**PREVIOUS CLINICAL-EPIDEMIOLOGICAL PROFILE (13 AGO) OF PATIENTS WITH NEUROPSYCHIATRIC DISORDERS IN A PRIVATE CLINIC OF NORTHERN BRAZIL, IN THE EASTERN AMAZON.**

**ABSTRACT**

Mental disorders are serious clinical and public health problems, in need of academic and scientific monitoring that might better understand the problem and propose solutions and actions. This study aims to verify the clinical and epidemiological profile of patients with various mental disorders treated by a private clinic in the city of Belém, in Pará, in the period between 2011 and 2012, through a quantitative approach. We analyzed 271 records from Neuropsychiatric sector. The results show that 65% of patients are women, predominantly in the age group between 36 and 40 years (27%). Among the drugs administered, stood antidepressants (50%) and anxiolytics (23%); and the most common pathologies groups are F40-F48 (52%), and F30-39 (32%). It was concluded that the observed clinical-epidemiological profile is peculiar, presenting some points in common with studies carried out in other Brazilian regions and the in-depth analysis of the presented results can contribute to the planning and success of Public Policies in Mental Health, as it provides data that enable changes in management and care, in order to improve the mental health of this state.

**Keywords:** Clinical and epidemiological profile; Psychic Disorders, Mental Health.

**1. INTRODUCTION**

Studies by the World Health Organization (2011) demonstrate that mental disorders represent a serious public health problem. Therefore, the objective of this study is to carry out a statistical survey to support public policy in mental health.

Several studies in recent decades have pointed to the need for advances in mental health practices, due to the recognition of the failure of the model of care centered in psychiatric hospitals, the low effectiveness of these hospitalizations, their chronic effects on hospitalized patients and the frequent complaints of violation of the human rights of patients in these institutions. Among them, we highlight the works of Amarante (1994), Giordano (1989), Lancman (1988), Lougon (1987), Moreira (1983), Sampaio (1989) and Urquiza (1991).

The need to create new alternative models and the establishment of a new mental health care network that could gradually replace hospitals triggered the implementation of a set of outpatient and primary care services, mainly from the 1980s onwards. These services aimed at reorganizing the expenses of hospital psychiatric care, for the development of an efficient extra-asylum network that would humanize the care offered (PORTOCARRERO, 1990).

This change in the focus of psychiatric care – from hospitalization to primary and secondary care services – made the incidence of hospitalization an important parameter in psychiatry, tending to gain relevance in quality assessment work. But, despite its strength as an indicator, when analyzed in isolation, it has no predictive value of good or bad assistance. There is a lack of indicators in this area, reflecting the little use of epidemiology in mental health. This occurs for several reasons, among them the difficulty of transposing instruments of epidemiology to this area and the difficulty of defining and specifying various aspects of mental illness (ALMEIDA FILHO, 1989).

The parameters commonly used in medical care sometimes do not adapt to the reality of mental health services (BASTOS; CASTIEL, 1994). Psychiatric diagnoses are of low reliability, either because of the lack of a theoretical framework that can be universally proven in the laboratory, or because of the quick and superficial way in which they are often performed. Furthermore, there is an extremely broad and detailed universe of diagnoses for a very limited range of therapies (SARRACENO et al., 1994).

Establishing the prevalence of mental illnesses is a complex task: difficulty in defining its beginning and end; complaints that are often indistinguishable from personal problems faced in daily life, permeated by socioeconomic crises, social instability, etc.; in addition to the excessive “medicalization” of the population, expressed by the maintenance of care for patients who could be gradually disconnected from the services (ALMEIDA FILHO, 1987).

After the psychiatric reform, more humane care was sought for patients with mental illness, so that they could be integrated into family and social life, from a perspective of inclusion and not exclusion, as was seen in the treatments previously used. It was found that diseases such as depressive disorders and cardiovascular disorders are rapidly replacing malnutrition, perinatal complications, and infectious diseases in underdeveloped countries, where four-fifths of the world's population live. In countries in Asia and Latin America, this epidemiological transition has been taking place without proper planning of public health services and assistance. (THORNICROFT; MAINGAY, 2002).

Although mental disorders cause just over 1% of mortality, they account for over 12% of disability due to illness. This percentage increases to 23% in developed countries. (ANDRADE; SILVEIRA, 2006).

It is noteworthy that of the ten main causes of disability, five of them are psychiatric disorders, with depression responsible for 13% of disabilities, alcoholism for 7.1%, schizophrenia for 4%, bipolar disorder for 3.3% and obsessive- compulsive by 2.8%. (ANDRADE; SILVEIRA, 2006).

In adulthood, large differences emerge between men and women in relation to mental disorders, with women showing greater vulnerability to anxiety and depressive symptoms. (ANDRADE; SILVEIRA, 2006).

Several epidemiological studies have demonstrated gender differences in the incidence, prevalence, and course of mental and behavioral disorders. Women have higher prevalence rates of anxiety and mood disorders than men, while men have a higher prevalence of disorders associated with the use of psychoactive substances, including alcohol, antisocial and schizotypal personality disorders, impulse control disorders and attention deficit disorders and hyperactivity in childhood and adulthood. In disorders whose prevalence is similar in men and women, differences in age of onset, symptom profile, and response to treatment are observed. (ANDRADE; SILVEIRA, 2006).

Several Brazilian states sought new mental health paradigms, and in the State of Pará, the State Council for Mental Health established the gradual replacement of the hospital-centered system by an integrated and varied network of health and social care services, comprehensive care for patient asylums and safeguarding the rights of the mentally ill, among other issues. In Belém, the implementation of prevention, diagnosis, treatment, and reintegration services for people with mental disorders was proposed; the demystification of mental illness; the development of predominantly out-of-hospital actions and psychiatric hospitalizations through health units and specialized emergency services. The health unit serves as a gateway to the health system, constituting its own level of care, where the professional has the chance to reconcile the various aspects of referral of the individual affected by the mental disorder and, in this sense, the private clinics have sought to adapt to offer their patients a multidisciplinary treatment and in accordance with the established precepts. (BELÉM MUNICIPAL HEALTH SECRETARIAT, 2002).

According to the Municipal Health Secretariat of Belém (2002), the health units, whether public or private, have the objective of accompanying people with mental disorders throughout their treatment, so that they, together with their families, , receive the necessary support for the stabilization of the clinical condition, facilitating their reintegration into society, must establish a link between the different levels of health care and other resources available in the community to patients and their families, monitor the patient's adherence to treatment and the quality of the services provided, carry out health education actions involving the patient, the family and the community, the reduction of prejudice on the part of the population and especially on the part of health professionals, and the qualification of the service provided.

Currently, around 400 million people around the world suffer from mental or neurological disorders, or from psychosocial problems, such as alcohol and drug abuse. The vast majority suffer silently with their disease, and with the social exclusion that the disease causes. (WORLD HEALTH ORGANIZATION, 2001).

According to Rabelo et al. (2005), the profile of patients with mental disorders, although essential for implementing changes in care policy, is not always known. Faced with the various objectives and challenges of a private outpatient neuropsychiatric health unit, it is necessary to know the profile of the patient who is attended to in this service, as it enables a better intervention by the health team with future clients, whether or not they come from hospital. The public sector, a better elaboration of care protocols for this target public in the private sector, and as a subsidy for the promotion of new public policies, and improvement of those that already exist, since there is a lack of demand for epidemiological studies on patients in the private sector , which for the shame of the stigma, of having a neuropsychiatric disease, for example, do not seek public hospitals. So, is relevant to add to SUS data, these patients who are outside the statistics that are mostly measured in public neuropsychiatric care units in the state of Pará.

**2 THEORETICAL FRAMEWORK**

2.1 THE CARE OF PATIENTS WITH MENTAL DISORDERS

Through the National Mental Health Policy of the SUS, supported by law 10.216/01, an attempt is made to consolidate a model of mental health care, where patients with mental disorders should be treated preferentially in community mental health services, with the right to be included in the family, at work and in the community.

To this end, the Ministry of Health (2001) has sought to change the hospital-centered model to a model based on the exceptionality of hospitalization and the prevalence of out-of-hospital care.

The model advocated by the Ministry of Health (2001) deinstitutionalizes long-stay patients, understood as those hospitalized for a period longer than one year, through a therapeutic project aimed at social reintegration.

Although the law guarantees inclusion in the family (art. 2nd, sole paragraph, item II), it is not always possible, as it depends on the economic and social conditions of the family members, to enable the discharge of patients for whom the return to the family becomes become impossible or inadequate for social reintegration.

According to the National Mental Health Policy (2001), another support instrument is the evaluation of psychiatric hospitals through the National Program for the Evaluation of the Hospital System (2002), especially focused on Psychiatry (PNASH – Psychiatry) with the objective ofimprove the quality of Hospital Services provided to SUS users, respecting the principles of universality and equityensuring adequate assistance and the existence of an individual therapeutic project for planned discharge. The results of the assessments already carried out led to the adequacy of several units, closure and indication of disqualification from the SUS of other units, although the Ministry of Health has contributed to changing the care model with the standardization of out-of-hospital mental health care services within the SUS, with the creation of financial incentives and evaluation of psychiatric hospitals.

In the 1980s, the first proposals and actions for the reorientation of assistance to people with mental disorders emerged.

In 1992, Ordinance SNAS nº 224/MS of 01/29/92 was edited, which established the guidelines and norms within the scope of the SUS, both for hospital care (Hospital – day, Psychiatric Emergency service in General Hospital, and for ambulatory (Basic Unit, Health Center and Ambulatory) and Centers/Psychosocial Care Centers (NAPS / CAPS) based on the experiences started in the 80's).

According to data from the Ministry of Health (2005), described in the Regional Conference for the Reform of Mental Health Services, in the decades that before showed advances towards the reversal of the traditionally hospital-centered and asylum psychiatric model that was established on country for more than 150 years, with a reduction of 57 psychiatric hospitals, with a consequent reduction of about 30,000 beds, which were replaced by more than 100 extra-hospital care services and about 2000 mental health care beds in general hospitals.

Such advances culminated in the creation of a permanent program for the organization and follow-up of care actions in mental health, aimed at consolidating advances and creating mechanisms for reversing the existing model and establishing mechanisms for continuous evaluation and supervision of hospital and outpatient services, provided for in Ordinance No. 799/2000.

From then on, the public policy for mental health, following the guidelines of theRegional Conference on Mental Health Services Reform andDeclaration of Caracas (2005) started to consider that hospitalizations in hospitals specialized in psychiatry should only occur in those cases in which all existing outpatient therapeutic alternatives have been exhausted, starting from the premise that the extra-hospital care model has demonstrated great efficiency and efficacy in the treatment of patients with mental disorders.

And in response to this, out-of-hospital targeted services have emerged that deal with these cases effectively without separating the patient from his family, even making them part of this process in most cases. Therefore, humanizing the actions of neuropsychiatry with new approaches, therapies, and services, greatly distancing the previously existing anachronistic services.

2.2 MENTAL HEALTH IN THE MUNICIPALITY OF BELÉM

The Municipality of Belém, with a population of 1,304,314 inhabitants until 1996, was characterized by the absence of a Mental Health Care Policy on the part of the municipal manager. As of 1997, with the victory of the Belém Popular Front (PT/PCdoB/PSB/PPS), it became possible to implement the Municipal Mental Health Policy, through the creation and expansion of the offer of services, with the objective of reversing the Assistance Model, as well as combating the abandonment and lack of assistance with which public managers treated people with mental disorders. (NASCIMENTO, 2001)

The municipal mental health care program, structured and based on the principles of the SUS and the Psychiatric Reform, took effect in 1997, through the following actions:

* + Creation of a Municipal Law (Law No. 7892/98) providing for assistance in Mental Health;
  + Creation of the Mental Health Care Center for adults (Adult Mental House);
  + Creation of the Mental Health Care Center for Children and Adolescents (Mental House – Children and Adolescents);
  + Creation of two Mental Health Centers (one in Icoaraci and the other in Mosqueiro), with a team composed of a psychiatrist, psychologist, social worker, and nurse;
  + Structuring of Basic Health Units to care for people with mental disorders, through training, qualification, and acquisition of psychotropic drugs;

The Mental Health Centers have been operating their assistance within the Health Units themselves in a single shift (morning or afternoon) for five days a week. They have a multidisciplinary team formed by a psychiatric doctor, a psychologist, a nurse, and a social worker. The Basic Health Units of the Municipality of Belém are composed of 29 municipal health units and are gradually being structured to meet the mental health demands of the population. It should be noted that among the 29 (twenty-nine) units, 8 (eight) provide mental health care. (BELÉM MUNICIPAL HEALTH SECRETARIAT, 2013).

The private initiative must place itself as of great strategic value in this reformulation, which will have the objective of helping and facilitating the mechanisms for coping with the difficulties observed in daily practice, through a case study and deepening of the theoretical framework, as well as articulating an updated communication and continuous, among reference public services, hence the observance of creating data in private clinics that complement public statistics, so that such data are used for the exercise of citizenship in terms of the interests of neuropsychiatric patients and their respective families , because unlike 50 years ago, when patients were hospitalized, treated and funded by the government, today, they are pseudo-assisted politically by tiny aid pensions, and such studies,they will also serve as subsidy for the creation of projects, protocols and sets of laws to support in a differentiated way those who are different.

**3 METHODOLOGICAL ASPECTS**

3.1 RESEARCH CHARACTERIZATION

The methodology used in this study will be based on the interpretation of quantitative data and, for this purpose, research was carried out in journals that deal with the performance of neuropsychiatry, as well as documental and observational analyzes that support quantitative research, based on experimentation, making intensive use of technique statistics, correlating the variables and verifying the impact and validity of the experiment. It is important, however, to adapt the techniques to the type of design adopted. That is, such research translates opinions and information into numbers to be classified and analyzed using statistical techniques (RODRIGUES, 2007).

This research was based on analyzes of medical records from a private clinic, whose name will not be disclosed at the request of the owner of the clinic, and on bibliographic review studies for the preparation of this article, found in scientific databases such as: Sielo, LILAC, Data SUS, PubMed. and Bireme. The collection of bibliographic material and search of journals were carried out by the researchers themselves.

This is an observational and descriptive study, of the retrospective type, on the clinical and epidemiological aspects of patients with neuropsychic disorders in a private clinic in Belém do Pará, from January 2011 to December 2012, after contactinitial contact with the institution to apply for the research and subsequent authorization from the clinic for the analysis of 271 medical records to begin.

3.2 CHARACTERIZATION OF THE PRIVATE CLINIC.

The private clinic is located in the neighborhood of São Braz, in the city of Belém do Pará, and presents itself as a clinic with multiple activities in the areas of psychology, psychiatry, physiotherapy, speech therapy, psychopedagogy, occupational therapy and arts, focusing on general neuropsychiatric diagnostic demands, receiving patients referred by health plans or from private sources; offering a variety of services at an outpatient level, during business hours.

The clinic operates in a large, airy house, built with 15 rooms, distributed to the professional facilities of each specialty carried out by a total of 19 employees, including: 2 Psychologists; 1 Psychiatrist; 3 Physiotherapists; 3 speech therapists; 3 Psychopedagogues; 2 Occupational Therapists; 1 Arts Instructor, in addition to administration and operational support professionals.

The clinic was conceived as a small outpatient therapeutic unit, where each patient could be carefully assisted, being submitted to the most modern therapeutic resources, both in the clinical sphere, as well as in the psychological, family and social spheres, so that one can get to know better how diseases evolve, how they could and should be treated and followed up, using all available therapeutic resources.

It is a private, independent neuropsychiatric care institution, with no financial, teaching or research ties with any other institution. It obtains its resources from providing care services to patients and family members with neuropsychiatric disorders.

Its work philosophy is based on the concept of bonding, which is the therapeutic relationship that is established between the patient and his therapist/psychiatrist, through which the therapist obtains the necessary conditions to establish the base of the treatment that will provide the best possible recovery.

The clinic also offers its patients a daily Therapeutic Program, with group activities, guided by psychologists, an occupational therapist, and a physiotherapist, which are repeated throughout the week, which allows each therapist to follow the evolution of each patient, thus enhancing the scope of treatment.

The Unit has assistant psychiatrists who monitor patients daily, and who, in addition to assisting patients with any complications, they may have also provide the physician in charge with all necessary coverage for the best conduct of the treatment. The program assists patients and their families on an outpatient basis, and in some cases provides support to colleagues and family members who opt for Home Hospitalization, providing medication and professionals who are properly trained and supervised by the doctor in charge.

3.3 CHARACTERIZATION OF PATIENTS ASSISTED AND RESEARCH SUBJECTS

The clinic provides care for patients with neuropsychic diseases, as well as accompanying patients who need evaluation and/or follow-up in any of the clinical specialties in which it operates.

In short, neuropsychiatric diseases are those that affect emotions, behavior, thinking, and our perception of the world, such as depression, alcoholism, and schizophrenia. The diagnosis is made through a clinical history, that is, a conversation and some complementary blood and imaging tests. Treatment consists of lifestyle guidelines, often associated with medication or psychotherapy. Normally, the best results are given at the onset of symptoms, but even in advanced cases, complete disappearance of the symptoms can be achieved.

In general, the clinic assists patients diagnosed, among others, by: Depression; Bipolar Affective Disorder (formerly known as Manic Depressive Psychosis); Schizophrenia and other Psychoses; Alcohol Dependence; Drug Addiction; Pathological gambling; Obsessive-compulsive disorder; Panic Syndrome; Social phobia, Specific phobia; Tourette's Syndrome; Post-traumatic stress; Anorexia, Bulimia, compulsive overeating; Insomnia; Alzheimer's and other memory problems; Attention Deficit Hyperactivity Disorder; Problems related to sexuality; Autism; Mental Retardation and Personality Disorders

Psychiatric illnesses are often an intensification of symptoms that almost all of us experience daily, such as sadness and fear, but which end up interfering a lot with normal life and whose duration is very prolonged. In other cases, symptoms can be perceived initially in the body, such as an acceleration of the heartbeat in Panic Syndrome or the fatigue and lack of appetite that may be present in depression. On the other hand, neuropsychiatric illnesses can be associated with other clinical illnesses such as thyroid problems, tumors, or infections in the brain.

**4 RESULTS AND DISCUSSION**

As for the medical records evaluated, it was found that there is a predominance of females, which is almost double the frequency of male patients, since 65% were female against 35% male. Taking into account that men seek less specialized professional help in health services, as shown in Graph 1.

Graph 1: Sample of neuropsychiatric patients at the clinic, segregated by sex

Source: Clinical patient records. Research was carried out in 2012 by the authors.

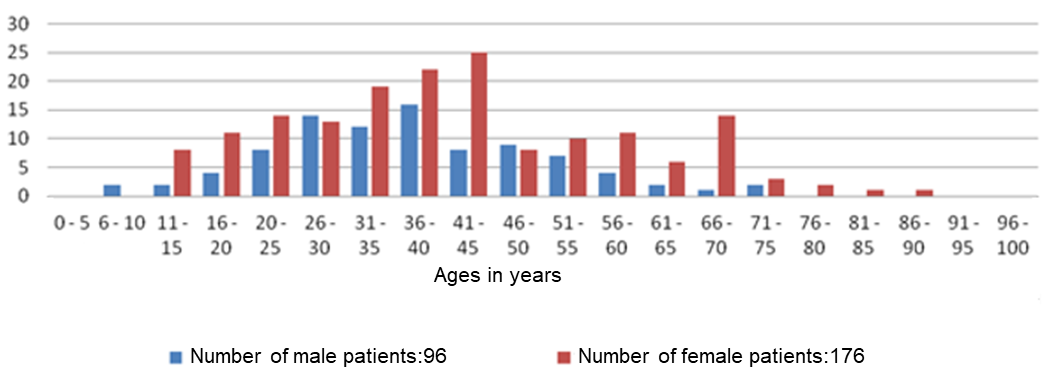
According to Motta (2005), this was a proportion that was similar to his study in which a percentage of 69% of female individuals was reported, and 31% of males.

AccordingKaplan and Sadock (1997) apud Gama (2012), state in their work that females have significantly higher rates than males for all disorders, especially anxiety and depression disorders (Humor).

In contrast, Azevedo (2000) found an inverse statistical difference taking epidemiological data in children and adolescents, since 60% were male and 40% female, but Ajuriaguerra and Marcelli (1991), Apud Azevedo (2000) reported the existence of a greater representation of boys in relation to girls in the consulting population with disorders. Therefore, this proportion is unnecessary in distribution in individuals younger than 14 years old.

Regarding the age groups served, the most predominant among men was the range between 36 and 40 years old, which corresponds to approximately 17% of the male population. Among women, the highest incidence of attendance occurred in the age group corresponding to the interval between 41 and 45 years, which corresponds to a percentile of 14% of the female population. That said, there is a higher frequency of females in almost all age groups, except in the 6 to 10 age group; and in the range of 46 to 50 years old, and in those that do not have any frequency, as shown in Graph 2.

Graph 2: Occurrence of neuropsychiatric diseases segregated by gender and age group



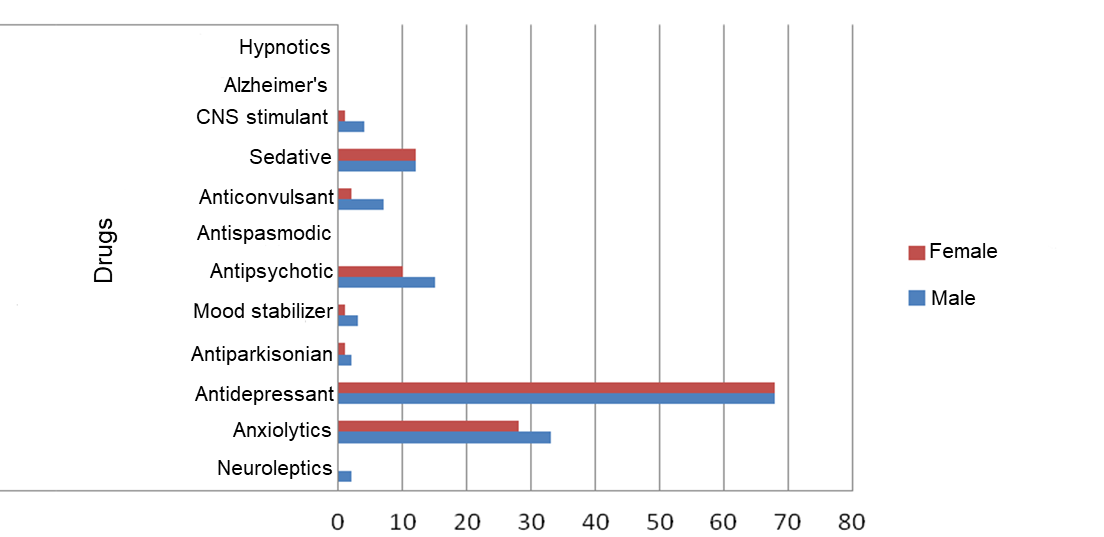
Source: Clinical patient records. Research was carried out in 2012 by the authors.

Ratifying these data, for Sampaio (2008), the age group most affected in females is 40 to 44 years old (18.4%). Second, Castro (2005) presented as the most affected age groups, those between 41 and 50 years old, with 29% of the individuals found in the group he researched. Moreno (1999) stated that individuals between 25 and 59 years old are more vulnerable to mental disorders.

In Motta's research (2005), the predominant demographic profile found was that of patients aged 30-39 years. In contrast to Sampaio (2008), the most affected age group of males is between 20 to 24 years old (23.5%) and the least affected is between 45 to 49 years old (13.15%), totally contradicting the research mentioned above. , as well as for Gama (2012), the results indicate that the patients are men between 21 and 30 years old (37.94%). Discrepancies explained by the nature of the various studies, since they have divergent target audiences regarding neuropsychiatric pathologies in different hospitals and centers, each with a pathological nature and different patient demands.

As for the drugs administered, the use of antidepressants stands out in approximately 50% of the cases, and anxiolytics in 22% of the cases. As for their percentage frequency between genders, they can report that antidepressants correspond to 46% and anxiolytics to 22% of all medications taken by men, among women, antidepressants reach 55% of the medications taken by them, and anxiolytics to 23% of the total number of drugs used by female members, as shown in Graph 3.

Graph 3: Frequency of psychiatric medications prescribed, broken down by category



Source: Clinical patient records. Research was carried out in 2012 by the authors.

These results are a reflection of the pathologies found in the articles, however drugs of different therapeutic natures can be used in mental health concomitantly, however some authors report the most incidentally used. Such as Oliveira (2006) reports that the most used drugs are antidepressants and antianxiety drugs.

According to Carvalho (2009), it was observed that in patients with severe depressive disorders, the drugs prescribed were quite diverse. Being distributed in 33.4% of the cases, there was an association of fluoxetine, dienpax, captopril, hydrochlorothiazide. The remaining cases of patients with depressive disorder represented 33.2% and had an association of diazepam and neozine. In 33.4% of other cases, treatment was performed with haldol, akinetrizim, pivotril, and tegretol. In contrast, Carvalho (2009), when analyzing the drugs in the medical records, it was found that the hospital where the research was carried out predominantly uses typical antipsychotics because they are more affordable, even with more adverse effects compared to the 2nd generation or atypical ones.

As for established diagnoses, the most frequent groups of psychiatric pathologies are F40-F48 (neurotic disorders, stress-related disorders, and somatoform disorders) in approximately 50% of diagnoses; and F30-39 (Mood [affective] disorders) by 32%. of all cases, as shown in Table 1.

**Table 1: Frequency of Diagnosis**

|  |  |
| --- | --- |
| DIAGNOSIS ACCORDING TO ICD 10 | SAMPLE FREQUENCY |
| Organic mental disorders, including symptomatic ones (F00-F09). | 4 |
| [Mental and behavioral disorders due to psychoactive substance use (F10-F19)](http://www.datasus.gov.br/cid10/V2008/WebHelp/f10_f19.htm) | 5 |
| [Schizophrenia, schizotypal disorders and delusional disorders (F20-F29)](http://www.datasus.gov.br/cid10/V2008/WebHelp/f20_f29.htm) | 14 |
| [Mood [affective] disorders (F30-F39)](http://www.datasus.gov.br/cid10/V2008/WebHelp/f30_f39.htm) | 90 |
| [Neurotic disorders, stress-related disorders and somatoform disorders (F40-F48)](http://www.datasus.gov.br/cid10/V2008/WebHelp/f40_f48.htm) | 140 |
| [Behavioral syndromes associated with physiological dysfunctions and physical factors (F50-F59)](http://www.datasus.gov.br/cid10/V2008/WebHelp/f50_f59.htm) | 9 |
| [Adult personality and behavior disorders (F60-F69)](http://www.datasus.gov.br/cid10/V2008/WebHelp/f60_f69.htm) | 2 |
| [Mental retardation (F70-F79)](http://www.datasus.gov.br/cid10/V2008/WebHelp/f70_f79.htm) | 1 |
| [Disorders of psychological development (F80-F89)](http://www.datasus.gov.br/cid10/V2008/WebHelp/f80_f89.htm) | 0 |
| [Behavioral disorders and emotional disorders that usually appear during childhood or adolescence (F90-F98)](http://www.datasus.gov.br/cid10/V2008/WebHelp/f90_f98.htm) | 13 |
| [Unspecified mental disorder (F99)](http://www.datasus.gov.br/cid10/V2008/WebHelp/f99_f99.htm) | 0 |
| TOTAL | 278 |

Source: Clinical patient records. Research was carried out in 2012 by the authors.

In order to confirm the similarities with what was researched in this article, it can be observed that Oliveira (2006) reported that the main psychiatric disorders found in his source are depression, panic disorder, and anxiety.

For Moreno (1999), the individuals in his research with anxiety or depressive disorders were the ones who most sought psychological help, and Gama (2012) noted that the most frequent pathology were bipolar affective disorder in association with a mild or moderate depressive episode (20.51%). And, Motta (2005), further stressed that asAnxiety disorders not triggered exclusively by exposure to a specific situation (53%) were the main presentation of the disease, with mixed anxiety and depressive disorder also standing out in another group (56%).

Although, Gama (2012), going against the findings of this research, analyzed that the group with the most pathologies found is F20-F29. Results was also found by Castro (2005) in your searchregarding the psychiatric disorders that had their diagnoses based on ICD 9, the most prevalent being psychose with 7517 diagnoses (31.1%), while regarding the diagnoses based on the ICD 10, 9495 diagnoses (39.3%) of mental disorders are schizophrenia, schizotypal and delusional disorders with 4163 (17.2%); followed by mental and behavioral disorders due to the use of psychoactive substances with 2204 (9.1%) and mood disorders (affective) with 1906 (7.8%).

For Sampaio (2008), the most common type of illness diagnosed at HCGV was unspecified schizophrenia (F20.9) with 52.7% incidence at the Hospital de Clinicas Gaspar Viana.

Regarding the number of diagnostic occurrences, among the male population, the same groups were observed to have more incidents, that is, F40-F48 (neurotic disorders, stress-related disorders, and somatoform disorders) with 49% of psychiatric diagnoses; and F30-39 (Mood [affective] disorders) by 24%. of all cases among men, as shown in Table 2.

Table 2: Frequency of psychiatric diagnoses according to cid 10, male gender

|  |  |
| --- | --- |
| FREQUENCY OF PSYCHIATRIC DIAGNOSES ACCORDING TO ICD 10 MALE GENDER | SAMPLE FREQUENCY |
| Organic mental disorders, including symptomatic ones (F00-F09). | 0 |
| [Mental and behavioral disorders due to psychoactive substance use (F10-F19)](http://www.datasus.gov.br/cid10/V2008/WebHelp/f10_f19.htm) | 3 |
| [Schizophrenia, schizotypal disorders and delusional disorders (F20-F29)](http://www.datasus.gov.br/cid10/V2008/WebHelp/f20_f29.htm) | 8 |
| [Mood [affective] disorders (F30-F39)](http://www.datasus.gov.br/cid10/V2008/WebHelp/f30_f39.htm) | 26 |
| [Neurotic disorders, stress-related disorders and somatoform disorders (F40-F48)](http://www.datasus.gov.br/cid10/V2008/WebHelp/f40_f48.htm) | 53 |
| [Behavioral syndromes associated with physiological dysfunctions and physical factors (F50-F59)](http://www.datasus.gov.br/cid10/V2008/WebHelp/f50_f59.htm) | 6 |
| [Adult personality and behavior disorders (F60-F69)](http://www.datasus.gov.br/cid10/V2008/WebHelp/f60_f69.htm) | 2 |
| [Mental retardation (F70-F79)](http://www.datasus.gov.br/cid10/V2008/WebHelp/f70_f79.htm) | 0 |
| [Disorders of psychological development (F80-F89)](http://www.datasus.gov.br/cid10/V2008/WebHelp/f80_f89.htm) | 0 |
| [Behavioral disorders and emotional disorders that usually appear during childhood or adolescence (F90-F98)](http://www.datasus.gov.br/cid10/V2008/WebHelp/f90_f98.htm) | 9 |
| [Unspecified mental disorder (F99)](http://www.datasus.gov.br/cid10/V2008/WebHelp/f99_f99.htm) | 0 |
| TOTAL | 107 |

Source: Clinical patient records. Research was carried out in 2012 by the authors.

Finding results segregated by sex but with a divergent nature, Sampaio (2008) reported that in the group aged 30 to 34 years, the F20.0 group was the most incident, corresponding to 37% of cases.

Already, among the female population, groups F40-F48 and F30-39 were observed as more incidents, arranged in a decreasing way, respectively, since the group F40-F48 (neurotic disorders, stress-related disorders and somatoform disorders) has 51% of psychiatric diagnoses; and the F30-39 group (Mood [affective] disorders) has 37%. of all cases among women. According to Sampaio (2008), these results differed from his own, since the F20.9 group in his research had a higher incidence when contrasted with all age groups of females surveyed, as shown in Table 3.

Table 3: Frequency of psychiatric diagnosis according to cid 10 female sex

|  |  |
| --- | --- |
| FREQUENCY OF PSYCHIATRIC DIAGNOSES ACCORDING TO ICD 10 FEMALE GENDER | SAMPLE FREQUENCY |
| Organic mental disorders, including symptomatic ones (F00-F09) | 4 |
| [Mental and behavioral disorders due to psychoactive substance use (F10-F19)](http://www.datasus.gov.br/cid10/V2008/WebHelp/f10_f19.htm) | 2 |
| [Schizophrenia, schizotypal disorders and delusional disorders (F20-F29)](http://www.datasus.gov.br/cid10/V2008/WebHelp/f20_f29.htm) | 6 |
| [Mood [affective] disorders (F30-F39)](http://www.datasus.gov.br/cid10/V2008/WebHelp/f30_f39.htm) | 64 |
| [Neurotic disorders, stress-related disorders and somatoform disorders (F40-F48)](http://www.datasus.gov.br/cid10/V2008/WebHelp/f40_f48.htm) | 87 |
| [Behavioral syndromes associated with physiological dysfunctions and physical factors (F50-F59)](http://www.datasus.gov.br/cid10/V2008/WebHelp/f50_f59.htm) | 3 |
| [Adult personality and behavior disorders (F60-F69)](http://www.datasus.gov.br/cid10/V2008/WebHelp/f60_f69.htm) | 0 |
| [Mental retardation (F70-F79)](http://www.datasus.gov.br/cid10/V2008/WebHelp/f70_f79.htm) | 1 |
| [Disorders of psychological development (F80-F89)](http://www.datasus.gov.br/cid10/V2008/WebHelp/f80_f89.htm) | 0 |
| [Behavioral disorders and emotional disorders that usually appear during childhood or adolescence (F90-F98)](http://www.datasus.gov.br/cid10/V2008/WebHelp/f90_f98.htm) | 4 |
| [Unspecified mental disorder (F99)](http://www.datasus.gov.br/cid10/V2008/WebHelp/f99_f99.htm) | 0 |
| TOTAL | 171 |

Source: Clinical patient records. Research was carried out in 2012 by the authors.

**5 CONCLUSIONS**

The analysis of the data fulfilled its purpose, as it allowed knowing the epidemiological profile of patients with mental disorders assisted by a private clinic of the State of Pará. It is important to build a new look at care based on dialogue and creativity that enables the social transformation of the role of professionals in the exercise of their practice. It is with this new look at care that we want to dwell. The clinical model presented in the thinking and doing of modern professionals still assumes a space of power, with relevant acceptance and consideration in health care systems. But the resulting care gives it a simplifying character, maintaining the principles of reduction and separation between knowledge, agents, and elements of nature.

The effort of the city's mental health network in an attempt to break with the care model still in force, centered on the clinic and disease, is notorious. The implementation of diversified therapeutic activities in psychosocial care centers allows the integration of users in different categories of support, enabling socio-educational and human transformation.

For psychiatric reform to occur effectively, valuing network professionals and institutional support for planned activities at all levels of management are fundamental.

The municipality studied is moving towards quality mental health care, valuing the potential of the individual, effectively cooperating for social inclusion and involving different sectors of society, in search of a better quality of life for all.

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