Psychiatric hospitalization and maintaining the treatment outside the hospital

INTERNAÇÃO PSIQUIÁTRICA E A MANUTENÇÃO DO TRATAMENTO EXTRA-HOSPITALAR

INTERNACIÓN PSIQUIÁTRICA Y CONTINUIDAD DEL TRATAMIENTO EXTRAHOSPITALARIO

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ABSTRACT

The objective of this study was to identify common features between people that have been recently discharged from psychiatric hospitalization. A quantitative exploratory study was performed at an outpatient mental health service center. The sample was comprised by patients who had recently been discharged. A questionnaire was used and the study was approved by the Review Board. Interviews were performed with 48 patients who were in average 39 years old. Diagnosis for Schizophrenia and Schyzotypal Disorders were prevalent for 33.3% of the sample. An average 13 patients were discharged from psychiatric hospitalization every month, 62.5% of which had been previously hospitalized. In the studied period, 12.5% of the sample required rehospitalization. Psychiatric hospitalization proved to be a necessary resource in crisis episodes and as part of the psychiatric treatment, especially of severe mental disorders. It is evinced that there is a need for adequate treatment maintenance in community health care services to avoid the need of rehospitalizations.

KEY WORDS

Psychiatric nursing.
Rehabilitation nursing.
Mental Health Services.
Patient discharge.

RESUMO

O objetivo desse trabalho foi identificar características comuns entre pessoas que tiveram alta hospitalar de internação psiquiátrica recente. Foi realizado um estudo quantitativo exploratório em um serviço ambulatorial de saúde mental. A amostra foi composta por pacientes egressos de internação. Utilizou-se um questionário e a pesquisa foi aprovada pelo CEP. Estrevistou-se 48 pacientes com idade média de 39 anos. Diagnósticos de Esquizofrenia e Transtornos Esquizotípicos foram prevalentes em 33,3% da amostra. Em média treze pacientes recebem alta de internação psiquiátrica hospitalar ao mês e 62,5% deles tinham internações anteriores. No período, 12,5% da amostra necessitou de reinternação. A internação psiquiátrica demonstrou ser um recurso necessário aos momentos de crise e parte da manutenção do tratamento psiquiátrico, principalmente dos transtornos mentais graves. O que evidencia a necessidade de uma manutenção adequada do tratamento nos serviços de atendimento comunitário para que a necessidade de reinternações seja evitada.

DESCRITORES

Enfermagem psiquiátrica.
Enfermagem em reabilitação.
Serviços de Saúde Mental.
Alta do paciente.

RESUMEN

El objetivo de este trabajo fue identificar características comunes entre personas que tuviesen alta hospitalaria de internación psiquiátrica reciente. Se realizó un estudio cuantitativo exploratorio en un servicio ambulatorio de salud mental. La muestra se compuso de pacientes egresados de internación. Se utilizó un cuestionario, y la investigación fue aprobada por el CEP. Fueron entrevistados 48 pacientes con edad media de 39 años. Los diagnósticos de esquizofrenia y transtornos esquizotípicos prevalecieron en el 33% de la muestra. En promedio, trece pacientes reciben alta de internación psiquiátrica hospitalaria al mes y 62,5% de ellos tenían internaciones anteriores. Durante el período, 12,5% de la muestra necesitó de reinternación. La internación psiquiátrica demostró ser un recurso necesario en los momentos de crisis, y parte de la continuidad del tratamiento psiquiátrico, principalmente de los transtornos mentales graves, lo que pone en evidencia la necesidad de una adecuada continuidad del tratamiento en los servicios de atención comunitaria para que las reinternaciones sean evitadas.

DESCRIPTORES

Enfermería psiquiátrica.
Enfermería en rehabilitación.
Servicios de Salud Mental.
Alta del paciente.

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INTRODUCTION

Since early times, humanity faces difficulties to deal with differences and disagreements from common sense and life[1]. In psychiatry, the treatment of madness has sometimes been based on intolerance towards mental patients' behaviors, with their reclusion as an option to chase away what is different and *protect* society.

Despite the evolution in psychiatric treatment and the understanding of madness as the representations of certain mental illness symptoms, the cause(s) of these illnesses and their cure remain a challenge. Hence, for many mental illnesses, psychiatric treatment becomes extensive and marked by repeated hospitalization, mainly when treating severe mental disorders[2-3].

Psychiatric hospitalizations involve different inquiries, based on the biased goal of their application. On the one hand, the goal is to treat, deliver care and protect mental patients from behaviors that are dangerous for themselves and/or other people; on the other, their autonomy is also limited and can even reach the point of limiting their civil rights. This is not a simple and practical option.

Professional mental health care today reflects countless discussions and changes that culminated in the deinstitutionalization process of patient care. In Brazil, psychiatric hospitals, the main sites for these treatments, are no longer the base of the care system, making room for an increasingly complex extra-hospital service network[4-5].

As psychiatric hospitalization is an extremely important procedure in the configuration of care and the evolution of the main psychiatric diseases, however, it is still very much used. In many clinical situations, hospitalization is prudent and can even be imperative, mainly for the most severe cases[3].

Today, psychiatric hospitalization is indicated for severe cases, when extra-hospital resources for treating or managing the problem have been exhausted, while hospitalizing people in asylum institutions is prohibited. Situations of mental disorders with at least one of the following conditions are considered severe cases: risk of self-harm, risk of harming others, risk of harm to public order, risk of social exposure, severe disability for self-care[3]. Its goal focuses on stabilizing the patient: minimizing risks, surveying psychosocial needs, adjusting psychopharmacological treatment and reinserting patients in their social context. Medical professionals are responsible for carefully and ethically analyzing each case in order to verify when psychiatric hospitalization is necessary.

Law 10.216, issued in 2001, is essentially a letter of principles[6]. Bill 3.657/89, which preceded the law, represented the just perception of the urgent need to reform psychiatric care and fight for the guarantee of mental patients' civil rights. It triggered debates and collisions between representatives from corporate entities of health professionals, civil associations, users and relatives and political groups, resulting in Law 10.216.

In summary, the current law addressed the guarantee of mental patients' basic rights, including the right to have access to the best diagnostic and therapeutic resources available, in a diversified service network; it highlights the need for specific deinstitutionalization policies and acknowledges psychiatric hospitalization as another valid therapeutic resource, provided that it is high-quality.

This paper intends neither to simplify nor polemize the applicability of hospitalization in mental illness treatment. The researchers consider that the discussion on its applicability is complex and also comes up against its social, cultural and economic representation. Nevertheless, when based on judicious medical assessments supported by qualified services, with specialized and committed professionals, hospitalizations can be an important therapeutic measure in the treatment of mental illnesses.

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OBJECTIVE

This research aimed to get to know who mental disorder patients recently discharged from psychiatric hospitalization are and their common characteristics.

METHOD

Approval for this research was obtained from the **Research Ethics Committee** of the Teaching Health Center *Joel Domingos Machado* at the University of São Paulo at Ribeirão Preto Medical School (protocol 254/CEP-CSE-FMRP-USP). An exploratory, descriptive and prospective research was carried out between December 17th 2007 and April 17th 2008.

The **Place** of study was the Mental Health Center (NSM), an outpatient care unit linked with the Teaching Health Center *Joel Domingos Machado* at the University of São Paulo at Ribeirão Preto Medical School - USP - Brazil (CSE-FMRP-USP).

The study **population** comprises the universe of all patients living in the West of Ribeirão Preto and enrolled at the abovementioned outpatient service. The **sample** included all service clients discharged from psychiatric hospitalization during the study period. For data **collection**, a questionnaire was used with the following variables: *Gender; Age (date of birth); Patient's education level; Patient's marital status; Number of children; Patient's occupational situation; Patient's personal income; Whom the patient lives*

with, Housing conditions; Number of people living in the same house; Family income; Psychiatric diagnosi(e)s; Patient's knowledge on his/her disease; Manifestation time of psychiatric disorder; Belief in psychopharmacological treatment; Knowledge of name of prescribed drugs; Prescription: Previous hospitalizations (number); Date of last psychiatric hospitalization; Place of last hospitalization; motive for hospitalization, Duration of last psychiatric hospitalization. **Data analysis** involved central trend measures in SPSS software, version 10.0.

RESULTS

Patients discharged from hospital

During four months, 54 patients were discharged from a psychiatric hospital and received care at the service. This represented an average 13 hospitalization per month, without cases in which the same patient needed re-hospitalization. The sample included 48 patients who agreed to participate in the research.

Six patients were excluded from the study: two refused to participate; one was transferred to another service; one patient's discharge from hospital was suspended and his appointment postponed; two did not attend the consultation and the outdated enrollment in the information system of the public service system made any active search impossible. The sample patients' demographic, social and economic characteristics are presented in **Table 1**.

Thirty patients were women and 18 men, with a mean age of 39 years, ranging from 18 to 75 years. Among the sample patients, 39.6% were single and 37.5% married. Patients who had already been married or had lived with a fixed partner and were separated or divorced represented 16.7% of the sample, while 6.3% were widowed.

As for the number of children, 41.7% did not have any child and 27.0% three or more children. Patients with one or two children corresponded to 31.3% of the sample, divided as follows: subjects with only one child 16.7% and with two children 14.6%.

It was verified that 31.2% of the patients denied gaining any income, 37.5% reported one minimum wage (R$ 380 at the time of research) and 18.8% two minimum wages. Among the patients discharged after recent psychiatric hospitalization, 87.5% gained two or less minimum wages as a personal income. Only one patient declared revenues of three minimum wages and five declared four minimum wages or more as a personal income.

The large majority of patients (93.8%) lived with their relatives. Two patients reported that they lived alone and one lived with friends. In 78.8% of cases, patients discharged after hospitalization lived in their own home, while 27.1% paid rent and one patient mentioned living in his car, who was classified as a *street dweller*.

Table 2 - Relative frequency distribution of main diagnoses and comorbidities among patients discharged after recent psychiatric hospitalization at an Outpatient Mental Health Service - Ribeirão Preto - 2008

Variables	Characteristics	N(%)
Age (full years)	Mean age 39 years Patient aged 34 years or older Variation: 18-75	24(50.0)
Gender	Male Female	18(37.5) 30(62.5)
Marital status	Single Married/Living with a Fixed Partner Divorced/Separated Widowed	19(39.6) 18(37.5) 8(16.7) 3(6.3)
Number of Children	None One Two Three or more	20(41.7) 8(16.7) 7(14.6) 13(27.0)
Education	Illiterate Unfinished primary education Finished primary education Unfinished secondary education Finished secondary education Finished higher education	2(4.2) 17(35.4) 7(14.6) 9(18.8) 10(20.8) 3(6.3)
Occupation	Has Never Worked Unemployed Does occasional "gig" jobs Informal regular job Formal regular job On leave Retired	3(6.3) 12(25.0) 3(6.3) 2(4.2) 5(10.4) 4(8.3) 19(39.6)
Personal Income*	None One minimum wage Two minimum wages Three minimum wages Four or more minimum wages	15(31.2) 18(37.5) 9(18.8) 1(2.1) 5(10.4)
Whom patient lives with	Lives alone Lives with relatives Lives with friends	2(4.2) 45(93.8) 1(2.1)
Housing Condition	Own Rented Other (street dweller)	34(70.8) 13(27.1) 1(2.1)
Number of people in the house	Up to two Three or four Five or six Seven or eight	12(25.2) 28(58.4) 4(8.2) 4(8.2)
Family Income*	None Two minimum wages Three minimum wages Four or more minimum wages	1(2.1) 12(25.0) 21(43.7) 14(29.2)

*At the time of research, one minimum wage corresponded to R$ 380. Figures between parentheses are percentages (N=48 with N = absolute number of patients under analysis).

Mood (affective) Disorders grouped diagnoses for 29.2% of sample patients. Of all patients in this sample, 29.2% presented a psychiatric comorbidity. Twelve had received two diagnoses (25.0%) and two had three diagnoses (4.2%). None of the patients had received more than three psychiatric diagnoses. Among patients with two diagnoses, three cases were observed in which one mental illness diagnosis was associated with drugs use (psychoactive substances, alcohol and multiple drugs). In five other cases, the diag-

nosis of personality disorder was associated with other disorders. One diagnosis of emotionally unstable personality disorder was associated with dementia in human immunodeficiency virus disease.

Diagnosis time was verified in full years, and ranged from less than one year to 20 full years. On the average, the discharged patients' disease time was 4.4 years, and 50% had been diagnosed with a psychiatric illness about 3.5 years earlier. Diagnosis time was less than one year for 41.6% of patients, 20.8% between one and five years, 29.2% between six and ten years and 8.4% between eleven and twenty years.

Fifty-six percent of patients did not know the name of the mental illness they were victims of and why they were being monitored at the mental health service. Hence, only 21 patients could name the mental illness they had been diagnosed with.

Family income exceeded three minimum wages for 72.9% of patients. The patient who affirmed living on the street denied gaining a family income and twelve patients reported a monthly family income of two minimum wages.

Among subjects for whom only one diagnosis was registered, diagnoses classified in the group of Schizophrenia and Schizotypal Disorders prevailed in 33.3% of the sample. In this group, the Schizophrenia diagnosis stood out in ten subjects, corresponding to 20.8 % of the sample, as described in **Table 2**.

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Diagnosis description	N (%)
Schizophrenia, schizotypal and delusional disorders	**16 (33.3)**
F20.0 - Schizophrenia	10(20.8)
F20.9 - Schizophrenia, unspecific	1(2.1)
F23.1 - Acute polymorphic psychotic disorder with symptoms of schizophrenia	1(2.1)
F23.9 - Acute and transient psychotic disorder, unspecified	1(2.1)
F25.0 - Schizoaffective disorders	3(6.3)
Mood (affective) disorders	**14(29.2)**
F31.0 - Bipolar affective disorder	4(8.3)
F31.1 - Bipolar affective disorder, current episode manic without psychotic symptoms	1(2.1)
F31.6 - Bipolar affective 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, stress-related 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 [HIV] disease + Emotionally unstable personality disorder	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 disorder + Schizotypal disorder	1(2.1)
F60.3 and F 31.5 -Emotionally unstable personality disorder + Bipolar affective disorder, current episode severe depression with psychotic symptoms	1(2.1)
F60.3 and F32.0 - Emotionally unstable personality disorder + Mild depressive episode	1(2.1)
F60.9 and F 41.0 E - Personality disorder, unspecified + Generalized anxiety	1(2.1)
F60.3 and Z91.5 - Emotionally unstable personality disorder + 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 + Bipolar affective 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 disorder	1(2.1)
Total	**48(100.0)**

Regarding the discharged patients' knowledge on the psychopharmacological treatment they had been prescribed, most of them either did not or partially knew the name and prescription of all drugs they had been prescribed, as shown in **Table 3**.

Table 3 - Knowledge of patients discharged after recent psychiatric hospitalization about psychopharmacological prescription at a Mental Health Outpatient Service - Ribeirão Preto - 2008

Knowledge about prescription	Frequency (%)
None	12(25.0)
Partial	15(31,2)
Total	21(43,8)
Total	**48(100,0)**

Although they could not or partially knew the name of the prescribed drugs, when asked about the importance of maintaining psychopharmacological treatment, 81.2% of the patients considered that drugs treatment was important.

The psychiatric hospitalization

Among discharged patients, 62.5% had already been hospitalized at least once before the most recent hospitalization. The number of previous hospitalizations ranged from one to three, as described in **Table 4** below.

Table 4 - Distribution of number of previous hospitalizations of patients discharged after recent hospitalization at a Mental Health Outpatient Service - Ribeirão Preto - 2008

Previous Hospitalization	N(%)	Number of hospitalizations	N(%)
No	18(37.5)	0	18(37.5)
Yes	30(62.5)	1	9(18.8)
		2	3(6.3)
		3	1(2.1)
		4	3(6.3)
		5	4(8.3)
		6	1(2.1)
		9	1(2.1)
		10	5(10.4)
		11	1(2.1)
		12	1(2.1)
		13	1(2.1)
Total	**48(100.0)**	**151**	**48(100.0)**

Figures between parentheses are percentages (N=48 with N = absolute number of patients under analysis)

For 37.5% of sample patients, the recent hospitalization was the first psychiatric hospitalization in their lives. Among discharged patients, five had already been hospitalized ten times before the recent hospitalization and nine had already been hospitalized once. The mean hospitalization rate was 3.14. Information on the behaviors that motivated the recent hospitalization were collected from the referral form filled out for patients on the occasion of their discharge, which the mental health service receives when they come for the medical appointment. These behaviors are described in **Table 5**.

Table 5 - Description of behaviors determining hospitalization needs among patients discharged after recent psychiatric hospitalization at a Mental Health Outpatient Service - Ribeirão Preto - 2008

Motives for hospitalization registered on referral form	Frequency	%
Akathisia (collateral effect medication)	1	2.1
Alcohol use or abuse and aggressive behavior	1	2.1
Aggressiveness, irritability, psychomotor agitation	12	25.0
Suicide ideas or attempt	17	35.4
Resistant somatoform delusions	2	4.2
Psychotic symptoms (delusions, hallucinations, mania)	14	29.1
Hypersexuality	1	2.1
Total	**48**	**100.0**

Figures between parentheses are percentages (N=48 with N = absolute number of patients under analysis).

Most of the hospitalizations observed in this research were based on high risk for the patient or other people's life and health. Suicide ideas, with or without suicide attempts caused the hospitalization of 35.4% of the sample subjects. The manifestation of psychotic symptoms motivated the hospitalization of 29.1% and aggressive behaviors another 25%.

One patient was hospitalized due to akathisia, an adverse effect caused by the use of an antipsychotic drug (Haloperidol). Due to the use of alcoholic beverages, one patient suffered a considerable mood change that resulted in his hospitalization because of aggressive behavior. One hospitalization was due to hypersexualized behavior. On the average, these patients remained hospitalized for 27 days. The shortest hospitalization period was two days and the longest 160 days. Only eight patients affirmed having turned to an emergency health service during the month before the most recent hospitalization.

Psychiatric rehospitalization

Out of 48 subjects interviewed during four months, six (12.5%) were rehospitalized during the data collection period, four men and two women. These patients' mean age was 32 years, 50.0% were single, without children and retired. The low education level was characteristic in 66.7% of rehospitalized patients. Only one had a fixed job and was on a leave of absence. Individual income corresponded to one minimum wage in 50% of cases. Five lived with relatives in their own house. One was a street dweller and affirmed living in his car. Family income did not exceed two minimum wages.

None of them knew the name of their disease. On the average, rehospitalized patients had been diagnosed for 8.3 years. Three patients had been diagnosed with Schizophrenia, one with Bipolar affective disorder, one with two diag-

noses (Emotionally unstable personality disorder and Mild depressive episode) and one with three diagnoses (Mental and behavioral disorders due to use of alcohol – dependence syndrome, together with Schizophrenia and Bipolar affective disorder). None of the rehospitalized patients knew the names of all drugs they were taking.

DISCUSSION

This research identified that the patients discharged from psychiatric hospitalization in this sample are mostly women (62.5%), live with relatives (93.8%), in their own home (70.8%), where they live with three or four people (58.4%). Individual income did not exceed one minimum wage (R$ 380) for 66.7% of patients, observing that 54.2% have finished primary education and that only 14.6% have some kind of regular job. These findings are similar to other studies involving patients attended by community care services[7-9]. In this and other studies, it is verified that low education and socioeconomic levels affect many psychiatric patients' lives.

It is known that, among the ten main disability-provoking physical and mental health conditions, five are related to mental disorders, especially: depression, alcoholism, bipolar affective disorder, schizophrenia and obsessive compulsive disorder[8]. In this study, these disorders were present, with the highest prevalence found for diagnoses classified under Schizophrenia, schizotypal and delusional disorders and Mood Disorders (ICD 10 F20-F29; F31-33), in accordance with different studies in the area[8-9].

These are severe illnesses, often accompanied by manifestations of symptoms that limit patients' labor, social and leisure activities. Besides, they trigger discrimination and stigmatization[10-11]. Considering this aspect, low education and socioeconomic levels can be related with the severity of the symptoms manifested in these diseases. The constant manifestation of the symptoms and adverse effects of medication treatment impair mental patients' relations with their families and social context[12]. In this research, the occurrence of adverse effects was so severe in one patients that it ended up being the reason for another hospitalization.

In view of the extent of this harm, adequate treatment maintenance is needed for non-hospitalized patients attended by community care services. Thus, the prevention of relapse can minimize damage and favor patients' social relations, turning health service, nurses and other professionals' activities fundamental in this daily reality.

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 drugs use (psychoactive substances, alcohol and multiple drugs). One of the cases of patients with three diagnoses was related with drugs use. It is known that drugs addiction is often connected with the manifestation of mental illnesses and represents a public health problem nowadays[13].

Patients discharged from hospitalization showed low knowledge levels on the name of their mental illness and their psychopharmacological treatment. Although a large majority of the sample showed recent diagnosis and treatment (less than one year), 56% could not tell the name of the mental illness they were victims of and why they were being monitored at the mental health service and 56.2% did not know or partially knew about the drugs they had been prescribed.

Although they either did not know or partially knew the names of the prescribed drugs, when asked about the importance of psychopharmacological treatment maintenance, 81.2% of patients considered drugs treatment important. These little coherent opinions seem to reflect what is observed in practice.

Although they absorb health professionals' orientations on the importance of psychopharmacological treatment, in general, non-adherence affects about 50% of patients[14-15]. Among patients treated with conventional antipsychotics, 40% stop taking their medication during the first year of treatment and 75 % within two years[16].

Treatment is a fundamental element in patients' lives. For them, who go through this hospitalization and rehospitalization process, other daily-life activities are organized around the possibilities of treatment, as the fact of being hospitalized or not completely changes this population's daily reality. Hospitalization represents not only a treatment form for patients, as relatives report difficulties to live with the disorder of madness and consider hospitalization a moment when they can relax and live calmly[17].

Extra-hospital services need to work towards the goal of hospitalizations, which is to stabilize patients (minimizing risks, surveying psychosocial needs, adjusting psychopharmacological treatment and reinserting patients in their social context), in which care systemization is quite a correlated strategy.

Symptoms like *psychic anxiety*, *hostility* and *emotional retraction* were symptoms with a significant degree of severity among the discharged patients ($c2=183.712$; $p<0.000$ – Friedman's Test). These symptoms were also related with the recent hospitalization. The main reasons for hospitalization were precisely hostility (aggressiveness, irritability, psychomotor agitation), suicide ideas or suicide attempt and psychotic symptoms (delusions, hallucinations, mania).

The reasons described above are in accordance with *Law No 10.216, issued on June 04th 2001*. Nowadays, psychiatric hospitalization is indicated for severe cases, in which extra-hospital service approaches were not sufficient, i.e. when extra-hospital resources for treating or managing the problem were exhausted. Severe cases are considered situations in which a mental disorder is present, with at least one of the following conditions: risk of self-harm, risk of harming others, risk of harm to public order, risk of social exposure, severe disability for self-care[17].

Although a large part of the sample presented recent diagnosis and treatment (less than one year), 56% could not tell the name of the mental illness they were victims of and why they were being monitored at the mental health service and 56.2% did not know or partially knew about the drugs they had been prescribed. Patients discharged from hospitalization showed low knowledge levels on the name of their mental illness and their psychopharmacological treatment.

Another important result was that, although they did not know or partially knew the names of the prescribed drugs when asked about the importance of maintaining the psychopharmacological treatment, 81.2% of patients considered medication treatment important. This opinion does not seem to exert practical influence on adherence though, as 70.8% of patients were classified with low treatment adherence.

CONCLUSION

In this study, the researchers attempted to deepen their knowledge on patients who use the current public mental health service network and needed psychiatric hospitalization during their treatment. Among other goals, this knowledge aims to generate reflection and support to collaborate in the dynamics between mental health knowledge and practice. Professional commitment to knowledge in its relation with practice is an important source of evolution.

The innovations produced by the change in psychiatric care paradigms demand further research and adaptations, so that health professionals and services can attend to these clients' demands. As a result of judicious psychiatric hospitalizations marked by shorter institutionalization period, patients and relatives have increasingly become the main mental health care providers. In this context, the chronicity of mental disorders makes these people live with the hospitalization-rehospitalization process, and their daily activities are organized around the possibilities of mental disorder treatment.

Thus, today, knowing whom people discharged from psychiatric hospitalization are makes it possible to identify characteristics that can promote the determination of the best treatment and professional support to patients and their caregivers. The discharged patients analyzed in this study represent the population attended by a public health service, but long-term studies will be accomplished to consider these patients' psychiatric hospitalization and treatment maintenance in further depth.

Research and interventions in the needs of patients discharged after hospitalization and their caregivers are important for mental health service professionals' systematic action. The data demonstrated that, on the average, 13 patients per month are discharged from psychiatric hospitalization and attended by the service. In most cases, treatment maintenance of "non-institutionalized" patients is based on psychopharmacology, signs and symptoms, resorting to hospitalization in case of increased health risks. This type of care does not absorb daily and collective needs that also interference in the maintenance of these treatments and which lack interventions.

Considering the whole evolution of the mental illness care paradigm and its complexity in view of symptom manifestations: limitations on psychopharmacological treatment, family overload, social prejudice, lack of services and professionals, this research attempted to characterize one moment in the life history of mental patients in order to reflect on systemized mental health nursing care. This systemization will be elaborated based on a new research project, to be developed as from 2009 together with the University of São Paulo at Ribeirão Preto College of Nursing-USP.

New possibilities for care delivery to people who suffer due to a disease will always exist. Nowadays, mental health care demands that professionals attempt to understand the patients' world, their emotional needs and life, acting either punctually or not to stimulate psychosocial skill development.

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