

Clinical stability, diagnosis and catchment area: the patients of a university-based psychiatric outpatient clinic

Estabilidade clínica, diagnóstico e território: os pacientes de um ambulatório psiquiátrico universitário

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ABSTRACT

Objective: This study aimed to characterize the patients assisted at the general outpatient clinic of the Psychiatry Institute of *Universidade Federal do Rio de Janeiro* (IPUB-UFRJ) and to assess these patients' clinical stability. **Methods:** This cross-sectional study collected information using a structured questionnaire filled in by the patient's physician. The questionnaire, specifically developed for this purpose, included sociodemographic data; the dwelling area; psychiatric diagnosis according to ICD-10; clinical stability assessment by means of five psychiatric instability criteria and the physician's global clinical impression over the six previous months. Clinical stability was defined as a negative answer to all five pre-defined instability criteria. **Results:** Overall, 1,447 questionnaires were filled in. The sample was composed of 824 (57%) women; with an average age of 49 years; 1,104 (76.3%) patients lived in the city of Rio de Janeiro and 343 (23.7%) lived outside the city; 983 (67.9%) patients had a severe mental disorder (SMD) diagnosis and 946 (65.3%) patients were considered stable. Statistically, the clinical stability by dwelling area did not differ. The most frequent clinical instability criterion was "exacerbation or emergence of acute manifestations of the disease". **Conclusion:** The major part of the patients displayed a SMD and was considered clinically stable.

Keywords

Severe mental disorders, mental health services, outcome study, outpatient care, psychiatry.

RESUMO

Objetivo: Este trabalho buscou caracterizar os pacientes atendidos no ambulatório geral do Instituto de Psiquiatria da Universidade Federal do Rio de Janeiro (IPUB-UFRJ) e avaliar sua estabilidade clínica. **Métodos:** Este estudo descritivo, transversal, coletou informações utilizando um questionário estruturado preenchido pelo médico assistente. O questionário, especificamente desenvolvido para esse propósito, continha dados sociodemográficos, área de moradia, diagnóstico psiquiátrico de acordo com a CID-10, avaliação da estabilidade clínica por meio de cinco critérios de instabilidade psiquiátrica e a impressão clínica global do médico, nos últimos seis meses. A estabilidade clínica foi definida como uma resposta negativa a todos os cinco critérios de instabilidade predefinidos. **Resultados:** No total, 1.447 questionários foram preenchidos. A amostra foi composta por 824 (57%) mulheres, com média de

Received in
7/2/2018
Approved in
7/28/2018

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DOI: 10.1590/0047-2085000000208

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Palavras-chave

Transtornos mentais graves, serviços de saúde mental, avaliação de resultados, assistência ambulatorial, psiquiatria.

idade de 49 anos; 1.104 (76,3%) pacientes residentes na cidade do Rio de Janeiro e 343 (23,7%) residentes fora da cidade; 983 (67,9%) pacientes com diagnóstico de transtorno mental grave (TMG) e 946 (65,3%) pacientes foram considerados estáveis. Estatisticamente, a estabilidade clínica por área de moradia não apresentou diferenças. O critério de instabilidade mais frequente foi “recrudescimento ou o surgimento de manifestações agudas da doença”. **Conclusão:** A maioria dos pacientes apresentava um TMG e foi considerada clinicamente estável.

INTRODUCTION

The idea of an outpatient clinic specialized in psychiatry in Brazil emerged with the implementation of the Mental Hygiene Welfare Policy in the 1920s, and it aimed to prevent mental disorders in the population. The policy, which had a hygienist and normalizing nature, was in force until the 1980s, when the Consulting Board of the Governmental Health Insurance Administration developed the Reorientation Plan for Psychiatric Care. This plan invested strongly in public assistance, reforming psychiatric hospitals and expanding the extramural network of outpatient clinics¹.

In the 1990s, within the scope of the Healthcare Reform, in which Brazil's National Healthcare System (SUS) was implemented, the Ministry of Health assumed, as its official policy, the project of the Brazilian Psychiatric Reform, considered a paradigmatic change in the model of care, as it introduced innovative forms of care organization and notions like network and territory². Thus, the National Mental Health Policy started to have, among its objectives, the full exercise of citizenship, and not only the control of symptoms. This policy recommends the substitution of the traditional model (medical- and hospital-centered) and the articulation of the care network, aiming at the individual's integrality. Within this logic, Primary Care became the preferred entrance door to the Healthcare System, which includes Mental Health³.

In the current context of changes guided by the Psychosocial Care Network⁴, the permanence and function of the psychiatry outpatient clinic, historically articulated to the psychiatric hospital, have been questioned. The main criticism focuses on: (1) the lack of articulation between mental health outpatient clinics and the services network of the SUS, especially Primary Care⁵; (2) the outpatient clinic's mode of functioning as “the expression of a model that emphasizes biological treatment to the detriment of the psychodynamic, phenomenological and psychosocial dimensions of psychopathologies”⁶; and (3) the possibility that it is a “facilitator of chronification processes”⁷.

Among the studies carried out at university-based outpatient clinics, we highlight the pioneering work developed by Campos and Fortes⁸ at *Universidade Federal do Rio de Janeiro*. The authors described the patients of the Medical Psychology and Mental Health Service outpatient clinic of *Hospital Universitário Clementino Fraga Filho* (HUCFF), by sampling the patients' medical records, in 1989.

Other works conducted in university services aimed to characterize their patients through sociodemographic data. Louzada⁹ identified the patients of the Psychology Nucleus of *Universidade Federal do Espírito Santo* in 1996 by means of a chart-review. Santos *et al.*¹⁰ characterized the patients of the Clinic School of *Universidade de São Paulo* in 1987 and 1988. Oliveira *et al.*¹¹ carried out a retrospective study at the Student Psychological Care Service (SAPPE) of *Universidade Estadual de Campinas* (Unicamp), which included profile characterization and a survey of the complaints of the students who visited the service from 1987 to 2004. Padilha *et al.*¹² characterized the patients assisted at the psychiatric emergency service of Unicamp's *Hospital das Clínicas* between May 2010 and May 2011.

The number of studies in this field has been increasing and they provide important contributions to the improvement in the services in the Mental Health area. However, research on the sociodemographic characterization and clinical stability assessment of the patients of university-based psychiatry outpatient clinics, as well as their articulation to the Public Policies established by the SUS (for example, catchment area and deinstitutionalization), are scarce in the specialized literature.

Instability in patients with severe mental disorders (SMD) is associated with clinical deterioration after each relapse. It is a stress factor to both the patient and his family and it has serious repercussions on his quality of life¹³⁻¹⁵. Olivares *et al.*¹⁵ carried out a systematic review in which they evaluated numerous clinical studies, investigating the clinical stability of patients with SMD. As a result of this review, the authors hierarchized the most frequently used indicators in the literature as stability predictors and factors associated with relapse in patients with schizophrenia. Among the most frequently found components to define relapse, the following ones were cited: (1) occurrence of hospitalization; (2) symptom exacerbation or reemergence; (3) damage to oneself or violent behavior; (4) suicidal or homicidal ideation; (5) imprisonment; (6) changes in medication or patient management; (7) use of substances, among others. Among numerous references to relapse factors, non-adherence to antipsychotic medication¹⁶ was one of the most frequently reported factors.

Based on the premise that patients assisted at the general outpatient clinic of IPUB are under long-term follow-up, have SMD and are in a condition of clinical stability, the present

study hypothesizes that patients who are viewed as having severe illness can be followed up and stabilized at psychiatry outpatient clinics. The main objective is to characterize the patients and to assess their clinical stability.

METHODS

Design

This study is oriented by the quantitative research perspective and has a descriptive cross-sectional design. It was carried out during three consecutive months in 2015, based on the research "The general psychiatric outpatient clinic of IPUB and the proposal for the Exit Door: a sociodemographic assessment of the patients", approved by Institutional Review Board at our institution, and informed consent was waived in this retrospective study.

Study's location

The city of Rio de Janeiro has the second highest Human Development Index (HDI) of the state of Rio de Janeiro (0.799). Geographically, in terms of health planning, it is divided into five large regions with distinct characteristics, known as Planning Areas (APs)¹⁷: (1) AP-1 covers the Historic Center of the city and concentrates the largest proportion of people living in shantytowns (29.0%); (2) AP-2 is subdivided into AP-2.1 and AP-2.2. Due to its geographical configuration, which includes the Southern Zone of the city, it symbolizes the city of Rio de Janeiro. It is classified as having a high HDI; (3) AP-3, subdivided into AP-3.1, AP-3.2 and AP-3.3, presents the largest population contingent of the city (37.9%) and large complexes of Urban Fragility Areas; (4) AP-4, a region of urban expansion for high- and middle-income populations, has the lowest population density of the city; and (5) AP-5, subdivided into AP-5.1, AP-5.2 and AP-5.3, is a region of urban expansion for low- and middle-income populations. It corresponds to 48.4% of the city's territory and has the lowest HDI¹⁷.

The general outpatient clinic of IPUB is located in AP-2.1, at the Praia Vermelha campus of UFRJ, in the district of Botafogo, and is considered one of the main entrance doors to psychiatric care in the city for people aged 18 to 65 years old. With approximately 1,300 psychiatric consultations per month, its care is totally included in the SUS. Most of the patients are referred from primary care by means of a Regulatory System (SISREG) and evaluated by a Reception Group to start treatment in the service. In addition to assistance in Psychiatry, Psychology, Nursing, Nutrition, Social Work and other services, the outpatient clinic functions as a teaching and research setting. It is important to mention that patients with substances use disorders are not seen at this outpatient service specifically but are followed up in specific program of the institution called Alcohol and Drugs Project (PROJAD).

Participants

Information about patients enrolled in the IPUB with psychiatric consultations scheduled at the general outpatient clinic during the period from July 15 to October 15, 2015 were included in the study. The three-month interval was considered as a proxy for the treatment period of the patients, who are usually assisted in monthly, bimonthly and quarterly intervals. Thus, the three-month interval would be assessing the great majority of the outpatient clinic's patients. To be included in the study, the patients must have been followed up by the same physician in the six months prior to the beginning of the study.

Instrument

We developed an instrument to collect sociodemographic data and clinical information from the patient's medical records. In addition to data from medical records, the instrument included a clinical stability assessment referring to the six previous months and performed by the physician assistant in two different ways: based on a clinical criteria set and also based in an overall clinical impression. The following information was collected/assessed by the instrument:

1. Sociodemographic variables. Sex; date of birth; dwelling area per planning areas (AP) or district and city;
2. Clinical variables. Clinical information: periodicity of consultations (assessed by the frequency with which the patient was regularly assisted by the physician and categorized as: monthly, bimonthly, quarterly and others); year of the beginning of the patient's follow-up at the institution; clinical diagnosis and comorbidities of the ICD-10 Classification of Mental and Behavioral Disorders¹⁸ (based on the physician assistant's clinical assessment), and clinical stability assessment.

Clinical stability assessment

Five relapse factors were selected from the ones most frequently found in the literature and in international guidelines. They were used as a proxy for instability criteria in the clinical stability assessment: (1) Occurrence of psychiatric hospitalization^{15,19-21}. (2) Exacerbation or emergence of acute manifestations of the disease^{15,22,23}. (3) Change in medication or a significant increase in the doses used to treat the underlying disease.^{15,16,19,23,24} (4) Significant suicidal ideation and/or suicide attempt.^{15,21,24,25} (5) Worsening of the primary mental disorder due to psychoactive substance use/abuse.^{15,20-22,25,26} The answer to these five criteria encompassed two options: Yes/No. Clinical stability was defined as the negative answer to the five instability criteria. In this assessment, if one single affirmative answer to any of these criteria occurs, the patient is considered unstable.

Due to the frailty in the literature to establish criteria for the assessment of clinical stability in psychiatric patients, and in order to increase the reliability of the stability assessment in this study, another assessment level was proposed in the instrument: a criterion of the physician assistant's global clinical impression to assess stability through a dichotomous answer (Yes/No).

Training

The form was filled-in by the physician assistant. The research authors promoted group and individual trainings to explain how to fill-in the form. The psychiatrists received information about the research and its objectives, the psychosocial care network, and were introduced to the instrument. Each item of the form was discussed, including information collection from the medical records, the patient's medical assessment in the six previous months and the indicated moment for data collection.

Data collection

At the beginning of each shift, all the physicians received the research form attached to the scheduled patient's medical record and a map of the city of Rio de Janeiro. At the end of each consultation, the psychiatrists filled in the form with the requested data and, at the end of their shift, all the forms were collected. If the patient was absent, his form remained attached to the medical record to be filled in in a subsequent consultation.

The data were extracted from the forms and included in an electronic data capture system that converted the information into a database.

Statistical analysis

Measures of central tendency (means) and relative frequencies (proportions) were obtained, with 95% confidence intervals. The statistical significance of the differences was assessed by means of Student's t-tests for means and chi-square tests for proportions.

Agreement between stability assessed by the criterion of the physician's clinical impression and stability assessed through the answers to the five clinical criteria was assessed through Kappa statistic. The statistical significance for the differences of the proportion of stable patients according to geographical area was tested by the chi-squared test. All the analyses were performed with the software Stata 14.

RESULTS

Sociodemographic and clinical characteristics

Overall, 1,498 questionnaires were filled in in this study. Of these, 51 were excluded from the analysis for having been filled in incorrectly. The final sample consisted of 1,447 filled

in questionnaires referred to patients (824 women and 623 men). Age varied from 16 to 89 years, with average age and standard deviation (SD) of 49.13 years and 12.83 years, respectively.

Geographical distribution

All the Planning Areas of the city of Rio de Janeiro were considered in the distribution of the dwelling area, as well as other cities in and out of the State of Rio de Janeiro. A total of 343 (23.70%) patients lived outside the city, distributed across the major part of the State's macro-regions, and also in one city in the State of São Paulo and one city in the State of Minas Gerais. The distribution by dwelling areas in the Planning Areas of the city can be seen in figure 1.

Clinical stability assessment in the six previous months

In the clinical stability assessment of the sample by means of the five criteria, we found that 946 patients (65.38%) [95% CI: 62.88-67.78] were considered stable, with the "best clinical situation", that is, all five criteria were negative.

Clinical stability and dwelling area

Regarding to clinical stability, we found the following results: AP-1.0 (61.25%); AP-2.1 (63.07%); AP-2.2 (66.94%); AP-3.1 (66.05); AP-3.2 (58.33%); AP-3.3 (64.39%); AP-4.0 (68.60%); AP-5.1 (66.67%); AP-5.2 (66.67); AP-5.3 (64.29%); and outside the city (68.51%). There was no statistically significant difference when we correlated clinical stability with dwelling area (p -value = 0.85).

Clinical and comorbid diagnosis

All the diagnostic categories of ICD-10 for Mental and Behavioral Disorders were identified in the sample. We found that SMD, which belongs to categories F20-F29 – Schizophrenia, schizotypal, and delusional disorders, and F30-F39 – Mood [affective] disorders, corresponded to 435 (30.0%) and 548 (37.9%) patients respectively, totaling 67.9% of the sample.

Other comorbid psychiatric and neurological diagnoses were identified in 65 patients (5.5%). Of these, eight presented a third diagnosis. The most frequent comorbid diagnosis was F-60 (Disorders of adult personality and behavior).

Clinical stability and diagnostic category

When we investigated clinical stability by diagnostic category, we identified that, for 646 (61.41%) of the 983 patients with SMD, the five criteria were negative; therefore, they were stable in this assessment. This result means that the two most frequent diagnostic categories of the sample (F 20 – F29; F30 – F39) account for 2/3 of the patients considered stable (Table 1). The statistical analysis showed that there is no difference between the stability in these two diagnostic categories (p = 0.22).

Clinical assessment criteria

Of the five instability clinical criteria, the highest percentage of positive answers was identified in the criterion “exacerbation or emergence of acute manifestations of the disease”, followed by the criterion “change in medication or a significant increase in the doses used to treat the underlying disease”. The statistical analysis showed the prevalence (p-ratio) among the five criteria, using the hospitalization criterion as reference.

In addition, it showed that stability between the two criteria above is statistically significant ($p < 0.001$) (Table 2).

Stability assessment by clinical criteria versus the physician assistant’s clinical impression

In the stability assessment by means of the physician assistant’s clinical impression, we observed that 1,051 patients (72.63%) were considered stable. From the point of view of

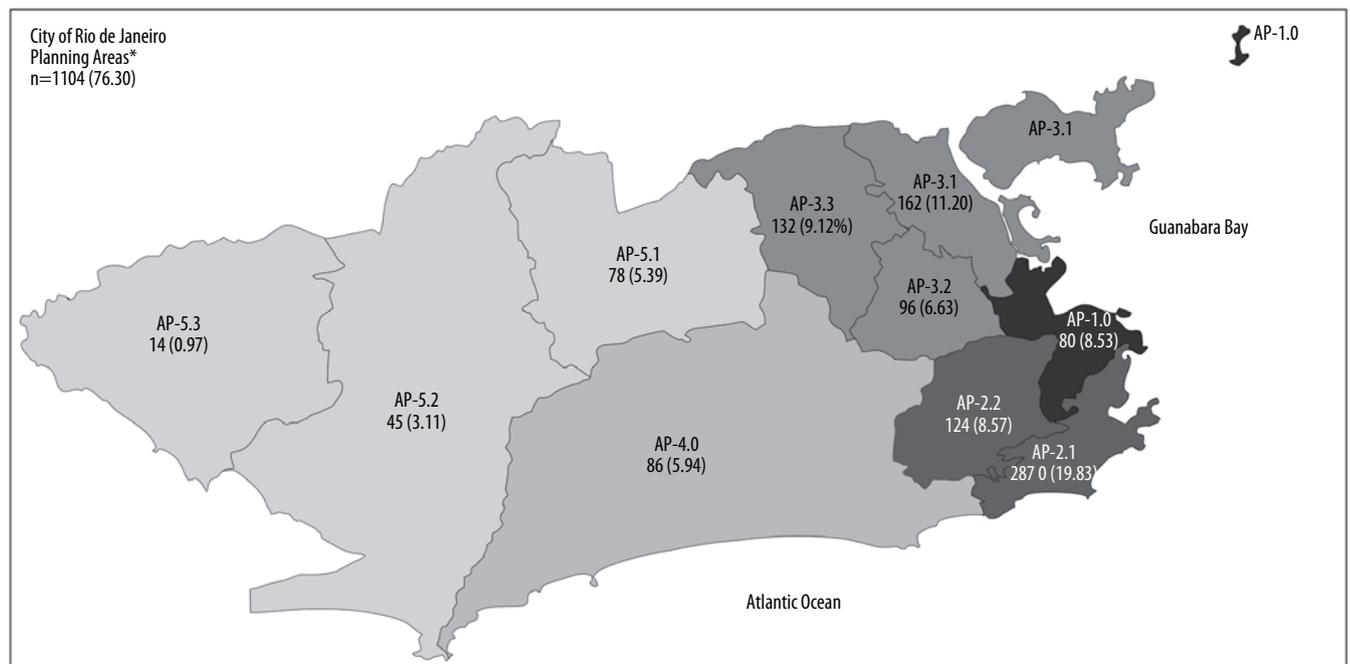


Figure 1. Sample distribution by dwelling areas in the Planning Areas (APs) of Rio de Janeiro, RJ, 2015. Data presented as n (%) * Planning Areas. AP-1: Old Town, with 15 districts, 294.919 population; AP-2: Middle Class Residential Districts, with 25 districts, subdivided into AP-2.1 and AP-2.2, 1.020.321 population; AP-3: Industrial & Commercial Zone, with 80 districts, subdivided into AP-3.1, AP-3.2 and AP-3.3, 2.432.022 population; AP-4: Lightly Settled Zone, High class residential areas in coast, with 19 districts, 919.429 population; AP-5: Rural Zone & Industrial Complexes, with 20 districts, subdivided into AP-5.1, AP-5.2 and AP-5.3, 1.723.613 population. Source population: IBGE; IPP; SUBAV.2012.

Table 1. Sample distribution of the frequency of stability by clinical criteria according to the ICD-10 diagnostic categories – Rio de Janeiro, RJ, 2015 (n = 1,447)

Diagnostic Category – ICD-10	Clinical stability				Total
	No		Yes		
	n (%)	95% CI	n (%)	95% CI	n (%)
F00-F09 (Mental and behavioral disorders)	7 (26.92)	13.20-47.15	19 (73.08)	52.84-86.79	26 (100.0)
F10-F19 (Mental and behavioral disorders due to psychoactive substance use)	8 (80.0)	43.82-95.35	2 (20.0)	4.64-56.17	10 (100.0)
F20-F29* (Schizophrenia, schizotypal and delusional disorders)	140 (32.18)	27.95-36.73	295 (67.82) [§]	63.26-72.04	435 (100.0)
F30-F39* (Mood [affective] disorders)	197 (35.95)	32.03-40.06	351 (64.05) [§]	59.93-67.96	548 (100.0)
F40-F48 (Neurotic, stress-related and somatoform disorders)	63 (47.73)	39.31-56.27	69 (52.27)	43.72-60.68	132 (100.0)
F50-F59 (Behavioral syndromes associated with physiological disturbances and physical factors)	0 (0)	31.62-45.60	3 (100.0)	54.39-68.37	3 (100.0)
F60-F69 (Disorders of adult personality and behavior)	71 (38.38)	6.27-20.13	114 (61.62)	79.86-93.72	185 (100.0)
F70-F79 (Mental retardation)	10 (11.49)	3.92-49.43	77 (88.51)	50.56-96.07	87 (100.0)
F80-F89 (Disorders of psychological development)	2 (16.67)	2.37-82.00	10 (83.33)	17.99-97.62	12 (100.0)
F90-F98 (Behavioral and emotional disorders with onset usually occurring in childhood and adolescence)	1 (25.0)	8.26-83.15	3 (75.0)	16.84-91.73	4 (100.0)
G00-G99 (Diseases of the nervous system)	2 (40.0)		3 (60.0)		5 (100.0)
Total	501 (34.62)		946 (65.38)		1,447 (100.0)

95% CI: confidence interval. * Categories considered as Severe Mental Disorders SMD. § p-value between the clinical stability of the diagnostic categories ($p = 0.22$).

the five instability criteria, this proportion was smaller (65%). The concordance estimate by the Kappa statistic was 0.68 ($p < 0.001$) which is considered a meaningful agreement (Table 3).

The highest disagreement was identified in the criterion "exacerbation or emergence of acute manifestations of the disease", with 96 patients among the 152 stable patients, followed by the criterion "change in medication or increase in dosage", with 83 patients. The criterion with the lowest disagreement was suicidal ideation and/or suicide attempt, with 7 patients.

Clinical stability and periodicity of consultations

The periodicity of consultations presented the following distribution: bimonthly – 626 patients (43.26%) [95% CI: 40.72-45.83]; quarterly – 423 patients (29.23%) [95% CI: 26.94-31.63]; monthly – 341 patients (23.57%) [95% CI: 21.44-25.82]; others – 57 patients (3.94%) [95% CI: 3.05-5.07]. Of the 946 stable patients according to clinical criteria, 808 (85.41%) were followed up in bimonthly and quarterly consultations.

Clinical stability and assistance period

Stability assessed by clinical criteria showed an increasing tendency as the patient's assistance period increased.

The statistical analysis showed that this was statistically significant ($p < 0.001$) (Table 4).

The clinical stability assessment did not present relevant differences by sex. Of the 824 female patients, 539 (65.41%) were stable, and of the 623 male patients, 407 (65.33%) were stable. Therefore, the proportion of stability by sex was practically the same (p -value = 0.97).

DISCUSSION

As far as we know, this is the first study that assesses the sociodemographic profile and clinical stability of patients assisted in a psychiatry outpatient clinic of a university, in the context of the National Healthcare System, as well as in the context of the national and international literature. An extensive literature review was carried out and few studies on this topic were identified. In this scenario, this study has an unprecedented nature.

In our study, the sample consisted predominantly of female patients, with average age of 49 years, distributed across all the major Planning Areas of the city of Rio de Janeiro, mainly in AP-2 (28.4%), followed by AP-3 (27%), AP-5 (9.5%), AP-4 (5.9%) and AP-1 (5.6%). Inhabitants of other cities

Table 2. Frequency of the five instability criteria for clinical stability assessment in the sample – Rio de Janeiro, RJ, 2015 (n = 1,447)

Instability criteria	Positive answer			
	n (%)	95% CI	p-ratio	p-value
Hospitalization	47 (3.25)	2.44-4.29	reference (1)	–
Suicidal ideation and/or suicide attempt	49 (3.39)	2.56-4.45	1.04	0.86
Psychoactive substance use or abuse	53 (3.66)	2.80-4.76	1.12	0.54
Change in medication or increase in doses used to treat the disease	374 (25.85)	23.65-28.16	7.79	< 0.001
Exacerbation or acute manifestation of the disease	416 (28.75)	26.47-31.13	8.85	< 0.001

95% CI: confidence interval.

Table 3. Concordance of clinical stability by clinical impression and stability assessed by clinical criteria – Rio de Janeiro, RJ, 2015 (n = 1,447)

Stability by clinical impression (physician)	Stability by clinical criteria		Total
	Yes	No	
Yes	899*	152 ^S	1,051
No	47 ^S	349*	396
Total	946	501	1,447

* Agreement. ^S Disagreement. *Kappa* = 0.68; SE (0.026); $p < 0.001$.

Table 4. Relationship between stability by clinical criteria and assistance period in IPUB's outpatient clinic – Rio de Janeiro, RJ, 2015 (n = 1,447)

Period (months)	Stability by clinical criteria	
	Yes	Total
6-24	73 (51.41)	142 (100.00)
25-60	148 (59.44)	249 (100.00)
61-120	279 (65.03)	429 (100.00)
> 120	446 (71.13)	627 (100.00)
Total	946 (65.38)	1,447 (100.00)

Data presented as n (%); $\chi^2 = 25.32$ (3 *df*); $p < 0.001$.

in and out of the state of Rio de Janeiro corresponded to 23.7% of the outpatient clinic's patients. We consider these preliminary findings important to the discussion of the IPUB's catchment area in the mental health care network, especially in relation to the access, risk areas in the city and supply of specialized professionals. They can help to understand the role played by the university-based outpatient clinic in the regionalization guideline of SUS.

The clinical variables showed that 67.9% of the patients had SMD and 65.3% of the sample was considered clinically stable. Among the clinically stable patients, the majority was being followed up at the outpatient clinic with a bimonthly periodicity, followed by the quarterly periodicity, and were being assisted at the institution for more than 10 years (47.14%).

In the stability assessment by clinical criteria, the statistical analysis identified that there were no significant differences in the stability of patients belonging to categories F20-F29 and F30-F39, nor regarding patients' sex, and dwelling area.

The data showed a prevalence of the female sex (57%), which is in accordance with the last census conducted by IBGE (Brazilian Institute of Geography and Statistics).²⁷ In the sample, the sex ratio (75.6) was lower than the calculated ratio (88.0) for the city of Rio de Janeiro²⁷. However, when compared to the sex ratio (52.1) calculated for the medical consultations of the Primary Care Services in the city of Rio de Janeiro in 2012, in which women were responsible for 65% of the assistances (the usual pattern of primary care services in Brazil)²⁸, the sex ratio of the IPUB's patients is higher. This means that the outpatient clinic of IPUB assists more male patients compared to primary care. This is in line with other studies that found that males made greater use of specialized mental healthcare²⁹.

We found correspondences to the profile of the HUCFF outpatient clinic's patients, outlined by Campos and Fortes⁸, concerning sex prevalence and residence close to the outpatient clinic's area.

The majority of studies conducted about the profile of services' patients in Brazilian universities present chart-review⁸⁻¹². In our work, we used a structured questionnaire for data collection based on the medical records and on a medical assessment by clinical criteria and clinical impression.

The prevalence of diagnoses considered severe and persistent is in accordance with the institution's level of complexity. On the other hand, the findings related to comorbid diagnoses (5.5%) are in disagreement with current knowledge about high rates of comorbidities in the group of schizophrenias and in bipolar disorder, like substance-related disorders and anxiety disorders, among others³⁰. A possible explanation is the existence of the Alcohol and Drugs Project (PROJAD) in the IPUB, which is a specific service for patients with SMD who are addicted to substances.

Unlike the major part of the studies in the literature that discuss instability focusing on the relapse of patients with schizophrenia^{13,15,22}, our study investigated clinical stability in patients assisted in the outpatient clinic during three months, regardless of the disorder they presented. In the review carried out by Olivares *et al.*¹⁵, hospitalization emerged as the most cited relapse factor in 47 of the 87 investigated publications (54%) and in 54 publications (62%) when exacerbation of symptoms was added. In our study, hospitalization presented the lowest percentage of the sample (3.25%), followed by suicide attempt (3.39%), substance use/abuse (3.66%), change in medication or increase in dosage (25.8%), and exacerbation of symptoms (28.7%). Non-adherence to antipsychotic medication, considered a potential factor for relapse and reported in numerous studies^{13,15,16}, was not included in our criteria because this factor is more frequently identified in studies with patients suffering from their first episode of schizophrenia¹⁶, and not in patients being regularly followed up.

We believe that the frequency of SMD in the sample, specifically categories F20-F29 (30.0%) and F30-F39 (37.8%), is expected in the IPUB outpatient clinic's patients because it is a specialized psychiatric institution of medium complexity that has two wards for the hospitalization of patients in risk situation.

In the stability assessment by clinical criteria, the low frequency of positive answers to factors related to severity/relapse in the literature, such as hospitalization^{15,16,19-21}, exacerbation of symptoms^{15,22,23} and suicide attempt^{15,21,24,25}, among others, would be expected, as the investigation showed that the majority of the patients in the sample were stable.

The two most frequent clinical criteria for severity used in the stability assessment, "exacerbation of symptoms" and "change or increase in the medication dose", if combined with the less frequent criterion "hospitalization", may suggest that the regular follow-up at the outpatient clinic with drug treatment, among other therapeutic approaches, reduces hospitalizations and contributes to the stabilization of patients. On the other hand, it is possible that the criterion "change in medication" may not be related to clinical instability, but rather, to possible adverse effects of the medicines.

When we relate stability assessment by clinical criteria to the diagnostic categories, the most important finding regards patients with SMD who presented significant stability percentages, such as: F20-F29 = 64.0% and F30-F39 = 67.8%. The confidence interval analysis of the stability percentages of these categories did not show differences among them, and the p-value did not show statistically significant differences. In the sample, the category that presented the highest clinical stability was F70-F79 (Mental retardation),

and the one that presented the lowest stability was F40-F48 (Neurotic, stress-related and somatoform disorders).

The degree of agreement observed between the five clinical criteria and the physician assistant's clinical impression, adjusted by Kappa (68%), can be interpreted as meaningful. It may indicate that the two assessment of stability are convergent, even though they are epistemologically opposed. The discrepancy between these assessments was observed in some patients assessed as clinically unstable by means of the clinical criteria, and stable according to the clinical impression of the physician assistant. Likewise, 47 patients assessed as stable by means of clinical criteria were considered unstable by the physician assistant.

Assessment of the follow-up frequency among stable and unstable patients showed that 808 stable patients (85.3%) visited the outpatient clinic with a bimonthly and quarterly periodicity.

There were no important differences identified for stability assessment in the 142 patients who were being followed up at the outpatient clinic for 6-24 months. The relationship between stability and assistance period gradually changed, as it was observed in the 627 patients who were being followed up for more than ten years. Of these, 28.8% were unstable and 71.1% were stable; therefore, stability prevailed as time went by.

The problematization of the guidelines for the functioning of mental health outpatient clinics acquired greater visibility when the Ministry of Health started to analyze these services⁵. The analysis found that these clinics provide care for users with less severe disorders, have a weak articulation to the healthcare network, low problem-solving capacity, and huge waiting lists, among others.

The study carried out by Severo and Dimenstein⁷ about the role and pertinence of the mental health outpatient clinic in the context of the psychiatric reform showed demands concentrated on psychiatry outpatient clinics and lack of articulation of the mental health network with primary care and with other social care devices. It considered that the existence of mental health outpatient clinics in the hospital-centered model is unjustified, and pointed to the need of investments in research about these clinics in Brazil, in order to promote reflections and changes in the assistance model, and to strengthen the Brazilian psychiatric reform.

Data from the research conducted by Prata *et al.*³¹ in the city of Rio de Janeiro between 2009 and 2013 show trends that help us reflect on the current assistance model, such as: the expansion of the Family Health Strategy (ESF) in the city; reports made by managers providing evidence that the ESF has been opening itself to mental health and that there are difficulties in the cases' longitudinal follow-up due to work overload; narratives of workers in family health teams manifesting the sensation of lack of training and low perception of the therapeutic potential of primary

care; violence in the territories, among others. Among the described narratives, we highlight the managers' different points of view about the assistance model, depending on their involvement in mental health or in the ESF.

Therefore, based on the results of our study, mainly: a) the majority of the general outpatient clinic's patients have SMD; b) they are followed up in bimonthly and quarterly psychiatric consultations; and c) they became stable as the years went by - and because we do not have a waiting list in the clinic, other points of reflection have emerged, such as: 1) the IPUB's model of assistance showed that people with SMD may be properly treated, with adequate clinical psychiatric support, and maintain themselves stable. 2) However, what should we do with the stable patient? Should we refer him to the Family Clinic for the continuity of the follow-up or not? 3) In addition to clinical stability and territory, in the case of patient referral, what other criteria should we take into account?

We believe that clinically stable patients who wish to continue their psychiatric care outside the IPUB and have access, in their dwelling areas, to assistance in public services of primary and secondary mental health care should be referred. Therefore, to obtain significant answers, such reflections presuppose a dialog and articulation, regarding their complementary aspects, between the IPUB and other public services of the mental health assistance network in and out of the city.

Our study presents some limitations, such as: a) difficulty in assessing stability based on a non-longitudinal study design and without evaluation of previous information contained in the patient's medical records; b) the three-month period of data collection, which might have been insufficient to assess the universe of patients followed up at the outpatient clinic; c) the period of training of the physicians assistants, which may have been insufficient and may have generated inconsistencies/imprecisions when the professionals filled in the instrument; d) the non-utilization of validated clinical assessment scales; e) the number and comprehensiveness of the stability factors present in the instrument.

However, this is the first study carried out with a sample that, instead of selecting, included all patients with scheduled consultations in the study's period. The non-utilization of a clinical scale was an intentional option that aimed to make the assessment resemble, as much as possible, a real assistance provided for patients. As for the criteria used to assess stability, it is possible to state that the search for a consensus in relation to criteria in the field of psychiatry has been a challenge, as shown by Olivares *et al.*¹⁵ in their review. Therefore, to assess the clinical stability of the IPUB's patients, we used five relapse factors as a proxy for instability criteria. We keep in mind that the design of the study does not allow to conclude that the outpatient clinic might guarantee more stability among patients just because

most of them are currently stable. However, we believe that the connection with the Institution and assistances provided on a regular basis may contribute to patient stability.

In view of what has been found, it would be interesting that this work is further developed, with a broader sociodemographic assessment and the enhancement and validation of our instrument. Furthermore, it would be interesting that the study stimulated research to map patients who were referred to the assistance network aiming to monitor their follow-up.

CONCLUSION

The data analysis confirms our hypothesis that patients with SMD can be followed up and stabilized clinically in the psychiatry outpatient clinic. Thus, it is possible to consider that the IPUB's general outpatient clinic adopts care practices that make the Institute a specialized place to follow up and stabilize patients with SMD.

CONTRIBUTIONS

All authors contributed significantly to the conceiving of the study, methodological approach, analysis and interpretation of the data, as well as in the elaboration of the article, revision of the content and approved the final version to be published.

CONFLICTS OF INTEREST

The authors report no conflicts of interest.

ACKNOWLEDGEMENTS

We thank the physicians of IPUB's general outpatient clinic and the psychiatry residents of the year of 2015 for their participation. We also thank IPUB's Invoicing Sector and Rafael Augusto de Freitas Rios.

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