



THE EPIDEMIOLOGICAL PROFILE OF USERS OF A PSYCHOSOCIAL CARE CENTER

O PERFIL EPIDEMIOLÓGICO DOS USUÁRIOS DE UM CENTRO DE ATENÇÃO PSICOSSOCIAL EL PERFIL EPIDEMIOLÓGICO DE LOS USUARIOS DE UN CENTRO DE ATENCIÓN PSICOSSOCIAL

Girleane Feitoza dos Santos¹, Yanna Cristina Moraes Lira Nascimento², Regina Célia Sales Santos Veríssimo³,
Jairo Calado Cavalcante⁴, Mércia Zeviani Brêda⁵, Juliana Bento de Lima Holanda⁶

ABSTRACT

Objective: to describe the epidemiological profile of users of a psychosocial care center (CAPS). **Method:** this is a descriptive quantitative study, with 168 users undergoing effective monitoring in a CAPS in Maceio, Alagoas, Brazil, in January 2010, which used a structured form as a tool for collecting data from the medical records; in the analysis, one used the statistics, through absolute and relative frequency and a 95% confidence interval. The project was approved by the Ethics Committee of Universidade Federal de Alagoas, under the Process 020134/2009-34. **Results:** there was a prevalence of users within the age group from 40 to 49 years (40.6%); female (65.5%); and with incomplete elementary education level (33.6%). There was a predominance of diagnoses of schizophrenia (53.9%); mood disorders (35.7%); and neurotic disorders (10.4%). The most frequent comorbidity was arterial hypertension (31.3%). **Conclusion:** the study showed the positive effect of the care provided, the difficult access of some neighborhoods to CAPS, and the disarticulation of the support network. **Descriptors:** Epidemiological Profile; Psychosocial Care Center; Users of Mental Health Services.

RESUMO

Objetivo: descrever o perfil epidemiológico dos usuários de um centro de atenção psicossocial (CAPS). **Método:** trata-se de um estudo quantitativo descritivo, com 168 usuários em acompanhamento efetivo no CAPS de Maceió-AL, em janeiro de 2010, que utilizou como instrumento para a coleta de dados nos prontuários um formulário estruturado; para análise, recorreu-se à estatística, por meio de frequência relativa e absoluta e intervalo de confiança de 95%. O projeto foi aprovado pelo Comitê de Ética da Universidade Federal de Alagoas, sob o Processo n. 020134/2009-34. **Resultados:** houve prevalência de usuários da faixa etária de 40 a 49 anos (40,6%); do sexo feminino (65,5%); e do nível de escolaridade elementar incompleto (33,6%). Predominaram os diagnósticos de esquizofrenia (53,9%); transtornos de humor (35,7%); e transtornos neuróticos (10,4%). A comorbidade mais frequente foi a hipertensão arterial (31,3%). **Conclusão:** o estudo evidenciou o efeito positivo do cuidado prestado, o difícil acesso de alguns bairros ao CAPS e a desarticulação da rede de apoio. **Descritores:** Perfil Epidemiológico; Centro de Atenção Psicossocial; Usuários de Serviços de Saúde Mental.

RESUMEN

Objetivo: describir el perfil epidemiológico de los usuarios de un centro de atención psicosocial (CAPS). **Método:** esto es un estudio cuantitativo descriptivo, con 168 usuarios en acompañamiento efectivo en un CAPS en Maceió, Alagoas, Brasil, en enero de 2010, que utilizó como instrumento para la recogida de datos en los prontuarios un formulario estructurado; para el análisis, se utilizó la estadística, por medio de frecuencia relativa y absoluta e intervalo de confianza de 95%. El proyecto fue aprobado por el Comité de Ética de la Universidade Federal de Alagoas, bajo el Proceso 020134/2009-34. **Resultados:** hubo prevalencia de usuarios de la franja etaria de 40 a 49 años (40,6%); del sexo femenino (65,5%); y del nivel de educación primaria incompleta (33,6%). Predominaron los diagnósticos de esquizofrenia (53,9%); trastornos de humor (35,7%); y trastornos neuróticos (10,4%). La comorbilidad más frecuente fue la hipertensión arterial (31,3%). **Conclusión:** el estudio evidenció el efecto positivo de la atención prestada, el difícil acceso de algunos barrios al CAPS y la desarticulación de la red de apoyo. **Descriptores:** Perfil Epidemiológico; Centro de Atención Psicosocial; Usuarios de Servicios de Salud Mental.

¹Nurse graduated at Universidade Federal de Alagoas (UFAL). Maceio (AL), Brazil. Email: girleanefeitoza@hotmail.com; ^{2,3,6}Nurses, MS in Nursing, Professors, School of Nursing and Pharmacy of Universidade Federal de Alagoas (ESENFA/UFAL). Maceio (AL), Brazil. Emails: yanna_cristina@hotmail.com; salesregina@hotmail.com; julianabento@yahoo.com.br; ⁴MS in Medicine. Professor of Biostatistics at the School of Medicine (FAMED) da UFAL. Maceio (AL), Brazil. Email: jairocalado@terra.com.br; ⁵PhD in Nursing. Professor at the Graduate Program in Nursing of ESENFA/UFAL. Maceio (AL), Brazil. Email: merciazb@gmail.com

INTRODUCTION

Epidemiological studies carried out over the last 15 years show that mental health problems have become the main cause of disability and a major cause of morbidity in the contemporary societies.¹

According to the World Health Organization (WHO), the prevalence of mental disorder in the course of the life of an adult ranges from 12.2% to 48.6%, accounting for 14% of disabilities, occupying about 30% of the total load of non-communicable diseases and nearly 3/4 of the global burden of neuropsychiatric diseases.²

The WHO and the Pan American Health Organization (PAHO) also reveal that the magnitude of mental health problems will increase within 25 years, and there's an estimate that 1 in every 4 people on the planet will face some kind of mental disorder, which may be depression, schizophrenia, mental retardation, a disorder of childhood and adolescence, dependence on alcohol or drugs, or Alzheimer's disease.¹

In Brazil, the care for people undergoing psychic suffering has gradually become, in recent decades, under the influence of international experiences which proposed new models and practices of institutional transformation in mental health outside the asylum context.^{3,4}

Among the clinical strategies, the psychosocial care centers (CAPS) emerged as services replacing the psychiatric hospitals, whose purpose is offering care for the population within a given delimited area, prioritizing rehabilitation and psychosocial reintegration of the person undergoing a mental disorder, articulating the support network to make feasible the access to work, leisure, exercise of civil rights, and strengthening of family and community ties.^{4,5}

Currently, the country has 1,742 CAPS, 47 of them in Alagoas, which occupies the position of seventh state with better national coverage per capita (0.90).⁶ However, in the state capital, Maceio, there're only 5 CAPS (the only tools from the replacing network) to care for the population of about 1 million inhabitants, something which reveals an insufficient number of services with regard to the overall population. Besides, the demand for this kind of service in the city is quite high: only on the first quarter of 2010, the data reveal that the psychiatric hospitals in Maceio admitted 1,206 people; many people suffer from mental disorders and need specialized services.⁷

For this, there's a need for political organization, which, in this case, comes from the mental health policy, responsible for setting priorities among health care needs, conditions, services, treatments, and prevention and promotion strategies, as well as choices to be made with regard to its funding. The services and mental health strategies need to be well coordinated between themselves and between other sectors, expanding the support network, such as: social security, education, employment, and housing.

Epidemiological data on mental health should be monitored and analyzed so that decisions can be continuously adjusted, in order to face the new challenges.¹

This kind of study provides the governmental spheres with information, enabling the allocation of funding for the mental health area and helping to plan the health services offered to the community.

In the face of this, the study aims to describe the epidemiological profile of users of a CAPS.

METHOD

This is a quantitative research, with a descriptive design, carried out in January 2010 in a CAPS in Maceio, whose study population were users of this service. The sample consisted of 168 users and the criteria for selecting subjects was having, during their treatment, the authorization for high complexity/cost outpatient procedures (APAC). This APAC is the authorization which the Federal Government grants to the city for allowing the remuneration of the paid procedures offered by a CAPS to its users.

Data collection was conducted through the reading of medical records, using a structured form as a tool, based on the variables under investigation: sex, age group, religion, education level, family income, employment status, profession/occupation, homeland, psychic complaints at the time of admission to the CAPS, diagnoses according to the ICD-10, comorbidities, date of last admission, type of service, number of admissions to psychiatric hospitals, referrals, therapeutic activities offered, and controlled medicines.

Data were stored and analyzed by means of statistical resources of the software Epi-Info 3.4.1, through relative and absolute frequency and a 95% confidence interval; they're presented in tables and figures.

The study was authorized by the Coordination of the Mental Health Program of

the Municipal Health Secretariat of Maceio, submitted to the Research Ethics Committee of Universidade Federal de Alagoas, and approved under the Process 020134/2009-34.

RESULTS

The socioeconomic status of the studied population has its representation described in Table 1, and it revealed that the highest frequencies of users on a rehabilitation process in the CAPS were female (n = 110, 65.5%). Regarding age, there's a greater prevalence in

the age group from 40 to 49 years (n = 67, 40.6%). In turn, with regard to the variable religion, one observed an approximate frequency between Catholic users (n = 67, 50%) and Protestant users (n = 59, 44%). One also revealed, during the research, the low education level among the subjects, with 22 (15.7%) illiterate users, 66 (47.2%) with elementary level, and only 1 (0.7%) with incomplete higher education.

Table 1. Socioeconomic characteristics of the study population of a CAPS in Maceio, 2010 (n = 168).

Variable	n (%)	Variable	n (%)
Sex		Family income (minimum wage)	
Male	58 (34.5)	< 1	15 (53.6)
Female	110 (65.5)	From 1 to 2	10 (35.7)
Age group (years)		> 2 to 4	2 (7.1)
19 to 29	9 (5.5)	> 4	1 (3.6)
30 to 39	42 (25.5)	Employment status	
40 to 49	67 (40.6)	Informal employment	19 (19.4)
> 50	47 (28.5)	Formal employment	31 (31.6)
Religion		Retired	3 (3.1)
Catholic	67 (50.0)	Unemployed	45 (45.9)
Protestant	59 (44.0)	Profession/occupation	
Others	8 (6.0)	Bus fare collector	7 (5.2)
Education level		Cook/housewife/housemaid	49 (36.3)
Illiterate	22 (15.7)	Driver	12 (8.9)
Elementary	66 (47.2)	Mason/hodman/general services	20 (14.8)
High school	51 (36.4)	Clerk	7 (5.2)
Incomplete higher education	1 (10.7)	Watchman	5 (3.7)
		Others*	35 (25.9)

*Various professions/occupations mentioned 1, 2, or 3 times in the medical records of users participating in the study.

Regarding family income, only 28 (16.7%) of the medical records reviewed presented registers of this variable, showing that most users have a family income less than 1 minimum wage (n = 15, 53.60%) and only 1 user presented a family income over 4 minimum wages (3.60%).

Often, financial assistance from the user to the family occurs through paid work. The study revealed that out of the 165 medical records containing registers of this variable, only a small portion of users of the CAPS has a stabilized job status (n = 19, 19.4%) characterized by formal employment, since the vast majority of users undergoing treatment is unemployed (n = 45, 45.9%).

Concerning the profession or occupation practiced, most users perform activities which don't require a high level of education. The most frequent group consisted of occupations and/or professions developing activities similar to household chores, such as cook/housewife/housemaid (n = 49, 36.3%), followed by mason/hodman/general services

(n = 20, 14.80%). Also stood out the number of users working in the sector of land transport, as driver (n = 12, 8.9%) and bus fare collector (n = 7, 5.20%).

With regard to the homeland of users, in order to check whether the care of the CAPS under study is in accordance with the territorial distribution of the Mental Health Coordination of the city, the results show that 89.1% (n = 147) of users are from its own coverage area, with 1.8% of users coming from the 3rd district, 58.2% from the 4th sanitary district (the CAPS under study is located in this district), and 29.1% from the 7th district, one realizes that the greatest number of users lives in the same district where the CAPS is located. It also became evident that there're users (n = 15, 10.9%) from various neighborhoods of Maceio, including the sanitary districts which have the coverage of other CAPS, as shown in Figure 1.

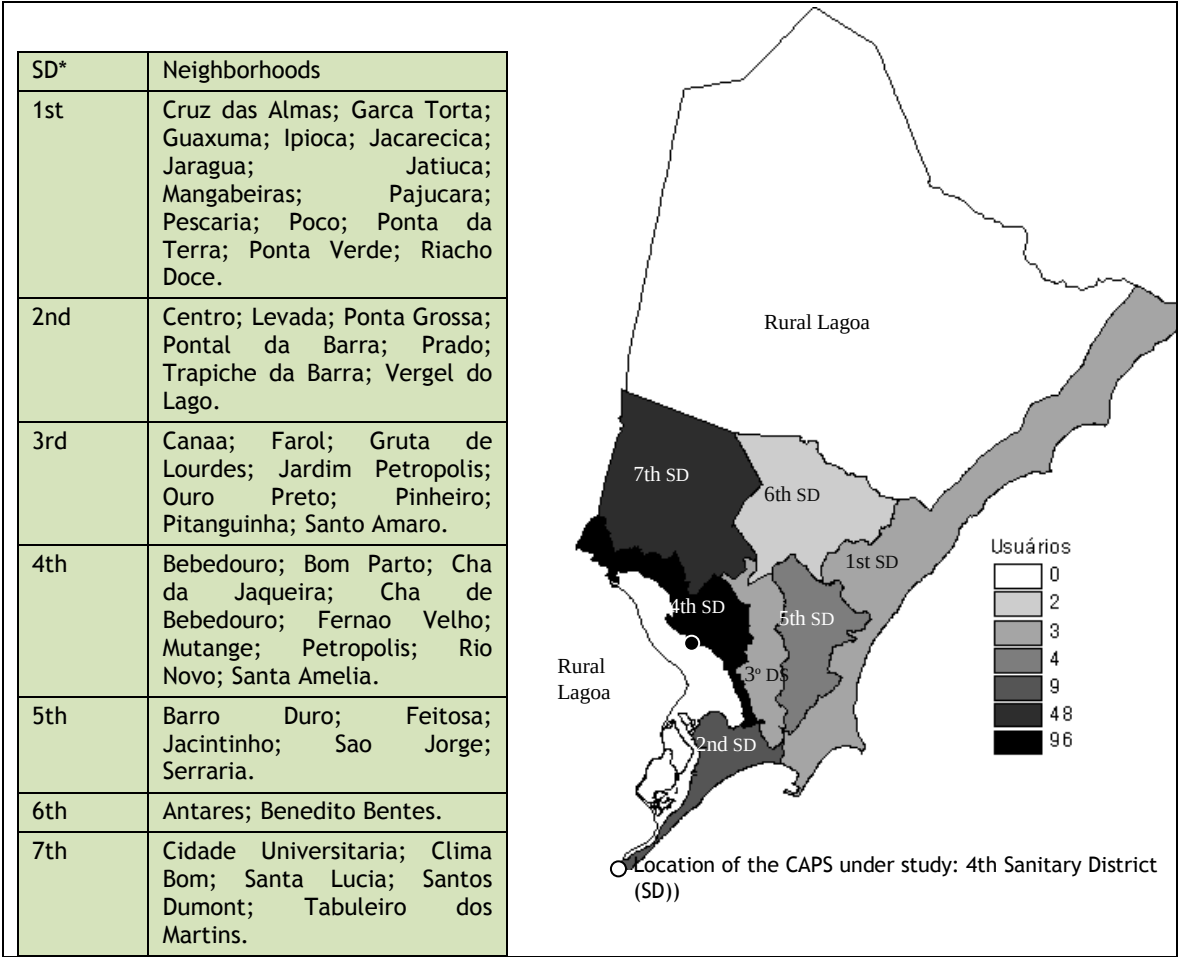


Figure 1. Sanitary district from where the users of the CAPS under study came in Maceio, 2010.

Regarding the diagnoses according to the ICD-10, Table 2 reveals that the most common diagnosis was schizophrenia/schizotypal and delusional disorders, and it was found in more than half of users admitted in the CAPS (n = 83, 53.9%), followed by mood disorder, also

having a high frequency, 55 (35.7%). Another diagnosis deserving attention was neurotic disorder, identified in 16 medical records (10.4%). Concerning the organic mental disorders and mental retardation, one found a low frequency (n = 11, 6.6%).

Table 2. Classification of the most frequently found primary diagnoses and comorbidities, according to the ICD-10, in the population of the CAPS under study in Maceio, 2010 (n = 168).

Variable	n (%)	Variable	n (%)
Primary diagnosis		Comorbidities	
Organic mental disorders	8 (4.8)	Parasitic diseases	3 (3.6)
Schizophrenia/schizotypal and delusional disorders	83 (53.9)	Depressive disorders	9 (10.8)
Mood disorders	55 (35.7)	Schizophrenia	2 (2.4)
Neurotic disorders	16 (10.4)	Other clinical conditions	9 (10.8)
Mental retardation	3 (1.8)	Other psychoses	11 (13.2)
		Panic disorder	6 (7.2)
		Mental disorders due to an organic cause	2 (2.4)
		Myopathies	7 (8.4)
		Arterial hypertension	26 (31.3)

It's worth highlighting that 26 (31.3%) out of the 83 users, in addition to having the main diagnosis, presented a secondary diagnoses, named in this study comorbidity. And that 26 (31.3%) users had systemic arterial hypertension (SAH).

The operational and clinical data can be seen in Table 3; one observed that over half of users treated in January 2010 were admitted within the period before 2008, most of them between 2005 and 2007 (n = 81,

49.10%), something which represents a period longer than two years of continuous treatment in the CAPS. Regarding the modality of treatment, 16 (9.50%) users are intensive, 68 (40.50%) are semi-intensive, and 84 (50.0%) are non-intensive.

Table 3. Operational and clinical features related to the population’s therapeutics under study in a CAPS in Maceio, 2010 (n = 168).

Variable	n (%)	Variable	n (%)
Treatment period		Referrals	
2002-2004	7 (4.2)	Spontaneous demand	99 (60.0)
2005-2007	81 (49.1)	BHU/FHS	19 (11.5)
2008-2009	77 (46.7)	Psychiatric hospital	10 (6.1)
Modality of treatment		Others	
Intensive	16 (9.5)	Activities carried out	
Semi-intensive	68 (40.5)	Community activities	
Non-intensive	84 (50.0)	1 (0.6)	
		Individual care	
		79 (47.0)	
Group care			
Admissions to psychiatric hospitals		152 (90.5)	
1 to 2	15 (50.0)	Home visit	1 (0.6)
3 to 4	1 (3.3)	Care for the family	5 (3.0)
> 5	14 (46.7)		

Only 30 users had a history of admissions to psychiatric hospitals before or during the admission to the CAPS, out of these 15 (50.0%) had 1 to 2 hospitalizations, concomitantly 14 (46.7%) had records indicating that they were admitted more than 4 times. The CAPS under study mostly receives the spontaneous demand (n = 99, 60.0%), only 10 (6.1%) users are referred by psychiatric hospitals and 19 (11.5%) users are referred by primary care.

Among the therapeutic activities offered by the CAPS within the period analyzed, the most frequently activity conducted was group care with 152 (90.5%) users, with a higher number of registers of participation in therapeutic workshop. Only one medical record had a recording of home visit and participation in community activities (0.6%). And only 5 (3.0%) medical records had recordings of care for the family.

Regarding the use of psychotropic drugs, Table 4 shows that 100% of the population under study uses controlled medicines, and in most cases they use more than one medicine. One notices that most users takes 1st generation anti-psychotic drugs, 101 (60.1%), and out of these the most frequently used were haldol, amplictil, neozine, and melleril, and 55 (32.7%) users adopt 2nd generation anti-psychotic drugs. Among the antidepressants, the least frequently used was that from the new generation (n = 3, 1.8%). A large number of users (n = 100, 59.5%) use hypnotics/anxiolytics/benzodiazepines and only 13 (7.7%) users take mood stabilizers. It’s noteworthy than 102 (60.7%) users take anticholinergics/antihistamines/beta-blockers and that among these medicines the most frequently observed were phenergan and biperiden.

Table 4. Classes of drugs most frequently used in the study population from a CAPS in Maceio, 2010 (n = 168).

Variable	n (%)
Use controlled medicines	
Yes	165 (100.0)
Classes of medicines used	
1st generation anti-psychotic	101 (60.1)
2nd generation anti-psychotic	55 (32.7)
Tricyclic antidepressant	47 (28.0)
New generation antidepressant	3 (1.8)
SSRI antidepressant	49 (29.2)
Hypnotic/anxiolytic/benzodiazepine	100 (59.5)
Mood stabilizer	13 (7.7)
Anticholinergic/antihistamine/beta-blocker	102 (60.7)
Non-mood stabilizing antiepileptic	46 (27.4)

DISCUSSION

By analyzing the data on socioeconomic features of users treated in the CAPS, one noticed that the results were similar to many studies.⁸⁻¹¹

The predominance of women in the CAPS was also found in other studies.^{8,12} One also observes that in Western populations the prevalence of non-psychotic mental disorders is higher in females (20.0%) than in males (12.5%).¹³ Some authors justify this discrepancy with regard to sex indicating that

women exhibit a marked vulnerability to anxious and depressive symptoms, especially associated to the reproductive period.¹⁴ This shows that hormonal changes can be one of the triggering factors of mental disorders, as well as psychosocial and environmental factors, often caused by the stress of routine household chores without interruptions and without remuneration, in which men, culturally, tends to have no participation.^{10,13}

Women’s participation in the performance of household chores is clearly seen by analyzing the occupation of most users of the CAPS, in view of the predominance of

professions and/or occupations, such as cook, housewife, and housemaid, also found in studies by Pelisoli.⁸

Another occupation deserving attention, performed by both sexes, were: hodman and general services (which also shows features of household chores or assistance), followed by driver and bus fare collector. Surveys conducted in Rio Grande do Sul, Brazil, reveal the high prevalence of psychiatric disorders, such as mood disorders, post-traumatic stress disorder, and antisocial personality disorder among drivers, whether associated to the use of alcohol and other psychoactive substances or robberies and stress in traffic.¹⁵

It's worth observing that the most prevalent professions and/or occupations were those not requiring a high education level, since the elementary level prevails. The education level influences on the ability to rationalize, to think through the problem, to design and verbalize it. The literature reveals that studying causes well-being, showing that the lowest rates of mental illness appeared in people attending a higher level course and, thus, the higher risks were observed in people who attended elementary and high school.¹⁰

It was also evidenced in this study data similar to the study in which the dominant education level was elementary school (36.78%).⁹ The low education levels reflect the socioeconomic profile in the state of Alagoas, which presents disastrous educational indicators not only for young adults, but also for children. Alagoas is the Brazilian state whose adult population has the lowest average education and the highest illiteracy rate. It also has a low per capita income, being regarded as the poorest state in Brazil, as well as that having the lowest average real income and the highest proportion of poor people.¹⁶

The situation of Alagoas described above confirms the predominance of family income below 1 minimum wage, often derived solely from assistance program grants of the Federal Government. However, few registers in the medical records with regard to this variable lead to a non-reliable result, since there's no standardization in the register form, besides the absence of data on most of the medical records reviewed. Generally, the lack of information for the variable may be regarded as a problem, compromising the data analysis. In this study, it wasn't possible to know the family income of 140 users (83.3%) of the CAPS, revealing that the services should improve the quality of the information registered in the medical records.

Regarding the association to the disorders, to the low per capita income, one also indicates decreased power, social disability, and, therefore, more susceptibility to mental illness. In the literature, one of the vital events strongly associated to the production of stress is undergoing severe financial difficulties.¹⁰ One also notices that the per capita income is directly related to the work situation. In the CAPS under study, about half of the users are unemployed (45.9%). This result was also found out by other studies, something which reveals a higher rate of users who don't work (35.64%) and have no specific work activity (20.0%).⁹ Concerning those who have informal employment, financial instability and the need to work every day, often, cause stress, which is also one of the evils of this century.¹⁰

Another worrying fact is the age group from 30 to 49 years (68.1%), the most reported one, confirming similar groups, because within this period there's a higher professional productivity.¹⁰ As mental disorders are among the most disabling diseases ends up generating job loss and deficit in family income, often by virtue not only of disturbing symptoms, but also discrimination.¹ It's believed that one of the factors which can lead to mental illness in this age group is the accumulation of stressful situations in daily life for years.

The adaptation to stressors and the development of mental disorders may also be related to the individuals' spirituality. Nowadays, many studies claim that people become more religious when they're sick. In high psychological stress situations, religion is often used to help coping with or adapting to suffering situations. People beg God's help seeking comfort and support from members of their religious communities, demonstrating the positive relation of the religious tie to the therapeutics.¹⁷

Formerly, a large percentage of the population was regarded as Catholic by tradition; this profile has gradually changed after the Protestant Reformation, with no significant differences between Catholics and Protestants, as perceived in several studies.^{10,17}

Regarding the demographic categorization, the CAPS under study, by caring for users who live in localities covered by other CAPS, ends up getting overcrowded and, as a consequence, this may compromise the quality of care. Also deserved attention the reduced amount of users coming from the 3rd Sanitary District (still a reference area of care for the CAPS), given that this district consists

of rich neighborhoods, where most people belong to the middle and upper classes of the society in Maceio. Such an evidence may be associated to the socioeconomic factor, given that some studies claim that the highest prevalence of people with mental and behavioral disorders who use public services are among the low-income population, the least favored one.¹⁸

Regarding the diagnostic classification, according to the ICD-10, and aware of the need for reformulations in the diagnostic method directed towards the person, as advised by the extended clinic model, and not in the disease, based on symptoms categorized by the classification code, in this study the most frequent diagnostic hypotheses were schizophrenia, mood disorder, and neurotic disorder, respectivamente.¹⁹ There's a prevalence of cardiovascular diseases as comorbidity, as observed in other epidemiological studies.^{8,9,11}

Unlike what was found in this study, a CAPS in Rio Grande do Sul, Brazil, showed a change in the order of most frequent diagnoses, revealing a higher prevalence of neurotic disorders (stress-related and somatoform) (22.39%), mood disorders (21.21%), and schizophrenia (6.3%).⁸ Besides characterizing the profile of users of a mental health service in Maceio, the data suggest that the CAPS are fulfilling their replacing role with regard to the psychiatric hospitals and, though there're still many problems, they show a positive effect of the care provided by the CAPS to patients undergoing psychological distress. It's observed that the greater the insertion time in CAPS, the higher possibility users have to decrease the amount of medication used.¹²

Another effect that the replacing services (the CAPS) have provided may be seen in the reduction of admissions in psychiatric hospitals for users undergoing a crisis, as observed in this study, given that most of the few hospitalizations occurred before the creation of CAPS. Studies carried out in a CAPS in southern Brazil claim that the data found in this study, that there's a significant decrease in the occurrence of crises among users cared for at the CAPS, something which favors reducing the number of psychiatric hospitalizations. Another fact which is worth highlighting was pointed out by Tomasi with regard to the users treated at the CAPS on a non-intensive basis is the observed decrease in drug use followed by an increasing participation in groups, showing the need for weaning the medication taking into account the addicting power of some medicines.¹²

One also observes that the permanence and adherence to the therapeutics in the CAPS positively affects these results. It's by thinking of the time the user will need to recover that the Ministry of Health advises to reduce the user's attendance to the CAPS when she/he shows a progress. The MH also established, through the Portaria 189/2002, the maximum amount of people that the CAPS II will be able to treat according to the kind of service: if intensive, at most 45 users per month, if semi-intensive, at most 75, and if non-intensive, at most 100 users, with the possibility of reaching the highest overall total of 220 users admitted to the service.⁵ This reveals that the CAPS under study, by caring for 168 users in a month, is in accordance with the limits allowed by the regulation.

Therefore, one realizes that in the CAPS under study changes often occur in these modalities, since, depending on the crisis, users get into the service in intensive care, and then move to the semi-intensive and non-intensive care afterwards. This modality change was identified at the time of collecting data; some changes were noticed in the kind of service for some users, who, besides, had already been discharged from the service.

A fact is still a matter of concern: the length of stay in treatment at the CAPS has proven to be very long, more than 50% (n = 88) of users are undergoing a continuous treatment at the CAPS for more than three years. Some authors show the existence of a new chronicity related to the new services, highlighting that a part of the clientele of mental health services is chronic by nature, because users have two usual features: severe difficulty with regard to social contact and a tendency to inappropriately use mental health services.²⁰

The CAPS should play a resistance role with regard to chronification, extending beyond control of symptoms, by stimulating the participation of users in the autonomous community spaces, appreciating family involvement and social inclusion.¹⁰ There's a need for expanding and articulating the network, making it possible that when the user gets sick in her/his territory, she/he is referred to the CAPS and, once recovered, she/he will return for outpatient follow up in the Family Health Strategy (FHS), thus preventing a user's long permanence in the medium complexity service. However, this study revealed the deficiency of the network, given that most users get to the service by their own will and not referred by primary care.

One also identified few records related to the therapeutics involving family, home visit, and community activities (extra wall). Most registers are related to the activities undertaken in groups, followed by individual activities within the CAPS.

Concerning the drug therapy, the concomitant use of several classes of psychotropic drugs deserve attention, something which requires from the physician a mastery of drug interactions, in order to prevent unwanted effects. Polytherapy is a useful tool for the treatment of coexisting diseases, but the combination of drugs may reduce the effectiveness and/or favor the emergence of adverse reactions with different severity degrees.²¹

In the CAPS under study, there's a high percentage of users taking 1st generation anti-psychotic drugs when compared to those who take the 2nd generation or new generation ones, since it's known that these drugs bring many side effects, and the drug which was developed later generally has fewer side effects, although some positive symptoms of schizophrenia respond better with 1st generation anti-psychotic drugs, i.e. the typical ones.²²

CONCLUSION

The study allowed one to identify the epidemiological profile of users of a CAPS in Maceio which may provide the Mental Health Coordination of this city with means for developing mental health care actions and designing the specific therapy, outlining strategies which make possible the care for the service users taking into account their individual and/or collective needs.

Recognizing the population's epidemiological profile is the first step for making any action effective and one can: evaluate the services, identify the determinants leading to illness, and understand the subjects undergoing suffering.

Another fact which caught attention was the prevalence of care due to spontaneous demand in that CAPS under study, showing that the support network is insufficient in the city of Maceio, whose coverage by the FHS reaches only 27%. It's expected that the health care system can, one day, work as an integrated circuit of sanitary units, whose point of entry in the territory is the FHS.

However, knowing the user one can rethink psychosocial care, checking if the proposed Psychiatric Reform has been put into practice in the replacing services, as this proposal is a

continuous process of thinking through the practices and recreating them.

As a suggestion, one highlights the need for discussing, along with professionals involved in the care provided by the CAPS, the importance of proper register in the medical records, "tools" that may constitute a research basis for the service. There's also a need for improving the expansion of the support network (CAPS with Primary Care), at the municipal level, in order to offer a wider variety of possibilities of psychosocial rehabilitation.

REFERENCES

1. Brasil, Ministério da Saúde. Direção-Geral da Saúde/ OMS. Relatório Sobre a Saúde no Mundo (2001) - Saúde mental: nova concepção, nova esperança. Brasília: Climepsi Editores; 2002.
2. World Health Organization. Mental Health Gap Action Programme: scaling up care for mental, neurological and substance use disorders; 2008.
3. Brasil. Lei n. 10.216, de 6 de abril de 2001. Dispõe sobre a proteção e os direitos das pessoas portadoras de transtornos mentais e redireciona o modelo assistencial em saúde mental. Brasília: Diário Oficial da União; 09 abr 2001.
4. Sousa ECB, Silva JC, Silva TGF, Santos RCA, Miranda FAN. Percepção de alunos de graduação em enfermagem sobre o papel da família junto ao portador de transtorno mental no contexto da reforma psiquiátrica no Brasil. Rev enferm UFPE on line [Internet]. 2011 Sept [cited 2012 June 20]; 5(7):1644-50. Available from: <http://www.ufpe.br/revistaenfermagem/index.php/revista/article/view/1773>
5. Brasil. Ministério da Saúde. Secretaria de Atenção à Saúde. Departamento de Ações Programáticas Estratégicas. Saúde mental no SUS: os centros de atenção psicossocial. Brasília (DF): Ministério da Saúde; 2004.
6. Brasil. Número de Centros de Atenção Psicossocial (CAPS) por tipo e UF e Indicador CAPS/100.000 habitantes, Brasil - dezembro de 2010 [Internet]. Área Técnica de Saúde Mental/DAPES/SAS/MS e Instituto Brasileiro de Geografia e Estatística; 2010 [cited 2012 June 24]. Available from: http://portal.saude.gov.br/portal/arquivos/pdf/2011_1_21caps_uf_dez.pdf
7. Informações de Saúde sobre Internações Hospitalares do SUS em Alagoas [Internet]. Brasília (DF): Ministério da Saúde. c2010 [cited 2010 Nov 25]. Available from: <http://tabnet.datasus.gov.br/cgi/tabcgi.exe?sih/cnv/sxal.def>

8. Pelisoli CL, Moreira AK. Caracterização epidemiológica dos usuários do Centro de Atenção Psicossocial Casa Aberta. Rev Psiquiatr Rio Gd Sul online [Internet]. 2005 Sept-Dec [cited 2011 Jan 10]; 27(3):270-7. Available from: http://www.scielo.br/scielo.php?pid=S0101-81082005000300006&script=sci_arttext
9. Barros EMD. O perfil dos usuários inscritos no CAPS II - TM de Montes Claros de 2002 a 2008. In: Anais do II Congresso Brasileiro de Saúde Mental; 2010 June. Rio de Janeiro, Brasil. Rio de Janeiro: ABRASME; 2010.
10. Bozza M, Oliveira JHG. Levantamento epidemiológico sobre os principais transtornos mentais na cidade de Imperatriz-Maranhão. Revista Eficaz [Internet]. 2010 [cited 2011 Jan 10];1-16. Available from: http://www.institutoeficaz.com.br/revistacientifica/wp-content/uploads/2009/12/Jos%C3%A9-Humberto_Revista1.pdf
11. Osinaga VLM, Furegato ARF, Santos JLF. Usuários de três serviços psiquiátricos: perfil e opinião. Rev Latino-Am Enfermagem [Internet]. 2007 Jan-Feb [cited 2011 Jan 10];15(1):70-7. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0104-11692007000100011&lng=pt&nrm=iso&tlng=pt&userID=-2
12. Tomasi E, Facchini LA, Piccini RX, Thumé E, Silva RA, Gonçalves H, et al. Efetividade dos centros de atenção psicossocial no cuidado a portadores de sofrimento psíquico em cidade de porte médio do Sul do Brasil: uma análise estratificada. Cad Saúde Pública [Internet]. 2010 Abr [cited 2011 Jan 10]; 26(4):807-15. Available from: <http://www.scielo.br/pdf/csp/v26n4/22.pdf>
13. Araujo TM, Pinho OS, Almeida MMG. Prevalência de transtornos mentais comuns em mulheres e sua relação com as características sociodemográficas e o trabalho doméstico. Rev Bras Saude Mater Infant [Internet]. 2005 July-Sept [cited 2011 May 05];5(3):337-48. Available from: <http://www.scielo.br/pdf/rbsmi/v5n3/a10v5n3.pdf>
14. Andrade LHSG, Viana MC, Silveira CM. Epidemiologia dos transtornos psiquiátricos na mulher. Rev psiquiatr clín [Internet]. 2006 [cited 2011 May 05];33(2):43-54. Available from: <http://www.hcnet.usp.br/ipq/revista/vol33/n2/43.html>
15. Faller S. Psicopatologia e comportamento de risco em motoristas no Brasil [Dissertação]. Porto Alegre (RS): Programa de Pós-Graduação em Ciências Médicas: Psiquiatria,

- Universidade Federal do Rio Grande do Sul; 2010.
16. Urani A. Um diagnóstico socioeconômico do Estado de Alagoas a partir de uma leitura dos dados da Pesquisa Nacional por Amostra de Domicílios do IBGE (1992-2004). Inst de Est do Trabalho e Sociedade [Internet]. 2005 [cited 2011 Sept 14]. Available from: http://www.iets.org.br/biblioteca/Um_diagnostico_socioeconomico_do_Estado_de_Alagoas.pdf
17. Koenig HG. Religião, espiritualidade e transtornos psicóticos. Rev psiquiatr clín. 2007; 34(1):95-104.
18. Ballone GJ. O que são Transtornos Mentais. 2008 [cited 2010 Nov 02]. In Psiqweb [Internet]; [about 7 screens]. Available from: <http://www.psiqweb.med.br/site/?area=NO/LerNoticia&idNoticia=230>
19. Brasil. Ministério da Saúde, Secretaria de Atenção à Saúde, Núcleo Técnico da Política Nacional de Humanização. Clínica ampliada, equipe de referência e projeto terapêutico singular. 2.ed. Brasília: Ministério da Saúde; 2007.
20. Pande MNR, Amarante PDC. Desafios para os CAPS como serviços substitutivos: a nova cronicidade em questão. Ciênc Saúde Coletiva [Internet]. 2011 Apr [cited 2011 Oct 22];16(4): 2067-76. Available from: http://www.cienciaesaudecoletiva.com.br/artigos/arquivos/imagens/20091127121611_1docx.
21. Coelho PV, Brum CA. Interactions between antidepressants and antihypertensive and glucose lowering drugs among patients in the HIPERDIA Program, Coronel Fabriciano, Minas Gerais State, Brazil. Cad Saúde Pública [Internet]. 2009 Oct [cited 2011 Jan 05];25(10):2229-36. Available from: http://www.scielo.br/scielo.php?pid=S0102311X2009001000013&script=sci_arttext
22. Stefanelli MC, Fukuda IMK, Arantes EC, organizadores. Enfermagem Psiquiátrica em suas dimensões assistenciais. Barueri: Manole; 2008.

Submission: 2012/06/25

Accepted: 2013/01/11

Publishing: 2013/03/01

Corresponding Address

Yanna Cristina Moraes Santos Lira
 Conjunto Village Campestre I, Qd H, R. 12
 nº60 / Cidade Universitária
 CEP: 57072-900 — Maceió (AL), Brazil