

Management of mental health care in general hospitals: A psychosocial perspective on clinical hospitalizations

Gestão do cuidado em saúde mental no hospital geral: uma abordagem psicossocial das internações clínicas

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ABSTRACT The article analyzes the management of mental health care in general hospitals based on the experience of clinical hospitalizations involving psychosocial demands. This is a qualitative and quantitative study, descriptive and exploratory in nature, based on the guidelines of methodological triangulation, conducted in a university general hospital in the state of Alagoas, which does not have psychiatric beds. The study analyzed 406 medical records of patients hospitalized between 2016 and 2019 with referrals to the mental health team, as well as two focus groups with professionals and residents (n = 18) and three individual interviews. Qualitative data were examined using the Collective Subject Discourse methodology. The results reveal weaknesses in addressing mental health demands, related to the absence of specialized infrastructure, the fragmented professional training of teams, and weak integration with the Psychosocial Care Network (RAPS). The study reaffirms the importance of managing mental health care in general hospitals from a psychosocial perspective, integrated with RAPS and grounded in the principles of Brazil's Unified Health System and the Psychiatric Reform.

KEYWORDS Mental health. Hospitalization. Psychosocial care. Hospitals general. Unified Health System.

RESUMO O artigo analisa a gestão do cuidado em saúde mental em hospital geral a partir da experiência de internações clínicas com demandas psicossociais. Trata-se de pesquisa quali-quantitativa, de caráter descritivo e exploratório, baseada nas diretrizes da triangulação de métodos, realizada em hospital geral universitário do estado de Alagoas que não dispõe de leitos de saúde mental. Foram analisados 549 atendimentos em saúde mental a partir de 406 prontuários de pacientes internados entre 2016 e 2019 com registros de atendimento pela equipe de saúde mental, além de dois grupos focais com profissionais e residentes (n = 18) e três entrevistas individuais. Os dados qualitativos foram analisados pela metodologia do Discurso do Sujeito Coletivo. Os resultados revelam fragilidades na abordagem das demandas em saúde mental, associadas à ausência de estrutura adequada, à formação profissional fragmentada das equipes e à frágil articulação com a Rede de Atenção Psicossocial (Raps). O estudo reafirma a importância de práticas de gestão do cuidado em saúde mental em hospital geral, orientadas por uma perspectiva psicossocial, integradas à Raps e fundamentadas nos princípios do Sistema Único de Saúde e da Reforma Psiquiátrica brasileira.

PALAVRAS-CHAVE Saúde mental. Hospitalização. Atenção psicossocial. Hospitais gerais. Sistema Único de Saúde.

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Introduction

For many individuals, hospitalization for clinical conditions represents an experience of crisis and vulnerability, in which physical and psychological aspects intertwine. Studies show that approximately 30% of patients admitted to general hospitals use psychoactive substances or have comorbidities associated with chemical dependency and mental disorders¹⁻⁴. It is also estimated that up to 60% of patients admitted to emergency units and clinical wards have some form of psychiatric disorder^{1,2,4}.

Despite this significant prevalence, general hospitals are poorly prepared to deal with these demands. In general, there is no adequate structure or trained professionals to manage psychological distress, which accentuates the fragmentation between clinical care and mental health care^{2,4}. The disconnect between the Psychosocial Care Network (RAPS) and medium- and high-complexity hospitals reveals persistent challenges to comprehensive care, making it difficult to overcome models focused exclusively on diagnosis and biological intervention³⁻⁵.

Law No. 10.216/2001 and the creation of Raps represented important advances in the redirection of psychiatric care in Brazil, proposing a community-based and interdisciplinary model of care. In this context, the general hospital was inserted as a focal point for mental health care, with a strategic role in accommodating clinical and psychological comorbidities³⁻⁵. However, an organizational logic centered on medical specialties and hard and soft-hard technologies still prevails, which hinders the recognition and management of mental distress in the hospital routine.

Recent studies emphasize the importance of understanding nursing professionals' perceptions of mental health care in general hospitals, highlighting the need for training and specialized support for the appropriate management of these patients^{5,6}. However, few studies address the perceptions of other healthcare team members⁷.

Caring for patients with mental disorders admitted to general hospitals presents additional challenges compared to treating other clinical conditions, due to both the specificities of these cases and the approach of healthcare teams toward them. Professionals often feel unprepared to provide care that comprehensively considers clinical demands and the psychosocial dimensions involved. Studies indicate that hospital teams struggle to deal with such complexities, often resulting in approaches focused solely on the physical and biological aspects of the disease. Consequently, psychosocial needs tend to be neglected, compromising comprehensive care and the effectiveness of mental health interventions in the hospital setting^{3,5,7}.

The hospital studied is a university institution under full management within the Unified Health System (SUS), focused on teaching and providing medium and high-complexity care. It is important to note that it is a general hospital with no mental health beds or psychiatric wards. Psychiatric needs are addressed in the clinical and surgical wards through consultations conducted by psychology and psychiatry with professionals from the care team and medical and multidisciplinary residencies⁴.

In this context, the uniqueness of the university hospital as a research locus stands out, not only because of its integration into the public health system but also because of its role in training professionals to work in both healthcare and psychosocial care in hospital settings, in line with the principles of the Psychiatric Reform.

Given this complexity, this study aimed to analyze the profile of patients hospitalized for clinical morbidity at a general university hospital who presented mental health needs, as well as to understand the perceptions of healthcare team members regarding the care provided to these cases⁴. The investigation was based on the concept of management as a shared practice, experienced in work processes and in the relationships between individuals, technologies, and institutions,

aiming to improve care and foster coordination between the RAPS and other levels of care.

Material and methods

This is a descriptive, exploratory, and qualitative study conducted at a general university hospital in the public health system in the state of Alagoas. The study combined two complementary methodological strategies: documentary analysis of inpatient medical records, covering the period from January 1, 2016, to November 30, 2019; and qualitative research with healthcare team professionals. This period was chosen due to the beginning of the use of electronic medical records in inpatient units, which ensured greater availability and completeness of data in the Admission Management System. The methodological framework followed the guidelines of method triangulation as a strategy to capture the complexity of the study object⁸. Therefore, data collection was conducted through three complementary strategies:

1. A spreadsheet was requested from the Information Technology Unit of the hospital under study, containing variables collected from the Electronic Health Record (EHR) regarding hospitalizations with psychiatric and psychological care during the study period: gender, age, education level, city of residence, and length of stay.
2. Focus groups were held with members of the multidisciplinary team involved in direct care of hospitalized patients.
3. Interviews were conducted with members of the care team who were unable to participate in the focus groups.

The universe of 549 records of care provided by the mental health team (psychiatry and psychology) in hospitalizations due to clinical morbidity corresponds to 406 medical

records. Descriptive statistical analysis of the quantitative data was performed using Microsoft Excel[®] software, with calculation of absolute and relative frequencies⁴.

The qualitative stage was based on two focus groups (with 18 participants) and three individual interviews with professionals who were unable to attend the groups. The review of qualitative data in the EHR was conducted using a summary table to record the information found in the progress reports on the care spreadsheet and the full transcription of the focus groups and interviews⁴.

The data presented in this article corresponds to the analysis of data related to the sociodemographic and clinical profile of hospitalizations (quantitative data) and the narratives of professionals obtained in focus groups and interviews (qualitative data).

Research subjects were invited to participate in two focus groups, composed of up to 12 members, including professionals, medical residents, and residents from multidisciplinary residencies involved in the care of patients admitted to the units studied. A total of 18 people participated: 11 professionals and 7 residents. The groups were held on two separate dates in November 2019. The first group had 13 participants, and the second, 5. Three additional participants contributed to the study through individual interviews⁴.

The construction and analysis of the qualitative material followed the Collective Subject Discourse (CSD) methodology, which allows for the visualization of collective thoughts reflected in individual testimonies and opinions⁹. Guiding questions were used to address: perception of mental health demand and approach; difficulties in providing care to people with mental health distress; and strategies for addressing network gaps.

The research was approved by the Human Research Ethics Committee (CEP) of the Aggeu Magalhães Institute of the Oswaldo Cruz Foundation (IAM/Fiocruz Pernambuco), in compliance with Resolutions No. 466/2012 and No. 510/2016 of the National Health Council.

It was developed after the CEP approved the project and instruments, with the Certificate of Submission for Ethical Assessment (CAAE) No. 19561519.3.0000.5190. Approval opinion no. 3,646,740 was presented to the Teaching and Research Management of the Professor Alberto Antunes University Hospital of the Federal University of Alagoas (HUPAA-Ufal) to obtain the Letter of Consent⁴.

Results and discussion

The data obtained in the research were organized according to the nature of the instruments used. Below, we present the quantitative results regarding the profile of hospitalized

patients with mental health needs, followed by a qualitative analysis of the perceptions of healthcare professionals regarding the challenges of mental health care in the general hospital.

Quantitative results: profile of hospitalized patients

The analysis of 406 medical records of patients admitted due to clinical morbidity in a general hospital revealed that the majority were female (80%), with a predominant age range between 30 and 59 years (50%) and mostly from the urban area (state capital), representing 54% of the cases, as shown in *table 1*⁴.

Table 1. Summary sociodemographic profile of people admitted to selected clinics who presented mental health demands at the Professor Alberto Antunes University Hospital, Federal University of Alagoas, Maceió (AL), 1/1/2016 to 30/11/2019

Characteristics	Internal Medicine (n / %)	Oncology (n / %)	Surgery (n / %)	Gynec./Obst. (n / %)	Total (n / %)
Gender					
Masculine	41 / 46	20 / 51	19 / 40	0 / 0	80 / 20
Feminine	48 / 54	19 / 49	28 / 60	238 / 100	326 / 80
Origin					
Maceió	55 / 62	18 / 46	25 / 53	119 / 52	217 / 54
Other AL's cities	34 / 38	21 / 54	22 / 47	112 / 48	189 / 46
Age range (grouped)					
< 30 years	17 / 19	4 / 10	4 / 9	129 / 56	154 / 38
30-59 years	47 / 53	24 / 62	29 / 62	102 / 44	202 / 50
≥ 60 years	25 / 28	11 / 28	14 / 30	0 / 0	50 / 12

Source: Prepared by the author, 2019.

The prevalence of mental disorders in women is a significant public health concern, with varying rates reported across different populations and contexts. Studies indicate that women are more susceptible to mental disorders than men, with factors such as socio-economic status, motherhood, and life events playing crucial roles. The prevalence rates of

Common Mental Health Disorders (CMHDs) among women vary widely, influenced by demographic, social, and economic factors¹⁰⁻¹².

Regarding the origin of hospitalized individuals, data from the 2019 National Health Survey indicate that, of a total of 16.3 million people with a mental disorder, the majority are concentrated in urban areas and are between

45 and 59 years of age, with the highest proportion being female¹³.

However, the methodological choice of exclusively using data available in the EHR imposed some limitations on sociodemographic characterization, notably the absence of variables such as marital status, occupation, income, social security status, and race, which are not systematically collected at the time of admission. This limitation stems from the fact that the admission form does not require completion of this information, which hinders broader analyses of the sociodemographic profile⁴. For example, the variable of race stands out, whose registration became mandatory in 2017 in data collection instruments used by public health services, such as medical records, forms, and registries, aiming to enable more complete studies on the epidemiological profile according to ethnic-racial criteria and to support the planning of public policies aimed at different population groups¹⁴. However, it was not yet included in the hospital records.

The analysis of the sociodemographic profile of patients hospitalized for clinical morbidities who presented demands related to mental health allows us to reflect on recurring patterns in the literature, although the available studies demonstrate distinct approaches and methodologies. In the present study, we chose to use the International Classification of Diseases (ICD-10) as the criterion for categorizing mental disorders because this is the reference used by the hospital's psychiatry department in their development⁴. Of the 281 psychiatric consultations performed, 73% confirmed a diagnosis of mental disorder, according to the ICD-10. A higher frequency of mood

disorders was observed, especially moderate (F32.1) and severe (F32.2) depressive episodes, present in 26% of cases, followed by anxiety disorders (F41), with 15%, and organic mental disorders, such as delirium (F05), with 10%. The distribution by inpatient unit showed that depressive disorders were more prevalent in internal medicine (23%), general surgery and specialties (20%), and obstetrics-gynecology (33%). In the oncology unit, organic mental disorders stood out, representing 36% of interconsultations⁴.

Finally, the scarcity of recent, systematic studies on mental health care in general hospitals in the Northeast region is noteworthy, hindering more robust comparisons. However, it also highlights the importance and timeliness of this study. The data presented here contribute to broadening our understanding of the mental health needs identified in the hospital setting and can support training initiatives, improving clinical records, and strengthening RAPS, particularly in the area of coordination between hospital care and psychosocial care.

During the study period, January 2016 to November 2019, 28,682 admissions were made across internal medicine, oncology, general and specialized surgery, and obstetrics-gynecology units, with 549 consultation-liaison psychiatry and psychology services identified. This figure represents a 1.9% share of mental health care, but represents an underreported number, considering that the initial use of electronic medical records was not uniform across all units (*table 2*)⁴.

Table 2. Distribution of hospitalizations in the selected units and percentage of hospitalizations with mental health consultations recorded in the Hospitalization Management System. Professor Alberto Antunes University Hospital, Federal University of Alagoas, Maceió (AL), 01/01/2016 to 11/30/2019.

Inpatient Unit	Hospitalizations	Interconsultation		Interconsultation		Interconsultation	
	(n)	Psychiatry (n)	(%)	Psychology (n)	(%)	Total(n)	(%)
Gynecology/ Obstet.	14,555	133	0.9	184	1.3	317	2.2
Surgery	10,733	49	0.5	22	0.2	71	0.7
Internal medicine	2,042	73	3.6	38	1.9	111	5.4
Oncology	1,352	28	2.1	22	1.6	50	3.7
General total	28,682	283	1.0	266	0.9	549	1.9

Source: Prepared by the author, 2019.

The 549 psychiatric or psychological consultations highlighted, among the qualitative records, episodes of psychomotor agitation, anxiety attacks, suicide attempts, substance abuse, and psychological distress resulting from social factors⁴.

The analysis of the 549 referrals to the Mental Health team revealed that the majority were made by medical professionals,

responsible for 47% of the records. Next, referrals by the nursing team (29%) and social services (16%) stand out. To a lesser extent, it was found that, in 8% of cases, the referral originated from the Mental Health team itself, which may indicate the proactive role of the multidisciplinary residency program, in which psychology routinely participates in ward rounds, as shown in *table 3*⁴.

Table 3. Professionals responsible for identifying and forwarding demands to the Mental Health team at Professor Alberto Antunes University Hospital, Federal University of Alagoas, Maceió (AL), 01/01/2016 to 11/30/2019

Professionals responsible for referral	N = 549/Frequency(%)
Medical team	47
Nursing team	29
Social Service	16
Mental health team	8
General total	100

Source: Prepared by the author, 2019.

The distribution of registered referrals highlights the central role of the medical team in identifying mental health needs in the general hospital, followed by the significant role of nursing and social services. By highlighting the referral processes and

the actors involved, these quantitative data contribute to contextualizing the qualitative findings presented below, which deepen our understanding of how professionals perceive and address the challenges of mental health care in the general hospital.

Qualitative results: professionals' perception of mental health care

Clinical and surgical admissions to general hospitals are care resources for restoring a person's health. Therefore, professionals must be prepared for the various changes imposed by the physical and mental illness of patients they care for, striving to provide the care necessary for their condition.

The qualitative analysis highlighted three central ideas constructed from the CSD: 1) perception of demand and approach in mental health; 2) difficulties in assisting people with psychological distress; and 3) strategies for mental health care in a general hospital⁴.

Regarding CSD1, the first Central Idea (CI) describes how participants perceive the approach to people experiencing mental health distress as related to soft technologies. The second CI demonstrates the care provided to hospitalized individuals during a mental health crisis, and the third CI demonstrates the organization and work processes of the mental health team at HUPAA-Ufal⁴. These perceptions can be seen in the following statements:

1. Perception of demand and approach to mental health

CSD1A - Many patients hospitalized for clinical conditions present with psychological distress, sometimes without prior diagnosis. In our daily practice, we use active listening, conduct social interviews, and rely on the support of psychology and social services to better understand these patients' needs. Multidisciplinary resident visits to clinics and case discussions help us identify signs of depression or delirium, allowing for more appropriate interventions. When necessary, we seek expert opinions to ensure continuity of mental health care. (Subjects: F06, F20, TE25, RP11, E07, AS02, P05, TE8, RP23, RM14, 2019).

CSD1B - Most cases are resolved here at the hospital, but there was a psychotic episode and psychomotor agitation, and there was no psychiatric care

on the day, so she was taken to the specialized hospital. A postpartum woman broke the glass shower in the ward bathroom and cut herself. She was experiencing withdrawal symptoms, and the patient wanted to smoke, otherwise it would cause a seizure. The nurse complied with her request, but was criticized by her colleagues. Sometimes a psychiatrist is called, but it's up to the general practitioner to remove the person from the episode at that moment. In my opinion, a psychiatric hospital would be the last option, but our wards are collective, and often the patient has an episode, and the ward is full. Regarding therapy, mental health is still heavily linked to medication, and this is the psychiatric hospital's approach, combined with containment and isolation to prevent the expression of the disorder's causes. (Subjects: M, MP14, TE25, E07, F06, E24, R01, 2019).

CSD1C - The Psychosocial Unit has 10 psychologists and 4 psychiatrists to serve the outpatient clinics and clinics. Staffing is based on shifts, and when someone is on vacation, there is no substitute, so care is provided within 48 hours. We are unable to maintain a routine of visits. We respond to requests from the team; we evaluate and monitor patients. Obstetrics and gynecology is the clinic with the highest number of requests, having previously experienced a suicide. Psychiatrists work alongside the psychiatric residency team. When possible, the case is discussed with the team to integrate knowledge, recorded in the medical record, and a telephone number is left with the team, in addition to a recommendation to schedule an appointment for the outpatient clinic. (Subjects: P16, P5, MP14, 2019).

The CSD1A highlights the importance of relational techniques in healthcare, highlighting qualified listening, interviews, visits, and multidisciplinary supervision as important resources for mental health care. This practice, carried out daily among professionals, patients, and family members, fosters acceptance, bonding, and the identification of psychosocial needs, providing a lightweight technological arsenal essential for effective care⁴.

The various experiences aimed at transforming the healthcare work process need to incorporate elements that consider the micropolitical dynamics of everyday care practices. The interactions between macropolitical and micropolitical dimensions manifest themselves in the management and organization of healthcare services, fundamentally shaped by the active and creative presence of live work in action—that is, by the concrete actions of workers in their relationships with patients¹⁵.

This perspective helps us understand the discourses presented, which reveal how professionals act sensitively and creatively when faced with the complexities of mental suffering in a general hospital. Qualified listening, attentive attention to patients' daily lives, and the use of soft technologies, such as bonding and expanded clinical practice, are direct expressions of living work in action. Even faced with structural limitations and workload, professionals seek to reinvent care in the daily routine of the wards, seeking unique responses to mental health needs.

These micropolitical elements, highlighted in the discourses, reveal that the delivery of care does not depend solely on institutional guidelines or protocols (the macropolitical dimension), but is embodied in small gestures, shared clinical decisions, sensitive reception, and interprofessional coordination, which shape the actual work process. Thus, the discourses reinforce the importance of strengthening spaces that value listening, dialogue, and the protagonism of healthcare workers in the delivery of care.

Although recognized as essential, qualified listening requires time and an empathetic approach, which is not always feasible, especially for nursing professionals, whose routines are characterized by overload and adherence to protocols. Consequently, the team transfers this demand to psychology, awaiting subsequent guidance on case management. This movement highlights the rigidity of hospital routines, which sometimes limits the connection between professionals and patients⁴. In

addition to listening, interviews are considered a strategic tool used by nurses, physicians, nurse practitioners, and social workers to capture the patient's reality, their health needs, socioeconomic context, social ties, and support network. This instrument can have different purposes depending on professional training, but is central to mental health work².

The practice of daily visits carried out by the multidisciplinary residency and the weekly discussion of cases, with the participation of the preceptor, contribute to the in-service training process. These actions are anchored in the principles of the Expanded Clinic, allowing us to understand the health-disease process in its psychosocial dimension and favoring the shared construction of care, in addition to strengthening interprofessional articulation⁴.

Regarding mental health demands, psychology is positively referred to as an important support for the team. However, the collective discourse also reveals limitations: interprofessional work is not yet fully implemented in all units, either due to the fragmentation of care processes or the lack of professionals in certain areas, which requires working in multiple clinics without regular team connections⁴.

The qualitative results of CSD1B and CSD1C highlight the complexity of mental health care in general hospitals, particularly regarding the perception, approach, and coping with situations of psychological distress in patients hospitalized for clinical and surgical conditions. The collective discourses reveal social representations marked by ambivalence, fear, stigma, lack of preparation, and resistance, while also pointing to concrete possibilities for progress, such as strengthening multidisciplinary work and integration with the service network⁴.

The CSD1C expresses the increasingly common condition of precarious work, represented by the reduction of professionals for the development of work, bringing limits to the development of mental health care, considering that the absence of psychiatrists on certain days or times of the week can lead to

the displacement of the user in a crisis situation to a psychiatric hospital, as well as that the reduced number of psychologists does not allow for anticipation of requests, resulting in care only on demand. Responding quickly to requests is important, as cases often reach the team already with greater psychological impairment. However, this recommendation is not always implemented due to work overload and hinders the pedagogical function of consultation-based consultation due to the reduced number of professionals, compromising the possibility of team meetings to improve care⁴.

Regarding the difficulties encountered in providing care to people with psychological distress, the CSD2 describes the collective perception of fear and resistance on the part of the healthcare team. The other two central ideas present the same frequency of key expressions (21 – 32%), the second relating to the team's feeling of unpreparedness for mental health care and the third referring to the hospital organization being inadequate for this type of care.

2. Difficulties in assisting people with mental health problems:

CSD2A - I'm afraid to deal with psychiatric patients because I don't know how to act. We immediately think someone with depression might have a breakdown. There's a belief that any unusual behavior is the psychiatrist's doing. Sometimes, a patient has had a miscarriage and is crying, and they want to call psychiatry, but what she really needs is support. We don't know how to differentiate emotional distress from disorder. I was once very distressed by a patient who broke the bathroom windows. No one knew how to intervene, and it paralyzed the staff. We were hoping she would get out soon, because it seems like the entire hospital grinds to a halt in the face of a crisis. (Subjects: P18, P16, P20, R11, P05, P07, P08, MP14, P25, P24).

CSD2B - I don't feel prepared to care for patients with mental illness. I've never had any training for

it, but we need to be, because people with mental disorders also require clinical and surgical care and can be treated here. Most of us studied to deal with organic diseases, not with subjective ones. There's a lack of training, and the hospital doesn't encourage it. I've seen postpartum women talking about jumping out of windows, and no one knew what to do. Mental illness hinders our care. (Subjects: R23, E02, P20, R09, P25, P24, P18, P08).

CSD2C - The hospital isn't structured to care for patients with mental disorders. When these patients arrive, we feel unsafe because there aren't enough resources, staff, and conditions. The windows don't have bars, and the glass is dangerous. We've had a suicide. The staff is overwhelmed. The network outside doesn't work either. The clinic doesn't have a psychologist, and it takes six months for a psychiatrist to see them. We refer them because we know someone. But that's not a network. (Subjects: M, MP14, TE25, E07, F06, E24, R01).

The CSD2A demonstrates how the stigma associated with mental suffering remains deeply rooted in hospital routine. As the discourses demonstrate, the figure of the 'psychiatric patient' is still associated with unpredictability, aggressiveness and disorganization, reinforcing historical stereotypes of madness as a threat¹⁶⁻¹⁹. The stigma surrounding mental health continues to negatively influence professionals' performance, favoring outdated practices, resistance to psychosocial care, and low qualifications. This influence reinforces the adoption of the biomedical model and, combined with the disarticulation of the RAPS, compromises the continuity of treatment and the effectiveness of interventions²⁰. These representations fuel professionals' fears and translate into attitudes of rejection and early referral to psychiatry.

The feeling of unpreparedness, referenced in CSD2B, is a direct result of training centered on the biomedical model, focused on organic disease and curative-based technical-scientific interventions^{20,21}. As participants state, the

lack of specific training to address psychological distress leads them to act through ‘trial and error’, exacerbating the suffering of both patients and staff. Furthermore, maintaining the biomedical model and rejecting the psychosocial perspective represent obstacles to deinstitutionalization and the consolidation of broader, more comprehensive care^{22,23}.

The hospital’s structural difficulties in handling mental health demands, described in CSD2C, are barriers that must be overcome to enable safe, comprehensive care. The lack of dedicated beds, architectural insecurity, staff overload, and a lack of operational protocols hinder the handling of complex situations. Furthermore, the weak coordination with the RAPS and primary care services reinforces the hospital’s isolation in mental health care^{4,20}. The inadequate infrastructure conditions of general hospitals, coupled with the lack of intersectoral communication, contribute to the fragmentation of care, poor quality of care, and hinder the construction of an effective care network²⁴.

3. Strategies for mental health care in general hospitals:

CSD3A - I see that multidisciplinary work makes a difference. When we discuss the case with other professionals, the approach improves significantly. Psychiatry residents help, and psychology also provides important support. It’s also necessary to include the family in the case discussions, but not everyone has this support. The anti-asylum movement isn’t just about closing psychiatric hospitals; it’s about expanding the services that accommodate these people. The CAPS is an important reference. So, we’re looking for these service networks. It’s important to strengthen the network because, whether in a general hospital or a psychiatric hospital, the time will come when the person will return home. Expanding the network improves conditions [...] I think the work of the CAPS is very important because it’s multidisciplinary and closer to the home. (Subjects: P5, F20, TE08, RP11, RM15, P16, AS18).

CSD3B - O hospital precisa investir em capacitação em saúde mental. Essa área é transversal. Já tentamos oferecer capacitações, mas a adesão é pequena. Falta incentivo, especialmente entre os médicos. Acho que deveríamos começar pelos residentes. Se não dá pra mudar quem está há muito tempo, que ao menos a nova geração se forme com outra visão. (Sujeitos: P16, MP14, E7, P5, AS18).

Despite the difficulties, the discourse also reveals possibilities for progress. Expanded clinical practice, the use of soft technologies such as listening and bonding, and multidisciplinary rounds and case discussions appear as effective strategies for integrating mental health care into daily hospital practice^{4,22}.

Professionals highlighted the need for mental health training as a priority strategy for transforming practices. However, training alone is insufficient. It needs to be combined with ongoing education processes, built on the concrete experiences of workers, capable of generating critical reflection, problematization, and effective change in care delivery. Studies suggest investing in interprofessional training, case discussion routines, technical support aligned with the psychosocial model, and actions focused on workers’ mental health, aiming to strengthen comprehensive care and support the planning of full-bed hospitalizations^{4,20,22}.

The conceptual transformations occurring in health education management pose challenges for professionals, managers, and training institutions, requiring the development of new theoretical and conceptual approaches that foster a more critical and reflective practice regarding the reality and work processes in health services. This implies breaking with views that dissociate theory and practice in professional training, in addition to requiring a shift in how workers are understood: from task executors to individuals capable of critically analyzing the context in which they work and the dynamics of their professional practice²⁵.

Transforming professional training processes has become a social imperative, aiming to prepare workers with comprehensive training, capable of providing comprehensive and humanized care. To this end, it is essential that they develop skills for teamwork and decision-making that consider not only the individual clinical condition, but also the patient's social context, available resources, and the most appropriate intervention strategies²⁶.

The predominance of professional health training based on content-based technicality leads to the early fragmentation of individuals into specialties, which ultimately strengthens conservative care practices. This logic disregards higher education proposals that prioritize problem-solving methods and encourage student leadership in knowledge construction²⁷.

Within the SUS, continuing education represents a powerful strategy for transforming training practices, care, and public participation, among other practices. The hospital where the study took place is a university institution that trains health professionals within the SUS and, therefore, faces the significant challenge of addressing mental health care across all its units. Therefore, it requires being attuned to the needs of individuals seeking services and their demands, aligned with reflections on practice and the interactions between users and workers that result from it⁴.

Final considerations

The analysis of hospitalizations due to clinical comorbidity associated with mental health demands, conducted in a general university hospital, revealed a context marked by significant challenges to the comprehensiveness of care in the SUS.

The present study showed that people hospitalized for clinical morbidity in a general university hospital have a profile marked by social vulnerabilities and psychological distress often associated with the use of

psychoactive substances and mental disorders, such as anxiety and depression. This finding confirms the importance of the connection between mental health and hospital care, especially in a teaching hospital, which combines educational and care potential within the SUS.

The qualitative analysis allowed us to understand, from the perspective of the care team members, the institutional and organizational constraints that hinder the delivery of comprehensive mental health care in this setting. Among the main challenges are the lack of systematic ongoing education processes, the weak connection with RAPS services, and the hegemony of a disease-centered biomedical model that obscures the subjective and social dimensions of suffering.

Despite this, care initiatives developed daily by professionals were also observed, based on listening, welcoming, and interprofessional mediation, revealing the potential for providing care in freedom even in the face of adversity. The study thus reaffirms the importance of strengthening public policies that promote the integration of mental health into the hospital network, the valorization of teamwork, matrix support, and critical training for health professionals.

Given the complexity of the needs presented by people with mental health problems hospitalized due to clinical comorbidities, it is essential that general hospitals be recognized as strategic spaces for mental health care within the SUS. This implies investing in work management and health education initiatives that contribute to the transformation of technical care models, defending comprehensive care, life, and human rights.

Collaborators

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