**PREVIOUS CLINICAL-EPIDEMIOLOGICAL PROFILE OF PATIENTS WITH NEUROPSYCHIATRIC DISORDERS IN A PRIVATE CLINIC OF NORTHERN BRAZIL, IN THE EASTERN AMAZON (2011-2012)**

**ABSTRACT**

Mental disorders are serious clinical and public health problems, in need of academic and scientific monitoring that might better help understand the problem and propose effective 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 eastern amazon, 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, antidepressants (50%) and anxiolytics (23%) stood out, and the most common groups of pathologies 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 conducted by the World Health Organization (2021) have shown that mental disorders represent a serious public health concern. Therefore, the objective of this study is to carry out a statistical survey to support the development of public policies in mental health.

Over the past decades, several studies have demonstrated the ineffectiveness of the hospital-centred model in mental healthcare, highlighting its chronic effects and the frequent violations of human rights (Boni *et al.*, 2025; Brazil, 2011; Hirdes, 2009; Amarante, 1994; Giordano, 1989; Lancman, 1988; Lougon, 1987; Moreira, 1983; Sampaio, 1989; Urquiza, 1991).

From the 1980s onwards, the implementation of outpatient and primary care services in mental health began, aiming to gradually replace psychiatric hospitals and redirect resources towards a more humane, community-based network (Lima *et al.*, 2020; Portocarrero, 1990).

The transition from a hospital-centred model to strategies based on primary and secondary care transformed hospitalisation rates into one of the main evaluative parameters of contemporary psychiatry. However, despite its symbolic strength, this isolated indicator is insufficient to assess the quality of the care provided. This limitation reveals a structural problem: the lack of specific indicators in mental health, stemming from the incipient incorporation of epidemiology into the field. This gap is exacerbated by the difficulty in adapting epidemiological tools to the particularities of mental health and the inherent complexity of defining and measuring mental disorders (Amado, 2017; Almeida Filho, 1989).

The indicators traditionally used to evaluate medical care often prove inadequate for the reality of mental health services. This inadequacy is largely due to the low reliability of psychiatric diagnoses, which lack theoretical foundations validated by laboratory methods and are often established superficially. Moreover, there is a marked discrepancy between the extensive diagnostic classifications available and the limited range of effective therapeutic resources (Lima, 2022; Bastos; Castiel, 1994; Sarraceno *et al.*, 1994).

Estimating the prevalence of mental disorders is highly complex due to factors such as the lack of clear boundaries marking the onset and end of clinical episodes, the overlap between psychological symptoms and social issues, and the excessive medicalisation of the population. This medicalisation is evident in the prolonged follow-up of patients, even in cases where gradual discharge from services would be appropriate (Häfele *et al.*, 2023; Almeida Filho, 1987).

Following the psychiatric reform, there was an attempt to consolidate a more humane model of care, focused on the social and familial inclusion of individuals with mental disorders, in contrast to the exclusionary practices previously dominant. At the same time, developing countries home to the majority of the global population are experiencing an epidemiological transition from infectious and nutritional diseases to mental disorders and chronic conditions such as cardiovascular diseases. However, this shift has not been proportionally accompanied by adjustments in public health planning (Albuquerque, 2022; Thornicroft; Maingay, 2002).

Although mental disorders account for just over 1% of global mortality, they represent more than 12% of the global disease burden in terms of disability, rising to 23% in developed countries. Among the top ten causes of disability, five are psychiatric disorders, including depression (13%), alcoholism (7.1%), schizophrenia (4%), bipolar disorder (3.3%), and obsessive-compulsive disorder (2.8%). Furthermore, there are significant gender differences in adulthood, with women being more vulnerable to symptoms of anxiety and depression (Bonadiman *et al.*, 2017; Andrade; Silveira, 2006).

Epidemiological studies reveal gender-based differences in the prevalence, incidence, and progression of mental disorders. Women exhibit higher rates of anxiety and mood disorders, whereas men predominate in disorders related to substance use, antisocial personality, and impulse control. Even in disorders with similar prevalence between genders, differences are observed in age of onset, symptom profiles, and treatment response (Loiola *et al.*, 2020; Andrade; Silveira, 2006).

Several Brazilian states have adopted the new paradigms of mental health care. In the state of Pará, the State Council for Mental Health established the gradual replacement of the hospital-centred system with an integrated and diverse network of healthcare and social support services, comprehensive care for asylum patients, and the safeguarding of the rights of individuals with mental disorders. In Belém, the implementation of services for prevention, diagnosis, treatment, and reintegration of individuals with mental disorders was proposed, along with the demystification of mental illness, the development of predominantly extra-hospital-based actions, and psychiatric hospitalisations through health units and specialised emergency services. Health units act as the entry point to the healthcare system, constituting a specific level of care where professionals can coordinate various referral pathways for individuals affected by mental disorders. In this context, private clinics have sought to adapt in order to offer their patients multiprofessional care aligned with established principles (Macedo *et al.*, 2017).

According to Macedo *et al.* (2017) both public and private health units aim to monitor individuals with mental disorders throughout their treatment so that they, together with their families, receive the necessary support for clinical stabilisation and social reintegration. These units should establish links between the various levels of health care and other resources available in the community for patients and their families, monitor treatment adherence and the quality of services provided, carry out health education initiatives involving patients, families, and communities, reduce stigma particularly among health professionals and improve the quality of care provided.

Currently, nearly one billion people worldwide suffer from mental or neurological disorders, or from psychosocial problems such as alcohol and drug abuse. The vast majority suffer silently not only from their illness but also from the social exclusion it causes (World Health Organization, 2021).

According to Ximenes (2019), Cruz *et al.* (2015), and Rabelo *et al.* (2005), the profile of individuals with mental disorders although crucial for implementing changes in care policy is not always known. Given the various objectives and challenges of a private outpatient neuropsychiatric health unit, it becomes necessary to understand the profile of patients treated in this service. Such knowledge enables more effective intervention by the health team for future clients, whether from public hospitals or not; it also allows for the development of more refined treatment protocols tailored to this target group in the private sector, while serving as a basis for fostering new public policies and improving existing ones. This is particularly relevant considering the current lack of epidemiological studies on patients in the private sector, many of whom avoid public hospitals due to the stigma associated with having a neuropsychiatric condition. Therefore, incorporating these individuals into mental health data helps complement the statistics derived predominantly from public neuropsychiatric facilities in the state of Pará.

In light of the increasing demand for qualified knowledge in the field of mental health, the primary objective of this study was to analyse the profile of patients with neuropsychiatric disorders through a review of medical records from a private institution located in the city of Belém, Pará. To this end, specific goals were outlined to enable a more in-depth examination of the phenomenon: to identify the most prevalent age group among patients with neuropsychiatric disorders; to examine the incidence of these disorders by gender, correlating them with the most frequent diagnoses; and to present the frequency and nature of medications used in treatments, providing relevant data to enhance the therapeutic strategies adopted in the local clinical context.

**2 METHODOLOGICAL ASPECTS**

2.1 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 statistical techniques, 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 initial contact with the institution to apply for the research and subsequent authorization from the clinic for the analysis of 271 medical records to begin. And, despite the predominant descriptive approach, we sought to interpret the data in a contextualized way, relating them to the specialized literature and to the available national epidemiological data.

2.2 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 provided 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.

2.3 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.

2.4 INCLUSION/EXCLUSION AND DIAGNOSTIC CRITERIA

A total of 291 medical records were requested, but 271 records belonging to patients with a registered diagnosis of neuropsychiatric disorder who were treated at a private clinic located in Belém do Pará between January 2011 and December 2012 were included in the study. The 20 medical records that were incomplete, duplicated or did not have a formally registered diagnosis according to the criteria of the ICD-10 (International Classification of Diseases and Related Health Problems - 10th Revision), which was the system used by the clinical team during the period in question, were excluded. The data were tabulated in electronic spreadsheets (Microsoft Excel®) and subsequently evaluated to infer associations between gender, age group and diagnostic groups.

2.5 LIMITATIONS OF THE STUDY

This study had limitations that should be considered when interpreting the results. First, it was a retrospective sample obtained from medical records of a single private clinic, which implies selection bias and limited the generalization of the findings to other populations, especially those served by the public health system; in addition, the lack of standardized data on the clinical evolution of patients and possible therapeutic outcomes restricted the longitudinal evaluation of the effects of the treatment; and another critical point was the dependence on the quality and completeness of the records in the medical records, with 20 records excluded due to the lack of essential information, given that, even evaluating all the records in the clinic (291), it was not possible to completely control the socioeconomic and cultural variables, which can directly influence the manifestation and search for treatment of neuropsychiatric disorders. Despite these limitations, the study provided relevant subsidies for future research with larger samples and prospective methodologies.

**3 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.

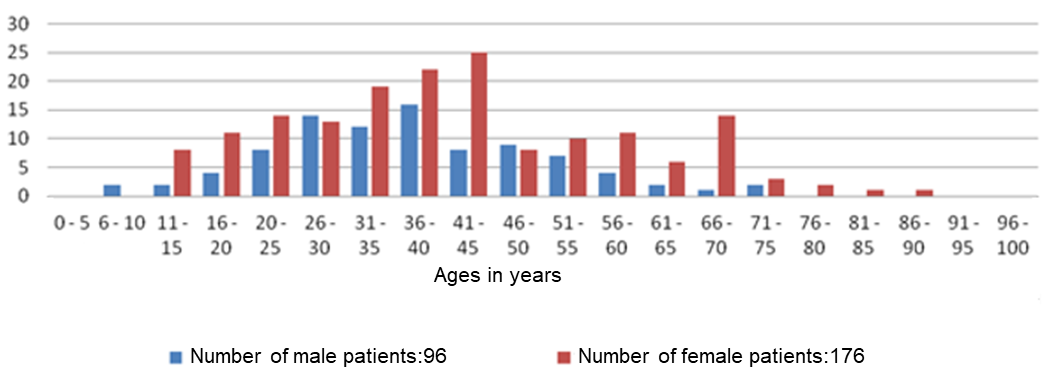
According to Motta (2005), this was a proportion that was similar to his study in which a percentage of 69% of female individuals was reported, and 31% of males.

According to Kaplan and Sadock (1997), as cited by 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



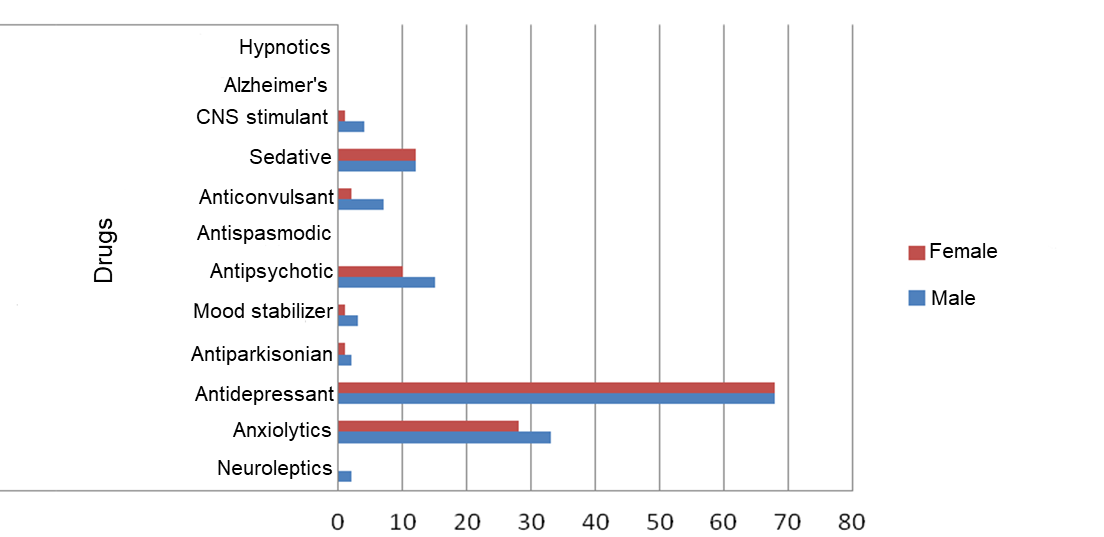
Source: Clinical patient records. Research was carried out in 2012 by the authors.

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. Similar results were also found by Castro (2005) in his study regarding 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.

**4 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, and is widely accepted and considered relevant 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 studied municipality is advancing towards providing 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.

Disclaimer (Artificial intelligence)

Author(s) hereby declare that NO generative AI technologies such as Large Language Models (ChatGPT, COPILOT, etc.) and text-to-image generators have been used during the writing or editing of this manuscript.

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