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RESEARCH

THE MENTAL DISORDER PROFILE OF PATIENTS TREATED AT THE CENTER FOR PSYCHOSOCIAL CARE (CAPS)

PERFIL DO PORTADOR DE TRANSTORNO MENTAL EM TRATAMENTO NO CENTRO DE ATENÇÃO PSICOSSOCIAL (CAPS)

PERFIL DEL PACIENTE CON TRASTORNO MENTAL EN TRATAMIENTO EN EL CENTRO DE ATENCIÓN PSICOSOCIAL (CAPS)

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ABSTRACT

Objective: Featuring the mental disorder profile of patients treated at the Center for Psychosocial Care. **Method:** a descriptive study conducted with 300 mental disorder patients from April to June 2014. The data were analyzed through descriptive statistics. **Results:** 63% of the interviewees were women, 34.7% were between 40 and 49 years old, 44.7% were single, 59.4% had more than eight years of schooling, 38.4% were unemployed, 50.4% had per-capita income below one minimum wage, and 61% showed clinical comorbidity. As for mental disorders, 33.6% had Bipolar Affective Disorder, 19.1% had Schizophrenia, and 18.6% had Depression. Also, 78.6% needed hospitalization, 67.7% attempted suicide, 39% took more than three prescribed medications, and 52% took more than five tablets per day. **Conclusion:** Knowing the features of this clientele is essential to set intervention strategies, as well as to improve the quality of the care provided to them.

Keywords: Mental Disorders; Health Profile; Mental Health.

RESUMO

Objetivo: *caracterizar o perfil do portador de transtorno mental em tratamento no Centro de Atenção Psicossocial.* ***Método:*** *estudo descritivo realizado com 300 portadores de transtorno mental de abril a junho de 2014. Os dados foram analisados por meio de estatística descritiva.* ***Resultados:*** *63% dos entrevistados eram do sexo feminino, 34,7% na faixa etária dos 40 aos 49 anos, 44,7% solteiros, 59,4% com mais de oito anos de escolaridade, 38,4% desempregados, 50,4% com renda per capita inferior a um salário mínimo e 61% apresentavam comorbidade clínica. Sobre os diagnósticos de transtorno mental, 33,6% tinham transtorno afetivo bipolar, 19,1% esquizofrenia e 18,6% depressão. Ainda, 78,6% necessitaram de internação, 67,7% tentaram suicídio, 39% tinham prescrição de mais de três medicamentos e 52% precisavam ingerir mais de cinco comprimidos diários.* ***Conclusão:*** *o conhecimento das características dessa clientela é indispensável para se estabelecer estratégias de intervenção e melhoria na qualidade da assistência prestada.*

Palavras-chave: *Transtornos Mentais; Perfil de Saúde; Saúde Mental.*

RESUMEN

Objetivo: *caracterizar el perfil del paciente con trastorno mental en tratamiento en el Centro de Atención Psicosocial.* ***Método:*** *estudio descriptivo realizado con 300 portadores de trastorno mental de abril a junio de 2014. Los datos fueron analizados a través de estadística descriptiva.* ***Resultados:*** *63% de los entrevistados eran mujeres; 34,7% entre 40 y 49 años; 44,7% solteros; 59,4% con más de ocho años de escolaridad; 38,4% desempleados; 50,4% con ingreso per cápita inferior a un sueldo mínimo y 61% presentaban comorbilidad clínica. Sobre los diagnósticos de trastorno mental, 33,6% tenían trastorno afectivo bipolar; 19,1% esquizofrenia y 18,6% depresión. Aún, 78,6% necesitaron internación; 67,7% intentaron suicidio; 39% tenían prescripción de más de tres medicamentos y 52% precisaban ingerir más de cinco comprimidos diarios.* ***Conclusión:*** *es indispensable conocer las características de esta clientela para establecer estrategias de intervención y mejorar la calidad de la atención.*

Palabras clave*: Trastornos Mentales; Perfil de Salud; Salud Mental.*

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INTRODUCTION

Mental disorders are responsible for a significant part of the diseases, occupying an important space in the prevalence of chronic diseases worldwide. They can affect the individual at any stage of their life, regardless of gender and social class. They present psychological and/or behavioral manifestations associated with functional impairment due to biological, social, psychological or genetic alteration.[1-2]

It is estimated that 450 million people suffer from mental, neurobiological or psychoactive substance disorders, with an estimated of 25% of the world's population - one in four people - at some point in their lives will be affected by these diseases. Mental disorders are 12% of the global burden of disease with an estimated increase to 15% by 2030.[2]

Historically, mental health treatment was guided by exclusionary practices and carried out in large asylums. Since 2001, with the approval of Law 10.216, there has been a redirection of the mental health care model in the country, driven by the ideals of the psychosocial model. This model has the construction of a network of services as its premise that must constitute true spaces of sociability, reception, care and social relationships articulated among themselves, with basic care and with the community.[3]

In this context, a network of psychosocial care for people with mental disorders and needs arising from the use of crack, alcohol and other drugs is established, and the Psychosocial Care Center (CAPS) is one of the components of the specialized psychosocial care network. The reception and care of people suffering from mental disorder in their territory.[4]

It is a substituting service in increasing expansion. In 2000 there were 208 CAPS in the country, by 2014 the figure reached 2,209 and the latest data published in 2015 related to mental health indicate national coverage of 0.86 CAPS/100 thousand inhabitants and the increase in the expansion of these services in all regions of the country.[4]

Faced with the expansion of the CAPS, its importance in the articulation of the mental health network, the need for continuous follow-up to those with mental disorders and aiming at the best practices in this area of knowledge, which are in fact confluent to the needs of the clientele served, in this study, the purpose of this study is to characterize the profile of the mental disorder patient under treatment in the CAPS.

MATERIAL AND METHOD

This is a descriptive study of a quantitative approach, carried out in two CAPS in the city of Curitiba, from April to June 2014, with 300 patients with mental disorders. The study included those patients with mental disorders over 18 years old who attended CAPS to perform their treatment activities during the data collection period. Those who were in a situation of exacerbation of psychiatric signs and symptoms were excluded, in an eventual attendance or who were not able to answer the questions during the interview, according to the evaluation of the health team of the service.

The participants were invited to participate in the research by verbal invitation. There 370 participants of the 510 registered in the two CAPS approached, 300 accepted to participate, 14 refused, and 56 did not fit the inclusion criteria. The 140 individuals who were not approached did not attend CAPS during the period of data collection.

Data were collected through a structured interview and medical records. The data collection took place simultaneously in the two services, carried out by ten trained interviewers who remained throughout the operation service, so all those with mental disorders that fit the inclusion criteria were addressed. A questionnaire was used, composed of questions related to the demographic, socioeconomic, clinical, and pharmacotherapeutic characteristics of the participants, constructed for this research. It was applied in a pilot test with 30 mental disorder patients who did not integrate the final study population.

For the analysis, there was double tabulation checking and coding of the questions. The data were entered into a database in the Excel® program and, after verification and correction of possible typos, transported to the BioEstat® Program.

The study was approved by the Research Ethics Committee of the Federal University of Paraná, number 406.158/2013, and all ethical aspects were safeguarded by Resolution 466 of December 12, 2012, of the National Health Council. This study received funding from CNPq - universal notice - process number 480625/2013-1.

RESULTS

Of the 300 participants in the study, 189 (63%) were female, 104 (34.7%) were in the 40-49 age group, 184 (61.4%) were white, 134 44.7%) were single and 126 (42%) said they practiced the Catholic religion. It was identified that 178 (59.4%) of the interviewees had more than eight years of education, 237 (79%) dropped out, and 115 (38.4%) were unemployed.

Among the interviewees, 135 (45%) indicated family income as the main source of income, 136 (45.3%) obtained one to 2.5 minimum wages as individual income in the month before data collection, 151 (50.4% %) had below a minimum wage per capita income and 256 (85.3%) reported living with relatives. The minimum salary in force at the time of data collection of R$ 724.00 was considered to carry out the calculations referring to income.

Regarding the use of tobacco and alcohol, 96 (32%) of the interviewees reported being smokers, 33 (11%) used alcohol. Of them, 13 (39.4%) consumed them sporadically. Also, in the last year, 30 (10%) used illicit drugs, 23 of them (7.6%) used marijuana.

Table 1 shows that 183 (61%) of the participants had clinical comorbidity. Of the total number of clinical health problems cited, 93 (28.8%) were cardiovascular and endocrine diseases 75 (23.3%). Of the 183 mentally ill patients who reported clinical comorbidity, 72 (39.3%) had two health problems, and 152 (83%) mentioned using medications for the treatment of clinical diseases.

As for the diagnoses of mental disorders in the interviewees' records (one individual could have more than one diagnosis), bipolar affective disorder (BAD) – 123 (33.6%); Schizophrenia – 70 (19.1%); And depression – 68 (18.6%) were prevalent. Still, 147 (49%) had disease time between one and ten years, and 200 (66.7%) were treated at CAPS for less than one year.

Table 1 - Distribution of patients with mental disorder under treatment in the CAPS according to the clinical variables – Curitiba, Paraná, Brazil, 2014

Variables	N	%
Clinical Comorbidity		
Yes	183	61
No	117	39
Total	**300**	**100**
Type of clinical comorbidity		
Cardiovascular problems	93	28.8
Endocrine problems	75	23.3
Musculoskeletal problems	74	23
Respiratory problems	16	5
Gastrointestinal problems	16	5
Neurological problems	15	4.7
Ophthalmologic problems	7	2.2
Kidney problems	7	2.2
Liver problems	7	2.2
Immunological problems	6	1.8
Problem of labyrinthitis	6	1.8
Total	**322***	**100**
Amount of clinical comorbidity		
1 Clinical comorbidity	81	44.3
2 Clinical comorbidities	72	39.3
≥ 3 Clinical comorbidities	30	16.4
Total	**183**	**100**
Use of medication for clinical comorbidity		
Yes	152	83
No	31	17
Total	**183**	**100**
Diagnosis of mental disorder†		
Bipolar affective disorder	123	33.6

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Table 1 - Distribution of patients with mental disorder under treatment in the CAPS according to the clinical variables – Curitiba, Paraná, Brazil, 2014

Variables	N	%
Diagnosis of mental disorder†		
Schizophrenia	70	19.1
Depression	68	18.6
Neurotic, stress-related and somatoform disorders	35	9.6
Disorders of personality	28	7.7
Mental and behavioral disorders due to use of SPA§	17	4.6
Schizophrenic Disorders and Delusional Disorders	13	3.6
Others	12	3.2
Total	**366‡**	**100**
Time of illness		
< 1 year	15	5
1 to 10 years	147	49
> 10 years	135	45
Did not know how to report it	3	1
Total	**300**	**100**
Treatment time in the Psychosocial Care Center		
< 1 year	200	66.7
1 to 2 years	75	25
> 2 years	23	7.6
Did not know how to report it	2	0.7
Total	**300**	**100**

*One participant could have more than one clinical comorbidity; † diagnosis according to ICD-10 indicated in the medical record of each participant; ‡ The same participant could have more than one diagnosis of mental disorder. §SPA: Psychoactive Substance.
Source: the author (2014).

Regarding the need for hospitalization due to mental disorder, 236 (78.6%) of the participants presented a history of hospitalization. Of them, 120 (40%) stated that they did not correctly use the medications prescribed for the mental disorder at the time of admission. Among the subjects requiring hospitalization, 205 (68.3%) were admitted to a psychiatric hospital, 35 (11, 6%) in a general hospital, 125 (41, 6%) in emergency care units and 46 (15, 3%) in CAPS III. It is emphasized that the same participant could have been hospitalized in more than one place.

Table 2 shows that 203 (67.7%) of the interviewees attempted suicide. Of them, 142 (47.4%) were female, 63 (31%) reported more than three attempts. Of the total number of methods used in the attempt, the most used were exogenous intoxication (132, 41%). And among the substances of choice, the use of drugs was indicated 125 times (79, 2%).

Table 2 - Distribution of patients with mental disorder under treatment in the CAPS by gender according to variables related to the suicide attempt – Curitiba, Paraná, Brazil, 2014

Variables	Sex				Total	
	Male		Female			
	(n)	%	(n)	%	(n)	%
Suicide attempt						
Yes	61	20.3	142	47.4	203	67.7
No	50	16.6	47	15.7	97	32.3
Total	**111**	**36.9**	**189**	**63.1**	**300**	**100**
Number of attempts						
1 attempts	21	10.3	40	19.7	61	30
2 attempts	17	8.4	22	10.8	39	19.2
3 attempts	10	5	23	11.3	33	16.3
> 3 attempts	11	5.4	52	25.6	63	31
Did not know how to report it	2	1	5	2.5	7	3.5
Total	**61**	**30.1**	**142**	**69.9**	**203**	**100**
Method used Exogenous intoxication						
Exogenous intoxication	32	9.9	100	31.1	132	41
White gun	19	5.9	45	14	64	19.9
Hanging	19	5.9	28	8.7	47	14.6
Running over	10	3.1	21	6.5	31	9.6
Precipitating	6	1.9	19	5.9	25	7.8
Others	10	3.1	13	4	23	7.1
Total	**96***	**29.8**	**226***	**70.2**	**322***	**100**
Substance used in exogenous intoxication						
Medications	27	17.1	98	62.1	125	79.2
Raticide and pesticide	8	5.1	11	6.9	19	12
Others	4	2.5	9	5.7	13	8.2
Did not know how to report it	1	0.6	0		1	0.6
Total	**40**	**25.3**	**118**	**74.7**	**158***	**100**

*Question with more than one possibility of response. Source: the author (2014).

When analyzing the total number of medication prescribed to the participants by drug class, there was a predominance of antipsychotics and mood stabilizers, represented by 251 (32.3%) and 177 (22.8%), respectively. It was found that 117 (39%) of the interviewees had more than three drugs prescribed. Of the 296 mentally ill patients taking oral medication, 154 (52%) had to take more than five pills daily for the treatment of mental disorder. To identify the drug class, the names, and quantity of drugs prescribed for the treatment of the mental disorder, the copy of the last medical prescription was used in the chart of each interviewee, according to Table 3.

It is also observed that the basic health unit was indicated 227 times (48%) as the place where the interviewees acquire the drugs prescribed for their treatment in mental health. The were 134 (44.7%) participants who reported having difficulties accessing the prescribed medication, with prevalence being the lack of the drug in the basic health network, 7 (42.4%) and not having the financial resources to buy it, 77 (41.8%).

Table 3 - Distribution of the mental disorder patients under treatment in the CAPS according to variables pharmacotherapeutic, Curitiba, Paraná, Brazil, 2014

Variables	N	%
Drug class		
Antipsychotic	251	32.3
Mood Stabilizer	177	22.8
Anxiolytics and sleep inducers	170	21.9
Antidepressants	158	20.4
Other medications	20	2.6
Total	**776***	**100**
Quantity of prescription drugs		
1 drug	33	11
2 drugs	52	17.3
3 drugs	98	32.7
> 3 drugs	117	39
Total	**300**	**100**
Amount of pills ingested per day		
1 pills	16	5.4
2 to 5 pills	126	42.6
> 5 pills	154	52
Total	**296†**	**100**
Acquisition of drugs		
Basic health Unit	227	48
Own resource	165	35
Popular pharmacy	35	7.4
Psychosocial Care Center	28	6
Others (direct with the doctor and judicial)	17	3.6
Total	**472***	**100**
Difficulty in acquiring medicines		
Yes	134	44.7
No	166	55.3
Total	300	100
Type of difficulty		
It was missing in the basic health network	78	42.4
They did not have the money to buy it	77	41.8
Prescription problems	16	8.7
It was missing for sale at the pharmacy	9	4.9
Burocracy	4	2.2
Total	184*	100

*Question with more than one possibility of answer; †four respondents were prescribed only for injectable drugs.
Source: The author (2014).

DISCUSSION

Individuals in the age group of 25 to 54 years old had high rates of mental disorder. Women are more affected by anxiety, mood, and somatoform disorders, while psychoactive substance use disorders are prevalent in men. Women are more vulnerable to hormonal and psychological factors and have more ability to identify changes in their health status and seek specialized treatment services,[5] which may have contributed to the prevalence of women in the study.

As to education, studies[6-8] found lower levels of education, differing from this study. However, despite the longer education, it is important to note that there was a predominance of interviewees who dropped out, which may indicate a consequence of the limitations imposed by the mental disorder. Also, some of the reasons for dropping out of school are factors that can be modified by inclusive measures in education and in health network that allows articulation among health workers, education professionals, family, and society. Regarding the marital situation, other authors[6-8] corroborate the results found when observing in their research the prevalence of single people.

The situation of those with mental disorders in the formal labor market is still guided by the historical conception that the "madman" is incapable and unproductive for labor relationships. However, it is precisely through work, an essential component for the implementation of psychosocial rehabilitation, autonomy, and citizenship, that the person with mental disorder can be reinserted in society, and solidarity economy is an important strategy for social inclusion.[3,6]

The perspective of the solidarity economy contrasts with competition and the impoverishment of social relationships at work, based on the collective, cooperation, self-management, a new form of production of products and relationships.[3] In this area, 1,008 experiences were mapped in all regions of the country regarding initiatives to generate work and income for people with mental disorders by the Ministry of Health in 2013.[4]

In the discussion about the demographic and socioeconomic characteristics of the participants, it should be considered the fact that the mental disorder presents with specific changes related to the thought, emotion, perception, and behavior that can reflect in the daily activities of the people affected by it, with compromise in life affective, economic, professional and educational. Also, the need for long periods of withdrawal for the treatment of the disorder contributes to the interruption of studies, hindering for these individuals to enter the labor market and to maintain the employment relationship.[9,10]

Most of the participants did not use alcohol and other drugs. However, when considering the repercussions of the use of these substances on the physical and mental health of people, it is pertinent to argue that 32% of the interviewees were smokers, 11% used alcohol and 10% have used illicit drugs in the last year, especially marijuana.

The use of tobacco among people with mental disorders is high. It is estimated that 70% to 90% of people with TAB and schizophrenia are smokers and people with depressive disorders, anxiety and schizophrenia have a greater difficulty in quitting smoking.[1] Likewise, an integrative review[11] on smoking and schizophrenia found an average prevalence of 59% of smokers in this population. The use of nicotine may interfere with drug therapy, worsen the symptoms of the disorder, providing more occurrence of seizures and vulnerability to respiratory and cardiovascular diseases.

The use of psychoactive substances by people with mental disorders may be greater than evidenced by epidemiological studies since it is poorly diagnosed in clinical practice. This implies less recovery and reduced therapeutic response to medications. It is estimated that 50% of people with severe mental disorders develop problems associated with the use of alcohol and other drugs.[12]

Mental disorder patients use psychoactive substances to mitigate the signs and symptoms of the disease or the side effects of medications. However, the use worsens the prognosis, exacerbating the symptoms of the disease, predisposing to a greater number of episodes and consequent relapses, hospitalizations and high risk of suicide. In people with severe mental disorders, "even in small doses and by chance, the consumption of psychoactive substances can have worse consequences when compared to people without such disorders."[12:7]

Epidemiological studies have shown a high prevalence of marijuana use among patients with mental disorders, from 23% to current use, 42.1% for use in life and 22.5% for abuse. Their consumption by people with mental disorders such as schizophrenia, mood disorders, and anxiety may have a negative impact on the evolution of the disorder, either in the acute phase of the disease or the more advanced stages.[13]

Regarding the clinical profile of the interviewees, the literature describes a higher proportion of deaths due to cardiovascular causes in people with mental disorders than expected for people of the same gender and age group in the general population, as well as a high prevalence of obesity, smoking, sedentary lifestyle, hypertension and dyslipidemia.[14,15] There is also a description of the association between endocrine problems, such as subclinical hypothyroidism and the appearance of depressive symptoms.[16]

Some of the reported clinical problems can be prevented with health education and the mitigated consequences if diagnosed and treated early. Healthy life habits should be encouraged by health professionals as well as nutritional monitoring. However, in spite of the high prevalence of clinical comorbidity in people with mental disorders, this population has some-

times been underestimated by health professionals, leading to neglected care regarding clinical aspects.[14,17]

Patients with mental disorders who present clinical comorbidity, and to the medications prescribed for the disorder, need to use other medications. This implies complex therapeutic regimens, which may compromise the continued and appropriate use of the drug to achieve the best therapeutic response. Also, there is the risk of drug interactions and intentional and unintentional poisoning by medications.

Regarding the diagnoses of mental disorder, it is known that the TAB has complex clinical presentations, causing functional impairment to the patient and their relatives and attending with high morbidity and mortality. Also, it generally manifests in the formative phase of life, reflected in intrapersonal, educational and financial difficulties. The TAB (type I and II) has an estimated prevalence of 1.5%, but when the diagnostic criteria are broadened, it is observed a prevalence of the so-called bipolar spectrum of 3 to 8.3% .[18]

Schizophrenia was prevalent in 1% of the population. It represents the main form of psychosis, usually presenting in late adolescence and early adulthood. It also affects men and women, but its appearance is more precocious in men. Its manifestation is related to alterations of the thought, of the sense-perception and the will, to the bizarre behavior, affective blunting and apragmatism. Positive and negative symptoms reflect the daily life of people with schizophrenia in social isolation, lack of interest in the external world, introspection, lack of insight about the disease and, in some cases, deficits in self-care and manifestation of aggressiveness.[1,18]

Regarding the depression, it is estimated that its prevalence is 3 to 11% in the general population, associated with disabilities and more frequent in women, young people with low socioeconomic level and education, single or separated and unemployed.[19-20] Depression has symptoms related to anhedonia, significant reduction of energy, loss of confidence, low self-esteem, feelings of self-doubt and excessive guilt, thoughts of loss and death. Changes in sleep, eating, and sexual activity may occur, such as loss of libido.[1]

Regarding the hospitalization history, poor adherence to medication therapy in mental health treatment has been positively associated with the need for rehospitalization and exacerbation of signs and symptoms.[8-9] Most hospitalizations occurred in a psychiatric hospital by the public mental health policy in force in the country, advocating the treatment of people with mental disorders in territorially based, community-based devices working in articulated networks.

The high number of hospitalizations in psychiatric hospitals is a worrying fact when considering that this reality is directly related to the disarticulation or little articulation and the capacity of effectiveness and resolution of the mental health care network. Also, it indicates that remnants of hospital-centered treatment still permeate everyday life, the actions of health professionals and the relationship of society to the person with mental disorder.[21]

The lack of follow-up after hospital discharge, lack of information and guidance about the disorder and its chronic course, drug use, and the deficit of out-of-hospital services can be predictors of the need for hospitalization in psychiatric hospitals. Besides the increasing expansion, they are still insufficient, and there is a difficulty in ensuring continuity of treatment in substitutive devices.[21]

Regarding the attempted suicide, people with mental disorders are three to 12 times more likely to commit suicide when compared to individuals without psychiatric illness. About 95% of people who attempt or commit suicide have a previously diagnosed mental disorder. It is noteworthy that 45 to 70% of people who attempt suicide have mood disorders and 19 to 24% have a history of a prior attempt, with a higher risk of retreating in the three months after the first attempt.[1]

According to the report on suicide prevention issued by the Pan American Health Organization in 2014, one person commits suicide every 40 seconds and many others attempt unsuccessful attempts. More than 800,000 individuals die each year, representing a worldwide rate of 11.4/100,000 inhabitants. Suicide is considered the second leading cause of death among people aged 15-29 worldwide. In Brazil, 11,821 people committed suicide in 2012, representing a suicide rate of 5.8/100,000 inhabitants.[22]

A study[23] that analyzed suicide mortality in Brazil from 2000 to 2012 revealed that consummate suicide was 3.7 times more frequent in men than in women, 86.9% of suicide deaths were due to self-harm (hanging, firearm, precipitation of high places) and 13.1% due to intentional exogenous intoxication, with emphasis on the use of pesticides and drugs. Regarding regional differences, the highest incidence occurred in the South region, with 9.8 cases/100,000 inhabitants. Suicide in this region declined in men and increased in women.

Regarding the pharmacotherapeutic profile, antipsychotics are the drugs of choice for the treatment of psychotic episodes in both acute and maintenance phases, since they block dopaminergic activity, exacerbated in this condition. The main side effects of the use of antipsychotics are extrapyramidal effects, metabolic syndrome, and sexual dysfunction. Extrapyramidal effects may occur in the first few days or weeks of use and are dose-dependent, most often reversed with decreased dosage or, depending on severity, with discontinuation of the drug. They are characterized by acute dystonia, parkinsonism, akathisia, tardive dyskinesia and neuroleptic malignant syndrome.[18,24]

Concomitant use of medicines may increase the possibility of side effects and drug incompatibility. This creates difficulties for the self-administration of drugs by patients with mental disorders and may be indicative of worsening of their health status and non-adherence to drug therapy.[7]

However, it should be emphasized that, considering the complexity of the mental disorder and the associated clinical and psychiatric comorbidities, in some cases, a complex drug regimen may be necessary to achieve the best health status of the mentally ill person and reduce morbidity and mortality.

Regarding the difficulties related to the acquisition of medicines, the Unified Health System has advanced in the organization of programs such as the National Medicines Policy, the adoption of the National Relation of Essential Medicines and the popular pharmacy program, aimed to guarantee the access of the population. However, although programs focused on pharmaceutical care and drug costs account for a large part of public health investment in Brazil, people with mental disorders experience failures in the provision of the drug by public health services, which has a negative impact on adherence to medication use.[8]

CONCLUSION

This study characterized the demographic, socioeconomic, clinical and pharmacotherapeutic profile of the mental disorder patients undergoing treatment at CAPS. Thus, it can contribute to guide multi-professional intervention, guiding actions, policies and rehabilitation practices in the context of the psychosocial model, when considering the individuality and uniqueness of the person in psychic suffering.

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