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Feasibility of general hospitals psychiatric units in Brazil

ABSTRACT

OBJECTIVE: To comprehend the stigma against people with mental disorders still persists in the culture of general hospitals and acts as a limiting factor in the implementation of psychiatric units in general hospitals in Brazil.

METHODOLOGICAL PROCEDURES: A qualitative social survey was outlined based on action research strategy as of the agreement to adopt a psychiatric unit in a general hospital in Taubaté, Southeastern Brazil. Data was obtained through interviews, participant observation and talks on the psychiatric unit project given to the hospital's clinical *staff*.

RESULTS: The investment made by the healthcare authority enabled the stigmatizing conceptions (violence, moral weakness and untreatability) present in the hospital culture in question to be resignified by means of clinical and sanitary discussions, which enabled the implementation of the psychiatric unit. The analysis showed that these concepts persist in this context because of a healthcare system that limits the access of people with mental disorders.

CONCLUSIONS: The attitude of the healthcare authority, who decided to adequately fund the general hospital's psychiatric unit and exerted his influence over the hospital, was decisive for the outcome of the case. The main difficulty in implementing psychiatric units at general hospitals is not the overcoming the existing stigma in the culture of general hospitals, but rather a difficulty which is strategic in nature: the lack of an affirmative policy for these units.

DESCRIPTORS: Personnel, Hospital. Health, Knowledge, Attitudes, Practice, Mental Health Services. Psychiatric Department, Hospital, organization & administration. Hospitals, General. Hospital Administration. Qualitative Research. Mental Health Policy.

INTRODUCTION

Psychiatric units in general hospitals (PUGH) consist of a set of mental health services inserted in a general hospital framework.[3] Considering that the main service is in inpatient setting, creating a PUGH is an alternative to using psychiatric hospitals to treat patients with severe mental disorders in acute states. In this paper, the term PUGH is used as a synonym of inpatient setting.

After the Second World War, a large number of PUGH was opened in Western Europe and North America.[5] This occurred because of several reasons: 1) politically, the rights granted to citizens resulted in the creation of a social network, the so-called Welfare State, which guaranteed the right to a health system, and 2) technologically, due to the development of effective biological treatments and psychosocial rehabilitative activities.

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In Brazil, PUGHs began to be discussed in the 1970s, in the context of the sanitary and psychiatric reforms. As of the 1980s, the first academic papers based on the international literature and on real experiences were published and provided evidence on the appropriateness of PUGH to the Brazilian scenario[13] and, in 1992, the Health Ministry issued regulations on the operation of PUGHs.

In 2005, according to the World Health Organization (WHO[a]), Brazil had 0.12 psychiatric beds in general hospitals for every 10 thousand inhabitants (approximately 2210 beds), accounting for 4.7% of the total number of psychiatric beds in the country. Compared to the 180 countries that disclosed this information, Brazilian data show that the figures are below the average: 0.84 psychiatric bed per 10 000 inhabitants in general hospitals, representing 21% of the total number of psychiatric beds.

Using this percentage as a reference and considering that, according to the Health Ministry, the total number of psychiatric beds in Brazil should not exceed 2.4 per 10,000 inhabitants,[b] there is a lack of over 6,000 psychiatric beds in general hospitals in Brazil, if we consider a parameter of 0.5 psychiatric bed in general hospitals per 10 000 inhabitants.

To understand the reasons behind the still small number of PUGH in Brazil, a model, suggesting that there are mutual forces acting between the following factors, was used: lack of financial resources and the stigma against people with mental disorders.

It is believed that stigma impacts negatively on healthcare agencies and policy makers in terms of funding for the mental health area, thus jeopardizing certain actions and interferes in the resocialization process of the target-population. This reinforces the belief that there is no other kind of treatment for mental disorders than exclusion.

In Brazil, according to Andreoli et al,[1] there was a decrease in public funding for mental health when compared to resources allocated to other areas. The amount, which represented 5.5% in 1995 – higher than the 5% rate recommended by the WHO –, fell to 2.3% ten years later.

This cut was made to the mental health budget dedicated to psychiatric hospitalizations, which significantly harmed the implementation of new PUGH. It is estimated that the amount reimbursed for a hospitalization per diem in a PUGH (rate adopted by the Brazilian Health System – SUS) is six times lower than the cost of a patient day.[c]

This fact has not deserved any kind of technical explanation from the healthcare agencies, who are key-players in allocating resources to meet the health needs of the population. In explicit terms, nothing indicates this was a strategic decision. Some agencies claim that the difficulty in implementing PUGH is at the operational level, and it is supposedly not feasible due to the resistance to the changes proposed.[d]

In fact, in certain general hospitals, a lack of interest in psychiatric health services was found, and this occurred without any clinical or even financial reason. An example of this are eleven out of the nineteen hospitals managed by the *Organizações Sociais de Saúde* (OSS – Social Health Organizations) in the state of São Paulo, which, despite receiving adequate funding for their costs, resisted the implementation of psychiatric beds despite the demand for hospitalization in their respective areas of coverage.

It is possible that this takes place because an organizational attitude contrary to the integration of mental health, which can also occur in other general hospitals, can give margin to a lack of initiative on the part of healthcare authorities in defining a policy for these units. Such organizational attitude, in turn, could be explained by the stigma found in the culture of general hospitals.

In 2001, during the opening address in a WHO conference on World Mental Health Day, the United Nations president claimed for task-forces to fight stigma. The motto "Stop Exclusion: Dare to Care" was adopted by many countries and this encouraged several organizations to adopt inclusion policies.

However, there were no programs specifically aimed at general hospitals despite the fact that exploratory studies had confirmed the existence of stigma in these institutions, including in the ones that had a PUGH for a number of years.[14]

To understand long-term stigma in a general hospital, we adopted a social psychology concept of organizational culture from the theory of organizations. It is understood that the forms of expression of a group (rites, values, discourse, among others) are based on shared assumptions developed throughout the group's history, and which the group has learned to consider such assumptions to be the correct way of thinking and acting.[20]

It is assumed that the reactualization of the stigmatizing concepts in the general hospital are a consequence of repeated negative experiences in situations which could be adequately managed in a PUGH.

[a] World Health Organization. Mental Health Atlas; 2005.
[b] Ministério da Saúde. Pactos pela saúde. Brasília; 2006. v.5, p.140.
[c] Lucchesi M. Estudo da viabilidade da implantação de uma unidade psiquiátrica em um hospital geral [doctoral dissertation]. São Paulo: Faculdade de Medicina da USP; 2008.
[d] Lucchesi M. A gestão de unidades de saúde mental em hospitais gerais na grande São Paulo [dissertação de mestrado]. São Paulo: Faculdade de Medicina da USP; 2001.

This study aims at understanding the stigma against people with mental disorders in the culture of general hospitals as a limiting factor in the implementing psychiatric units in general hospitals in Brazil.

METHODOLOGICAL PROCEDURES

Nature and strategy of research

Seeing that this paper is based on social research,[16] we focused on the political, cultural and administrative aspects of PUGH. Extracting sense and meaning through subjects is a crucial structuring role of daily practices,[23] among which one finds the above-mentioned resistance to PUGH. Because of this, a qualitative approach was used.[10]

The chosen strategy was action research, which encompasses the most adequate conditions to investigate the phenomenon by encouraging social actors to reveal their opinions, thus establishing the contrast between discourse and practice.[11]

Design and sample

We chose the case study design in order to enable intense and procedural interaction between researcher and the other actors involved in the study. This design is useful in understanding *how* and *why* complex social phenomena occur, which cannot be interpreted outside their context. Having opted for action research, this case study is considered instrumental[21] in nature and emphasizes the transformation process, and leaves the specific *locus* of action in the background.

Even though this research may be replicated in other future cases, its universe is a theoretical proposition: the lack of PUGH policy in Brazil. In other words, its external validity is a result of an analytical generalization.[25] Therefore, we looked for a case that was more significant to, but not necessarily exemplary[8] of, the general hospitals that render services to the *Sistema Único de Saúde* (SUS – Brazilian National Health System).

The choice of the case study considered the possibility of carrying out fieldwork during the implementation of a PUGH in a general hospital: the university hospital in the city of Taubaté (Southeastern Brazil), which renders most of its services to SUS, through an agreement with the state healthcare manager.

Operationalizing fieldwork

The main researcher worked at the university hospital and was technical coordinator of the project to implement the PUGH. Fieldwork began in July, 2005, and lasted for a year, and was divided in three different stages: interviews, participant observation and talks. Since initial evidence refuted the influence of stigma as being able to overthrown the ongoing project, we expanded our focus, which going beyond the operational level, included the strategic level, emphasizing the historical context in order to understand the case.

During the first stage, semi-structured interviews were carried out with the key-players at the strategic and operational levels, who were categorized as being: directly connected to mental health (group A), responsible for the integration between specialized areas and for the interface with high management (group B), and members of higher staff (group C), as illustrated in the Table below.

In the second stage, participant observation took place at the same time as the other stages. As expected, there was no express opposition to the implementation of a PUGH, so informal contacts were prioritized, and the doubts, suggestions, stories and jokes[17] about the PUGH project that reflected stigmatizing concepts or represented a structured discourse capable of negatively impacting on the administration of the hospital were recorded systematically.

During the third stage, talks were given on the PUGH project directed to the clinics (general, pediatrics, gynecology and obstetrics, surgery an dermatology) at the university hospital where a psychologist acted as an observer and attempted to capture subliminal aspects (in the facial expressions of the audience, in background conversation) during the talks.

Data analyses

The results are presented and discussed in two sections: the context of the case – a result of the broader scope of the study encompassing the strategic level –, presented based on the interviews with key-informants; and the case report, based on participant observation and feedback on the talks given. The description of the results follows the sequence of events and privileges aspects that were stressed in the introduction of this paper. The role of the healthcare agency was also highlighted in regard to the partnerships established with hospitals that provide services to SUS.

To be reported, the phenomena observed were submitted to the following validity criteria:[15] verifying information, saturation of content, triangulation among the sources of evidence, and the degree of discursive articulation, including non-verbal aspects of communication (affection, intonation, among others). We also considered the harmony between the ideas expressed by a same actor throughout the process, in addition to the level of internal cohesion in the attitude of the institutions involved, according to the categories in the Table.

When describing the context, the goal was to establish how the needs of patients with severe mental disorders in acute states were mirrored in the agenda of the

healthcare agency,[24] in addition to how PUGHs were proposed to meet these needs.

In the case report, discursive practices that could negatively affect the ongoing project were examined, by assessing the possibility of resignifying the concepts that reinforced this negative attitude.

This study received the approval of the university hospital's Ethics Committee and management. It was also approved by the university's Ethics Committee and by the *Comissão de Ética para a Análise de Projetos de Pesquisa* (CAPEPesq – Ethics Committee on Research Project Assessment) of the *Hospital das Clínicas* of the School of Medicine of the *Universidade de São Paulo*.

RESULTS AND DISCUSSION

Contextualizing

Psychiatric hospitalization of the population in the Taubaté microregion (São Paulo State), totaling 500,000 inhabitants, had always taken place in other locations. In 1972, due to this inadequate model, the state healthcare agency created a program called "sector psychiatry",[6] and entered into 15 collaboration agreements with educational institutions, among which the university hospital in Taubaté, which belonged to a school of medicine.

In the beginning of the 1980s, when the hospital became part of the university, it had a limited scope, both teaching and service-wise, based on low and medium complexity interventions. This was contrary to SUS guidelines for university hospitals and affected public and private funding of the actions in health of the university, which resulted in lower growth rates in the field.

In the 1990s, when the regional boards were created, the state healthcare agency distributed the psychiatric hospitalization beds geographically. At the Taubaté board (which was responsible for the Taubaté microregion, Guaratinguetá and Cruzeiro), the reference for psychiatric hospitalization became the *Sanatório Jesus* (asylum), in Cruzeiro, which, shortly after, was no longer certified by the healthcare agency. In this process, differently from what mental healthcare professionals wanted, the high staff started to see the opportunity of saving resources in order to acquire new technologies for other areas of health.

The patients of the new accredited psychiatric hospital – in Itapira, 400km from Taubaté –, and their family members, were not satisfied with it, so the regional board met with the respective general hospitals under the state healthcare agency to address the implementation of a PUGH.

The regional board considered the university hospital the priority in having a PUGH because it belonged to a university that offered courses in the health field (Medicine, Nursing, Psychology and Social Service), and would thus train human resources to work in the region. The psychiatric service even wrote a project for a PUGH, however the hospital's top management did not adopt it.

The first PUGH in the region was eventually implemented in 1997, at the *Santa Casa* in Guaratinguetá where there was no organized team of qualified professionals as in the university hospital, but whose mission included caring for the needy.[4] Although the *Santa Casa* was aware that the PUGH would operate at a loss, it saw the possibility of making up for the deficit through other more profitable services provided.

In 2000, the psychiatric service obtained the support of the healthcare agency for a PUGH project at the university hospital. Therefore, an agreement for the implementation of the psychiatric unit was discussed. However, the agreement did not provide for complementary funding for the SUS table. The high staff denied the university the investment required by stating that the amount was too high, and, therefore, the agreement was not signed.

In 2003, the state government acquired, in Taubaté, the Hospital Regional do Vale do Paraíba (HRVP – Regional Hospital of the Paraíba Valley), which would be run by a private entity. The healthcare agency copied the OSS models, but in this case it allowed procedures within the *Sistema Supletivo de Assistência à Saúde* (SSAS – Complementary Healthcare System).

During the first months of negotiations between the regional board and the private entity, the parties agreed that a PUGH would be implemented at the HRVP with ten hospitalization beds. However, based on the argument that HRVP priorities were "high complexity services" – which are better paid by the SUS and the SSAS –, they did not follow through with the PUGH.

Table. Interviewee characteristics. Taubaté, Southeastern Brazil, 2005-2006.

Group	Strategic level / healthcare agency	n	Operational level / university hospital	n
A	Regional technical area	2	Psychiatric service	3
B	Regional board	2	Clinical Management	2
C	High *staff*	2	Top management	5

In an attempt to prevent high staff of the healthcare agency from being omissive of the situation, the regional board called attention to the problems in hospitalizing a patient in Itapira. The patient was placed far away from his home and community, and therefore was isolated seeing that they rarely received visits; in addition the families did not play a role in treatment and were not capable of monitoring the quality of service. The distance was often responsible for longer hospitalizations and adversely affected overall care. It was also resulted in unnecessary costs for the city administration, with gas, highway tolls, drivers and vehicle maintenance. In addition, since the hospital was in another region, it was not under the same mental health policies or the same city health councils of the Taubaté region. In the end, the regional board gave voice to people's arguments on the destination of the resources supposedly saved by closing down the only psychiatric hospital in the region.

Therefore, in July 2005, the healthcare agency announced R$ 570,000.00 (or USD 237,500.00) to be used in building a psychiatric unit at the university hospital. The university saw this as a potential source of future funding for the university hospital and, in consideration, asked that the operational deficit of the PUGH be "borne by the healthcare agency through a formal agreement".

The certainty on the part of the actors involved in the negotiations that PUGH funding would be guaranteed was essential to the validity of this study – and a necessary condition for replication –, because it kept the effect of a conditioning variable of the research under control: funding for PUGH services.

Case report

The installation capacity was set very close to the needs of the Taubaté microregion: based on the parameter of 0.5 psychiatric hospitalization bed in general hospitals per 10,000 inhabitants (established in this research), 25 beds would suffice.

From the total, the Taubaté university hospital (that had approximately 200 beds) would be able to implement twenty psychiatric beds, respecting the denominator that regulates human resources per PUGH bed under the OSS in the state of São Paulo (i.e. 10) and complying with Ministry of Health rules that limit the number of psychiatric beds to 10% of the total number of beds in the hospital, to prevent the unit from becoming a detached structure from the hospital's organizational framework.

In addition, 20 beds would result in proportionally lower costs than 10 beds, for instance, due to the rate of attending psychiatrists per bed, and the possibility of buying medication at a lower cost because of the amount. Moreover, more support would be given to medical internship in psychiatry and to training in mental health.

However, shortly after the financial resources were made available for the implementation of the PUGH, the top management of the university hospital was reluctant in setting up a unit that would operate at a loss. This is because the HRVP – managed by an OSS that was considered a model in effective management – had recently stopped offering the service. For the university, "there would be a price to pay" concerning the collaboration agreement with the healthcare agency, and offering mental health care at the university hospital was seen as "being on a rough time".

This proved to be the right time for the researcher to provide technical grounds for the implementation of a PUGH at the university hospital, seeing that this had not yet been done during negotiations. This stage of our study revealed a reluctance in changing, which was characterized by an anticipatory anxiety, a result of the attempt of trying to locate oneself in the process. Even though it was possible to notice the presence of stigma, there was nothing – underlying or explicit – in university hospital culture that would be able to negatively affect the implementation of the PUGH. To confirm this, we carried out an analysis of the more frequent stigmatizing concepts[22] – violence, moral weakness and intractability –, in an attempt to resignify them.

The association between violence and mental disorders was possibly due to the occurrence of crises, and this led to overestimating the frequency and severity of this clinical manifestation based on the argument that physical integrity of the hospital population would be at risk. This explains certain fears and humorous questions such as "What if the patient runs out of the PUGH, and runs into obstetrics or into pediatrics and wreaks havoc?"

To those who expressed concern for this kind of situation, we mentioned the existence of standard procedures to control crises, which commonly take place at healthcare providers, but which is neglected (or carried out poorly), due to the expectation that only specialized professionals should handle it. It was also stressed that violent episodes were by no means the rule in these cases,[12] in addition to the fact that the patients would only circulate within the PUGH.

This guidance was well received by the healthcare professionals at the hospital, and they agreed to them. They reexamined their initial opinion and asked that there be specific and in-depth training for emergency procedures.

The opinion that mental health patients were morally weak was expressed indirectly in the discourse of some individuals who asked, repeatedly, whether there would be a "place" for this or another coworker at the PUGH, who was apparently under stress. In general, they were joking about it, and obviously did not intend to hospitalize the coworker, but to warn him/her so that he/she would not go mad.

When we analyzed this discourse, the understanding was that self-control can manage unwanted behaviors, and that morally weak individuals be put in psychiatric hospitals as a disciplinary measure. However, we identified a latent feeling of fear that if self-control failed, the individual would be identified with patients who would really be hospitalized in the PUGH. Therefore, we were able to discuss the criteria which would lead to psychiatric hospitalization,[19] highlighting the fact that the individual in such a situations was unable to reorganize himself/herself satisfactorily without help.

Finally, the belief that mental disorders were untreatable, particularly at a general hospital, brought degeneration, which is frequently attached to patients with severe mental conditions, to the surface. Due to their chronic state, these patients supposedly required uninterrupted care, and this would negatively affect the image of the hospital.

In fact, there was the risk that providing inadequate care at the PUGH[7] – with long-term and repeated hospitalizations – would strengthen this misconception. For this reason, the need of fully restructuring the healthcare model across the Taubaté microregion was stressed, in order to enable the PUGH to operate properly.

During the discussions on the effectiveness of mental health interventions, we became aware of the contribution of the consultation-liaison psychiatry service[3] of the university hospital, in the 1990s, in promoting an adequate healthcare experience in hospital culture.

CONCLUSIONS

The historical resistance on the part of the university, and on the part of the university hospital, to the implementation of a PUGH was not due to stigma or to any other feature connected to mental health, but to a self-referenced view, outside the healthcare system, that limited the incorporation of more sophisticated services by the university hospital. The same view prevails in the other healthcare institutions in the city of Taubaté,[A] that until 2006 had not yet obtained the status of SUS health authority, or was the center of the microregional healthcare system.

This resistance was strengthened by a deliberate and passive attitude of the healthcare agency that, despite taking away the SUS accreditation from the psychiatric hospitals, did not establish policies to create an alternative for mental healthcare.

The lack of a PUGH at the HRVP is a milestone, and made it clear that the negotiations favored the healthcare provider. Despite the HRVP budget being able to meet the hospital's costs, the PUGH was not implemented very likely because of its low profitability.

In the university hospital, the investment made by the healthcare agency opened a communication channel with the hospital's organizational framework to resignify stigmatizing concepts that were reactualized in the healthcare context, to which mental health patients have limited access.

Therefore, differently from our initial hypothesis, stigma was not the most important limiting factor to implementing a PUGH. Overcoming this kind of resistance was possible due to the attitude of the healthcare agency that exerted its authority over the hospital provider and, mainly, made a decision to allocate adequate funding for the PUGH, equaling the operational costs with expected revenue. It should be noted that, if the hospital aimed at better financial results, this measure would have to be improved.

In practical terms, this means revising the amount paid by the federal government (according to the SUS table) and systematizing incentives from other levels of government, but also thinking of alternatives to fund PUGH so they can receive adequately for their efficiency. This could take place if funding was based not on a hospitalization per diem, but based on hospitalization as a whole, varying according to the patient's diagnosis and preestablished term of hospitalization, and including, when necessary, high-cost procedures which are available at general hospitals.

Therefore, if a shorter term of hospitalization were required, the hospital would have a margin and, on the other hand, the PUGH interface with the support network outside the hospital would be intensified. To avoid early hospital releases – which would result in increased repeated hospitalizations –, performance indicators should be adopted, such as the continuation of treatment in the network outside the hospital.

Using industrial products more,[9] in turn, could benefit hospitals in negotiating with suppliers and, it would result in the sectors interested in this consumer market to engage in demands for access to mental healthcare. To avoid unnecessary spending with complementary tests and expensive medication, process indicators should be established based on clinical guidelines.[18]

However, if the deliberately passive attitude of the healthcare agencies persists in regard to service providers, such initiatives may decharacterize the goal of the PUGH. After all, a poor strategy is fertile ground for (stigmatizing, capitalist, self-referenced) conceptions that can achieve great proportions and contribute to reproducing existing disparities, strengthening mental healthcare exclusion and favoring the interests of those who hold more power, much to the contrary of what is advocated by SUS principles.

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In future studies, it would be necessary to investigate strategic level variables related to the role of the healthcare agencies that perpetuates the lack of an affirmative policy for PUGH.

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