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Original Article

Minor psychiatric disorders in users of psychoactive substances

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Objective: To verify the prevalence of Minor Psychiatric Disorders according to the demographic and socioeconomic profile, type of drug used and the health conditions of users of crack, alcohol and other drugs. Methodology: Cross-sectional study, with a sample of 505 users. The Self-Reporting Questionnaire was used to verify the prevalence of disorders. Results: The prevalence found was 28.7%, higher among crack users, women, blacks, divorcees or widowers, unemployed, users with health problems, poor self-assessment of health and who are dissatisfied with family relationships. Conclusions: The presence of Minor Psychiatric Disorders may be related to some factors that include not only individual characteristics, but also social, cultural and economic issues, among others.

Descriptors: Substance-Related Disorders; Drug Users; Minor Psychiatric Disorders.

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Transtornos psiquiátricos menores em usuários de substâncias psicoativas

Objetivo: verificar a prevalência de Transtornos Psiquiátricos Menores de acordo com o perfil demográfico e socioeconômico, com o tipo de droga utilizada e com as condições de saúde dos usuários de *crack*, álcool e outras drogas. Metodologia: estudo transversal, com amostra de 505 usuários. Utilizou-se o S*elf-Reporting Questionnaire* para verificação da prevalência dos transtornos. Resultados: a prevalência encontrada foi de 28,7%, sendo superior entre usuários de *crack*, mulheres, negros, divorciados ou viúvos, desempregados, entrevistados com problema de saúde, autoavaliação de saúde ruim e que estão insatisfeitos com relacionamentos familiares. Conclusão: constatou-se que a presença dos Transtornos Psiquiátricos Menores pode estar relacionada com alguns fatores que incluem não apenas as características individuas, mas também questões sociais, culturais, econômicas, entre outras.

Descritores: Transtornos Relacionados ao uso de Substâncias; Usuários de Drogas; Transtornos Psiquiátricos Menores.

Trastornos psiquiátricos en usuarios de sustancias psicoactivas

Objetivo: verificar la prevalencia de Trastornos Psiquiátricos Menores de acuerdo con el perfil demográfico y socioeconómico, con el tipo de droga utilizada y con las condiciones de salud de los usuarios de crack, alcohol, y otras drogas. Metodología: estudio transversal, con amuestra de 505 usuarios. Se utilizó el Self-Reporting Questionnaire para verificación de prevalencia de los trastornos. Resultados: la prevalencia encontrada fue de 28,7%, siendo superior entre usuarios de crack, mujeres, negros, divorciados o viudos, desempleados, entrevistados con problemas de salud, mala autoevaluación de salud, y que están insatisfechos con relacionamientos familiares. Conclusión: constatado que la presencia de los trastornos psiquiátricos menores puede estar relacionada con algunos factores que incluyen no solamente las características individuales, pero también cuestiones sociales, culturales, económicas, entre otras.

Descriptores: Trastornos Relacionados con Sustancias; Consumidores de Drogas; Trastornos Psiquiátricos Menores.

Introduction

Minor psychiatric disorders (MPD) refer to the health status of individuals with symptoms of depression, anxiety or somatic symptoms; however, there are no criteria for the diagnosis of such disorders according to the DSM-IV (Diagnostic and Statistical Manual of Mental Disorders - Fourth Edition) and the ICD-10 (International Classification of Diseases - 10th Revision)[1]. Regarding the prevalence of these disorders worldwide, it is estimated that 4.4% of the global population suffers from depressive disorders and 3.6% from anxiety disorders. This prevalence varies depending on the region, with the highest rates of depression in the African Region (5.4%) and anxiety disorders in the Americas (5.8%)[2].

Most individuals with MPD present complaints such as sadness, anxiety, tiredness, decreased concentration, somatic problems, irritability and insomnia. These minor morbidities can also be named as common mental disorders, a term that reinforces the frequent character

of these disorders[3]. This type of complaint is one of the recurring demands in Primary Health Care, however, it often does not receive proper attention and treatment[4]. The literature indicates that users with MPD may present functional losses and impairments that are comparable or more severe than people with chronic disorders, with impact on economic, social and living standards of people and families[5].

For the detection of MPD, the Self-Reporting Questionnaire (SRQ-20) was created in 1980, which suggests a level of suspicion (presence/absence) of some mental disorder. It evaluates whether there is any disorder, but does not offer specificity of the type of existing disorder. Due to this screening character, this questionnaire is quite adequate for population studies, being very useful for a first classification of possible cases and non-cases[6].

According to the WHO, the social context of people and groups can significantly influence the emergence of mental health problems, such as MPD. Families living in poverty, minority groups, people with chronic health problems, people suffering from discrimination and human rights violations, neglected children and people exposed to the abuse of psychoactive substances (PAS) are the main vulnerable groups[7].

In a more challenging framework, MPD may be associated with the abusive use of PAS. This comorbidity may be an aggravating factor, inducing and perpetuating the condition of substance dependence or abuse. It also may interfere in the quality of life of the user of psychoactive substances, thus justifying a greater need for investigating this phenomenon[8-9].

Thus, this study aimed to verify the prevalence of Minor Psychiatric Disorders according to the demographic and socioeconomic profile, the type of psychoactive substance used and the health conditions of users of crack, alcohol and other drugs in the city of Pelotas-RS.

Methodology

This is a cross-sectional and exploratory study that integrates the research “Profile of Crack Users and Patterns of Use”, funded by the National Council for Scientific and Technological Development (CNPq), notice MCT/CNPq No. 041/2010.

The research was developed in a city in the interior of the state of Rio Grande do Sul that has two distinct services aimed at the psychosocial care of people who use crack, alcohol and other drugs. The prevalence of drug users was unknown (p = 0.50), a sampling error of 4% (d = 0.04) was admitted, under a 95% confidence level (α = 0.05), and the number of participants in each stratum was proportional to the total number of registered users. The final sample consisted of 505 users. The systematic selection of respondents was the direct random draw in the databases of the two services.

For the present study, the adapted SRQ score was adopted as dependent variable and the independent variables were demographic and socioeconomic profile, the type of drug that the interviewee had already used in life, whether he/she has a health problem, self-assessment of health and family relationships).

The SRQ is a questionnaire that contributes to the identification of psychiatric disorders in primary care. It was created in four developing countries (Colombia, Sudan, India and the Philippines) and validated in Brazil in 1986[10]. It consists of 20 questions designed to screen “neurotic” disorders. For a person to be considered as a possible case, one must reach a score of eight or more affirmative responses in the subscale of “neurotic” symptoms for women and six or more affirmative responses for men. This was obtained earlier by determining the sensitivity, specificity and positive and negative predictive values in other samples[11].

Initially, during the pilot test, we used the SRQ scale with 20 questions, but to facilitate the comprehension of the users, the participants requested to group four questions into two, since they addressed similar content, so the SRQ was used with 18 questions. In order to validate the internal consistency of the responses, the Cronbach’s Alpha Coefficient was applied, in which the results of the present study remained within the limit of 0.7 to 0.9, representing a good internal consistency[12], as observed in Table 1.

The questionnaires were coded by the interviewer and reviewed by the coordinators. The data was entered through the Microsoft Access 2003 database manager.

Data analysis was performed using the STATA 12 software and consisted in describing the absolute and relative frequencies of the demographic and socioeconomic characteristics of the entire sample, stratified according to SRQ score (positive or negative). Distributions of bivariate frequencies and descriptive measures (means and standard deviation) were used. The bivariate analyzes were performed with the purpose of describing and verifying proportional differences between the stratification groups through the Pearson Chi-square tests for the nominal variables and the Chi-square of Linear Tendency for the ordinal variables. The Student’s t-test was applied to verify differences between the average SRQ score of users (of crack and other drugs). The level of significance adopted in all tests was 5% ($p \leq 0.05$).

The research complied with the ethical principles of Resolution COFEN No. 311/2007 and Resolutions 196/96 and 466/12 of the National Health Council of the Ministry of Health. The project was approved by the Ethics and Research Committee of the Faculty of Nursing of the Federal University of Pelotas under opinion no. 301/2011.

Table 1. Cronbach's alpha of SRQ-18 (n= 505) Pelotas - RS, Brazil, 2012

Item	Cronbach's alpha*
Do you often have headaches?	0.82
Is your appetite poor?	0.82
Do you sleep badly?	0.82
Are you easily frightened?	0.83
Do your hands shake?	0.82
Do you feel nervous, tense or worried?	0.82
Is you digestion poor or do you have uncomfortable feelings in your stomach?	0.83
Odo you have trouble thinking clearly?	0.83
Do you feel unhappy?	0.82
Do you cry more than usual?	0.82
Do you find it difficult to enjoy your daily activities?	0.82
Do you find it difficult to make decisions?	0.82
Is your daily work suffering? Distress? Do you have difficulty doing your job?	0.83
Are you unable to play a useful part in life?	0.84
Have you lost interest in things?	0.82
Do you feel that you are a worthless person?	0.82
Has the thought of ending your life been on your mind?	0.82
Do you feel tired all the time?	0.82

*Cronbach's alpha with the removal of domain items; Overall Cronbach's Alpha = 0.83.
Source: Research project "Profile of crack users and patterns of use" - Pelotas 2014"[13].

Results

The study population consisted of 505 users of PAS. The demographic profile of the interviewees was predominantly males (83.8%), with white self-reported skin color (50.9%); more than half of the interviewees were single (53.3%). The mean age was 38 ± 13.1 years, with a minimum of 18 and a maximum of 76 years. The socioeconomic profile revealed individuals with low educational level, in which 77.8% had only complete or incomplete elementary education. Regarding family income, 26% had no income or income was less than one minimum wage (MW). Regarding the occupational status, 29.1% were unemployed and only 23.4% had a formal employment relationship.

Regarding the prevalence of MPD in the sample, 28.7% of the interviewees had positive screening on the SRQ scale. Table 2 shows the demographic and socioeconomic characteristics of drug users, stratified according to the SRQ score.

There is a direct relationship between SRQ score and age, and increased frequency of individuals with a positive screening for MPD between the ages of 30 and 39 years. However, these proportional trends were not statistically significant between groups.

There were statistically significant proportional differences between the groups with respect to color (p = 0.029). The study population was predominantly white; however, the relationship between skin color and the SRQ score shows predominance of black users with MPD in this group.

There were also statistically significant proportional differences between the SRQ score and the marital status (p = 0.008). The highest prevalence of MPD was in the group of people who declared to be divorced/ widowed/separated.

There were no statistically significant proportional trends between the groups and schooling.

There were statistically significant proportional trends between the economic activity status and the SRQ score (p = 0.02), with a higher prevalence of MPD among users who said they have not been working.

Despite the predominance of males among the interviewed users (83.8%), the prevalence of MPD was higher among women (32.9%), which deserved to be highlighted in the analysis.

Figure 1 shows the distribution of the SRQ score with stratification by sex and type of PAS used.

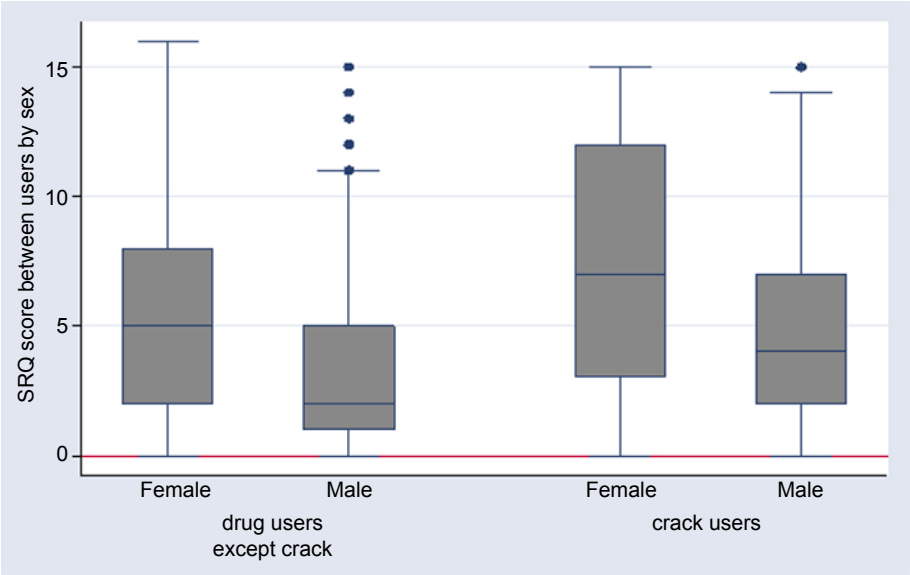
Of the 505 interviewed users, drug users (except crack) were the predominant group, with 369 respondents (73.1%), and those who reported using crack were 136 users (26.9%). However, Figure 1 shows that the SRQ score was higher among crack users. In both groups, females showed a greater dispersion and higher concentration of values above the median value of the sample (md = 3, mean = 4.1 and standard deviation = 3.7). Males presented lower median value of SRQ scores in both groups.

In relation to the types of PAS that has been used at least once in life by the users, the most frequently mentioned were alcohol (96.1%), tobacco (81.4%), marijuana (52.4%), cocaine (40.2%) and crack (26.7%).

Table 2. Distribution of SRQ score according to demographic and socioeconomic characteristics of users of crack, alcohol and other drugs (n = 505). Pelotas - RS, Brazil, 2012

Characteristic	Total n (%)	SRQ score		p-value
		Negative n (%)	Positive n (%)	
Sex				
Female	82 (16.2)	55 (67.1)	27 (32.9)	0.357*
Male	423 (83.8)	305 (72.1)	118 (27.9)	
Age group				
< 20	18 (3.6)	16 (88.9)	2 (11.1)	0.17†
20 to 24	65 (12.9)	51 (78.5)	14 (21.5)	
25 to 29	66 (13.1)	45 (68.2)	21 (31.8)	
30 to 39	133 (26.4)	94 (70.7)	39 (29.3)	
40 to 49	110 (21.8)	76 (69.1)	34 (30.9)	
50 to 59	84 (16.6)	56 (66.7)	28 (33.3)	
60 or more	29 (5.7)	22 (75.9)	7 (24.1)	
Skin color				
White	257 (50.9)	181 (70.4)	76 (29.6)	0.029*
Brown	98 (19.4)	76 (77.6)	22 (22.4)	
Black	111 (22.0)	70 (63.2)	41 (36.9)	
Other	39 (7.7)	33 (84.6)	6 (15.4)	
Marital status				
Married/with partner	170 (33.7)	130 (76.5)	40 (23.4)	0.008*
Single	269 (53.3)	191 (71.0)	78 (29.0)	
Divorced/widowed/separated	66 (13.0)	39 (59.1)	27 (40.9)	
Schooling				
No schooling	10 (2.0)	8 (80.0)	2 (20.0)	0.07†
Incomplete/complete elementary school	393 (77.8)	271 (69.0)	122 (31.0)	
Incomplete/complete high school	88 (17.4)	68 (77.3)	20 (22.7)	
Incomplete/complete higher education	14 (2.8)	13 (92.9)	1 (7.1)	
Activity Status Economic				
No	147 (29.1)	92 (62.6)	55 (37.4)	0.02†
Informal work	106 (21.0)	77 (72.6)	29 (27.4)	
Formal work	118 (23.3)	92 (78.0)	26 (22.0)	
Self-employed	123 (24.4)	91 (74.0)	32 (26.0)	
Eventual	11 (2.2)	8 (72.7)	3 (27.3)	
Family income‡				
No income	19 (3.8)	12 (63.2)	7 (36.8)	0.07†
< 1 salary	112 (22.2)	76 (67.9)	36 (32.1)	
1 to 2 salaries	199 (39.4)	137 (68.8)	62 (32.3)	
More than 2 to 4 salaries	114 (22.6)	90 (79.0)	24 (21.0)	
More than 4 salaries	48 (9.5)	40 (83.3)	8 (16.7)	
Did not know/did not inform	13 (2.6)	5 (38.5)	8 (61.5)	

Source: Research project "Profile of crack users and patterns of use"[13].
*Pearson's Chi-square test; †Chi-square test for linear trend; ‡Minimum wage at the time R$ 622.00.



Source: Research project "Profile of crack users and patterns of use"[13]

Figure 1. Distribution of the SRQ score among users by sex (n = 505). Pelotas - RS, 2012

Table 3. Distribution of the SRQ score according to the drugs that the interviewee had already tried (n = 505). Pelotas - RS, Brazil, 2012

Characteristic	Total n*(%)	SRQ score		p-value†
		Negative n (%)	Positive n (%)	
Alcohol				
No	19 (3.9)	12 (63.2)	7 (36.8)	0.432
Yes	477 (96.1)	341 (71.5)	136 (28.5)	
Tobacco				
No	92 (18.6)	71 (77.2)	21 (22.8)	0.164
Yes	402 (81.4)	281 (69.9)	121 (30.1)	
Crack				
No	370 (73.3)	283 (76.5)	87 (23.5)	0.000
Yes	135 (26.7)	77 (57.0)	58 (43.0)	
Cocaine				
No	296 (59.8)	228 (77.0)	68 (23.0)	0.000
Yes	199 (40.2)	124 (62.3)	75 (37.7)	
Marijuana				
No	233 (47.6)	170 (73.0)	63 (27.0)	0.353
Yes	256 (52.4)	177 (69.1)	79 (30.9)	
Synthetic substances				
No	449 (91.8)	321 (71.5)	128 (28.5)	0.386
Yes	40 (8.2)	26 (65.0)	14 (35.0)	

Source: Research project "Profile of crack users and patterns of use"[13].
*variable figure due to the possibility of multiple responses and users who did not inform; †Pearson's Chi-square test.

Table 3 shows the SRQ score distribution according to these substances.

When we verified the association between the drugs used and the SRQ score, it was observed that users who reported having used crack at least once in their life had a prevalence of PMD nearly twice higher than the study population (28.7% vs. 43%), followed by cocaine users (28.7% vs 37.7%). Participants who reported having used these two types of PAS had statistically significant proportional differences regarding SRQ score ($p < 0.05$).

After verifying the variance of the SRQ score among users (of crack and other drugs), it was found through the Student's t test that there is statistically significant evidence that the mean SRQ score differs between users ($p < 0.001$).

Table 4. Distribution of SRQ score according to health status and family relationship (n = 505). Pelotas - RS, Brazil, 2012

Characteristic	Total n (%)	SRQ score		p-value
		Negative n (%)	Positive n (%)	
Health problems				
No	323 (64.0)	256 (79.3)	67 (20.7)	0.000*
Yes	182 (36.0)	104 (57.1)	78 (42.9)	
Self-assessment of health				
Very good	107 (21.2)	92 (86.0)	15 (14.0)	0.00†
Good	258 (51.1)	200 (77.5)	58 (22.5)	
Fair	111 (22.0)	56 (50.5)	55 (49.5)	
Poor	24 (4.7)	10 (41.7)	14 (58.3)	
Very poor	5 (1.0)	2 (40.0)	3 (60.0)	
Relationship with family				
Dissatisfied	124 (24.6)	75 (60.5)	49 (39.5)	0.009*
Satisfied	378 (74.8)	283 (74.9)	95 (25.1)	
Did not answer	3 (0.6)	2 (66.7)	1 (33.3)	

Source: Research project "Profile of crack users and patterns of use"[13].
*Pearson's Chi-square test; †Chi-square test for linear trend.

Table 4 shows the association between the SRQ score and the characteristics related to the health status and to the family relationship between users.

Regarding the health status of the users, there was a higher prevalence of MPD among those who reported having health problems (42.9%), given that there were statistically significant proportional differences (p <0.001).

There was a direct relationship with statistically significant proportional tendencies in the pattern of answers of health perception and the increased prevalence of MPD, in which those with the worst assessment of health presented a higher prevalence (p <0.001).

The relationship with family and the SRQ score reveal that users dissatisfied with their relationships present more prevalence of MPD when compared to those who are satisfied, being this a statistically significant result (p = 0.009).

Discussion

Research shows that MPD can affect people from all regions of the world; however, the prevalence of these disorders has shown to be higher in specific population groups, which include the abusive users of PAS[2,7,14-16].

The present study revealed that the prevalence of MPD in the users of PAS was 28.7%, a result that is lower than that observed in a study conducted with PAS users in the state of Goiás (37.3%)[15]. However, when considering only those participants users who reported having used crack at least once in life, they had a higher propensity to develop MPD than the other PAS users. This result is in agreement with the literature when it points out that crack users present a higher occurrence of depressive and anxious symptoms than users of other substances[17].

The occurrence of MPDs may be related to some determinants that predict the onset of mental health disorders, which include not only individual characteristics, but also social, cultural, economic, political and environmental factors[2]. Thus, this shows that the biopsychosocial vulnerability of most PAS users could justify a higher prevalence.

In this study, the self-reported black color (36.9%), being divorced, widowed or separated (40.9%) and not being working at the time the interview took place (37.4%) were the individual characteristics that has statistically significant relation with positive screening for MPD. However, the gender variable, even without statistically significant differences, deserves to be highlighted, since although the majority of the interviewees were male, the prevalence of MPD was higher among women (32.8%). These results are in agreement with the literature, in which a higher prevalence of disorders was observed in most of these groups both in studies with PAS users and in population-based studies[4,15,17-18].

It was also verified the influence of the health status and family relationship in the variation of prevalence of MPDs. Participants who reported having a health

problem, self-rated their health as very poor and stated they were dissatisfied with the family relationships were those who presented the highest prevalence of MPD compared with those who reported having no health problem, who self-rated their health as good, very good or regular, and who have stated to be satisfied with family relationships.

These results show that the presence of psychic symptoms, such as anxiety and depression associated with PAS abuse, is frequent, emphasizing that the comorbidity MPD could increase the severity of PAS-related symptoms, as well as influence in several areas of the user's life, thus making it necessary to correctly identify them.

However, because this is a cross-sectional study, it cannot be confirmed whether the use of PAS leads to the presence of MPD or whether it is the presence of these disorders that influence the use of the substance. In any case, it is known that a social context of vulnerability can interfere both in the onset of MPD and in the use of PAS. In this way, there is the need for more in-depth knowledge about social factors of vulnerability in order to think and act more decisively to reduce social inequities. Obviously, a study focused on this goal could effectively raise health care that is based only on biological aspects to a higher level of biopsychosocial care.

Conclusion

The present study showed that the presence of the Minor Psychiatric Disorders can be related to some factors that include not only the individual characteristics, but also social, cultural and economic aspects, among others. Therefore, there is the need of a network of care to users of PAS in which the health professionals are attentive to the other, trying to identify their desires and needs, and for this purpose, the professional's look must go beyond the reason that led users to seek the health service. By adopting this behavior at the moment of care, the professional assumes that health and illness are not only objects, rather, they are the way of being and leading life.

References

1. Tavares JP, Beck CLC, Magnago TSBS, Greco PBT, Prestes FC, Silva RM. Scientific production on the minor psychological distress from the Self-report questionnaire. Rev Enferm UFSM. 2011; 1(1):113-23.

2. World Health Organization. Depression and Other Common Mental Disorders: Global Health Estimates. Geneva: WHO; 2017.

3. Cachoeira DVAC, Santos SCC, Meneganti APS, Negreiros NF, Cardoso L, Preto VA. Relation of sociodemographic profile with the risk of illness by mental disorders common among students of the nursing course. Rev Enferm UFPE on line. 2016; 10(12):4501-8.

4. Gama CAP, Campos RTO, Ferrer AL. Saúde mental e vulnerabilidade social: a direção do tratamento. Rev Latinoam Psicopatol Fundam. 2014;17(1):69-84.

5. Borges TL, Hegadoren KM, Miasso DI. Transtornos mentais comuns e uso de psicofármacos em mulheres atendidas em unidades básicas de saúde em um centro urbano brasileiro. Rev Panam Salud Publica. 2015 sep;38(3):195-201.

6. Santos KOB, Araujo TM, Pinho PS, Silva ACC. Avaliação de um instrumento de mensuração de morbidade psíquica: estudo de validação do self-reporting questionnaire (srq-20). Rev Baiana Saúde Pública. 2010 jul./set; 34(3):544-60.

7. World Health Organization. Mental Health: Action Plan 2013-2020. Geneva: WHO; 2013.

8. Kluwe-Schiavon B, Tractenberg SG, Sanvicente-Vieira B, Rosa CSO, Arteche AX, Pezzi JC, et al. Propriedades psicométricas da Cocaine Selective Severity Assessment (CSSA) em mulheres usuárias de crack. J Bras Psiquiatr. 2015; 64(2):115-21.

9. Grossi FT, Oliveira RM. Manejo clínico do usuário de crack. Minas Gerais: Diretrizes clínicas; 2013.

10. Harding TW, Arango MV, Baltazar J, Climent CE, Ibrahim HHA, Ladrido-Ignacio L. Mental disorders in primary health care: a study of their frequency and diagnosis in four developing countries. Psychol Med. 1980; 10:231-41.

11. Mari JJ, Williams P. A validity study of a psychiatric screening questionnaire (SRQ-20) in primary care in the city of São Paulo. Br J Psychiatry. 1986; 148:23-6.

12. Bruni AL. SPSS aplicado à pesquisa acadêmica. São Paulo: Atlas; 2009.

13. Oliveira MM, Coimbra VCC. Relatório Final: Perfil dos Usuários de Crack e Padrões de Uso. Pelotas (RS): Faculdade de Enfermagem da Universidade Federal de Pelotas. 2014; 85p.

14. Formigoni, MLOS, organizadora. Atenção integral na rede de saúde: módulo 5. – 11. e 12. ed. Brasília: Secretaria Nacional de Políticas sobre Drogas; 2017.

15. Lucchese R, Silva PCD, Denardi TC, Felipe RL, Vera I, Castro PA, Bueno AA, Fernandes IL. Common mental disorder among alcohol and drug abusers: a cross-sectional study. Texto Contexto Enferm, 2017; 26(1):e4480015.

16. Merchán-Hamann E, Leal EM, Basso ML, García EM, Reid P, Kulakova OV, et al. Comorbilidad entre abuso/

dependencia de drogas y el distrés psicológico en siete países de Latinoamérica y uno del Caribe. Texto Contexto Enferm. 2012; 21(espp): 87-95.

17. Horta RL, Horta BL, Rosset AP, Horta CL. Perfil dos usuários de crack que buscam atendimento em Centros de Atenção Psicossocial. Cad Saúde Pública. 2011 nov; 27(11):2263-70.

18. Gonçalves DA, Mari JJ, Bower P, Gask L, Dowrick C, Tófoli LF et al. Brazilian multicentre study of common mental disorders in primary care: rates and related social and demographic factors. Cad Saúde Pública. 2014; 30(3):623-32.

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