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LONG-TERM PATIENT IN PSYCHIATRIC HOSPITAL: CLINICAL OR SOCIAL CONDITIONS?

PACIENTE DE INTERNAÇÃO PROLONGADA EM HOSPITAL PSIQUIÁTRICO: CONDIÇÕES CLÍNICAS OU SOCIAIS?

PACIENTE DE HOSPITALIZACIÓN PROLONGADA EN HOSPITAL MENTAL: CONDICIONES CLÍNICAS O SOCIALES?

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ABSTRACT

Objective: to investigate the reasons for prolonged hospitalization in a psychiatric hospital. **Method:** an analytical cross-sectional study with 51 medical records of patients hospitalized for more than 45 days. The relationship between the mean length of stay with the variables Age Range, Family Support, and ICD-10 Groups was performed. ANOVA (test of variance) and, when recommended, the Kruskal-Wallis test were used. **Results:** the mean length of stay in patients with and without family support is 161.3 and 2623, respectively ($p = 0.00$). In the patients of the schizophrenia groups, schizotypal disorders and delusional disorders were 1469 days, and of mental retardation, 3217 days ($p = 0.02$). **Conclusion:** family support is a determining factor for prolonged hospitalization and it is possible to find a relationship between the length of stay and the diagnosis group. **Descriptors:** Hospitalization; Social Conditions; Hospitals, Psychiatric.

RESUMO

Objetivo: investigar os motivos de internação prolongada em hospital psiquiátrico. **Método:** estudo transversal analítico com 51 prontuários de pacientes internados por mais de 45 dias. Foi realizada a relação entre a média do tempo de permanência com as variáveis Faixa etária, Suporte familiar e Grupos da CID-10. Foi utilizado o ANOVA (teste de variância) e, quando recomendado, o teste de Kruskal-Wallis. **Resultados:** a média do tempo de permanência nos pacientes com e sem suporte familiar é 161,3 e 2623 respectivamente ($p=0,00$). Já nos pacientes dos grupos de esquizofrenia, transtornos esquizotípicos e transtornos delirantes foi 1469 dias e, de Retardo mental, de 3217 dias ($p=0,02$). **Conclusão:** o suporte familiar é fator determinante para o internamento prolongado e é possível encontrar relação entre o tempo de permanência e o grupo diagnóstico. **Descritores:** Hospitalização; Condições Sociais; Hospitais Psiquiátricos.

RESUMEN

Objetivo: investigar las razones de hospitalización prolongada en hospital psiquiátrico. **Método:** estudio transversal con 51 prontuarios de los pacientes hospitalizados en más de 45 días. Se realizó la relación entre la duración media de permanencia con la variables edad, apoyo familiar y grupos de la CID-10. Se utilizó el ANOVA (teste de varianza) y, cuando recomendado, el teste de Kruskal-Wallis. **Resultados:** la duración media de permanencia en pacientes con y sin apoyo familiar es 161.3 e 2623 respectivamente ($p = 0,00$). En los pacientes de esquizofrenia, trastornos esquizotípicos y trastornos delirantes fue de 1469 días, de retraso mental, de 3217 días ($p = 0,02$). **Conclusión:** el apoyo familiar es el factor determinante para la hospitalización prolongada y es posible encontrar la relación entre la duración de la permanencia y el grupo de diagnóstico. **Descriptores:** Hospitalización; Condiciones Sociales; Hospitales Psiquiátricos.

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INTRODUCTION

From the 1950s onwards, a movement began for the deinstitutionalization of psychiatric care.¹ The main reasons for its emergence were the questionable conditions of psychiatric hospitals, the civil and human rights movement, the emergence of more effective psychotropic drugs and the argument that treatment in the community is cheaper.² In Brazil, this struggle has been carried out by the "anti-asylum movement,"³ with criticism of the asylum chronicity and use of electroshock, demand of conditions of assistance to the population and humanization of services to the mentally ill.

The framework of the reform of Mental Health care in Latin America occurred with the Caracas Declaration of 1990.⁴ With the prerogative that the psychiatric care model based on hospitalization isolates the patient, making social incapacity possible, the link between psychiatric care and primary health care. Hospitalization would be used in recent cases, and preferably, in general hospitals.

Although the role of community-based treatment for quality of life is widely recognized, questions remain about the psychosocial performance and care offered. Infrastructure and operationalization of the service, training of professionals and integrated assistance involving patients and family are necessary. Often this comes up against those who have spent long years in psychiatric institutions. They are individuals with weakened social ties, reduced autonomy and comorbidities, sometimes, abandoned by their bodies and who reflect, in their way of being, and act the time of social seclusion.⁵ One of the great problems raised by some authors regarding the treatment in the state of confinement is about the conviviality among patients, the conjunction of different pathologies that can influence those in less serious states, contributing to the worsening of their clinical condition.⁶

According to the World Health Organization (WHO), mental, neurological and substance use disorders accounted for 13% of the global burden of morbidity in 2004.⁷ Knowledge of the clinical causes, that lead to psychiatric hospitalization, is a means for planning health actions, understanding the various factors that influence the course of each disorder and, thus, proposing actions that improve the quality of life of the patient.

In this study, the sociodemographic and clinical profile of the patients and the reasons for the long stay in a public psychiatric hospital were analyzed. Discussion on the

causes of these long-term hospitalizations is essential for the planning of interventions and allocation of resources in the health field. In addition, there is little information available on the profile of patients hospitalized for long periods in psychiatric hospitals in Latin America and the world.

OBJECTIVES

- To investigate the reasons for the prolonged hospitalization of patients in a public referral psychiatric hospital.
- To characterize the sociodemographic profile of patients with prolonged hospitalization attended at a referral psychiatric hospital.
- To trace the clinical profile of the sample studied, according to the 10th edition of the International Classification of Diseases.
- To analyze the clinical conditions that lead to prolonged hospitalization of the patient.
- To analyze the social conditions that contribute to the prolonged hospitalization time of patients in a psychiatric hospital.

METHOD

A cross-sectional, analytical study performed at the Hospital Escola Portugal Ramalho (HEPR), a reference for Maceió (AL), Brazil, and adjacent cities in the treatment of mental disorders. We analyzed 51 medical records of patients who were hospitalized for a time greater than 45 days, limit of days considered maximum for hospital admission, during the collection period, between 11/29/2014 and 12/30/2014.

The database was mounted and analyzed by Epi info Windows, version 3.5.4. The results for the qualitative variables are presented by means of simple and relative frequencies and, for quantitative ones, by mean and standard deviation. The analysis was performed through ANOVA (Analysis of variance) and Kruskal-Wallis test.

A collection instrument, with the variables Gender, Age, Color, Schooling, Profession, Marital Status, Length of Stay, Diagnosis by the International Classification of Diseases (ICD-10), Family Support and Medical Leave was created by the authors. With this data, we characterized the sociodemographic and clinical profiles of the sample, analyzing the frequency of mental and behavioral disorders, according to ICD-10, and grouped them into six major diagnostic categories that are used in Chapter 5 of the Handbook of Mental and Behavioral Disorders ICD-10 (ICD-10 Groups).

Finally, the average length of stay with the variables was related: Age group; Family support; ICD-10 groups and Medical discharge. To characterize the Age group, the sample was divided into four groups involving patients between 16 to 30, 31 to 45, 46 to 60 and those over 60 years. In order to characterize Family Support, we considered the existence of family references, and the support and regularity of the visits, data recorded in the medical records by the Institution's Psychology and Social Assistance department. Patients without family support were defined as those who had no family reference or who, despite having a reference, did not receive support and/or regular visits. To characterize medical discharge, those released by the responsible physician with good clinical conditions.

The research was approved by the Research Ethics Committee of the Federal University of Alagoas (UFAL), number CAAE 37959014.9.0000.5013.

RESULTS

We analyzed 51 medical records, comprising 32.28% of a total of 158 patients and 100% of those with more than 45 days of hospital stay, in the collection period. Most of the medical records belonged to male patients (54.9%), were between 31 and 45 years old (49%), were of brown color (74.5%), and were single (68.6%). Approximately, 57% of the patients were illiterate, and among the literate, 15.7% had only the incomplete fundamental level (table 1).

Table 1. Distribution by demographic variables. Maceió (AL), Brazil, 2014.

Variables	n	%	IC _{95%}	
Gender				
Female	23	45,1	31,1	59,7
Male	28	54,9	40,3	68,9
Age group				
16 to 30	9	17,6	8,4	30,9
31 to 45	25	49,0	34,8	63,4
46-60	12	23,5	12,8	37,5
61 or more	5	9,8	3,3	21,4
Color				
White	7	13,70	5,7	26,3
black	6	11,80	4,4	23,9
brown	38	74,50	60,4	85,7
marital status				
Divorced	4	7,80	2,2	18,9
No information	11	21,60	11,3	35,3
Single	35	68,60	54,1	80,9
Widowed	1	2,00	0,0	10,4
Schooling				
Illiterate	29	56,90	42,2	70,7
Incomplete Middle school	8	15,70	7,0	28,6
Complete Middle school	2	3,90	0,5	13,5
Incomplete Highschool	1	2,00	0,0	10,4
Complete Highschool	1	2,00	0,0	10,4
Incomplete higher education	2	3,90	0,5	13,5
Graduated	1	2,00	0,0	10,4
No information	7	13,70	5,7	26,3
Total:	51	100,0		

Source: Patient records at the HEPR.

The most frequent disorder was F20.1 (19.6%), which corresponds to Hebephrenic Schizophrenia. Second, are unspecified schizophrenia, F20.9, and severe mental retardation, F72.1, each with 15.7%. To facilitate analysis, these disorders were divided into six major diagnostic categories

(table 2) which are used by Chapter 5 of the ICD 10 Mental Disorders Manual, proposed by WHO. We found the group with the highest percentage (58.8%), of schizophrenia, schizotypal disorders and delusional disorders, followed by the mental retardation group, with 25.5%.

Table 2. Frequency of ICD 10 four digits groups. Maceió (AL), Brazil, 2014.

ICD 10 Groups	n	%	IC ₉₅ %	
Schizophrenia, t. Schizotypal and t. Delirious (F20)	30	58,80	44,2	72,4
Mental Retardation (F70)	13	25,50	14,3	39,6
Organic Mental Disorders, Including Symptomatics (F00)	3	5,90	1,2	16,2
Psychological Development Disorders (F80)	2	3,90	0,5	13,5
Mental and behavioral disorders due to the use of psychoactive substances (F10)	2	3,90	0,5	13,5
Mood Disorders (Affective) (F30)	1	2,00	0,0	10,4
Total	51	100,0		

Source: Patient records at the HEPR.

Regarding the length of stay (table 3), the mean number of days that patients from 16 to 30 years of age remained hospitalized was 155.11; For those aged between 31 and 45 years, was 1948.24; for those who are between 46 and 60, was 2616.5; And finally, for patients over 60 years, the mean was 3069.2 days.

Regarding the family situation, 36 of the 51 medical records were identified as patients who did not present any type of support; the mean number of hospitalization days of patients with family support was approximately 161.3, while those who did not, had a mean of 2623 days (table 3).

The two most frequent ICD10 diagnostic groups to the mean length of stay were related. The other four less frequent groups were not analyzed because of the need to homogenize the sample and because their

number was very small compared to the rest of the medical records, adding up to eight out of 51 patients. Medical discharge, prescribed by the attending physician, was also related to the average length of stay.

In table 3, the 30 patients who belong to the Schizophrenia group, schizotypal disorders and delusional disorders have a mean of 1469 days of hospitalization per patient. In contrast, the 13 patients in the Mental Retardation group had an average length of hospital stay of 3217 days per patient. Between medical discharge and length of stay we did not find a statistically satisfactory value. In this study, 80.4% of the patients were discharged because of their stable clinical situation.

Table 3. Average length of stay for qualitative variables. Maceió (AL), Brazil, 2014.

Variables	n	Average	Deviation	p
Age group (years) *				
16 to 30	9	155,11	87,3820	0,035
31 to 45	25	1948,2	2211,27	
46-60	12	2616	2906,70	
60 or more	5	3069	2028,69	
Family support *				
Yes	15	161,3	209,35	0,0
No	36	2623	2405,30	
Groups of ICD 10 **				
Schizophrenia, t. schizotypal and t. Delirious (F20-F29)	30	1469,3	1909,3	0,02
Mental Retardation (F70-F79)	13	3217,3	2949,4	
Medical release**				
Yes	41	1926,3	2428,4	0,86
No	10	1786,6	1862,9	

Source: Patient records at the HEPR.
Note: * Kruskal-Wallis ** Student's t test.

DISCUSSION

The results allow the discussion of the main mental disorders involved in prolonged hospitalizations in a psychiatric hospital, the relation of these hospitalizations with the socioeconomic profile of the patients and the distinction between the reasons for the long stay. We relate our data with those found in several studies and in the Department of Informatics of the Brazilian Unified Health

System - DATASUS, not only with the comparison between long-stay patients, but with the general number of hospitalizations, due to a shortage of inpatient studies for long periods in psychiatric institutions.

♦ Delimitation of the sociodemographic characteristics of the sample:

♦ Gender

Gender did not influence the hospitalization time. A discrete difference,

being the male predominance (54.9%) among the analyzed patients, showing consonance with the total hospitalizations recorded by DATASUS in the period from 2008 to 2014 was observed,⁸ which also shows a prevalence of males (64.48%) and several studies related to the general hospitalization of other psychiatric services.⁹⁻¹² Few studies have shown a predominance of females.^{13,14} The male predominance may be explained by the greater availability of beds for patients of this sex in HEPR. Or even, by the presence of the diagnoses found, especially Mental Retardation, which presents a ratio of 1.3 to 1.9 women to 13 men in the general population,¹⁵ and other diagnoses with a lower number of occurrences, such as behavioral disorders due to the use of Psychoactive substances and Psychological Development Disorders.¹⁶ However, the greatest predominance in this work was the ICD group of Schizophrenia, schizotypal and delirious disorders, pathologies that present equal proportions between the sexes according to Kaplan et al.¹⁶

◆ Age group

The vast majority of medical records belonged to the age group of young adults and adults (16 to 60 years), predominantly the percentage of adults between 31 and 45 years, 49%, which is in line with several studies carried out in psychiatric institutions^{10-13,17-8} and the DATASUS age profile,⁹ in which the most prevalent ranges were 30 to 39 years (25.98%) and 40 to 49 years (24.46%). This prevalence can be explained by the characteristics of the mentally ill in the age group, which requires a lot of care, besides financial and emotional costs, and the psychiatric hospitalization is the most easily found by the family in order to avoid the absolute abandonment of the patient. In our study, we observed a relationship of these values with the diagnostic categories found, and 56% of these adults (31 to 45 years old) presented a diagnosis that is found in the group of Schizophrenia, schizotypal disorders and delusional disorders. Secondly, with 36%, there is the mental retardation group. These values are important because they demonstrate that mental disorder has become unbearable for many families in the most productive time of life, characterized by family and professional consolidation and may have been responsible for a number of difficulties for the socioeconomic development of these patients.

◆ Color

As for color, predominance of browns (74.5%) was observed. In this question, there

is a difference with the data recorded in DATASUS,⁸ in which the prevalence was higher among whites (41.53%), followed by brown (26.3%) and records without information (25.76%). It is worth remembering that color is a variable in which the patient calls himself, and that, often, raises doubts to the individual, besides being neglected during the psychiatric anamnesis.

◆ Marital status

Approximately 69% of the records analyzed belonged to patients who did not get married. Second, were those who did not present information on marital status and only 8% were married. The large percentage of bachelors is in agreement with some studies^{10,13,18} and can be compared with the predominant age group of young adults, because the authors of this study believe that the age of early illness is important to determine an inadequate development of social relationship skills. The greater number of unmarried individuals in the sample can also be explained by the high frequency of patients with severe and persistent disorders, who, often, have difficulty establishing a married life.¹⁰ Another hypothesis would be the greater proportion of male patients, where there are reports in the literature suggesting more severe symptomatology and/or early onset in men, which would make marriage difficult, since, man, is often, responsible for the economic maintenance of the home.¹⁰ The large number of patients who do not present information on marital status demonstrate those found on the street, without information about the family and who use the psychiatric hospital as housing.

◆ Schooling

In relation to the educational variable, there is a predominance of illiterates (56.90%), followed by incomplete elementary school (15.7%). When analyzing the prevalence of schooling in some studies carried out in other psychiatric services,^{10,13,18} it is observed that the majority of hospitalized patients had an education degree related to elementary education. This situation may indicate that the severity of psychiatric symptoms and the complexity of mental illness have a negative impact on school development,¹³ reducing concentration and increasing school dropouts. It can also be explained by discrimination and negative stigma about the intellectual ability of a mentally ill patient. In addition, it is known that social groups exposed to precarious socioeconomic conditions, and consequently, low educational level, may be at greater risk of developing mental disorders.⁷

◆ Delimitation of clinical characteristics

The most frequent diagnostic category in the sample studied was schizophrenia, schizotypal disorders and delusional disorders (F20-F29). This data is in agreement with different studies⁹⁻¹¹ and in agreement with the one found in DATASUS on hospitalizations, according to the list of ICD-10 morbidity in the period from 2008 to 20148, where the prevalence of 35.83% is observed, occupying, this diagnostic category, the second place in hospitalizations. Schizophrenic patients occupy approximately half of the beds of psychiatric hospitals and this can be explained by the unfavorable course of the disease,¹⁶ in which the majority of patients present repeated hospitalizations, episodes of exacerbations and major affective disorder, and increased risk for suicide attempts. Associated with this, there is the economic cost, with pharmacological therapies and psychosocial interventions, and the social cost, due to exacerbations and functional deterioration, that contribute to the hospitals becoming the residences of such patients.

Secondly, we found the diagnostic category of Mental Retardation (F70 - F79), which in our patients, was severe and this is one of the reasons for this high prevalence, since they require greater supervision due to their limitations. Certain characteristics present in mental retardation, which may or may not be associated with another mental disorder, corroborate the social seclusion of these patients, such as hyperactivity, low frustration tolerance, aggression, affective instability, self-destructive, stereotyped or repetitive behaviors.

In DATASUS data, the highest prevalence of hospital admissions due to mental disorders is due to psychoactive substance, use disorders with 37.09%.⁸ However, this category, occupies the fifth position, since the sample of this study only selects prolonged inpatients, and it is known that the hospitalization of dependents is almost always brief. Patients diagnosed with psychoactive substance-related mental disorders, who were hospitalized for more than 45 days, were strictly due to judicial measures that required compulsory hospitalization.

◆ Correlating variables:

◆ Age range x Average Length of stay:

We observed, in table 3, that the increase in the average number of days of hospitalization varies directly proportional to the age group. Over the years, families "give up the mentally ill" and end up succumbing to psychiatric hospitals, as a way to alleviate

their emotional burden. At the same time that the elderly remain in the psychiatric hospital, for more time, which, is why specific therapy for the particularities of this age group is justified, young people between the ages of 31 and 45 are responsible for a large part of the long hospitalizations, with a longer one. The fact that these first hospitalizations occur at a young age also cooperates so that the patient loses his social role as an economically active subject and in the constitution of new family ties.

◆ Family Support x Average Length of Stay

Patients who did not have family support, accounting for 70.6% of the medical records, had an average stay of 2623 days, much higher than those with family support, that had a mean of 161.3 days (table 3). Without the possibility of family and community care, a process of hospital entry and exit begins, with successive readmissions. This contributes, in a specific moment, to the patient losing his reference to "where to return" or giving up investing in the creation of new bonds, in a process known as a revolving door.¹⁹ Another important factor is the social abandonment that these families are submitted in their day to day, that hinders the possibility of participating in the treatment of the patient and also perform their daily activities. Contrary to this, the relationship with the family can become important for adherence to drug treatment and in complementing psychotherapeutic treatment, creating a strong emotional base in which the patient can find support.

◆ Groups of ICD 10 x Average Length of stay

The group of ICD 10 that presented the longest time of stay in the hospital was the mental retardation, with more than 3000 days of average hospitalization. Secondly, the group of Schizophrenia, schizotypal disorders and delusional disorders. The first group is defined as an irreversible condition, characterized by a lower than average intellectual capacity, learning difficulties and social adaptation, and that, usually occurs in the early years of childhood. The patient with mental retardation will almost always mean a great economic "burden" for the family, that is responsible for their care, and their chances of work are very low. In addition, they present reactions, that, are inconsistent with the reality presented and are therefore unpredictable. This makes it difficult to coexist and requires the physical and mental disposition of the caregiver.

In relation to the second group, one of the great difficulties faced by relatives is the aggressiveness developed by these patients, so that, in certain situations, the only way out is restraint, pharmacological and physical. This makes the evolution of the disease and the exacerbations make the hospitalizations more and more frequent, the family feels more and more affected and increases the chance of abandonment.

♦ Medical discharge x Average Length of stay

Of the 51 records, 41 of them were discharged. This figure, which represents 80.4% of the patients, shows that most hospitalized patients were able to receive outpatient treatment. If we correlate the

presence of medical discharge, with the average length of stay, we will see a number of approximately 1926 days for those who are positive, while those who have not been discharged have a time of approximately 1786 days.

Among the various conditions that justified their stay after discharge, we found absence of family referral, compulsory hospitalization, allegation of lack of physical and socioeconomic structure on the part of the family to receive the patient at home and rejection of family members without justification (table 4).

Table 4. Reasons for stay in hospital. Maceió, 2014.

Variable	n	%
No reference	10	24
It has references, but the reasons below for permanence are observed:		
Due to compulsory hospitalization	9	21
The family reports that it tries to organize physically, economically and socially	7	17
The family refuses and gives no information	10	24
They left the hospital until the end of the collection	5	12
Total	41	100

Source: Patient records at the HEPR.

Patients who had no family reference were those brought by third parties, who did not carry documentation and who, even after mobilization by the social service, could not locate their relatives. Most of the time, they were found wandering in public streets, disoriented, with antisocial behaviors. Some of them had a minimum of personal reference, that is, they knew how to give their name and even personal address, however, when checking the information they perceived an implausibility or could not find someone responsible for the patient.

Patients who had a family reference were hospitalized for several other reasons. The lack of physical, economic and social structure was alleged by some families, and sometimes, verified by the social service, where low income families could be observed, numerous, in inadequate housing, far from psychosocial care centers or health units, that offer Mental health support. Therefore, this factor, is related to the lack of support and public policies of mobility, education, health and housing. Evidence of the need for family restructuring is that some of the families (approximately 12%) who, after having been discharged, asked the hospital to prepare to receive the patient, they actually performed the removal of the patient from the hospital until the end of our collection.

In addition to these factors, the simple family refusal to accept the patient, without justification is also a factor that promotes prolonged hospitalization and represents 24%. Families change their address or contact and do not inform the hospital, or, provide false contact information.

Another reason, which comprises 21% of the permanence, is the judicial determination, setting compulsory regime and, in this case, the exit is not linked to the conditions of clinical stability, because it was necessary to comply with the time determined by the judge for hospitalization. His acceptance by the institution would be adequate only in the acute situation of the disorder, but that would not justify its permanence for long periods, especially, in the abuse of psychoactive substances, main reason for the compulsory hospitalization.

As for the ten patients who were not discharged, among the main reasons, is aggressiveness, refractory to pharmacological and psychotherapeutic treatment, representing 70%. In this sense, some points must be investigated, among them, effectiveness and adherence to the treatment, because, even internally, there is the possibility of these patients being able to use devices to not ingest the medication. In the other study, 20% were patients with a

weakened global clinical condition, and only one patient (10%) corresponded to compulsory hospitalization, with a judicial order, for isolation for treatment of tuberculosis. It is understood that these patients would best benefit from general hospital treatment, with the resources to meet their needs.

CONCLUSION

Most of the long-stay hospitalizations, carried out at HEPR, presented particular reasons for each patient or their families. In most cases, these patients have a high inflow and outflow from the hospital, because, even when they have stabilized during hospitalization, when they return to their homes, they do not find, in the family, the support necessary to maintain the treatment and end up entering a cycle of successive crises. In this respect, it is worth noting, that some relatives have expectations about the treatment in the psychiatric hospitalization unit²⁰, which can, often, only be achieved with family therapy. Other patients are exclusive residents, as they do not have any family reference and the hospital works as a dwelling.

In addition to the family issue, state decisions provide a system of reception in the network of junk health, associated with the stigma that hangs over the psychiatric patient, that contributes to the oblivion of these people.

The need for changes to insert these patients into society is extolled. The Psychosocial Care Centers (CAPS) must present structure for intensive treatment through a multidisciplinary team that understands the individual as a whole. And for those who have nowhere to go, abandoned by the family, therapeutic residences should be the most appropriate indication. It is pointed out that, although these two entities already exist in the current health system, they present themselves on a low scale, with limited physical resources and physical structure and poorly trained professionals.

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