ORIGINAL ARTICLE

PROFILE OF PATIENTS TREATED AT A PSYCHOSOCIAL CARE CENTER PERFIL DE PACIENTES ATENDIDOS EM UM CENTRO DE ATENÇÃO PSICOSSOCIAL PERFIL DE PACIENTES ATENDIDOS EN UN CENTRO DE ATENCIÓN PSICOSOCIAL

Natalia Hiany Fonseca Santos¹ , Samara Frantheisca Almeida Barbosa² , Carolina Amaral Oliveira Rodrigues³ , Diego Dias de Araújo⁴ , Ricardo Otávio Maia Gusmão⁵ , Maria Aparecida Vleira⁶

ABSTRACT

Objective: to characterize the sociodemographic and clinical profile of patients treated at a Psychosocial Care Center. **Method:** this is a quantitative, cross-sectional, descriptive and documentary study, with medical records of users in a Psychosocial Care Center. Data was collected in December 2017 and January 2018 and organized into a database of the SPSS Program, version 20.0. **Results:** it was found, regarding the sociodemographic profile, that the majority of users were female; single; with average age of 36 years; with incomplete elementary school; didn't work; I had no children; had caregiver / companion. Regarding the clinical profile, most of them were in semi-intensive treatment; had any psychiatric hospitalization; presented diagnosis of schizophrenia and depression. **Conclusion:** it was considered that knowing the profile of these users can help managers and teams of Mental Health in the planning of local policies and health actions at various levels of care by enabling the strengthening of intersectoral relationships, since Mental Health care should be co-responsible for the Health, Social Welfare, Justice and Education sectors. **Descriptors:** Mental Health; Epidemiology; Mental Disorders; Humanization of Assistance; Mental Health Services; Psychoanalysis.

RESUMO

Objetivo: caracterizar o perfil sociodemográfico e clínico dos pacientes atendidos em um Centro de Atenção Psicossocial. **Método:** trata-se de estudo quantitativo, transversal, descritivo e documental, com prontuários de usuários em um Centro de Atenção Psicossocial. Coletaram-se os dados em dezembro de 2017 e janeiro de 2018, organizando-os em um banco de dados do Programa SPSS, versão 20.0. **Resultados:** verificou-se, quanto ao perfil sociodemográfico, que a maioria dos usuários era do sexo feminino; solteira; com idade média de 36 anos; com Ensino Fundamental incompleto; não trabalhava; não tinha filhos; possuía cuidador/acompanhante. Observou-se, em relação ao perfil clínico, que a maioria esteve em tratamento semi-intensivo; teve alguma internação psiquiátrica; apresentou diagnóstico de esquizofrenia e depressão. **Conclusão:** considerou-se que conhecer o perfil desses usuários poderá auxiliar gestores e equipes de Saúde Mental no planejamento de políticas locais e de ações de saúde nos diversos níveis de atenção por possibilitar o fortalecimento das relações intersetoriais, visto que o cuidado em Saúde Mental deve ser de corresponsabilidade dos setores de Saúde, Assistência Social, Justiça e Educação. **Descritores:** Saúde Mental; Epidemiologia; Transtornos Mentais; Humanização da Assistência; Serviços de Saúde Mental; Psicanálise.

RESUMEN

Objetivo: caracterizar el perfil sociodemográfico y clínico de los pacientes tratados en un Centro de Atención Psicossocial. **Método:** este es un estudio cuantitativo, transversal, descriptivo y documental, con registros médicos de usuarios en un Centro de Atención Psicossocial. Los datos se recopilieron en diciembre de 2017 y enero de 2018, y se organizaron en una base de datos del Programa SPSS, versión 20.0. **Resultados:** se encontró en cuanto al perfil sociodemográfico, que la mayoría de los usuarios eran mujeres; solteros; con edad promedio de 36 años; con escuela primaria incompleta; no funcionó; no tenía hijos; tenía cuidador / acompañante. En cuanto al perfil clínico, la mayoría estuvo bajo tratamiento semi-intensivo; tuvo alguna hospitalización psiquiátrica; presentó diagnóstico de esquizofrenia y depresión. **Conclusión:** se consideró que conocer el perfil de estos usuarios puede ayudar a los gerentes y equipos de Salud Mental en la planificación de políticas locales y acciones de salud en los diversos niveles de atención al permitir el fortalecimiento de las relaciones intersectoriales, ya que la atención de Salud Mental debería ser corresponsable de los sectores de salud; asistencia social; justicia y educación. **Descriptores:** Salud Mental; Epidemiología Trastornos Mentales; Humanización de la Atención; Servicios de Salud Mental; Psicoanálisis.

^{1,2,3,4,5,6}Montes Claros State University / Unimontes. Montes Claros (MG), Brazil. ¹ <https://orcid.org/0000-0002-7922-7093> ² <https://orcid.org/0000-0002-1438-985X> ³ <https://orcid.org/0000-0003-1804-619X> ⁴ <https://orcid.org/0000-0002-8927-6163> ⁵ <https://orcid.org/0000-0001-9941-1114> ⁶ ORCID: <https://orcid.org/0000-0001-8101-1729>

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INTRODUCTION

Mental disorders stand out as a public health problem worldwide,¹ being able to affect the individual at any stage of their life, regardless of gender and social class.² It is a low mortality rate, however, they contribute to a large burden of disability, cause impairment of the perception of reality, difficulties in interpersonal and family relationships and in the performance of daily activities, such as attending school, work, and even self-care, such as food and personal hygiene.³

In Brazil, there is a scarcity of national epidemiological data on mental disorders.⁴ The population is estimated to have a prevalence of 3% of severe and persistent mental disorders and 6% of severe psychiatric disorders caused by alcohol or other drug use. Thus, they become fundamental investments for the prevention and promotion of Mental Health in order to reduce the disabilities and impairment resulting from these disorders.⁵

At the end of the 1970s, the Brazilian Psychiatric Reform (BPR) began, characterized by the restructuring of the health care model, being effected with the approval of Law No. 10,216 of 2001. The Psychosocial Care Centers (PSCC) were created in 2011 and the substitutive devices were expanded with Ordinance No. 3088, establishing the Psychosocial Care Network (PCN) for people with suffering or mental disorder and with needs arising from the use of crack, alcohol and other drugs.⁶

The PSCC are the main strategy of Mental Health policy to replace the asylum and hospital-centered model, redefining concepts about the treatment of mental health. By proposing treatment in freedom, the inclusion of users as active subjects in their treatment is promoted in a multidisciplinary proposal that considers the history, culture and daily life in the construction of a Singular Therapeutic Project.⁷

These services are currently the center of the organization of mental health care in Brazil, regarding crisis care to people with mental disorders and problems resulting from the use of alcohol and other drugs, should be analyzed and understood in its complexity and effectiveness.⁸

In this sense, it is necessary to carry out investigations to support the systematization of care to patients seen at Psychosocial Care Centers.

OBJECTIVE

- To characterize the sociodemographic and clinical profile of patients treated at a Psychosocial Care Center.

METHOD

This is a quantitative, cross-sectional, descriptive and documentary study at CAPS II, from the city of Montes Claros - Minas Gerais, Brazil, from 2002 to 2016, specifically in the management sector. It is noteworthy that this location is one of the components of the psychosocial care network specialized in Montes Claros and offers services such as specialized medical consultation and with a general practitioner, consultation and performance of nursing procedures, psychological support, accompaniment with social worker, recreational activities and therapeutic workshops, family-oriented care, home visits, discussion groups and user assemblies, and intersectoral and territorial social reintegration actions for people with severe mental disorders. It is intended for crisis situations and high social and clinical vulnerability.

The universe of this study included medical records of patients who were admitted to CAPS II, distributed annually from 2002 to 2016: 2002-107; 2003-252; 2004-154; 2005-115; 2006-46; 2007-85; 2008-94; 2009-142; 2010-119; 2011-91; 2012-84; 2013-166; 2014-133; 2015-179; 2016-151, with a total of 1918 patients.

Subsequently, a sample was determined by probabilistic and stratified calculation. Thus, the number of medical records per year that would be used by lot was defined, namely: 2002-21; 2003-49; 2004-30; 2005-22; 2006-9; 2007-16; 2008-18; 2009-27; 2010-23; 2011-18; 2012-16; 2013-32; 2014-26; 2015-35; 2016-29, resulting in 370 medical records.

A data collection worksheet was used to guide the collection, prepared by the researchers, with sociodemographic variables: age; sex; marital status; schooling; occupation; presence of children and caregiver. It is revealed that the clinical variables were: initiation of treatment; source of referral; treatment modality; previous psychiatric hospitalization; diagnosis according to ICD-10; medication class; clinical comorbidities; smoking; alcoholism and illicit drugs.

A pre-test was performed to check for failures that could negatively interfere with data collection and the final results of this investigation. To this end, one randomly chose medical records from patients outside the study period and were not part of the final research.

Data was collected in December 2017 and January 2018 by one of the researchers. In the treatment of the data, double typing was performed in the software Statistical Package for Social Science (SPSS), version 20.0, and after verification of consistency, the data were analyzed by descriptive statistics (simple and percentage frequencies).

Through this study, the ethical aspects of Resolution 466/2012 were respected, with the approval of the Research Ethics Committee of the State University of Montes Claros, under the Consubstantiated Opinion No. 2,184,856 and Protocol CAAE- 71723417.5 .0000.5146.

RESULTS

It was found that the sociodemographic characteristics of the clients attended at CAPS II of Montes Claros - MG were as follows: female gender, 197 (53.2%); single, 218 (58.9%); age between 18 and 76 years old, average of 36 years old; incomplete Elementary School, 153 (41.4%); did not work 283 (76.5%); had no children, 211 (57%) and 300 (81.1%) had a caregiver. (Table 1).

Table 1. Sociodemographic characteristics of clients served at CAPS II of Montes Claros, MG, 2002 to 2016. (n=370)

Variables	n	%
Sex		
Male	173	46.8
Female	197	53.2
Marital status		
Single	218	58.9
Married	109	29.5
Divorced	27	7.3
Widow	11	3.0
Without information	5	1.4
Education		
Illiterate	26	7.0
Incomplete Elementary School	153	41.4
Complete Elementary School	30	8.1
Incomplete Highschool	36	9.7
Complete Highschool	74	20.0
Higher Education	16	4.3
Without information	35	9.5
Occupation		
Does not work	283	76.5
Works	71	19.2
Student	12	3.2
Without information	4	1.1
Children		
No	211	57.0
Yes	153	41.4
Without information	6	1.6
Caregiver/Companion		
No	70	18.9
Yes	300	81.1

It is noteworthy that the clinical characteristics of the clients served were as follows: origin of referral for spontaneous demand, 217 (58.6%); “semi-intensive” treatment modality, 205 (55.4%); psychiatric hospitalization, 193 (52.2%), in hospitals located in Montes Claros, 104 (28.1%); had a diagnosis of “schizophrenia”, 187 (50.5%), followed by 57 (15.4%) of “depression” most used

antipsychotics, 326 (88.1%) and anxiolytics, 199 (53.8%); some users were using antihypertensive drugs, 32 (8.6%); the age of beginning psychiatric treatment was between 15 and 29 years, 146 (39.4%); followed by 93 (25.1%) between 30 and 44 years old, average of 30.82 years and minimum and maximum variation between four and 74 years (Table 2).

Table 2. Clinical Characteristics of the clients attended at CAPS II. Montes Claros, MG, 2002 to 2016. (n=370)

Variables	n	%
Origine of referral		
Spontaneous demand	217	58.6
SAMU	34	9.2
Psychiatry Outpatient Clinic	27	7.3
Hospital	26	7.0
Family Health Strategy	12	3.2
Emergency Room	3	0.8
Others	51	13.8
Treatment Mode		
Non Intensive	68	18.4
Semi-intensive	205	55.4
Intensive	95	25.7
Without information	2	0.5
Previous psychiatric hospitalization		
No	177	47.8
Yes	193	52.2
Prontomente (Psychiatric Hospital)	104	28.1
Clemente de Faria University Hospital (General Hospital)	38	10.3
Psychiatric inpatient units in other cities (Psychiatric Hospital)	41	11.1
Mental disorders		
Schizophrenia	187	50.5
Depression	57	15.4
Stress and Somatoform	55	14.9
Neurotic Disorders		
Schizothymic Disorders and Delusional Disorders	41	11.1
Bipolar affective disorder	40	10.8
Mental retardation	20	5.4
Organic Mental and Behavioral Disorders	19	5.1
Psychotropic medications		
Antipsychotics	326	88.1
Anxiolytic	199	53.8
Antiparkinsonians	129	34.9
Mood stabilizers	115	31.1
Antidepressants	101	27.3
Other medications		
Anti-hipertensive	32	8.6
Anticonvulsants	18	4.9
Hypoglycemic drugs	12	3.2
Others	43	11.6
Age at start of treatment		
0 to 14	17	4.5
15 to 29	146	39.4
30 to 44	93	25.1
45 to 59	37	10
>=60	10	2.7
Without information	67	18.1

Table 3 refers to the comorbidities of the clients attended at CAPS II of Montes Claros-MG. It was identified that there were 54 (14.5%)

hypertensive patients, 67 (18.1%) smokers and 53 (14.3%) alcoholics.

Table 3. Comorbidities of clients served at CAPS II. Montes Claros-MG, MG, 2002 to 2016. (n=370)

Variables	n	%
Hipertension	54	14.6
Diabetes	19	5.1
Epilepsy	12	3.2
Cardiovascular Diseases	11	3.0
Smoking	67	18.1
Drinking	53	14.3
Other drugs	29	7.8

DISCUSSION

In this study, it was found that most users were female. It is evident that these results were similar to those obtained in other investigations, which aimed to characterize the profile of PSCC users.^{2,9-13} However, it was identified, in some studies, that most were male, despite the slight variation between genders.^{14,15}

Mental disorders are associated with different biopsychosocial aspects between men and women. It is noteworthy that the higher prevalence in females may be related to women's vulnerability to hormonal, social and psychological factors, the ease of identifying and admitting psychological distress and seeking help from specialized treatment services.^{2,16-17}

Regarding marital status, it was observed that most users in this study were single, similar to other investigations,^{2,11,13,18} however, in PSCCBarbacena-MG and PSCC II of Candeias-BA, there was a prevalence of married or in a stable union.^{12,15}

It is evident that marital status related to mental disorders is a controversial subject in the literature, because while some studies found an association, others did not. However, it can be seen that the psychiatric / psychological state can negatively influence the social and marital life of the individuals affected.^{17,19-20}

Regarding age, we found that, in this study, users were between 18 and 76 years old, with an average of 36 years. It is warned that there is no consensus in the literature about age, because in PSCC I, Orleans-SC and PSCC III, Campinas-SP, the average age was 42 years; in PSCC II of Passos-MG, most were between 49 and 79 years old; In the city of Candeias-BA, the average age was between 30 and 39 years old; in western Rio Grande do Sul, most were between 18 and 29 years old.^{10-12,14,21}

The person is subjected, in adulthood, to various stresses, which can cause anxiety, anguish and fear that can trigger mental disorders in individuals.^{11,22} It is noticed that mental disorder occurs mainly in the productive age, when the individual seeks insertion in the labor market or the formation of a family, making it difficult to perform social roles.¹⁸

As for education, most users had incomplete elementary school and did not work. Some were unemployed, retired or on leave by the National Institute of Social Security (INSS), according to data released in other studies,^{11,13,14,18} However, research conducted at CAPS II of Candeias-BA showed that the Most of the surveyed users had completed Highschool.¹²

It is noteworthy that most users had a low level of education and, consequently, difficulty entering the job market. It is inferred that, due to their low level of education, unfavorable professional

education and socioeconomic dependence, users are harmed in the competition for the labor market. This causes considerable impact on individuals and their families. The devaluation of the user in relation to his productive capacity can cause suffering due to obstacles to develop work and leisure activities.^{2,14}

Moving away from the treatment of mental disorders also contributes to the interruption of studies, that undermine the insertion of these individuals in the labor market and the maintenance of the employment relationship.^{2,14} In addition, it is the life trajectory of some users of mental health services in the exit from the labor market and the impossibility of return. It is clear that the lack of attention to social needs and basic functioning can corroborate a poor quality of life among people with severe mental disorders.^{2,14}

It was evidenced that, in this study, 57% of users had no children, contradictory findings to those found in other studies, in which the majority had children;^{11,23} However, investigations do not show the correlation between having or not having children and the occurrence of mental disorders, as mental disorders can affect all family members, including children.^{11,23}

In relation to the caregiver / caregiver variable, most of them had caregiver / caregiver, and among them, they are family and friends, similar to what was shown in a study conducted in Iguatu-CE, showing that the family was the primary responsible for accompanying the user to the Mental Health service.¹⁹ It is believed that family and friends are primarily responsible for monitoring and caring for users, which demonstrates the importance of family insertion in coping with psychological distress. Family members often assume responsibility for overseeing, encouraging and performing actions that the user cannot do alone.^{17,19,24}

It is noteworthy, in relation to referral, that most clients sought the service by spontaneous demand; This is similar to findings in other studies.¹⁴ On the other hand, it was found in Campinas, in PSCC III, that the health centers were the main responsible for the referrals.^{25,26}

Upon receiving more users referred by spontaneous demand, it is verified that there is a disarticulation of the health care network, assuming that the health units are inarticulate with the CAPS, maladjusting the functioning of the referral and counter-referral system.²⁷

Referral and counter-reference are considered to be some of the essential elements for the effective reorganization of work practices in order to promote the integration of health systems and networks. However, there are still many difficulties for health services to adhere to this practice.²⁸

It was found, in this study, that the most frequent treatment modality was “semi-intensive”; according to other studies;^{10,13} however, in CAPS II, in the municipality of Passos-MG, the majority was the “non-intensive” treatment modality.¹¹ According to the Ministry of Health, 9% need occasional semi-intensive care, and 3% of the Brazilian population needs intensive mental health care.^{10,29}

It is evident that 52.2% of the users had some psychiatric hospitalization; 28.1% were hospitalized at the Psychiatric Hospital of the moment in Montes Claros, and 11.1% were hospitalized at Psychiatric Inpatient Units of psychiatric hospitals in other cities. It has also been shown in other studies that most users have ever been admitted to a psychiatric hospital. Poor adherence to psychotropic drugs in Mental Health treatment revealed positive association with the need for readmissions and worsening of symptomatology.^{2,11,14}

In this study and in the aforementioned, the prevalence of hospitalizations in psychiatric hospitals is observed, however, data from this study were lower than in others. It is advocated, by the Mental Health public policy in force in Brazil, that the treatment of the Mental Health client should occur in territorialized devices, which work in articulated network.^{10,29} Psychiatric hospitalization rate indicators allow the evaluation of the functioning of the Mental Health service network, in its hospital, extra-hospital and social dimensions.¹⁰

It is considered that what may predispose to hospitalization in psychiatric hospitals is the lack of follow-up after hospital discharge, lack of guidance on mental disorder and medication use, the deficiency of substitute services to hospitals, which are still insufficient and have difficulties in ensuring continuity of treatment in an out-of-hospital manner.²

In relation to mental disorders, most users were diagnosed with schizophrenia followed by depression. These data resemble those of other investigations.¹⁴

On the other hand, it was analyzed that a study conducted at PSCC of Osório-RS showed that the most significant diagnostic hypothesis was depression; In the PSCC of Curitiba-PR, bipolar affective disorder, schizophrenia and depression were prevalent, respectively; In a PSCC II in the western region of Rio Grande do Sul, most users had moderate mental retardation and the second highest prevalence was schizophrenia.^{2,11-13,21}

It is emphasized that schizophrenia, depressive disorders and mental retardation are the most common diagnoses and cause disabilities, impairing the functionality and quality of life of individuals with mental disorders.³⁰ There are several aspects of symptomatology that cause

social or occupational dysfunction and are characterized by changes in thinking, sense-perception, loss of contact with reality and mood disturbances. In addition, the triggers of these mental disorders are not yet fully explained.³⁰

It is highlighted, in relation to depression, that there are symptoms such as hypotymia or depressive mood, anhedonia, low self-esteem, feelings of self-disapproval and thoughts of death, and their prevalence is estimated at 3 to 11% in the general population, more frequently among women, young people, people with low education and socioeconomic status, unemployed, single or divorced, as found in this study.^{2,10}

It is emphasized, as to the use of psychotropic drugs, that most used antipsychotics, followed by anxiolytics. The use of these drugs can be associated with the prevalent diagnoses in this study, schizophrenia and depression. These data resemble those of other research.^{2,11,13,14}

However, different data were obtained from a study conducted in a PSCC II of the city of Candeias-BA, showing that most of them used anticonvulsants and antidepressants.¹²

It should be borne in mind that seeking immediate relief from suffering and seeking medication as support is not always the best option for mental disorders in general. In addition to drug therapy, PSCC should offer other means of intervention in mental health, such as welcoming, therapeutic workshops, community and sociotherapeutic activities, home visits and family care, focusing on the client's integration with their social environment.^{2,10,12,17}

It was found that the age of the beginning of psychiatric treatment occurred in this study, around 30.82 years. This variable can be related to the age of onset of mental disorder, which is usually when the user seeks treatment to alleviate their suffering. In relation to the most frequent mental disorder in this study, schizophrenia, which typically occurs between late adolescence and mid-30s, may also begin late, but may later start later than 45 years; whereas depressive disorders manifest between 20 and 40 years. This information partially resembles the age at the beginning of this study.¹⁰⁻¹¹

In this study, it was found that, in relation to comorbidities, 14.5% of users were hypertensive; 18.1% were smokers and 14.3% were alcoholics. This is confirmed by the fact that 8.6% of users were on antihypertensive drugs. Other studies also showed the prevalence of hypertension, smoking, alcoholism and the use of antihypertensive drugs;^{2,9} in PSCC II of Passos-MG, it identified the prevalence of cardiovascular problems.¹¹

It is understood that psychosocial factors, depression and social situation are factors that do not act directly on heart disease, but may interfere in the behavior of individuals, such as

smoking, alcohol consumption and modification of physical activities, which may compromise cardiovascular health. Hypertension is a risk factor for the development of cardiovascular, cerebrovascular and renal problems, accounting for at least 40% of deaths from stroke and 25% of deaths from coronary artery disease. However, it should be warned that patients with mental disorders with clinical comorbidities often have their complaints underestimated by health professionals, with negligence of the clinical aspects of individuals.^{2,9,11}

In this study, smoking among individuals with mental disorders was lower compared to other studies. It should be noted that the use of this substance may be higher than evidenced by epidemiological studies, as it is little identified in clinical practice. It is estimated that 90% of people with schizophrenia are smokers, and more difficult to quit, as well as people with depressive disorders and anxiety. Nicotine can compromise drug therapy, exacerbate the symptoms of the disorder and predispose to increased seizures, as well as vulnerability to respiratory and cardiovascular disease.^{2,9}

The use of psychoactive substances by patients with mental disorders is sometimes intended to attenuate the signs and symptoms of the disease or the side effects of medications. It is warned, however, that it may worsen the prognosis, intensify the symptoms, increase the chances of relapse, hospitalizations and high risk of suicide. It is noteworthy in this study that the use of alcohol and other drugs was also lower compared to other studies.^{2,8,9}

Limitations are presented by this investigation, because it is a documentary study, secondary source of data, such as the lack of information in some medical records and because they are handwritten notes that, at times, made it difficult to understand the notes, however, This study has a sufficient sample to describe the sociodemographic and clinical profile of clients with mental disorders in the study scenario.

CONCLUSION

Through this investigation, the sociodemographic and clinical profile of clients treated at PSCC II of Montes Claros was characterized. Knowing the profile of these users can help managers and the Mental Health team in planning local policies and health actions at various levels of care by enabling the strengthening of intersectoral relationships, since health care Mentality must be co-responsible for the Health, Social Welfare, Justice and Education sectors.

It is recommended to complete the medical records and admission forms of clients in the Mental Health service of the scenario of this study,

so that investigations can be carried out without compromise due to the lack of important information, as well as providing continuity of care.

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Corresponding author

Carolina Amaral Oliveira Rodrigues

E-mail: carol_oliveira13@hotmail.com

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