Experiences about the use of psychotropic drugs among users of primary health care

Experiências acerca do uso de psicotrópicos entre usuários da atenção primária à saúde

Experiencias sobre el uso de psicofármacos entre usuarios de la atención primaria de salud

RESUMO

Objetivo: Traçar o perfil dos usuários de psicotrópicos vinculados a uma Unidade Básica de Saúde e investigar suas perspectivas futuras relativas à manutenção do tratamento. Método: Estudo descritivo com abordagem qualiquantitativa, realizado com 19 pacientes usuários de psicotrópicos. Os dados coletados foram organizados através da técnica Discurso do Sujeito Coletivo. Resultados: Quanto ao perfil dos participantes, a maioria eram mulheres com média de idade 55,05 e 73,68% deles não fazem acompanhamento no Centro de Atenção Psicossocial. Quanto ao perfil clínico, houve maior prevalência do diagnóstico de insônia (52,63%), e os psicotrópicos mais prescritos foram benzodiazepínicos (89,47%). Com relação ao Discurso do Sujeito Coletivo, 45,00% relataram não ter dificuldades para se adaptar ao medicamento, 68,42% apontaram melhora significativa e 41,67% acreditam não conseguir viver sem a medicação. Conclusão: Apesar dos benefícios do tratamento com psicotrópicos às pessoas que sofrem de transtornos psiquiátricos graves, é preciso garantir o uso racional dessas substâncias.

DESCRITORES: Assistência à Saúde Mental; Psicotrópicos; Atenção Primária à Saúde; Centros de Saúde.

ABSTRACT

Objective: To outline the profile of psychotropic drug users linked to a Basic Health Unit and to investigate their future prospects with regard to maintaining treatment. Method: A descriptive study with a qualitative and quantitative approach, carried out with 19 patients who used psychotropic drugs. The data collected was organized using the Collective Subject Discourse technique. Results: As for the profile of the participants, the majority were women with an average age of 55.05 and 73.68% of them were not being followed up at the Psychosocial Care Center. As for the clinical profile, there was a higher prevalence of a diagnosis of insomnia (52.63%), and the most prescribed psychotropic drugs were benzodiazepines (89.47%). With regard to the Collective Subject Discourse, 45.00% reported having no difficulties adapting to the medication, 68.42% reported significant improvement and 41.67% believed they could not live without the medication. Conclusion: Despite the benefits of treatment with psychotropic drugs for people suffering from severe psychiatric disorders, it is necessary to ensure the rational use of these substances.

DESCRIPTORS: Mental Health Care; Psychotropics; Primary Health Care; Health Centers.

RESUMEN

Objetivo: Perfilar el perfil de los usuarios de psicofármacos vinculados a una Unidad Básica de Salud e investigar sus perspectivas de futuro en relación al mantenimiento del tratamiento. Método: Estudio descriptivo con abordaje cualitativo-cuantitativo, realizado con 19 pacientes consumidores de psicofármacos. Los datos recogidos se organizaron mediante la técnica del Discurso del Sujeto Colectivo. Resultados: En cuanto al perfil de los participantes, la mayoría eran mujeres con una media de edad de 55,05 años y el 73,68% de ellos no estaban en seguimiento en el Centro de Atención Psicosocial. En cuanto al perfil clínico, hubo una mayor prevalencia de diagnóstico de insomnio (52,63%) y los psicofármacos más prescritos fueron las benzodiacepinas (89,47%). Respecto al Discurso del Sujeto Colectivo, el 45,00% refirió no tener dificultades para adaptarse a la medicación, el 68,42% señaló una mejoría significativa y el 41,67% creía que no podría vivir sin la medicación. Conclusión: A pesar de los beneficios del tratamiento con psicofármacos para las personas que sufren trastornos psiquiátricos graves, es necesario garantizar el uso racional de estas sustancias.

DESCRIPTORES: Atención a la Salud Mental; Psicotrópicos; Atención Primaria; Centros de Salud.

RECEBIDO EM: 07/09/2023 **APROVADO EM:** 12/10/2023

How cited: Souza RP, Silva NO, Sousa ML, Martins ÁKL, Oliveira CC, Albuquerque GA, Beltrão ICSL, Lucas TL. Experiences about the use of psychotropic drugs among users of primary health care. Saúde Coletiva (Edição Brasileira) [Internet]. 2024 [acesso ano mês dia];14(89):14i89p13134-13149. Disponível em:
DOI: 10.36489/saudecoletiva.2024v14i89p14i89p13134-13149

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INTRODUCTION

Among the main changes that have taken place in the last 50 years in the context of mental health care, we highlight the launch of the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM III) in 1980, which, although already replaced by the DSM V, was the most revolutionary at the time, since it proposed new diagnostic criteria for psychopathologies and strengthened the idea that psychological suffering has a biological basis[1]. In addition, the prospect of rapid and efficient treatment of mental suffering, together with advances in psychopharmacological studies, made medicalization one of the main forms of treatment[2].

Psychotropic drugs first came to prominence in the 1950s, emerging as an option for the treatment of various mental disorders, particularly anxiety, depressive and psychotic disorders[3]. Knowing that these substances act directly on the Central Nervous System (CNS) with risks of adverse effects and dependence, it is important that they are used rationally. Therefore, the rational use of medication can be understood as the client receiving the appropriate medication according to their clinical condition and for an adequate period of time without causing financial loss or organic dependence[4].

Thus, the exacerbated prescription and long-term use of this class of medication is a fact that deserves visibility and calls for reflection. In this context, the teams working in Primary Care (PC) stand out as an important strategy for monitoring the countless types of psychological suffering, especially in municipalities with a small population that don't have services such as Psychosocial Care Centers (CAPS), Therapeutic Residences and others. Thus, as primary care should be the user's gateway to the Unified Health System (SUS), it is also an important point of care in the mental health scenario[5].

However, mental health care in Primary Health Care (PHC) needs to improve its practices with regard to prescriptions and the consequent indiscriminate use of psychotropic drugs[5]. Although the teams are faced daily with situations aimed at meeting specific demands in mental health, which gives them the opportunity to develop resolutive actions, it is observed that most of the time, the professionals in

DOI: 10.36489/saudecoletiva.2024v14i89p13134-13149

these services do not feel prepared to act in these situations[6,7].

In addition, another problem in relation to the treatment of mental disorders is the lack of protocols to guide the team in monitoring users, as well as guidelines specifically aimed at treating these people at PHC level [5,6]. In this way, these factors converge so that the treatment of mental disorders is mainly directed towards the use of medication. [2,6-8]

Therefore, the aim of this study was to observe the different experiences of users of a Basic Health Unit in relation to treatment with psychotropic drugs, to investigate their future prospects for maintaining treatment and to contribute to the discussion on promoting the rational use of these drugs.

METHOD

This study is characterized as a descriptive field study with a qualitative and quantitative approach, which was carried out in a Basic Health Unit located in the city of Cedro, Pernambuco, Brazil. The unit serves a population of around 771 registered families, totalling approximately 2,498 people, and has a weekly schedule that organizes the flow of care according to specific groups and spontaneous demand. This institution is made up of a multidisciplinary team. As for mental health care, the unit has the support of the municipality's Expanded Family Health Center (NASF).

The participants in this study were 19 individuals who met the inclusion criteria: aged 18 or over, regardless of gender, schooling, religion and diagnosis or suspected diagnosis of mental disorder, being a user of the Family Health Unit, with a record in medical records and having been using psychotropic drugs for at least six months. The exclusion criteria were: people unable to verbalize their thoughts freely or people with cognitive impairment.

With regard to the data collection procedure, a semi-structured interview was carried out, as well as the application of a form which covered the socio-economic characteristics of the interviewees, their clinical profile and the psychotropic drugs prescribed. In addition, the patient's medical records were consulted in order to collect any clinical data they were unable to provide.

The interviews took place in October 2019 at the institution itself, in a private room. Thus, with the consent of the interviewee, a digital recorder was used as an auxiliary technological instrument/apparatus, so that the speeches could be recorded and later transcribed reliably for data analysis and discussion.

To analyze the data, the methodological technique created by Lefèvre & Lefèvre was adopted, called Collective Subject Discourse (CSD), which focuses on the connection of individual format discourses, constructed through a subjective question, effectively enabling the expression and cognition of a significant set of elements(9) .

In this technique, for each individual response to the questions, Key Expressions (KE) are selected which represent the most significant part of the response. These key expressions are consistent with the Central Ideas (CI) which, in turn, are a condensation of the discursive content presented in the KEs. From this material, a summary statement is constructed which must be described in the first person singular and which represents the community speaking in the person of an individual(9,10) .

In addition to the DCS, which is characterized as a method of retrieving and presenting the Social Representation (SR) obtained from empirical research, Microsoft Excel 2013 software was used to tabulate the quantitative data.

This study complied with all the formal guidelines for research involving human beings[11]. The project was therefore submitted to the Brazil Platform and sent to the Research Ethics Committee (CEP) of the Regional University of Cariri (URCA) for assessment and analysis, and was approved under opinion: 3.606.561.

RESULTS

Clinical and socio-economic profile of patients

The average age of the participants was 55.05 years, with a minimum of 18 and a maximum of 82. 78.95% of those interviewed were female. As for marital status, married individuals prevailed, corresponding to 47.36% of the participants, followed by divorced/separated with 26.31%, widowed with 15.78% and the lowest prevalence was single, 10.52%.

In terms of schooling, 73.68% had incomplete primary education, 10.52% had no schooling and no secondary education, and only 5.26% had primary education. Regarding monthly income, 68.42% receive more than one and less than three minimum wages, 21.05% receive government aid, and only 10.52% receive less than one minimum wage.

With regard to CAPS care, the majority of the population (73.68%) had never sought care, and of those who had, 10.52% had been followed up for more than a year and less than five years.

The most prescribed psychotropic drugs were benzodiazepines, identified in 89.47% of the participants. With regard to the average duration of psychotropic drug use, the highest prevalence, 63.15%, was between one and five years, followed by six to 10 years, 11 to 15 years and 20 to 30 years, with an equal prevalence of 10.52% each. The range of 16 to 20 years had the lowest prevalence, corresponding to just 5.26% of the sample.

Collective Subject Discourse

For the interview, we investigated users' impressions of the possibility of one day living without medication and still feeling well. The results are listed in Table 1.

In Central Idea A, the majority of participants (41.67%) revealed that

DOI: 10.36489/saudecoletiva.2024v14i89p13134-13149

they don't believe they will ever be able to live without their medication. It was possible to see in the interviewees' statements that although they are aware that medication can bring risks and undesirable effects, in their perception the benefits outweigh the risks and thus the well-being provided by the medication, in most cases, further strengthens its use.

Central Idea B includes the thoughts of the minority of participants, 20.83%, who believe that one day they will be able to live without medication. This percentage brings together the ideas of patients who are aware of the possible dependence and other adverse effects that medication can cause, and are therefore looking for alternatives to drug treatment, which is a positive point, despite the fact that the field of research presents limited options for combining or replacing drug treatment.

Central Idea C brought together the opinions of 37.50% of the participants who said they wanted to stop using medication, but found it difficult for various reasons. The reasons listed show that the medicalization of everyday situations is becoming increasingly

Table 1 – Relationship between the central idea of Question 1 and the proportion of responses according to the survey participants and DCS. Cedro - PE, 2019

QUESTION: DO YOU BELIEVE THAT ONE DAY IT WILL BE POSSIBLE TO LIVE WITHOUT THE USE OF MEDICATION TO FEEL BETTER? WHY?

CENTRAL IDEA		Informants	
		N	%
A	No, I don't think I can live without the medication anymore	10	41,67
B	Yes, I think it's possible to live without medication	5	20,83
C	I want to, but for various reasons I find it difficult	9	37,50
Total number of informants: 19			

DISCOURSE OF THE COLLECTIVE SUBJECT - DSC

Central Idea A: I don't think so, I know it could harm something if I take it, right (sic)? The doctor has already said that I'm dependent and I feel that I'm already dependent. If I stop I'll feel the same things as before, I've already tried to stop and all the symptoms came back. When I don't take [the medication], I don't feel well, I feel stressed, I lie down and turn from side to side and I spend the whole night like this, I start crying straight away and I don't eat, the night I don't take it, the next day, I can't even hold anything in my hands, I'm shaking! I get dizzy in the head, I feel like I'm going to die. I've already tried to stop the medication, but unfortunately I couldn't. I split the pills in half. I split the pills in half and took half each, but it didn't work, I couldn't sleep. I feel like asking the doctor for a stronger one, because this one is already weak. But one of the difficulties of using these drugs is the prescription, because they're not sold without a prescription. But I feel good taking the medicine, I'm calm, I eat, I sleep, I don't see it as a bad thing to have to take this medication. I can't live without it! Only if God wanted me to!

Central Idea B: I believe I can live without medication, I'm fighting to get off it. I don't want to be dependent on these mediations for the rest of my life, because I think it could harm me and cause other health problems. I want to quit! I believe that in a few years (sic) I can quit, but I know it's going to be very difficult, there's a lot of psychological influence and I know I need to wean off and be monitored. I have faith that God will take these medications out of my life, I have faith and I want to be strong enough to be able to live without the medication, because it's very bad to have to take them, they're strong drug.

Ideia Central C: I feel like stopping taking [the medication], I always ask God! I look to the Church for a way to heal myself, but because of problems within my family I get very nervous, so to avoid getting nervous (sic) I take the medication. But if I could I'd stop taking it, I can't take so many drugs anymore! I really want to stop, but I'm afraid of the consequences and I already feel a great need [for the medication]. When I don't take it, I can't sleep, I don't feel sleepy, I feel all the symptoms I had before again and the doctor has already told me not to stop, [also] I feel better when I take [the medication], with more courage.

*Participants can present more than one central idea in their speeches.

Source: direct research, 2019.

DOI: 10.36489/saudecoletiva.2024v14i89p13134-13149

common and is leading to dependency in many cases.

For the second question, which referred to difficulties in adapting to the medication, the central ideas are shown in Table 2.

In Central Idea A, the majority of respondents, 45.00%, said they had not had any difficulties adapting to the drug. In Central Idea B, 40.00% of the participants said they had not had any difficulties, but had experienced some reactions. These included drowsiness, paresthesia, a feeling of relaxation and vertigo. In Central Idea C, only 5.00% of the participants said they had had difficulties adapting to the psychotropic drugs. The main complaint was drowsiness at the start of treatment. Central Idea D reveals that 10% of patients said they had not had any difficulties adapting, although they did not see a significant improvement in their condition with the treatment in question.

The results of the third question, which asked whether drug therapy improved patients' mental health, are shown in Table 3.

In Central Idea A, 68.42% of participants stated that they feel a significant improvement with the use of drug therapy. Central Idea B is made up of the opinion of 31.58% of participants who believe that medication has improved their state of mental health, but the therapeutic benefits are limited.

Table 2 – Relationship between the central idea of Question 2 and the proportion of responses according to the survey participants and DCS. Cedro - PE, 2019

QUESTION: DID YOU HAVE ANY DIFFICULTIES ADAPTING TO THE PSYCHOTROPIC DRUG? TELL US ABOUT THE FIRST FEW MONTHS OF USE

CENTRAL IDEA		Informants	
		N	%
A	No, I didn't have any difficulties	9	45,00
B	No, I didn't have any difficulties, but I did feel some reactions	8	40,00
C	Yes, I had difficulties	1	5,00
D	No, I haven't had any difficulties, but I don't feel a significant improvement with the treatment	2	10,00
Total number of informants: 19			
DISCOURSE OF THE COLLECTIVE SUBJECT - DSC			
Central Idea A: I had no difficulties, I didn't feel anything bad when I started taking it, I didn't feel any symptoms and I still don't! It was easy. I've felt improvements, because I can sleep, the sleep has come [and] I feel good when I take it, because it's bad to not sleep, if I don't take it, I don't sleep!			
Central Idea B: I didn't have any difficulties, but I felt very sleepy in the morning when I started. My tongue was also numb, I felt dizzy and my mouth was dry. The first few times I took it, for just over a month, I felt relaxed and slept a lot, but it was only at first, then you get used to the medicine. When I got better, the doctor reduced the milligrams and I adapted well, it became normal, today it's as if I didn't even take this medication, it doesn't bother me at all! I don't feel any reaction to the medicine.			
Central Idea C: I had difficulties, [because] I felt very sleepy, but that only lasted about a fortnight.			
Central Idea D: No, but I continued to feel the same things for a while, even after I started taking the medication. I felt "agonized", with negative thoughts, without the will to live, without sleeping, and today [I] feel it, but it's less. I also feel very sleepy and drained by these drugs, just wanting to lie down.			
*Participants can present more than one central idea in their speeches.			
Source: direct research, 2019.			

DOI: 10.36489/saudecoletiva.2024v14i89p13134-13149

Table 3 – Relationship between the central idea of Question 3 and the proportion of responses according to the survey participants and DCS. Cedro - PE, 2019

QUESTION: IN YOUR OPINION, HAS THE USE OF DRUG THERAPY IMPROVED YOUR STATE OF MENTAL HEALTH? WHY DO YOU THINK SO?

CENTRAL IDEA		Informants	
		N	%
A	Yes, I feel a significant improvement in symptoms with drug treatment	13	68,42
B	Yes, but the therapeutic benefits of drug treatment are limited	6	31,58
Total number of informants: 19			

DISCOURSE OF THE COLLECTIVE SUBJECT - DSC

Central Idea A: In my opinion it has improved, my health has certainly improved, if we take the medicine properly it improves, because I didn't eat, I didn't take care of my children, I didn't take care of anything and little by little and with the conversations with the psychologist it has improved. I no longer feel anxiety and the symptoms I felt before, like [the] tremors. I also felt a lot of pain and the medication helped to control that pain and the medication also helps me sleep and if I sleep well I feel better, because if I don't take it I don't sleep. It's bad to work all day, come home at night and not be able to sleep, but with the medication I can sleep! If I don't take the medication, I want to go to sleep and I get scared at night. But when I'm better, sometimes I forget to take it and go four or five days without using it, then I start to feel [the] symptoms, a feeling of "unimpatience" and fear, and I start using it again. When I'm not taking it I feel a lot of things, [but] I feel a good feeling when I take (sic) [the medication].

Central Idea B: It got better, the medication did help, [especially] at the beginning, because the symptoms of anxiety diminished a lot, I was in better spirits, I felt "disgusted", desperate. But in other senses, to this day it's the same, I haven't got completely well. I still feel [the symptoms of mental disorders], but it's not like before, when I wasn't undergoing treatment. However, if anything bad happens, I already get discouraged, thinking about doing something stupid. The medication [has also] improved my insomnia, I can sleep better. After taking the medication, after two hours I'm "out", I don't wake up until the next day, but it's not as good a sleep as we get ourselves. I really want to stop taking it, because I want to sleep with my natural sleep, stop taking the medicine and try to see if I can sleep, but the doctor has already said that I can't. I used to take a natural medicine, but I couldn't sleep. When I go to the doctor and tell him the situation, he refers me to a psychologist, but the psychologist goes back to the doctor. And some days I'm better, some days I'm down. Today I want to quit, to stop using [the medication], but psychologically I feel I can't do it. So, if I could have avoided starting to use it, it would certainly have been better.

Source: direct research, 2019.

DISCUSSION

The age range found corroborates studies in which the average age was 56.6 years and 55 years (12,13) , but differs from another study in which the average age was 59.68 years, although it should be noted that in this study, 53.08% of the sample was elderly[14]. That said, averages can vary significantly due to a number of factors, such as the time the study was carried out and the size of the sample analyzed.

According to a 2019 study, it is common for the elderly to use more medication than other age groups in the population. In addition, psychotropic drugs are among the most used by this group, which is justified by the use of this class of drugs to mitigate somatic conditions and the frequent presence of psychiatric comorbidities among the elderly[15].

With regard to the predominance of females over males, this has already been observed in the literature[12-14,16-18] . This occurrence can be explained by a number of theories, including the fact that women are less resistant to taking medication, attend health centers more often, are more attentive to symptoms and seek help early. [17,19]

There may also be a tendency for women to be more susceptible to mental suffering when compared to men. However, it is important for health professionals to observe the determinants of this suffering, the need for diagnosis and appropriate prescriptions so that no

DOI: 10.36489/saudecoletiva.2024v14i89p13134-13149

patient suffers the damage of excessive or unnecessary treatment[4,12,20].

With regard to schooling, the average is low, which can be seen in other findings[12,14-17,19]. In most cases, a low level of education is associated with greater use of psychotropic drugs, and this variable can directly interfere with profession, monthly income, and consequently mental health. [21]

With regard to monthly income, it was found that the majority of participants earn more than one and less than three minimum wages, in line with other studies[12,16]. Situations such as unemployment and poverty reduce the prospects of improving the economic situation, bring negative feelings such as sadness, anguish and worries, which can lead to mental health problems and influence the use of psychotropic drugs to relieve the disorders generated by these problems[17].

The Psychosocial Care Center (CAPS) is a service of the Unified Health System (SUS), aimed at caring for people in mental or psychological distress (severe and persistent), with the aim of treating and rehabilitating the person to live with the family and society[21]. To this end, it has a multidisciplinary team with strategies that go beyond medicalization, such as therapeutic workshops, occupational therapies and monitoring of the patient and family in relation to the treatment instituted[18,21]. However, there was no prevalent use of this unit among the participants in this study, which may be related to the fact that the municipality does not have a CAPS center in its territory (this was one of the difficulties mentioned by the interviewees) or the preference for follow-up through primary care.

Among the psychotropic drugs prescribed, the highest prevalence was of the benzodiazepine class, a finding previously observed[12,13,15,19,20,22]. The predominance of this class of drugs is common in Brazil, and may be associated with the presence and ease of access to the main representatives of this class in the National List of Essential Medicines (RENAME), which guarantees their supply, prescription and dispensation in SUS services[18, 20].

With regard to the Collective Subject Discourse, the findings regarding the time and use of medications were similar to other studies, as the participants recognize the possibility of the drug-dependency relationship for users of psychotropic drugs, even if in many cases it is configured as an essential method[12,20]. The dependence caused by psychoactive agents may be associated with longer periods of use and a lack of critical thinking about long-term side effects[7,14] .

Some of the participants' statements prompt reflection on the responsibility and contribution of prescribing professionals to the prevalence of the use of psychoactive agents, since they can define the best treatment (appropriate drug, dosage and duration), when this conduct is not performed well, there is a possibility of errors in prescriptions that will lead to the inappropriate use of these substances[22].

In addition, it is known that some professionals oppose the psychosocial care model and ignore the basics of care (such as welcoming and dialog), which makes them partly responsible for using therapy based on the principles of biomedical rationality, in which medication is the central point of treatment[2,23]. This centralization is also seen in mental health services, which reduce therapy to the use of psychotropic drugs and in many cases the patient plays little part in deciding their treatment[16,24] .

It is also understood that religion influences this process, as this was mentioned by some participants. Religiosity can be related to improving and maintaining physical and mental health, so it can be used as a complementary therapy to health care[25].

CONCLUSION

The profile of the users studied is characterized by being female, married, with children, with an average age of around 55, incomplete primary education, farmers, with a monthly income of between one and three minimum wages. There was a higher prevalence of a diagnosis of insomnia, most of the interviewees did not attend CAPS and the most prescribed psychotropic drugs were benzodiazepines, used for between one and five years. Most of the interviewees reported that they had no difficulty adapting to the medication, noticed a significant improvement in their symptoms and did not believe that one day they would be able to live without it.

In view of the complexity surrounding the use of psychotropic drugs, discussing this issue sometimes becomes ambivalent, because while on the one hand the advancement of this class of drugs provides various benefits in treatment and new possibilities for people suffering from serious psychiatric disorders, on the other hand, their inadvertent use can be observed. It is therefore important to understand the problem so that psychotropic drugs can be used rationally, including in primary care.

In addition, it is necessary to continuously train professionals working at the PHC level, in order to consolidate humanized training, centered on holistic care and with truly effective and multidisciplinary therapeutic plans, because in addition to facilitating the management and resolution of visible organic disorders, it will provide effective follow-up of users with mental disorders.

A limitation is the lack of qualitative research that seeks to discuss the perceptions of users of psychotropic drugs and understand why they use them. We therefore suggest investigating the reasons behind the intense medicalization of psychological suffering and the impact on users, as this will make it possible to map out the limitations, false perspectives and real potential of using psychotropic drugs.

DOI: 10.36489/saudecoletiva.2024v14i89p13134-13149

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