SOCIODEMOGRAPHIC AND CLINICAL PROFILE OF PATIENTS TREATED AT THE PSYCHIATRIC UNIT OF A GENERAL HOSPITAL*

Thaise Liara da Silva[1], Mariluci Alves Maftum[2], Luciana Puchalski Kalinke[3], Thais Aidar de Freitas Mathias[4], Aline Cristina Zerwes Ferreira[5], Fernanda Carolina Capistrano[6]

[1]RN. M.Sc. in Nursing. Nurse at Instituto Federal Goiano. Morrinhos-GO-Brazil.
[2]RN. Ph.D. in Nursing. Faculty at Universidade Federal do Paraná. Curitiba-PR- Brazil.
[3]RN. Ph.D. in Health Sciences. Faculty at Universidade Federal do Paraná. Curitiba-PR- Brazil.
[4]RN. Ph.D. in Public Health. Faculty at Universidade Estadual de Maringá. Maringá-PR- Brazil.
[5]RN. Master's student in Nursing. Universidade Federal do Paraná. Curitiba-PR- Brazil.
[6]RN. Ph.D. student in Nursing. Universidade Federal do Paraná. Curitiba-PR- Brazil.

ABSTRACT: Descriptive and cross-sectional research undertaken at a Psychiatric Unit of a general hospital in Guarapuava, Paraná, to characterize the sociodemographic and clinical profile of patients with mental disorders being treated at a psychiatric ward of a general hospital. The research participants were 240 patients hospitalized in the first semester of 2011. The data were analyzed using frequencies and percentages and displayed in tables. The results indicate a profile of white, single people of productive age, with low education levels and at least one child. The prevalent period for the development of the mental disorders was more than 20 years earlier, starting in adolescence. The diagnosis of mental and behavioral disorders due to psychoactive substance use stood out. In conclusion, knowing the patients' sociodemographic and clinical profile permits the development of health actions and the strengthening of multiprofessional and intersectoral relationships.
DESCRIPTORS: Nursing; Mental health; Health profile; Mental health services.

PERFIL SOCIODEMOGRÁFICO E CLÍNICO DOS PACIENTES EM TRATAMENTO NA UNIDADE PSIQUIÁTRICA DE UM HOSPITAL GERAL

RESUMO: Pesquisa descritiva transversal realizada em uma Unidade Psiquiátrica de um hospital geral de Guarapuava, Paraná, com o objetivo de caracterizar o perfil sociodemográfico e clínico dos pacientes com transtorno mental, em tratamento em unidade de internação psiquiátrica de um hospital geral. Participaram da pesquisa 240 pacientes internados no primeiro semestre de 2011. Os dados foram analisados por frequências e percentuais e mostrados em tabelas. Os resultados apontam para um perfil de pessoas brancas, solteiras, em idade produtiva, com baixa escolaridade, com pelo menos um filho. Evidenciou-se prevalência do desenvolvimento dos transtornos mentais por mais de 20 anos, com início na adolescência, com destaque para o diagnóstico de transtornos mentais e comportamentais devidos ao uso substâncias psicoativas. Conclui-se que conhecer o perfil sociodemográfico e clínico dos pacientes possibilita o desenvolvimento de ações de saúde e o fortalecimento de relações multiprofissionais e intersetoriais.
DESCRITORES: Enfermagem; Saúde mental; Perfil de saúde; Serviços de saúde mental.

PERFIL SOCIODEMOGRÁFICO Y CLÍNICO DE LOS PACIENTES EN TRATAMIENTO EN LA UNIDAD PSIQUIÁTRICA DE UN HOSPITAL GENERAL

RESUMEN: Investigación descriptiva transversal realizada en una Unidad Psiquiátrica de un hospital general de Guarapuava, Paraná, con la finalidad de caracterizar el perfil sociodemográfico y clínico de los pacientes con trastorno mental, en tratamiento en unidad de internación psiquiátrica de un hospital general. Participaron de la investigación 240 pacientes internados en el primer semestre de 2011. Los datos fueron analizados por frecuencias y percentuales y organizados en tablas. Los resultados apuntan para un perfil de personas blancas, solteras, en edad productiva, con baja escolaridad, con por lo menos un hijo. Se evidenció prevalencia del desarrollo de los trastornos mentales por más de 20 años, con inicio en la adolescencia, destacándose el diagnóstico de trastornos mentales y comportamentales advenidos del uso de substancias psicoativas. Se concluye que conocer el perfil sociodemográfico y clínico de los pacientes posibilita el desarrollo de acciones de salud y el fortalecimiento de relaciones multiprofesionales e intersectoriales.
DESCRIPTORES: Enfermería; Salud mental; Perfil de salud; Servicios de salud mental.

Corresponding author:
Mariluci Alves Maftum
Universidade Federal do Paraná
Rua Lothário Meissner, 632 - 80210-170 – Curitiba-PR-Brasil
E-mail: maftum@ufpr.br

INTRODUCTION

Mental disorders figure among the most prevalent conditions and can affect individuals of any social class and in any phase of life. Epidemiological data from the World Health Organization show that approximately 650 million people around the world suffer from some kind of mental disorder, causing great individual, family and social suffering[1].

It is estimated that more than 10% of the global disease burden, measured in terms of disability-adjusted life years, can be attributed to mental disorders. When considering the disability factor, these disorders are responsible, around the world, for 25% of the sum of years lived with disability[1]. These data characterize the mental disorder as an important contributing factor to morbidity and premature mortality.

In Brazil, the Ministry of Health informs that about 3% of the general population suffers from severe and persistent mental disorders, 6% presents psychiatric disorders due to alcohol and drugs use and 12% requires continuing or occasional mental health care[2]. To attend to the growing demand, the Psychosocial Care Network (RAPS) was established in the Unified Health System, which prioritizes community-based services to reinsert the patients in society and rescue their citizenship. Therefore, articulation and integration among the different care points are recommended, such as Primary Health Care Services, Psychosocial Care Centers, Urgency and Emergency Services and Psychiatric Services in General Hospitals (UPHG)[3].

When the resources available in the community services are insufficient to effectively attend to the mental patients, hospitalization becomes necessary. In these cases, care in UPHG is prioritized, which are psychiatric wards located within the structure of a general hospital[4]. The General Hospitals are fundamental in the articulation between the primary and emergency mental health care services and their function is to offer care in cases of psychiatric emergencies, commonly characterized by crises or acute psychic symptoms(5-6). This increases the opportunity of integration between psychiatry and health care in general, avoiding the stigmatization of the mental illness and, consequently, the individual's social exclusion[6].

Although the mental health policies recommend psychiatric emergency hospitalization at these services, they are still being implemented, in view of the great delay in the number of UPHG all over Brazil. Particularly in Paraná, among the 3,316 psychiatric beds in the state, only 253 (7.62%) are located in General Hospitals[7].

Thus, the UPHG are considered relatively recent services in the RAPS and are currently expanding across the Brazilian territory. Against this background, added to the lack of research at these services, the importance of knowing the sociodemographic and clinical profile of the patients forwarded to the UPHG is highlighted with a view to permitting reflections on the planning and organization of these health services and of public policies , as well as to offer the health professionals support for the implementation of care that is more in accordance with these clients' reality.

Based on the above, the objective in this study was to characterize the sociodemographic and clinical profile of the mental patients being treated at a psychiatric ward of a general hospital.

METHOD

Descriptive and cross-sectional study undertaken at two psychiatric hospitalization services of a General Hospital (UPHG) in Guarapuava, Paraná, offering 30 beds for male and 30 for female patients. This is the only city in the 5th Regional Health District of the State of Paraná to offer psychiatric hospitalization, attending to 20 cities, besides other demands in the state.

The sample consisted of patients hospitalized at the UPHG between January 1st and June 30th 2011. Among the 461 patients hospitalized in that period, 240 complied with the inclusion criteria: being over 18 years of age, able to communicate verbally, able to understand the interview and to answer the questions and expecting to conclude the treatment with programmed medical discharge.

In addition, 221 patients were excluded: three because they were under age, three were indigenous, 13 were not communicative, 31 were unable to understand the interview and answer the questions, 49 refused to participate in the study after being contacted three

consecutive times and at distinct moments, 66 had not finished the treatment and 56 were discharged without programming, which made it impossible for the researcher to contact them. The indigenous population was excluded because this is considered as a particular theme area, in accordance with CNS Resolution 466/12.

The data were collected at the UPHG between January and June 2011, from Mondays to Saturdays, during the day, in line with the ward coordinator's recommendation. Therefore, the patient files were consulted and a structured interview was held with the participants during the hospitalization period.

The structured instrument contained questions to collect information on the sociodemographic characteristics: age, sex, city of residence, marital situation, race/ethnic origin, number of children, education, profession/occupation, income; and clinical characteristics: age of onset of mental disorder, first psychiatric diagnosis, current psychiatric diagnosis, length of diagnosis, use of psychoactive substances, clinical comorbidity and medication treatment.

Authorization for the research was obtained from the institution and approval from the Research Ethics Committee at Universidade Federal do Paraná under No. 1016.141.10.09.

The data were stored in a Google Docs® form and forwarded to an electronic database. The results were analyzed using the software Statistica® and presented as frequencies or percentages, means, medians, minima and maxima.

RESULTS

The age of the 240 participants – 84 women and 156 men – ranged from 18 to 80 years. The predominant age group was between 30 and 49 years old (n=137), mean 41.5 years, standard deviation ±12.8 and median 41. In addition, 49.6% of the participants (n=119) declared they were white and 72.1% (n=173) lived in the urban region. The interviewees' prevalent marital status was single (42.9%, n=103) and 66.3% (n=159) indicated having at least one child (Table 1).

The participants' predominant education level, according to Table 2, was unfinished primary education (52.5%, n=126), with 77.1% having dropped out of school (n=185), mainly for social reasons. Only 41.7% (n=100) of the participants remained active in the job market.

Table 3 shows that the mean age of onset of the mental disorder ranged between one and 78 years, with a mean age of 26.4 years, standard deviation ±13.1 and median 23. As regards the abuse of legal substances, 79.5% (n=224) of the participants affirmed this. The clinical comorbidities added up to 50.8% (n=131) with at least one comorbidity. These were higher among the men than the women, with Systemic Arterial Hypertension (12.1%) as the most mentioned comorbidity.

Table 1 – Distribution of interviewees according to sex and sociodemographic variables. Guarapuava-PR, 2011.

Sex / Variables	Female		Male		Total	
	N(84)	%	N(156)	%	N(240)	%
Age						
18 – 29 years	14	16,7	31	19,9	45	18,8
30 – 39 years	22	26,2	40	25,6	62	25,8
40 – 49 years	27	32,1	48	30,8	75	31,2
50 – 59 years	16	19	19	12,2	35	14,6
60 years or older	5	6	18	11,5	23	9,6
Region of residence						
Rural area	23	27,4	44	28,2	67	27,9
Urban area	61	72,6	112	71,8	173	72,1
Marital situation						
Fixedpartner/Married	28	33,4	53	34	81	33,7
Separated	16	19	25	16	41	17,1
Single	32	38,1	71	45,5	103	42,9
Widowed	8	9,5	7	4,5	15	6,3
Children						
Yes	63	75	96	61,5	159	66,3
No	21	25	60	38,5	81	33,7
Total	84	100	156	100	240	100

Table 2 – Distribution of interviewees according to sex, education, occupation and income. Guarapuava-PR, 2011.

Sex / Variables	Female		Male		Total	
	N(84)	%	N(156)	%	N(240)	%
Education						
Illiterate	9	10,7	16	10,3	25	10,4
Unfinished Primary Education	46	54,8	80	51,3	126	52,5
Primary Education	8	9,5	18	11,5	26	10,8
Unfinished Secondary Education	12	14,3	13	8,3	25	10,4
Secondary Education	6	7,1	22	14,1	28	11,7
Unfinished Higher Education	1	1,2	4	2,6	5	2,1
Higher Education	2	2,4	3	1,9	5	2,1
Professional Activity						
Active	53	63,1	47	30,1	100	41,7
On leave/Non-active	30	35,7	92	59	122	50,8
Retired	1	1,2	17	10,9	18	7,5
Personal Income Source						
Retirement	1	1,2	16	10,3	17	7,1
Benefit	44	52,8	32	20,5	76	31,7
Fixed Employment	5	6	15	9,6	20	8,3
None	26	30,4	42	26,9	68	28,3
Self-Employed	8	9,6	51	32,7	59	24,6
Total	84	100	156	100	240	100

Table 3 – Distribution of interviewees according to sex, mental disorder, medication, clinical comorbidities and psychoactive substance. Guarapuava-PR, 2011.

Sex / Variables	Female N(84)	%	Male N(156)	%	Total N(240)	%
Age of onset of Mental disorder						
0 – 10	6	7,2	3	1,9	9	3,8
10 – 19	22	26,2	82	52,6	104	43,3
20 – 29	17	20,2	22	14,1	39	16,3
30 – 39	20	23,8	18	11,5	38	15,8
40 – 49	10	11,9	20	12,8	30	12,5
50 or older	6	7,1	9	5,8	15	6,3
Does not know	3	3,6	2	1,3	5	2,0
First diagnosis						
F10 – F19	14	16,7	92	59	106	44,2
F20 – F29	16	19	30	19,2	46	19,2
F30 – F39	41	48,8	23	14,7	64	26,6
Others	13	15,5	11	7,1	24	10
Current diagnosis *						
F10 – F19	15	17,9	99	63,5	114	47,5
F20 – F29	50	59,4	49	31,4	99	41,3
F30 – F39	15	17,9	5	3,2	20	8,3
Others	2	2,4	2	1,3	4	1,6
No diagnosis	2	2,4	1	0,6	3	1,3
Psychoactive substance use**	N(52)	%	N(229)	%	N(281)	%
Alcohol and Tobacco	43	82,7	181	79	224	79,7
Marihuana	4	7,8	10	4,4	14	5
Marihuana and Crack	1	1,9	7	3,2	8	2,8
Marihuana, Crack and Cocaine	1	1,9	6	2,6	7	2,5
Crack	1	1,9	6	2,6	7	2,5
Cocaine, Solvent, Crack and Marihuana	1	1,9	5	2,2	6	2,1
Ecstasy, LSD, Cocaine, Solvent, Crack and Marihuana	-	-	5	2,2	5	1,8
Marihuana and Cocaine	-	-	4	1,7	4	1,4
Cocaine	-	-	4	1,7	4	1,4
Solvent, Crack and Marihuana	1	1,9	1	0,4	2	0,8
Length of diagnosis	N(84)	%	N(156)	%	N(240)	%
1st diagnosis	12	14,3	20	12,8	32	13,3
1 – 5 years	14	16,7	28	17,9	42	17,5
6 – 10 years	12	14,3	24	15,4	36	15
11 – 20 years	14	16,7	33	21,2	47	19,6
20 years or older	29	34,5	49	31,4	78	32,5
Not informed	3	3,6	2	1,3	5	2,1
Medication treatment						
Yes	53	63,1	78	50	131	55,6
No	31	36,9	78	50	109	45,4
Clinical comorbidities						
Yes	51	60,7	71	45,5	122	50,8
No	33	39,3	85	54,5	118	49,2

* F10 – F19: mental and behavioral disorders due to psychoactive substance use; F20-F29: Schizophrenia, schizotypal disorders and delusional disorders; F30-F39: Mood (affective) disorders.**The use of more than one psychoactive substance per participant was considered.

DISCUSSION

In general, the profile of the patients interviewed in this research is similar to that found in another study at a psychiatric emergency service of a general university hospital, located in the city of Sobral, Ceará, based on information from the histories of 191 patients[5].

Concerning the age range, the majority were adults, that is, in the longest phase of life, when personal accomplishments like marriage, child education and professional activities are supposed to reach their height and are intensely valued; the presence of mental disorders in this age range, however, often negatively influences the way of life, as it interrupts the patients' productivity due to their chronic nature[5,8].

A study[9] on the sociodemographic and clinical profile of psychiatric interns in the city of Fortaleza, Ceará, showed 37.3 years as the mean age when treatment is sought, similar to this study. This fact should be a source of concern in view of its consequences.

Concerning the distribution of the participants according to the place of residence, the majority lives in the urban region. In line with data from the Brazilian Institute of Geography and Statistics (IBGE), approximately 85% of the population in the State of Paraná lives in the urban region. In general, studies on mental disorders do not show any correlation between the prevalence of these disorders and the place of residence[10].

Most participants lived without a partner and were single. This information is confirmed in a study of patients treated at UPHG, demonstrating a prevalence of 74.8%[5].

Another relevant piece of information that appeared in this research is that the majority had children, comparable to another study of mental patients[11]. The literature review shows no correlations between having children or not and the occurrence of mental disorders though. It is important to highlight that mental disorders affect not only the patients, but all family members, particularly the children[12].

In case of mental disorders related to psychoactive substances, the affective bond between partners and children is considerably influenced. Similarly, the interpersonal relations are aggravated, mainly by the behavioral changes the psychoactive substance abuse causes and the social and legal problems this abuse can cause. Such situations can lead the stakeholders to despair, loss of physical contact and symptoms related to mood disorders, mainly depression[13].

The participants' predominant education level was unfinished primary education, corresponding to less than nine years of study in the Brazilian Education System[10]. The predominance of low education levels in the study population derives from the fact that most of the interviewees dropped out of school.

These data are similar to study results from different mental health services[14-15]. In a study developed at a CAPS ad in the State of Piauí, using the histories of 1043 patients, 40.1% had finished primary education[15]. In a study in Ribeirão Preto, São Paulo, involving 54 people with mental disorders, it was verified that 50% had only finished primary education, while 39.6% had finished secondary education and only 20.8% had graduated[14].

As regards the professional activities, most participants indicated being active in the job market, despite a relevant amount of people who had dropped out of their job. This characteristic may be related to the fact that, when considering the total number of mental patients, mainly related to drugs use, the participants may be exposed to different social losses related to the job market, which may have contributed to the dropout.

Nevertheless, based on the data, the patients' main income source is the Social Security Benefit, similar to other studies[16-17] of mental patients concerning formal employment and the receipt of retirement benefits.

In that sense, the social security costs of mental patients should be discussed, as well as these people's possible inclusion in the job market. At the IV National Mental Health Conference, the implementation of a productive inclusion policy in the formal job market was discussed, based on an integral and intersectoral approach, which means engaging the Secretaries of Health and Social Security in joint actions aimed at reducing the social security costs and guaranteeing the inclusion[18].

These patients' clinical profile highlights that the first diagnosis of mental disorder was reached during the adolescence, a period marked

by bodily changes, mainly related to sexual development, the consolidation of personality and social transformations, which comprise a moment of internal preparation for adult life. In this phase, an identity crisis may come about, which is considered normal but can interfere in the emergence of a mental disorder if not appropriately managed[8].

The mental and behavioral disorders due to the use of psychoactive substances are indicated as a source of concern in the Brazilian epidemiological context as experiments with these substances take place at an increasingly young age, making their use even more harmful in the biological and social sense, due to its relation with individual and collective risk behavior[19].

During the study period, for the male participants, the main diagnoses that led to the hospitalization were mental and behavioral disorders due to psychoactive substance use. Although the literature indicates increased consumption, in general, the greater use and its most significant consequences remain common in the male population. That is so because, traditionally, men feel immune to the different biological and mental diseases, which consequently decreases the adherence to prevention measures and search for primary services in this part of the population[20].

At the UPHG where the study was undertaken, patients with psychoactive substance use-related mental disorders are treated in the same environment as patients with psychotic and mood disorders, among others. It was evidenced that, besides the people being treated for addition, they consume some kind of legal psychoactive substance.

According to the II Household survey on psychotropic drug use in Brazil, when compared to women, men use more alcohol across the lifetime, a substance that also stood out in this study. Concerning tobacco, the same survey shows a slightly higher number of men than women[2].

The increasing availability of alcohol and drugs may be associated with the enhanced use of these substances among severe mental patients. In this case, it needs to be identified whether patients with other non-alcohol related disorders are addicted to or dependent on alcohol, thus identifying the comorbidity[21].

Among the female patients, the most prevalent diagnosis was schizophrenia, schizotypal and delusional disorders (F20 – F29), a fact that differs from the literature review, which indicates a higher prevalence of mood disorders (F30 –F39) among women, including depression and bipolar disorder[12].

Concerning the length of the diagnosis, the predominant length was 20 years or older. In this context, the literature highlights that mental disorders are the main source of disabilities and potential years of life lost because of their chronic nature[22].

Medication treatment was frequent, as most participants indicated using some psychotropic drug in the lifetime. Among the women, medication use was more frequent than among the men, with 63.1% and 50%, respectively.

The great use of psychotropic drugs can be justified by their use to control and reduce symptoms of mental disorders, mainly in those cases manifested through psychosis and depressed mood. Nevertheless, the medication treatment needs to be combined with non-medication treatments, including psychotherapy[11].

The fact that 45.4% of the participants answered that they had not used any psychotropic drug across the lifetime may be related to the large number of hospitalizations of psychoactive drug addicts. These people only benefit from medication in cases of intoxication and abstinence symptoms, but this generally takes place in the hospital context[23].

Concerning the clinical comorbidities, the fact that the interviewed men show a higher percentage of comorbidities than the women may also be related to the psychiatric diagnosis, as the use of psychoactive substances can contribute to the emergence of cardiovascular, lung and liver diseases[19].

An important association exists between mental disorders and clinical comorbidities. People with physical problems, such as cardiovascular and endocrine conditions, can develop depressive and anxious disorders, among others, showing the importance of the holistic approach in care delivery to these people[12].

The dualistic thinking disseminated in medicine directly influences the relation between mental disorders and clinical conditions, turning the recognition of clinical conditions in mental patients a difficult practice and vice-versa. In

that sense, these professionals need to recognize the existence of possible comorbidities to offer appropriate treatment to both conditions the mental patients experience.

FINAL CONSIDERATIONS

Based on the results, a profile can be designed that shows male patients of productive age, white, living in the urban region, single, with children and active in the job market. The education level is unfinished primary education, with a history of school dropout.

Links were observed between the participants' socioeconomic situation and mental disorder-related issues, with individual and collective losses. The low education was related to the disability the mental disorders provoke and to the use of psychoactive substances.

As regards the clinical profile, the mental disorders were manifested during adolescence and were related to drugs use, mainly among men, reflected in the current mental disorder diagnosis. Medication use was present in a significant part of the patients studied, as well as the development of clinical comorbidities.

What the work of the mental health nurse and multiprofessional team is concerned, knowing this profile helps to plan the mental health actions at the hospitalization institution as well as in the community through primary care. In addition, it can permit and strengthen the intersectoral relations, as the health, social service, justice and education sectors should be co-accountable for mental health care.

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