram prevalentes em 33,3% da amostra. Não souberam dizer qual era seu diagnóstico 56% da amostra, e apenas 43,8% souberam dizer corretamente nomes e dosagens dos medicamentos. Tinham pelo menos uma internação psiquiátrica anterior 62,5% deles. **Conclusões:** Conhecer quem são esses pacientes possibilita identificar características que podem fomentar a determinação do melhor tratamento, suporte profissional e elaboração de intervenções psicoeducativas que demonstraram ser necessárias a essa população.

Descritores: Enfermagem psiquiátrica; Enfermagem em reabilitação; Pessoas mentalmente doentes; Hospitais psiquiátricos; Saúde mental.

RESUMEN

Objetivo: Conocer quiénes son, hoy, las personas con trastornos mentales que obtuvieron el alta hospitalaria de internación psiquiátrica reciente, y cuáles son sus características comunes. **Métodos:** Investigación cuantitativa descriptiva en el período: 17/12/2007 a 17/04/08, a través de cuestionario acerca de las variables sociodemográficas, internaciones anteriores y conocimiento de los pacientes en lo que se refiere al diagnóstico y tratamiento psicofarmacológico. **Resultados:** Fueron entrevistados 48 pacientes. El promedio de edad fue 39 años y 30 pacientes eran mujeres. Diagnósticos de Esquizofrenia y Trastornos Esquizoides prevalecieron en 33,3% de la muestra. No supieron decir cuál era su diagnóstico 56% de la muestra, y apenas 43,8% supieron decir correctamente nombres y dosis de los medicamentos. Tenían por lo menos una internación psiquiátrica anterior 62,5% de ellos. **Conclusiones:** Conocer quienes son esos pacientes posibilita identificar características que pueden ayudar a determinar el mejor tratamiento, el soporte profesional y la elaboración de intervenciones psicoeducativas que demuestran ser necesarias en esa población.

Descriptor: Enfermería psiquiátrica; Enfermería en rehabilitación; Enfermos mentales; Hospitales psiquiátricos; Salud mental.

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INTRODUCTION

A few decades ago, psychiatry focused the treatment of mental illnesses on containing socially unaccepted behaviors, using the reclusion of these individuals as an option to drive away those who are different and “protect” society. For this reason, psychiatric hospitalization was, for a long time, considered a less therapeutic and more “prison” connotation. In reality, mental health care was based on the social intolerance to the “different” behavior of mentally ill persons, while its therapeutic purposes was not much explored⁽¹⁻²⁾.

After the changes made to the paradigms, as proposed in the movement that led to the Psychiatric Reform, there was a development of new and more effective psychiatric drugs, in addition to multidisciplinary programs aiming at improving treatment management. The referred health care then started to value psychosocial rehabilitation of individuals with mental illnesses as a form of therapy⁽²⁾. Psychiatric hospitalization would only be indicated for severe cases in which ambulatory and extra-hospital care would not suffice to contain the frequent episodes⁽³⁾.

Today, professional mental health care is the result of many discussions and changes that led to the process of deinstitutionalizing patient care. In Brazil, psychiatric hospitals, the main location where these treatments occur, are no longer the basis of the health care system, giving space to a network of extra-hospital service network of increasing complexity⁽⁴⁻⁵⁾.

However, as it is an essential procedure composing health care and evolution of the major psychiatric illnesses, psychiatric hospitalization remains a widely used resource. Hospitalization is often considered prudent in certain clinical situations, and can be considered imperative, especially concerning the most severe cases⁽³⁾.

Psychiatric hospitalization is currently indicated for severe cases when the resources for extra-hospital treatment or for managing the problem have been exhausted. Hospitalization in institutions with asylum-like features is currently prohibited. Cases are considered severe when the person has a mental illness and at least one of the following conditions: risk of self-harm, risk of harming others, risk of aggression to public order, risk of social exposure, severe self care disability⁽³⁾. The aim is centered on stabilizing the patient, minimizing risks, identifying psycho-social needs, adjusting the psychopharmacological treatment, and reintegrating patients to their social environment. It is the physician's responsibility to make a thorough and ethical analysis, each case individually, to verify when psychiatric hospitalization is in fact necessary.

This article does not have the purpose to simplify or polemicize the applicability of hospitalization in the treatment of mental illnesses. We understand that discussing its applicability is something complex, and it would also concern addressing its social, cultural and economic representation. Nevertheless, when founded on thorough medical evaluations and supported by qualified services with specialized and devoted professionals, hospitalization can be an important therapeutic measure in the treatment of mental illnesses.

The objective of this study was to learn about the people

with mental illnesses who had been discharged from recent psychiatric hospital care: who they are and what characteristics they have in common.

METHODS

A descriptive, prospective study was performed with all users of an outpatient mental health service who had been discharged from recent psychiatric hospital care. This study was approved by the Research Ethics Committee at the “Joel Domingos Machado” Teaching Health Center, Ribeirão Preto Faculty of Medicine – University of São Paulo – USP (Register 254/CEP-CSE-FMRP-USP).

The study location was the Mental Health Center, an outpatient care unit with the “Joel Domingos Machado” Teaching Health Center of the Faculty of Medicine – University of São Paulo – USP - Brazil (CSE-FMRP-USP).

The study included all users of the referred health center who had been discharged from psychiatric hospital care between December 17 2007 and April 17 2008, and agreed to participate in the present study by signing the Free and Informed Consent Form. In the regular routine at the referred health center, users who have been under psychiatric hospital care are seen by the physician to reestablish the procedures for extra-hospital care follow-up. Subjects were approached after their nursing appointment.

Data collection was performed using a questionnaire that addressed the following variables: gender; age; education level; marital status; number of children; current work situation; individual income; who they live with; housing conditions; family income; diagnosis; knowledge about the disease; time with the disease; previous hospitalizations (number), last hospitalization (date, location, reason, duration). Data analysis was performed by means of central tendency measures using SPSS 10.0.

RESULTS

In a four-month period, 54 people were discharged from psychiatric hospital care and assisted at the referred health care service. This represented an average 13 hospitalizations per month, disregarding cases when the same patient required re-hospitalization.

Six patients were excluded from the study: two declined to participate; one was transferred to another service; one's discharge was suspended, so the appointment was delayed; two did not attend the appointment, and their register in the public health network information system was outdated, making it impossible to locate them. The demographic, social and economic characteristics of the 48 patients from the sample are presented in Table 1. Thirty patients were women and 18 were men, and their mean age was 39 years, ranging between 18 and 75 years.

There was a balance regarding the subjects' marital status, with 39.6% of them single and 37.5% married. Patients who had been married or cohabited and were separated or divorced represented 16.7% of the sample, and 6.3% were widowed.

As for the number of children, 41.7% had none and 27.0%

had three or more children. Patients with one or two children added to 31.3% of the sample, being divided in: subjects with only one child (16.7%) and with two children (14.6%).

Regarding their education level, 17 patients had incomplete primary education (35.4%) and seven (14.6%) had complete primary education. Ten (20.8%) patients had complete secondary level education and nine (18.8%) had incomplete secondary education. Only two patients never had attended school and three achieved a higher education degree. It is stressed that most patients (54.2%) had only primary level education or less.

Few patients reported having a regular job at the time the study was performed, 31.3% of which stated being unemployed or have never worked. Four patients were in a sick leave from work due to their mental illness, and 39.6% of the sample reported that their pension was their only source of income.

It was found that 31.2% of patients denied having any income, 37.5% reported receiving one minimum salary (R\$ 380.00, at the time) and 18.8% of patients reported having an income of two minimum salaries. It was observed that among patients who had been discharged from psychiatric hospital care, 87.5% reported having a personal income of two minimum salaries or less. Only one patient reported receiving three minimum salaries and five reported receiving four minimum salaries or more.

The majority of patients (93.8%) reported that they lived with relatives. Two patients reported they lived alone and one of them lived with friends. Of all patients who had been discharged from psychiatric hospital care, 78.8% owned their homes. Another 27.1% paid rent and one patient reported he lived in his car, and was considered "homeless".

An average 3.5 people lived in each house. The number of people living in the same house ranged between one, for those who reported they lived alone, and eight, for those who lived with relatives or friends. It was observed that 58.4% lived with another three or four people in the same house, as shown in Table 1.

The family income for 72.9% of patients was of three minimum salaries or more. The patient who reported being homeless denied having any family income, and 12 patients reported a monthly family income of two minimum salaries.

Among the subjects who had only one registered diagnosis, there was prevalence of the diagnoses classified in the groups of Schizophrenia and Schizotypal Disorders in 33.3% of the sample. In this group, ten subjects were diagnosed with schizophrenia, corresponding to 20.8% of the sample, as shown in Table 2.

Mood Disorders (affective) grouped diagnoses of 29.2% of patients from the sample. Among the 14 subjects classified in this diagnostic group, moderate depressive episode and bipolar affective disorder stood out, affecting six (12.5%) and four (8.3%) patients, respectively. Three patients had been diagnosed with personality disorder and one with persistent somatoform pain disorder.

Of all patients in the sample, 29.2% had psychiatric comorbidity. It was verified that 12 had two diagnoses (25.0%) and two had three diagnoses (4.2%). None of the patients had more than three registered psychiatric diagnoses. Among patient with two diagnoses, there were three cases in which one of the

mental illness diagnoses was associated to the use of drugs (psychoactive substances, alcohol and multiple drugs). In other five cases the personality disorder diagnosis was associated with other disorders. There was one diagnosis for emotionally unstable personality associated with dementia in HIV disease.

Only two patients had three diagnoses. In both cases there was one diagnosis associated with the use of drugs and a diagnosis for schizophrenia associated with another psychiatric diagnosis (which were: affective bipolar disorder and emotionally unstable personality).

The time of diagnosed disease was observed as complete years, and ranged from less than one year to 20 full years. The mean time of disease of the discharged patients was 4.4 years, and 50% of them had about 3.5 years of diagnosed psychiatric illness. It was observed that 41.6% of discharged patients had less than one year of disease, 20.8% had one to five years, 29.2% had six to ten years, and 8.4% had 11 to 20 years of diagnosed disease.

A total 56% of the discharged patients did not know the name of the mental illness that affected them, which was the reason for their following treatment at the mental health service. Therefore, only 21 patients knew the name of the mental illness they were diagnosed with.

As for the discharged patients' knowledge about the psychopharmacological treatment they were prescribed, most were unaware or had only partial knowledge of the name and prescription of the drugs they were prescribed, as shown in Table 3.

Only 43.8% of these patients knew the correct names and doses of the drugs they were using, and 25% of them did not know the names of any of the drugs they were using in their treatment. Despite their lacking or partial knowledge regarding the names of the prescribed drugs, when asked about the importance of managing the psychopharmacological treatment, 81.2% of patients considered that drug treatment is important.

Psychiatric hospitalization

Among the patients who had been discharged from psychiatric hospital care, it was observed that 62.5% had already been hospitalized at least once before the latest hospitalization. The number of hospitalizations ranged from one to 13. The latest hospitalization was the first psychiatric hospitalization in the lives of 37.5% of the sample patients. Among the discharged patients, five had had ten previous hospitalizations before the latest hospitalization, and nine had been hospitalized once. The mean hospitalization rate was 3.1.

The information regarding the behaviors that motivated the latest hospitalization was collected using a patient reference guide, completed at the moment of discharge from hospital, and then delivered at the mental health service on the medical appointment. These behaviors are described in Table 4.

The risk towards one's own life and health or towards others supported the indication for most hospitalizations observed in this study. It was found that suicide ideation, with or without suicide attempt, was the reason for the hospitalization of 35.4% of the sample subjects. The presence of psychotic symptoms led to the hospitalization of 29.1% of the discharged patients,

Table 1 – Socio-demographic and economic characteristics of patients discharged from recent psychiatric hospital care.

Characteristics	N (%)
Age (complete years)	
Mean age of 39 years	24 (50.0)
Patients with 34 years or more	
Range: 18-75	
Gender	
Male	18(37.5)
Female	30(62.5)
Marital status	
Single	19(39.6)
Married/Cohabiting	18(37.5)
Divorced/Separated	8(16.7)
Widowed	3(6.3)
Children	
None	20(41.7)
One	8(16.7)
Two	7(14.6)
Three or more	13(27.0)
Education level	
Illiterate	2(4.2)
Incomplete primary education	17(35.4)
Complete primary education	7(14.6)
Incomplete secondary education	9(18.8)
Complete secondary education	10(20.8)
Complete higher education	3(6.3)
Occupation	
Never worked	3(6.3)
Unemployed	12(25.0)
Does eventual work "bicos"	3(6.3)
Regular informal work	2(4.2)
Regular formal work	5(10.4)
On sick leave	4(8.3)
Retired	19(39.6)
Personal income (patient)*	
None	15(31.2)
One minimum salary	18(37.5)
Two salaries	9(18.8)
Three salaries	1(2.1)
Four or more minimum salaries	5(10.4)
Who they live with	
Alone	2(4.2)
Lives with relatives	45(93.8)
Lives with friends	1(2.1)
Housing conditions	
Owns home	34(70.8)
Rent home	13(27.1)
Other (homeless)	1(2.1)
Number of people living together	
Up to two people	12(25.2)
Three or four people	28(58.4)
Five or six people	4(8.2)
Seven or eight people	4(8.2)
Family income*	
None	1(2.1)
Two salaries	12(25.0)
Three salaries	21(43.7)
Four or more minimum salaries	14(29.2)

*One minimum salary, corresponding to R\$ 380.00. The number in parentheses correspond to the percentages (N=48, with N = absolute number of studied patients). Ribeirão Preto-SP, 2008.

and aggressive behaviors caused the hospitalization of the other 25%. One patient was hospitalized for presenting akathisia, an adverse effect to an antipsychotic drug (Haloperidol).

The consumption of alcohol caused severe mood changes in a patient, which resulted in his hospitalization due to aggressive behavior. There was one hospitalization because of hypersexual behavior. The patients stayed in hospital for an average 27 days.

The shortest length of stay was two days, and the longest was 160 days. Only eight patients reported having sought emergency health service on the month before the latest hospitalization.

Psychiatric Rehospitalization

Of the 48 subjects interviewed in four months, six (12.5%) were rehospitalized in the data collection period (four men and

TABLE 2 – Frequency distribution related to the main diagnoses and comorbidities among patients who had been discharged from recent psychiatric hospital care.

Description of diagnoses	n (%)
Schizophrenia, Schizotypal Disorders and Delusional Disorders	16(33.3)
F20.0 - Schizophrenia	10(20.8)
F20.9 - Schizophrenia, unspecified	1(2.1)
F23.1 – Acute polymorphic psychotic disorder, with schizophrenic symptoms	1(2.1)
F23.9 – Acute and transient psychotic disorder, unspecified	1(2.1)
F25.0 – Schizoaffective disorders	3(6.3)
Mood disorders (affective)	14(29.2)
F31.0 – Affective Bipolar Disorder	4(8.3)
F31.1 – Affective bipolar disorder, current episode maniac without psychotic symptoms	1(2.1)
F31.6 - Affective bipolar disorder, current episode mixed	1(2.1)
F32.1 – Moderate depressive episode	6(12.5)
F32.2 - Severe depressive episode without psychotic symptoms	1(2.1)
F33.1 – Recurrent depressive disorder, current episode moderate	1(2.1)
Neurotic disorders, related to stress and somatoform disorders	1 (2.1)
F45.4 – Persistent somatoform pain disorder	1(2.1)
Disorders of adult personality and behavior	3 (6.3)
F60.3 – Emotionally unstable personality disorder	3(6.3)
Patients with two diagnoses	12(25.0)
F02.4 and F60.3 - Dementia in human immunodeficiency virus disease [HIV] + personality with emotional instability	1(2.1)
F10.2 and F32.1- Dependence syndrome (psychoactive substance) + Moderate depressive episode	1(2.1)
F10.7 and F25.9 – Residual and late-onset psychotic disorder (alcohol) + Schizoaffective disorder, unspecified	1(2.1)
F19.2 and F20.0 - Mental and behavioral disorders due to multiple drug use and use of other psychoactive substances + Schizophrenia	1(2.1)
F60.3 and F21.0 - Emotionally unstable personality + Schizotypal disorder	1(2.1)
F60.3 and F 31.5 - Emotionally unstable personality + Affective bipolar disorder, current episode depressive with psychotic symptoms	1(2.1)
F60.3 and F32.0 - Emotionally unstable personality + Mild depressive episode	1(2.1)
F60.9 + F 41.0 and - Personality disorder, unspecified + Generalized anxiety disorder	1(2.1)
F60.3 and Z915 Emotionally unstable personality + Personal history of self-harm	1(2.1)
F20.0 and F32.1 – Schizophrenia + Moderate depressive episode	1(2.1)
F20.1 and F71 – Hebephrenic schizophrenia + Moderate mental retardation	1(2.1)
F32.0 and 50.1 - Mild depressive episode + Atypical anorexia nervosa	1(2.1)
Patients with three diagnoses	2 (4.2)
F10.2 and F20.0 and F31.0 - Mental and behavioral disorders due to use of alcohol- dependence syndrome+ Schizophrenia+ Affective bipolar disorder	1(2.1)
F19.2 and F31.2 and F60.3 - Mental and behavioral disorders due to multiple drug use and use of other psychoactive substances + Schizophrenia+ Emotionally unstable personality	1(2.1)
TOTAL	48(100.0)

The numbers in parentheses refer to percentages, bold numbers refer to percentages per diagnostic class, with N = absolute number of patients studied. Ribeirão Preto-SP, 2008.

two women). These patients' mean age was 32 years, 50.0% were single, retired, and without children. Having a low education level was a characteristic in 66.7% of rehospitalized patients. Only one patient was formally employed and was on a sick leave. The individual income was one minimum salary in 50% of cases. Five patients lived with relatives and own their home. One patient was homeless and reported living in his car. The family income was not more than two minimum salaries.

None of the patients knew the name of their illness. Patients who were rehospitalized had in average 8.3 years of diagnosed disease. Three patients were diagnosed with schizophrenia, one

patient with affective bipolar disorder, one patient had two diagnoses (emotionally unstable personality and mild depressive episode) and one had three (mental and behavioral disorders due to use of alcohol–dependence syndrome with schizophrenia and affective bipolar disorder). None of the rehospitalized patients knew the names of all the drugs they used while following the treatment.

DISCUSSION

The present study identified that patients discharged from

TABLE 3 – Knowledge of patients who had been discharged from recent psychiatric hospital care about the prescribed psychopharmacological treatment. Ribeirão Preto-SP, 2008.

<i>Knowledge regarding the prescription</i>	<i>Frequency</i>	<i>Percentage</i>
None	12	25.0
Partial	15	31.2
Total	21	43.8
TOTAL	48	100.0

TABLE 4– Behaviors that determined the need to hospitalize patients who had been discharged from recent psychiatric hospital care. Ribeirão Preto-SP, 2008.

<i>Reasons for hospitalization registered on the reference guide</i>	<i>Frequency</i>	<i>Percentage</i>
Akathisia (drug side effects)	1	2.1
Alcohol consumption or abuse and aggressive behavior	1	2.1
Aggressiveness, irritability, psychomotor agitation	12	25.0
Suicide ideation or attempt	17	35.4
Resistant somatoform disorders	2	4.2
Psychotic symptoms (delirium, hallucinations, mania).	14	29.1
Hypersexuality	1	2.1
Total	48	100.0

psychiatric hospital care in this sample are mostly women (62.5%), living with relatives (93.8%), and own the house (70.8%) which they live with three or four people (58.4). The individual income was not more than one minimum salary (R\$380.00) for 66.7% of patients, noting that 54.2% had primary education or less and only 14.6% had some kind of regular job. These findings are similar to that of other studies performed with patients cared for at community services⁽⁶⁻⁹⁾. These and other studies have shown that low education and socioeconomic levels affect the lives of many mentally ill patients.

It is known that five of the ten main health conditions (physical and mental) causing disability are related to mental disorders, especially: depression, alcoholism, affective bipolar disorder, schizophrenia, and compulsive obsessive behavior⁽¹⁰⁾. It was found that these disorders were present in the sample, with prevalence of diagnoses classified in the group of schizophrenia, schizotypal disorders, delirious disorders and in the mood disorder group (F20-F29; F31 to 33 of ICD-10). These data are in agreement with those of several similar studies⁽¹⁰⁻¹⁾.

These are severe illnesses, which often include symptoms that affect the patients' work, social and leisure activities. Furthermore, they also trigger discrimination and stigmatization⁽¹²⁻³⁾. Considering this aspect, low education and socioeconomic levels can be related to severity of the symptoms seen in these diseases. The constant presence of symptoms and the adverse effects from the drug treatment make it difficult for mentally ill patients to relate to their family and social environment⁽¹⁴⁾.

In this study, the adverse effects were so severe in one patient that his rehospitalization was necessary.

Considering the extent of the harm, it is confirmed that there is a need for adequate treatment management in patients that are not hospitalized and being followed by community care services. This way it is possible to reduce relapses and thus minimize harms and favor the patients' social relationships. This makes

health service centers and the work of nurses and other health care professionals indispensable in this everyday scenario.

Psychiatric comorbidity was present in 29.2% of the sample. Among patients with two diagnoses, in three cases one of the mental illness diagnoses was associated with the use of drugs (psychoactive substances, alcohol and multiple drugs). Among the two patients with three registered diagnoses, one diagnosis was associated with drug use. It is known that drug addiction is often associated with the presence of mental illnesses and is currently a public health issue⁽¹⁵⁾.

Patients discharged from hospitalization had little knowledge regarding the name of their mental illness and their psychopharmacological treatment. Although a considerable part of the sample presented recent diagnosis and treatment (less than one year), 56% did not know the name of their mental illness and why they were being treated at the mental health center, and 56.2% did not know or had partial knowledge about the drugs they were prescribed.

Despite their lacking or partial knowledge about the name of the drugs they were prescribed, when patients were asked about the importance of following the psychopharmacological treatment, 81.2% stated they considered drug treatment important. These opinions with little coherence appear to show what is observed in practice.

Although patients understand the orientations they receive from health care professionals regarding the importance of the psychopharmacological treatment, it is observed that, in general, noncompliance affects 50%⁽¹⁶⁻⁷⁾. Among patients treated with conventional antipsychotic drugs, 40% suspended their medication in the first year and 75 % within two years⁽¹⁸⁾.

Treatment is a fundamental element in the patients' lives. They experience the process of hospitalization and rehospitalization and any other everyday life activity is organized according to the possibilities of treatment. After all, the fact of

being in or out of hospital changes this population's everyday life completely. Hospitalization does not only represent a form of treatment for the patient, considering that relatives report the difficulty of living with the confusion caused by the mental illness and consider hospitalization a moment for them to rest and live with tranquility⁽¹⁸⁾.

FINAL CONSIDERATIONS

In this study, we sought to deepen our knowledge about those who use the public network of mental health care and need psychiatric hospital care during their treatment. This knowledge has the aim to, among other objectives, generate critical thoughts and support to collaborate with the dynamic between knowing and doing in mental health. The professional commitment with knowledge and its relationship with practice is an important source for improvement.

The innovations encouraged by the changes in paradigms in psychiatric health care require more studies and adaptations for health care professionals and services to meet the demands of this clientele. With appropriate hospitalizations and shorter periods of institutionalization, patients and relatives assume a stronger position as the main care givers in mental health. In this context, the chronic aspect of mental disorders implies these people have to live with the process of hospitalization-rehospitalization, and

their everyday activities have to be organized according to the possibilities of treatment for the mental disorder.

Therefore, knowing who the patients discharged from psychiatric hospital care are, today, permits to identify characteristics that could support the determination of the best treatment and professional support for patients and their caregivers. The patients' lack of knowledge about their diagnoses and psychopharmacological treatment shows there is a need for psycho-educational interventions to improve their understanding about the mental illness and its implications. Interventions for treatment management, education, ventilation and episode relief can seek to meet the care demand of these people, without being restricted to simply guaranteeing compliance to the psychopharmacological treatment, but also aiming at identifying and minimizing risks, dealing with needs and the social, emotional, and financial conflicts that are created by the chronic presence of the mental illness.

Studies and interventions about the needs of patients discharged from hospitalization and their caregivers are important for a systematized practice of the professionals from mental health care services. The patients investigated in the present study represent the population assisted by a public health service, but long-term studies will be performed to perform a more thorough analysis of the patients' psychiatric hospitalization and treatment management.

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