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THE OTHER SIDE OF THE REVOLVING DOOR: COMMUNITY SUPPORT AND MENTAL HEALTH

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ABSTRACT. The Psychiatric Reform has, as a fundamental principle, the treatment carried out outside the hospital, considering that the hospitalization should be an option only when the extra-hospital resources are not effective enough. However, multiple psychiatric readmissions are still frequent. The present study focuses on what happens outside of the hospital doors, analyzing elements of the community life of people who suffer from mental disorders,questioning if those experiences are related to the frequent necessity of hospitalization. Therefore, the perception of community support was investigated in patients with a high number of readmissions, in comparison with patients in their first hospitalization, in a general hospital in Porto Alegre (Brazil). The results showed that the community is a powerful source of help in crisis situations; nevertheless, the readmitted patients have weaker social bonds and a longer distance from the *Atenção Básica* (Primary Care), in comparison with the other group. For that reason, the family becomes the main source of support, what leads to an overburden for the relatives, and the hospital acquires a special status for these people, who see the hospital as the only alternative in a situation of crisis.
Keywords: Mental health; mental health services; social support.

O OUTRO LADO DA PORTA GIRATÓRIA: APOIO COMUNITÁRIO E SAÚDE MENTAL

RESUMO. A Reforma Psiquiátrica tem como princípio fundamental o cuidado em liberdade e prevê a internação breve em hospital geral apenas quando esgotados os recursos extra-hospitalares. No entanto, as múltiplas reinternações em unidades psiquiátricas ainda são comuns no cotidiano hospitalar. O foco desse estudo está no que acontece para além dos portões do hospital, analisando elementos da vida comunitária dos portadores de sofrimento psíquico e se essas experiências se relacionam de alguma forma com a frequente necessidade de hospitalização. Para tanto, buscou-se investigar a percepção sobre apoio comunitário em usuários com alto número de internações, comparando com a de usuários de primeira internação, na unidade psiquiátrica de um hospital geral de Porto Alegre. Os resultados mostraram que a comunidade é uma potente fonte de ajuda em situações de crise, porém, usuários com múltiplas internações têm essas redes enfraquecidas e um afastamento maior da Atenção Básica, em relação aos usuários de primeira internação. Dessa forma, a família se torna a principal fonte de apoio, o que gera sobrecarga, e o hospital ganha um *status* diferenciado na vida desses usuários, considerado a única alternativa em situações de crise.
Palavras-chave: Saúde mental, hospitalização psiquiátrica, apoio social.

EL OTRO LADO DE LA PUERTA GIRATORIA: APOYO COMUNITARIO Y SALUD MENTAL

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RESUMEN. La Reforma Psiquiátrica tiene como principio fundamental el cuidado en libertad, con la posibilidad de recurrir a breves hospitalizaciones en hospital general, solamente cuando los recursos comunitarios resultan insuficientes. Sin embargo, los múltiples ingresos en unidades psiquiátricas siguen siendo comunes en la rutina de los hospitales. El enfoque de este estudio se radica en lo que sucede más allá de las puertas del hospital, haciendo un análisis de los elementos de la vida comunitaria de las personas con sufrimiento mental, y si esas experiencias están relacionadas de alguna manera con la frecuente necesidad de hospitalización. Con este fin, hemos tratado de investigar la percepción de apoyo comunitario en pacientes con alto número de ingresos, en comparación con pacientes en su primera hospitalización en la unidad psiquiátrica de un hospital general en Porto Alegre (Brasil). Los resultados mostraron que la comunidad es una poderosa fuente de ayuda en situaciones de crisis, pero los pacientes con múltiples ingresos han debilitado estas redes y están más lejos de la Atención Primaria, en comparación con el otro grupo. Por lo tanto, la familia se convierte en su principal fuente de apoyo, lo que genera sobrecarga, y el hospital recibe un *status* diferente en la vida de esos pacientes, considerado la única alternativa en situaciones de crisis.

Palabras-clave: Salud mental, hospitalización psiquiátrica, apoyo social.

The theme of the present study emerges from the professional practice in a psychiatric unit, during the first year of the Integrated Multiprofessional Residency in Health of *Hospital de Clínicas de Porto Alegre* (Porto Alegre Clinical Hospital - HCPA). In this twelve-month period, we noticed that some patients were frequently readmitted, many times without having little or no time of community and family life between one admission and another. This problem is not exclusive of one hospital; it has been dealt with in different researches around the world, being called “the revolving door phenomenon” (Bezerra & Dimenstein, 2011; Dahlan, Midin, Sidi & Maniam, 2013; Graca, Klut, Trancas, Borja-Santos, & Cardoso, 2013; Salles & Barros, 2007;Schmutte, Dunn&Sledge, 2010).

In a research carried out in the United States, Schmutte, Dunn and Sledge (2010) discovered a rate of 30% of frequent readmissions in one-year study, considering the criterion of three or more admissions within 18 months. In Portugal, Graca et al. (2013) found 10% of the patients at the revolving door in their sample, with at least three admissions in the five-year study, which represented 29% of the admissions in that period. In Brazil, studies on this theme registered the readmission rate without using a criterion to define the revolving door phenomenon. For example, within a two-year period, a study carried out in Rio Grande do Norte State registered a readmission rate higher than 60.3% (Bezerra & Dimenstein, 2011). In another Brazilian study, carried out in a unit of ambulatory care in Ribeirão Preto, with 48 patients who had left a psychiatric admission, it was verified that 62.5% of the patients had already been hospitalized at least once before the most recent admission; 29.2% had five or more previous admissions and 12.5% had been hospitalized during a four-month period (Cardoso & Galera, 2011).This latter research had, as a result, the verification that the maintenance of the treatment for non-institutionalized patients, most times, is based upon pharmacological therapy, recurring to hospitalization when there is an increase of signals and symptoms of the psychiatric condition. The authors believe that this type of care does not embrace other routine and collective necessities that also need attention and influence on the maintenance of the treatment (Cardoso & Galera, 2011).The new admissions in a short period after the hospital discharge, according to Vigod et al. (2013), can also be a reflection of a failure in the patient’s transition process from the hospital to the less intensive care in extra-hospital level.

Currently, in Brazil, the extra-hospital care structure in mental health has been increasing. According to the Presidential decree nº 7.508 (o Decreto Presidencial nº 7.508, 2011), each Health Care Region must have a psychosocial care service; this one must be integrated with the other services of that geographic space, organizing itself in increasing complexity levels. The regional psychosocial care services are part of the *Rede de Atenção Psicossocial* (Psychosocial Care Network- RAPS) (Portaria nº 3.088, 2011) –which has *Centro de Atenção Psicossocial* (Psychosocial Care Center - CAPS) as one of its devices. CAPS, in its various modalities, focuses on the care of people with serious persistent mental disorders and with needs caused by the abuse of alcohol and other drugs. The activities happen daily and according to the patients’ demands, carried out in each territorial area, with priority to collective spaces (groups, assemblies, meetings), in an integrated way with other attention points of the health care network and other sectors (Portaria nº 3.088, 2011).

However, there are still many challenges for the realization of a good offer of care for people under chronic mental disorders. According to Machado and Santos (2013),the patients themselves report that the services available in the extra-hospital network do not meet their necessities in full, because of internal issues – such as the offer of standardized treatment modalities, not adapted to the patients' singularities - , and also for the lack of services working uninterruptedly, such as CAPS III. Without those services, the patient under crisis situation does not have an option to be listened to and assisted in the territorial services, and the hospitalization is rarely avoided in urgency circumstances.

Porto Alegre City (Rio Grande do Sul State, Brazil), which has a population estimated in more than one million and 400 thousand inhabitants, counts on a population cover of 64.4% of *Atenção Básica* (Primary Care) services; 50.4% of them are covered by *Estratégia Saúde da Família* (Family Health Care Strategy - ESF) and two teams of *Consultório na Rua* (Doctor's Office on the Street). To support those services, there are seven *Núcleos de Apoio à Saúde da Família* (Centers for Family Health Care Support - NASF), which support 30.6% of the ESF. Regarding specialized services, the city has 12 CAPS (4 CAPS II for adults, 3 CAPSi, 3 CAPS ad III and 2 CAPS II ad), eight *Equipes de Saúde Mental e Matriciamento* (Teams for Mental Health Care and Matrix Support), eight *Equipes Especializadas de Atenção à Saúde da Criança e Adolescência* (Specialized Teams for Child and Adolescent Health Care - EESCA) and two *Plantões de Emergência Psiquiátrica* (Psychiatric Emergency Shifts), which are the access for the admissions (Prefeitura de Porto Alegre, 2015). In the hospital care, the city counts on 197 hospital beds for full mental health care, integrated with the general city hospitals, not considering the hospital beds in psychiatric hospitals, for the *Coordenação de Saúde Mental* (Mental Health Coordination) of the city considers that the hospitalization modality is not in accordance with the perspective of the psychiatric reform. Those beds are placed in units in different hospitals, but they do not perform under the logic of the territorial organization, like the other services of the city, which does not allow the patients to be always assisted by the same service, close to their homes and with a reference team that they know and who are able to continue and follow the case (Secretaria Municipal da Saúde de Porto Alegre, 2015).

For a good function of RAPS, it is necessary to problematize the fact that CAPS is not the only health care service responsible for looking after the patient under psychiatric suffering, even though the current scenario presents a centralization of the mental health care in this device (Scheibel & Ferreira, 2011). The other health care services must be integrated to offer the full care to the patients, including the services of *Atenção Básica* (Primary Care - AB), which are indispensable for monitoring the subjects' health, providing a longitudinal and broad care. It is also on the scope of AB that there is a fruitful field for thinking of health promotion, which can only be performed if the intersectorial efforts are put together, i.e., it is not only the health care field that must be committed with the subjects' health promotion. The intersectorial partnerships are a fundamental strategy to confront the problems concerning the environment, urbanization, unemployment, homing, abuse of substances, among others (Campos, Barros & Castro, 2004). Under this logic, it is evident that it is not only within health care services that health is made, but also in all spaces where the patients transit. For this reason, regarding the broad mental health care, it is also necessary to deal with the social support theme.

Most studies on this theme establish the analysis focus on the broad concept of social support, without making difference among the levels of those contacts (Canesqui & Barsaglini, 2012; Gonçalves, Pawlowski, Bandeira, & Piccinini, 2011; Rodrigues & Madeira, 2009). According to Gracia and Herrero (2006), the specific analysis of the community as a source of support has been a neglected aspect in literature; its main interest seems to be directed to the importance of the intimate relations and their effects on health and welfare.To the authors, the social support in community level is a construct that requires an analysis distinct from the intimate relations and confidence, for this type of bond causes a sense of belonging to a broader social structure and a feeling of social identity. From the validation of an instrument, the authors provided the construction of an evaluation model that allows to estimate the effect of the community support on the psychological adjustment, independently of the social support level in the confidence and intimate relations. The results of that investigation relate in a positive way the measure of the community support with the psychological welfare.

In this direction, Stella (2014) defends the importance of the study of the community, which can be understood as a mediating place between family life, municipality and society, where people recognize themselves and confirm their identities as they share characteristics such as same culture, common

territory, living space, similar socioeconomic level, and common historic bonds. The analysis of the community must be carried out from the understanding of Community Feeling, which is more than the simple sharing of geographic place, for community is considered a territorial and symbolic dimension of sociopsychological interaction and of place social identity (Stella, 2014).

In this context, this study aimed at analyzing comparatively the perception of the patients with a high number of psychiatric admissions with the patients of first admission, in a psychiatric unit, in relation to the community support in their original neighborhood.

Method

It is a descriptive and exploratory study of qualitative approach (Poupart et al., 2008), carried out at the psychiatric admission unit *(4º norte) of Hospital de Clínicas de Porto Alegre* (HCPA). That unit has a total of 36 beds; 26 of them assist the patients of SUS. According to a research carried out in that unit in the same year of the present study, the total of admissions via SUS in six months was 118, an average of 19.6 admissions per month, with the average admission period of 36 days (Zanardo, 2016). A semi-structured interview was carried out, with the participants divided in two groups: patients with at least five psychiatric admissions in their whole life and patients who were in their first psychiatric admission. The choice of the minimum number of admissions (5) to represent subjects with a high number of readmissions was due to the literature on this topic (Bezerra & Dimenstein, 2011; Machado & Santos, 2011) and to the observations carried out during the professional experience with the team at the data collection place.

Curiously, it was not possible to find, during the period of the interviews – from April through June of 2015 – patients who had 5 to 15 psychiatric admissions. Among the admitted patients, there were only people who were admitted less than 5 times or people who had had more than 15 admissions.That situation needed to be considered in the research, for the group of multiple admissions ended up being a group with a very high number of readmissions, what evidenced more seriousness in the psychic suffering and the chronification of the symptoms. Although we have noticed that all of them were in proper conditions to respond to the interview, it is evident that the answers of those participants were less complex, due to the decrease of the psychic functions occurring after repeated crises.

The interview had questions concerning the community life of the participants, their feelings in relation to their origin neighborhood, use of territorial health care services, among other aspects. For being a qualitative research, the total number of interviewed subjects was defined by the data saturation criterion, which is a concept broadly used in qualitative studies in health care area (Fontanella, Ricas& Turato, 2008). All the participants were older than 18 years; they were interviewed after the minimum period of one week in hospital admission, so that the acute symptoms had already been stabilized. The patients whose symptomatology of cognitive capacity that could cause high difficulty to answer the questions and patients unable to provide a written consent (legally interdicted or illiterate) were excluded from the research.

In total, ten interviews were carried out, with five participants in each group: four women and six men, living in peripheral neighborhoods of Porto Alegre, with different socioeconomic characteristics, and in the metropolitan region of the city. The average age of the group with multiple admissions was 50 years and the average age of the group in the first admission was 37 years; six patients had a serious depression episode, one was admitted because of risks related to eating disorder and the other three were admitted because of a psychotic disorder, two of them presenting aggravations concerning the abuse of alcohol and other drugs. Among the participants, only one of them received treatment in a CAPS. All of them lived with a family member, except one, who was living on the street. Only one participant could not stay until the end of the interview, claiming being sick as a result of the medication side effects.

The information obtained from the interviews were analyzed as proposed by Bardin (2004), in her content analysis. The author proposes a codification of the material collected, transforming the text raw data according to accurate rules, in a way to achieve a representation of the content. As for the ethical aspects, the research was approved under number 140691, by the Research Ethics Committee of *Hospital de Clínicas de Porto Alegre* (CEP/HCPA).

Results e discussion

From the reading of the transcribed interviews, it was possible to delineate some contents that emerged more than once in the participants' answers, with some particularities in the frequency that they emerged, when the answers of one group and another were compared. Based on that fact, two analysis categories were created: "Relation with the illness and the health care services" and "Bonding with the neighborhood and people nearby".

Relation with the illness and the health care services

In relation to the health care services, the hospital was mentioned as the only or main reference in three interviewees with multiple admissions. Two of them mention the fact of living near a hospital as an advantage of the place where they live, relating it to the neighborhood good infrastructure:

> *Look, [the neighborhood] is full of activity. It has many means of transportation... it has the hospital... The one which is close to my house is Hospital A[2]. But Hospital B is also close* (N, 59 years old, more than 20 admissions).

> *You know my neighborhood?... It has Hospital C where I was admitted once* (I, 50 years old, around 20 admissions).

In the interviews with patients at the first admission, two of them mentioned the hospital assistance as a preference – in ambulatory level or admission - , but not as the only reference for health care service. One of them reports the experience of having used hospital services and CAPS AD and CAPS II services as well:

> *I interacted with the staff there [CAPS], there was a psychologist, the psychiatrist there was also very nice to me. The nurses, everything, I liked there. It's been a short time I left there. Because I chose to stay only with the hospital [ambulatory] ... Because everything I said there [at CAPS] I had to say to the hospital psychiatrist, so I preferred to stay only with this psychiatrist.* (V, 33 years old, first admission).

Another interesting point is that almost all the interviewees with multiple admissions (four patients) expressed a relation of little intimacy with their reference primary care unit. There are even some confusion related to the elementary care services and the specialized ones, and their role.

> *I go more frequently to CAPS. At CAPS, I have everything, uh? Unless I need a general practitioner near my house, then I go. By at CAPS it is better because I schedule the appointment, it is already scheduled. It is not even necessary to wait in the line* (A, 45 years old, 19 admissions).

> *[Do you remember the name of your health care unit?] No. It's CAPS, isn't it?* (N, 59 years old, more than 20 admissions).

Interviewee N, above mentioned, did not even know the name of his health care unit, mentioning CAPS as a reference. It becomes clear, along the interview, that this patient had never been at CAPS, but, even so, he had in his imaginary that unknown place as the main care point. The speech of this and other patients reflects the logic that mental health is understood as a demand of specialized care, when the preference is the *Atenção Básica* (Primary Care - AB) as the first access of people to the health care system, including the ones that demand mental health care (Ministério da Saúde, 2013; Portaria nº 3.088, 2011). Those findings are in accordance with the results found by Sallesand Barros (2007), in which patients and their families pointed out that the admission was the best treatment form, and did not know

[2]The names of the institutions were not mentioned for ethical reasons

the substitute services, demonstrating the lack of advising to patients and their families, or even the lack of integration or absence of services in the region.

In the current conjecture, the practices in mental health care at AB can be carried out by any professional, preferably being supported by *the Núcleos de Apoio à Saúde da Família* (Centers for Family Health Care Support - NASF) (Ministério da Saúde, 2013). However, many times, AB workers experiment doubts and fears when dealing with people under psychic suffering. There is a discourse towards lack of training for those workers to realize that kind of activity, but we believe that those difficulties are beyond this issue, for there is a logical repetition of the biomedical specialism, which makes the responsibility of AB more difficult and reinforces the trust of the demands to the ones that have the "power of healing", the specialists (Camuri& Dimenstein, 2010).

Among the interviewees in the first admission, only two of them express the same distance from the services of the primary health care. Both are men and do not justify this distance for confusion or lack of knowledge, like the participants mentioned before. Instead of that, there is the idea of "I have never needed to take care of myself" in their speeches.

> *I don't go [to the health care center] because I don't need ... But I think I'll start to go there. Due to the fact I'm here, even for me to continue the treatment, I'll start to go.* (F, 32 years old, first admission).

> *[Did you go to the health care center?] No. [Why?] Because I never needed to* (S, 41 years old, first admission).

According to the *Política Nacional de Atenção Integral à Saúde do Homem* (Brazilian National Policy for Full Care of Men's Health) (Ministério da Saúde, 2009), there is a difference between men and women regarding the search for health care services. While women go more frequently to primary care units, men end up accessing the health care system by means of specialized care, which has, as a consequence, the harm caused by the care delay and a higher cost to *Sistema Único de Saúde* (Unified Health System - SUS). The reasons for this resistance to the access are mainly cultural, such as genres stereotypes, fear of the vulnerabilitythat the illness can bring and the loss of the main provider position (Ministério da Saúde, 2009). Apparently, for mental health care, this standard is repeated, maybe in an even more complex form, once the mental disorder is connected to emotional and subjective aspects of human beings. There is a dichotomy, as if taking care of mental health were not part of the basic health care, when, in fact, the primary care for mental health is an essential part of the general primary care (OMS, 2009).

Still regarding the use of the hospital services, it is useful to point out some issues of the regulation of psychiatric beds in the city. In Porto Alegre, the patients that look for psychiatric admission in crisis situations are not always referred to the same hospital. The person could be admitted for the first time at the place where the data for this research was collected, and if (s)he needed another admission, there would not be a guarantee that (s)he would be admitted to the same place; the person could go to another hospital in the city, and, many times, be subjected to a very different therapeutic approach. This fact could be noticed in the report of some participants, such as the one of this woman, telling about the fear of being admitted:

> *My daughter-in-law said: the family doesn't want her to stay in Hospital A, Hospital B... There are many places, uh? Then they say: I found a place for MH. Where? At* Hospital de Clínicas *[place of the collection]. "Wow, it's wonderful, mom". Because they [the family] all are treated here* (MH, 59 years old, first admission).

MH demonstrates that, for the patients, there are different distinctionsin the perception of the quality of the psychiatric admissions in Porto Alegre. In the group of multiple admissions, the recurrence occurred in different hospitals. There is an evident lack of standardization and communication within the hospital care network that assists the patients with mental care necessities, who realizes that, depending on the hospital (s)he will be admitted to, (s)he may have different treatment forms.

Within this category, the thematic in relation to the own illness also emerged. When asked about their life in community (relations with the neighbors, use of community spaces, etc.), three patients with multiple admissions mentioned the impact of the psychic suffering on that living, while only one participant of the group with one admission talked about this subject:

> *There are options [for leisure], but I don't like to go out. I don't like to be in the middle of many people, I don't feel fine* (A, 45 years, 19 admissions).

> *When I'm feeling nervous, … I stay in bed, only lying in bed... when I'm not willing to do things, a leave all the activities... When I'm fine, I go every day [to the church]* (I, 50 years old, around 20 admissions).

We understand that the patients with more admissions – who, consequently, have been dealing with the disease for longer – end up restricting their social life because of the illness. It can be inferred that the symptoms themselves (phobic behavior, paranoid or depressive conditions, for example), take the subject to the isolation. However, in addition to that, there is a culture of excluding the "crazy one", despite of the changes in the models of mental health care (Salles & Barros, 2007). Reflections of that can also be noticed in the following analysis category, when the interviewees talk about the bonds established with neighbors and relatives.

Bonding with the neighborhood and people nearby

In the interviews, many differences could be noticed when we compared the views of one group and another regarding their community life; however, there was an almost unanimous answer: all the participants reported to like the place where they live, and expressed identification feelings with their neighborhood, except one of them, who lived under a peculiarity that justifies this difference: it was a person living on the street. That patient, however, remembered the time when he had been living for 14 years in the same neighborhood, in a city of Porto Alegre metropolitan area, having reported a very positive experience, making it evident the association of moving from that neighborhood with the beginning of his symptoms and admissions.

> *[And did you feel that that neighborhood in the other city was an important part of your life?] Yes, it was good. I liked it there. [During the 14 years that you lived there, did you have any admissions?] No, no. The admissions started here in Porto Alegre .. The parties, the drinking, started here... I didn't talk to anyone* (JN, 61 years old, 18 admissions).

When asked about the relation with their neighbors, all the participants reported positive living experiences, bringing two different types of relations established with that group. There is the cordial relationship, in which the neighbors interact in a respectful way, but more distant, only greeting each other when passing on the street; there is also an aiding relationship, in which there is a feeling that the neighbors are people on whom they could count in case of need. Among the patients with multiple admissions, four describe a cordial relationship with their neighbors, only of greeting. Only one of them mentioned an aiding relationship:

> *I meet, say hello, let the person pass, but don't keep asking "how are you, how are things?", you know? Nobody sticks the nose into others' lives* (I, 50 years old, from 15 to 20 admissions).

> *It's "good morning", "good afternoon", "good evening" and it's enough* (N, 59 years old, more than 20 admissions).

In their turn, the patients of first admission brought experiences of aiding relationships with more frequency.Three of them mentioned an aiding relationship with other neighbors and two of them reported only cordial relationships.

> *They are very helpful,when I was in crisis, they took the car to take me to the hospital. ... I call her granny, but it's only one neighbor, she always assisted me when I needed* (J, 20 years old, first admission).

> *I have a better relationship with the ones who live next to my house, if I need something, I go there and ask for her help* (V, 33 years old, first admission).

> *The neighbors ask "are you OK?"... If she [the neighbor] sees the house closed, she already gets worried* (MH, 59, first admission).

It is important to highlight that the cordial relationship, even being more distant, seems to be considered an advantage in the living with the neighbors by most part of participants. One of them understands this relationship as a bond, followed by a "participation" sensation:

> *There is a bond, like... It is not the one of affinity, understand? But it is about greeting, there is this bond... Different people come to live in the neighborhood, but in time, they get used and live together. And there's always this participation: "hey, is everything OK?" "how are you?"* (F, 32 years old, first admission).

The idea of participating of a group is in accordance with the theories approached in the study of Gracia and Herrero (2006) about the type of bonding that is established with the community, which provides a sense of belonging to a broader social structure and a feeling of social identity. In the speech of another participant, a feeling of identity with the neighborhood is explicit:

> *[Do you feel that the neighborhood is an important part of your life?] Yes. [How?] My living with other people... I like the neighborhood, like to live there. I don't want to leave so soon. I really like, I'm in love with the neighborhood* (S, 41 years old, first admission).

According to Gracia, Herrero an Musitu (2002), many authors point out the important role of close people on crisis or disease situations, highlighting that the members of a community tend to look for support from people who are around, instead of specialists. In the same direction, Dahlan et al. (2013) understand the social support as the only factor associated to smaller readmissions rates. In our results, we found the recognition of the neighborhood as a source of help, more common among the ones with fewer admissions. The interviewees with multiple admissions report an experience of more distance from the community members.

On the other hand, family is mentioned more frequently by the group with multiple admissions, even without any questions made on this topic. Three of them mentioned the closeness with the family as an important factor of community life (they live near relatives), while only one member of the first-time-admission group mentioned it:

> *[Do you think that the place where you live is an important part of your life?] It's near the place where all the family lives. This is the importance. All the brothers and sisters live in the same courtyard* (S, 39 years old, more than 20 admissions).

Apparently, the isolation from broader social contacts highlight the family relationships. Nowadays, there is more participation of the family in the post-hospitalization period, which was excluded from this care in the asylum model. However, this responsibility, in many cases, is overloading for the caregivers (Mello & Schneider, 2011).

During the interviews, another theme emerged from the participants' speech, concerning the structure of the dwelling locations, such as security, urban mobility, access to entertainment and location of the neighborhood in relation to the city's central points. Three participants of the group with multiple admissions indicate the drug trafficking as a factor present in their neighborhoods, in a very normalized way in peoples' routine:

> *There were community spaces, like squares... But now it's only drugs... There are many drug takers there, but most people in the neighborhood are all cool people* (S, 39 years, more than 20 admissions).
>
> *It's like that: when they [people involved with drug trafficking] will shoot, they warn: "stay home 'cause there will be shooting"* (I, 50 years old, 15 to 20 admissions).
>
> *At night, it's dangerous, there's drug trafficking. A lot. But for people who know it, it's not, but for the foreigners, it's dangerous.* (A, 45 years old, 19 admissions).

In the first-admission group, only one participant mentioned the trafficking issue during the interview, problem that is combined with serious structural problems, such as lack of pavement, open sewers and illegal power grids. However, it was in this group that compliments to the structure of the neighborhood appeared more frequently (three participants, in comparison to only one participant of the other group):

> *It's good 'cause there are two buses that pass here... There is a grocery store on the corner, the bakery the next street. It's paved* (V, 33 years old, first admission).
>
> *There are many markets, drugstores, it's like a downtown area. There are many reference points, stores, buses and taxis. It's a bustling neighborhood* (S, 41 years old, first admission).

One more time, there is a difference in the frequency of those contents. This difference shows that, in this research, the patients who had more admissions lived in neighborhoods with fewer resources and more insecurity, i.e., poorer neighborhoods. This disparity indicates an association with poverty and more incidence or seriousness of mental health disorders, which is a topic very commonly dealt with in recent studies (Rocha et al., 2012). Poverty is considered as a *Determinante Social da Saúde* (Health Social Determinant - DSS), considering that most part of SUS patients live in poverty situation. When DSS are discussed nowadays, not only are the description of the objective impacts aimed, but also the psychosocial implications and the possibilities to interfere with this reality, by means of closeness, and, mainly, by means of the fostering of the participation and a joint construction with the communities (Sarriera, Saforcada & Inzunza, 2015).

In short, besides the disparities related to the local dwelling location conditions, many other themes demonstrated that there are differences in the view of one group and another. The perceptions of the role of the high-complexity services and the use of the services of primary care, the way that the mental disease affects social and community life, and the ways that the patients relate to the community and the family present particularities when a group that has been through successive psychiatric admissions is investigated.

Final considerations

The community is a source of support and help in times of crisis situations. It is possible to notice feelings of identity and sense of belonging in the speech of both groups, but it is evident, in the interviews, that the patients with a higher number of admissions live the community relations with a certain distance and more superficial bonds. Family, in those cases, take place of those broader relations, becoming the only source of support to those people, who can end up avoiding the public space for fearing discrimination. This fact, besides being harmful to the person, who steadily loses his/her identity as a citizen, has other consequences, such as the increase of the relatives' overload, who can see hospitalization a possibility to "rest" from this responsibility.

This way, the hospital gains a different status in those peoples' lives. As we have pointed out in the discussion session, the hospital is shown as a preference to the first-admission group, and as the only possible solution to the crises faced by the multiple-admission group. In addition to that, there is a distance from the territorial health care services, especially from the reference primary units. Therefore, there is a necessity to incentive and to optimize the formal and informal support sources in the patients' territory, rescuing bonds and resuming community life habits, increasing the sense of belonging to a

broader social structure. The literature consulted also highlights that the territorial mental health care services (CAPS, *Hospital Dia*, etc.) may be empowered with the support of associations, self-help groups, social groups of neighborhood associations, among other devices that provide people more life quality – and that it is really worth that this information is known and used as a work strategy by the professionals who deal with this kind of population.

Some issues regarding the neighborhoods structure were also mentioned by the participants, such as lack of security, transportation, entertainment, among others. It is worth to remark that, indeed, the peripheral neighborhoods of Porto Alegre are precarious, but the reflection intended in this study is that, besides struggling for improvements to reduce stressors, it is also important to strengthen the social bonds of the communities. It is necessary to empower the communities, stimulating public health policies to act together with those natural support network among people, and to work in the opposite direction of the excluding logic.

Lastly, it is important to highlight that the results of this research show that, the more psychiatric admissions the person has, the more susceptible they are to be readmitted. Consequently, the bonding with their own routine becomes weaker, and it becomes harder for them to readapt to it. Taking into account the fact that the psychiatric suffering has the social isolation as a characteristic, it is necessary more efforts for those people to be stimulated to participate of community life. Finally, there are no doubts regarding the fact that preventing readmissions is a primary aim for mental health care.

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