







Mental health care centered on benzodiazepines: a reality of the Family Health Strategy**O cuidado em saúde mental centrado nos benzodiazepínicos: uma realidade da Estratégia Saúde da Família****El cuidado en salud mental centrado en las benzodiazepinas: una realidad de la Estrategia Salud de la Familia**

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Objective: to analyze the practice of professionals from the family health strategy in caring for the mental health of patients using benzodiazepines. **Methods:** exploratory, qualitative study, using semi-structured interviews, carried out in a municipality in the interior of the state of Ceará, Brazil, treated by the content analysis technique. **Results:** ten professionals from the Family Health Strategy participated, being four HCA, four nurses and two doctors with working time ranging from one year and nine months to 28 years, with an average time in work of 10 years. Of these, eight had higher education and two had secondary education. Two categories emerged: *The medicalizing care* and *The disjointed care for benzodiazepine weaning*. In the practice of professionals with patients, it was verified the indiscriminate use of benzodiazepines, difficulties in adherence and follow-up of care, impotence in management of chronic use and disjointed health actions. **Conclusion:** there is a need to reorient health practices and empower professionals for their work. Mental health care must be articulated with the user and family, and the various services, in an integrated way for better quality of life and assistance.

Descriptors: Anti-anxiety agents; Mental Health; Family Health Strategy; Health service.

Objetivo: analisar a prática dos profissionais da estratégia saúde da família no cuidado com a saúde mental de pacientes que utilizam benzodiazepínicos. **Método:** estudo exploratório, qualitativo, com o uso de entrevistas semiestruturadas e realizado em município do interior do estado do Ceará, Brasil, tratados pela técnica de análise de conteúdo. **Resultados:** participaram dez profissionais da Estratégia Saúde da Família, sendo quatro ACS, quatro enfermeiros e dois médicos com tempo de atuação variando entre um ano e nove meses a 28 anos, apresentando um tempo médio no trabalho de 10 anos. Destes, oito possuíam nível superior e dois, nível médio. Duas categorias emergiram: *o cuidado medicalizador* e *o cuidado desarticulado para o desmame de benzodiazepínicos*. Verificou-se na prática dos profissionais com usuários, o uso indiscriminado de benzodiazepínicos, dificuldades na adesão e seguimento do cuidado, impotência no manejo do uso crônico e ações em saúde desarticuladas. **Conclusão:** depreende-se a necessidade de reorientação das práticas em saúde e empoderamento dos profissionais para sua atuação. O cuidado em saúde mental deve ser articulado com usuário e família e os vários serviços de forma integrada para melhor qualidade de vida e assistência.

Descritores: Ansiolíticos; Saúde Mental; Estratégia Saúde da Família; Serviços de saúde.

Objetivo: analizar la práctica de los profesionales de la estrategia salud de la familia en el cuidado a la salud mental de los pacientes que utilizan benzodiazepinas. **Método:** estudio exploratorio, cualitativo, con el uso de entrevistas semiestructuradas y realizado en el municipio del interior del estado de Ceará, Brasil, tratado por la técnica de análisis de contenido. **Resultados:** participaron diez profesionales de la Estrategia Salud de la Familia, siendo cuatro ACS, cuatro enfermeros y dos médicos, con un tiempo de trabajo que oscilaba entre un año y nueve meses y 28 años, presentando un tiempo medio en el trabajo de 10 años. De ellos, ocho tenían un nivel de estudios superior y dos un nivel secundario. Surgieron dos categorías: *el cuidado medicalizador* y *el cuidado desarticulado para el retiro gradual de las benzodiazepinas*. Se verificó en la práctica de los profesionales con los usuarios el uso indiscriminado de benzodiazepinas, dificultades en la administración y seguimiento del cuidado, impotencia en el manejo del uso crónico y acciones en la salud desarticuladas. **Conclusión:** se aprecia la necesidad de reorientar las prácticas en salud y empoderar a los profesionales para su puesta en práctica. El cuidado de la salud mental debe articularse con el usuario y la familia y los diversos servicios de forma integrada para una mejor calidad de vida y asistencia.

Descriptor: Ansiolíticos; Salud Mental; Estrategia de Salud Familiar; Servicios de salud.

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INTRODUCTION

One of the main gateways for the Brazilian population to access and prescribe medication is through Primary Health Care (PHC). Mood changes, anxiety and insomnia are the disorders that most affect the population today, being identified more frequently in PHC. For the treatment of these disorders, it is common in the Family Health Strategy (FHS) to prescribe benzodiazepines (BZD), the most used pharmacological class, with a wide therapeutic index, high safety limit, good tolerance and efficacy, factors that contribute to professionals doctors over-prescribe in some cases¹.

BZDs have sedative, hypnotic, anxiolytic, muscle relaxant and anticonvulsant effects. Its high consumption is interpreted as the medicalization of society to resolve conflicts in the modern world such as anxiety, stress, difficulties at work, among other daily challenges. Concurrently, they cause irritation in health units, due to the constant search for prescription renewals, representing a great challenge for PHC professionals².

According to data from the World Health Organization (WHO), Brazil is the country with the highest rate of diagnoses of people with anxiety disorders in the world, in which 9.3% of the country's population suffers from these disorders³. In Brazil, Europe and Latin America, there has been an increase in the use of psychotropic drugs in recent decades⁴. In Brazil, data indicate that prescriptions for these drugs constitute 50% of prescriptions for psychotropic drugs⁵.

Studies on the abusive use of psychotropic drugs in the FHS indicated that most of the public who abuse these medications frequent the Health Unit often. This abusive use increases with advancing age of users, most of whom do not have a mental disorder that justifies the use of these medications. However, monthly access to health professionals, because they have other chronic diseases (hypertension and diabetes), makes it easier to request psychotropic prescriptions along with medications to treat their underlying diseases⁶.

There are several reasons that contribute to the increase in the indiscriminate use of BZDs, from the lack of knowledge of the risks on the part of the user to the lack of preparation of professionals at the time of prescription and guidance, thus increasing the risk of developing serious consequences by the medication use⁷. In addition, it also draws attention⁸ to the fact that there is no reassessment of the clinical case using psychotropic drugs, whereby most individuals who use this medication come to the health service only to renew the medical prescription, generating a social medicalization. In view of this, many countries⁹⁻¹⁰ have been committing to try to formulate new mental health policies, implementing strategies and action plans that guarantee universal access and equitable care.

There is a worrying scenario in view of the indiscriminate use of BDZ by users in PHC, considering that the main reasons for prescriptions are for insomnia and anxiety, which shows that health care is based on psychotropic drugs. Thus, it is necessary to strengthen network care, with different points of psychosocial care, contributing to the non-segregation of users and also so that it is not characterized as being the responsibility of a single service¹¹.

In this perspective, it encouraged us to promote reflections on the problem of indiscriminate use of BZD in PHC, given that the profiles of users are recognized and little progress is made in the evolution of effective strategies to face them. Thus, this STUDY AIMS to analyze the practice of professionals from the Family Health Strategy in caring for the mental health of patients using benzodiazepines.

METHODS

This is an exploratory study, of a qualitative nature, carried out with professionals from the FHS units in the urban area of a municipality in the interior of the state of Ceará, Brazil.

The municipality's PHC is composed of seven FHS teams with oral health (four at the main facility and three in the rural area) and a type 1 Family Health Extended Support Center (NASF), with 100% coverage of family health. Secondary care has a small hospital equipped with a surgical center; a Type 1 Psychosocial Care Center (CAPS) and a Type 1 Dental Specialty Center (DSC), in addition to a Pharmaceutical Assistance Center (PAC), where special and expensive control medications are distributed. It has an estimated population of 18,745 inhabitants, and it is located 394 kilometers from the capital of the state of Ceará. It is located in the Sertão dos Inhamuns Microregion in the extreme part of the south center of Ceará and is part of the 18th Decentralized Health Area (DHA) of Iguatu, Ceará.

The following inclusion criteria were used: health professionals working in the FHS units in the urban area who agreed to participate in the research. And of exclusion, professionals who were on leave, on vacation or with a deviation from their role. In this research, the expression "health professionals" will refer to the diversity of people who work in the FHS with higher and secondary education levels.

Data were collected in the period of July and August 2019, through semi-structured interviews, scheduled at the researched workplaces, with an average duration of 30 minutes each, being recorded and later transcribed in full.

The analysis of the material apprehended in the data collection was analyzed qualitatively, using the content analysis technique, which presents the steps of pre-analysis,

exploration of the material and treatment of results and interpretation¹². At first, the interviews and transcriptions were carried out.

Then, we proceeded to read this content, keeping the proposal of the study in mind. Significant excerpts and recording units were identified in order to identify explicit messages and non-implicit meanings in the statements of health professionals about their practice with patients using BZD. Afterwards, the units were aggregated and interpreted, and categories were created to address aspects of relevance.

The ethical precepts established in Resolution No. 466/2012 of the National Health Council on research involving human beings were respected¹³, as well as the Letter of Consent for authorization from the Municipal Health Secretary with subsequent approval by the Research Ethics Committee from the Universidade Estadual do Ceará (UECE), under Opinion No. 3,285,552/2019. The research subjects were represented by the letter "P" which means participant, followed by a number according to the chronological order of the interviews (P1, P2, P3...).

RESULTS

The research had the participation of 10 professionals related to the care of users of BDZ, being: four ACS, four nurses and two physicians with working time ranging from one year and nine months to 28 years, with an average time at work of 10 years. . Of these, eight had higher education and two had secondary education.

At this stage of the investigation, from the analysis of the corpus, two categories emerged, namely: *The medicalizing care* and *The disjointed care for benzodiazepine weaning*.

The medicalizing care

In offering care to users who use BZD, it was learned that attention is focused on the distribution of medications and on the medical professional, cited as the main responsible for these users.:

... I have, like, a great connection, they even always ask me to get the prescription for them, or I inform them very clearly... (P3)

Yes, the contact they have the most is with the doctor at the unit, not much with me... We try, right, to make them come to the unit not only when the prescription is completely empty. (P7)

Many professionals do not see themselves as part of this care process and emphasize the importance of articulations to obtain special prescriptions for patients in their areas. However,

one highlighted a different practice from the others, informing support and listening to patients; and another revealed difficulty in dealing with patients who chronically use medications and resist guidelines. Also, the use of BZD as a continuous practice and the concern for dispensing prescriptions was pointed out:

... my practice with them is listening... that's it, right, on a daily basis. It's the conversation, it's the support I can give to each of them... (P4)

... there are patients who, on their own, either reduce the dose, or increase the dose [...] they don't do what they are told very much, no... (P9)

... then you come to the FHU, I follow up, check the medication they are using, the amount prescribed [...] a culture of abusive has been quite common for a while... (P10)

The disjointed care for benzodiazepine weaning

There was difficulty in weaning from BDZ, due to the fact that users did not follow the guidelines and due to the chronicity of use, expressing the need for an integrated work:

... the hardest thing to try is to remove this medication, because they have been using it for a long time [...] So it's like that, it has to be a joint work [...] an interdisciplinary work. (P5)

... most of these users already use the medication chronically, and when asked if they have tried to reduce the dose of the medication and suspend it, most of them report that they cannot go without it... (P9)

Disarticulation, fragmentation and specific actions regarding the weaning of the BDZ were also pointed out, limited to reproducing the prescriptions.

Irritability and lack of family support appear as a consequence of withdrawal crises due to weaning, with conflicts at home, so that the family members themselves articulate for the return of the BDZ:

...I follow this issue of weaning very closely, [...] one of the main causes that occur soon after the user goes into abstinence, is irritability. And family members usually complain more about that, right? - "Oh! You took the medication, there's no one who can handle this guy in the house anymore. Exactly, to go back to medication, because of irritability... (P10)

The difficulty in dealing with the chronic use of BZDs in their territories, especially due to non-adherence to the guidelines by users and family members, is brought up:

... and when you give them another medication, they are reluctant to change it. Not many are willing to change... (P9)

... I really like having this time frame of six months when I start, but it is very common for me to get a patient who is already two, three, four, five years benzodiazepine use. So it's a more delicate situation [...] they need to discontinue the use of these drugs, not just stop taking them abruptly, it's necessary to do a coherent weaning... (P10)

The maintenance of prescriptions resonates as necessary due to the high demand in chronic use, users' insistence, little family support in weaning, lack of alternative therapies and professional difficulty to intervene in the problem due to lack of knowledge about mental health.

... so what I know is that people seek these medications more, because they are not able to sleep [...] Or because they are nervous, or because they are going through a very difficult problem in their life, a matter of family relationships... (P1)

... I often don't help because I don't have the knowledge... (P2)

The importance of network integration was defended to support professionals and comprehensive care, through interprofessional work:

... in relation to referrals, I think that, for some time now, it has been improving, because today we have the Family Health Extended Support Center (NASF) and the Psychosocial Care Center (CAPS) [...] I think communication is still very flawed... (P1)

...I think there is no communication [...] many patients who seek the unit and undergo treatment at the CAPS, and often the unit does not know that the patient is accompanied by the CAPS... (P4)

A fragmentation of care was noticed, focusing only on referrals, mainly to CAPS, with a positive response from users. It was noted that the CAPS is the preferred access for unresolved cases in the FHS, to which NASF professionals are invited if "necessary":

... if we see any need, we are referred to a psychologist at the NASF or to the CAPS [...] We have the CAPS in the city, we refer them to any of these entities [...] I always get in touch with the psychologist later [...] For me to stay on the loop, not just refer them and not know what happened to them... (P7)

...we always refer [...] generally, the doctor and I go, make the visit, refer them to the CAPS, the family does not take them, right, then sometimes we send them directly to request a home visit from the CAPS... communication is good [...] we always have CAPS, NASF and hospital, we always communicate... (P8)

DISCUSSION

Problems related to mental health and psychosocial disorders have been evidenced in modern society, affecting people's social behavior. This results in the abusive use of special control medication, without clinical need, leading to mass illness, which in most cases can be generated more as a social fact than a clinical one¹⁴.

The difficulty of individuals to deal with psychic suffering has been progressively observed, causing a pharmacological epidemic of psychotropic drugs, called the medicalization

of suffering, to anesthetize this daily pain. Among the most used drugs for anxiety disorders are BZD¹⁵.

The first analyzed category, "*The medicalizing care*", showed the practice of professionals with patients in indiscriminate use of BZDs, especially to minimize insomnia and anxiety and mood problems, being permeated by a care centered on the prescription of these drugs and on the doctor, professional responsible for this practice. This assertion corroborates a research that points out that medical practice, assuming its profoundly technical version, with quick consultations and hasty diagnoses aiming at the largest number of visits, makes it impossible for qualified listening in reception, with massive prescription of psychotropic drugs and the medication of symptoms¹⁶.

Another study demonstrates the process of medicalization of life linked to a biological health care model, centered on the figure of the doctor, on the prescription of medication and without responsibility for political and social issues in the territory, shifting responsibility to individual factors¹⁷. An integrative review emphasizes that in medicalization and in the consequent social and political lack of responsibility, suffering is not seen as a possibility of transformation in the ways of living and relating⁶.

There were both welcoming practices that seek to support and listen to users, as well as those outdated that aim only at prescribing BZDs, without contributing to a new way of producing health. Accordingly, the lack of preparation of professionals in mental health care leads to an increase in the prescription of psychotropics and the demand for ease of acquisition, as well as difficulties in weaning these drugs due to the resistance of patients and lack of support from relatives. These factors¹⁸ interfere with the operationalization of work in different dimensions and limit the actions of professionals in the integrality of care, causing concern and negative consequences for themselves.

Mental health actions were shown to be carried out by primary care teams if they are restricted to repetition of prescriptions, dispensing of psychotropic drugs and referrals to the specialist without primary follow-up. The patient with mental health needs, treated in primary care, must have the right to be welcomed, individually and listened, so that comprehensive care can be achieved¹⁹. This situation is aggravated by the deficiency in the training of medical professionals in content related to mental health, in addition to the lack of knowledge of non-pharmacological measures in the treatment of mental disorders and insomnia²⁰.

For this, it is necessary to use new learning and intervention methodologies, new models and new bilateral support practices for professionals from different backgrounds²¹. The use of these devices in work processes underpins the relationships, trust, bond and support necessary

for the production of care, promoting co-responsibility of those involved, autonomy and encouragement for self-care, with greater possibility of coping with the various situations of health.

Regarding the category “*The disjointed care for benzodiazepine weaning*”, the discourse and practices reiterate the indiscriminate use of BZD, recognizing the fragmentation of care and limitations in conduct. These difficulties converge with an investigation also carried out with FHS professionals, through which the indiscriminate use of BZD was also verified, however, they did not identify the cause in their own conduct²³. The same work shows that for those surveyed, only changes in the management and behavior of other professionals would solve the problem²².

The participation of family members plays a key role in directing the treatment of people with substance abuse problems. However, when such inclusion is not effective in practice, the proposed treatment plan to address the bonding problems found in drug addiction may be impaired and the established goals may not be achieved²³.

In order to guarantee comprehensive care, the actions developed in PHC must focus on the family, with a view to overcoming the paradigm of the traditional clinic of the care model, focused on the disease and on the fragmentation of the subject, for a model centered on the user's health. In the present study, the focus of care restricted to the prescription and use of medications.

These practices may indicate the lack of empowerment of professionals and difficulties in taking the initiative to share responsibilities, which may be a consequence of insufficient access to learning and organization processes that guide decision-making in the service²². Professionals also need to give support to face individual family problems, develop group activities and integration with the network and community spaces, offering not only pharmacological treatment, but also seeking alternative collaborations to solve problems²¹.

For PHC to happen with positive effects on care, it is necessary to organize the work process and train health professionals, strengthening intersectoral partnerships and articulation with the entire Health Care Network (HCN) for integrated and co-responsible care, important for the restoration and promotion of health in users with mental suffering. However, in health services, there is a common doubt and discussion about who takes care of what or what types of users should or should not be referred to the specialized service. Although some devices improve mental health care in the territory, it is necessary to reflect on possible difficulties of integration into the network and its flows, to influence the management of cases¹¹.

The unpreparedness of professionals in dealing with people with mental suffering was shown, in the absence of: the use of alternative therapies, space for this public in the agenda, organization of the flow, interprofessional and intersectoral care, and others.

Despite welcoming users, listening, talking and guiding, when necessary, the respondents recognized difficulties in resolving the chronic use of BZD in their territories. In this scenario, family support and integration with all services that make up the Psychosocial Care Network are essential to redirect care focused on the disease and on the fragmentation of care, towards user-centered health care. The speeches resembled a work on the conception of PHC professionals regarding mental health care, in which the articulation of the service was insufficient, and some professionals did not recognize the competences of the teams¹⁸.

This reality applies to mental health care, which is among the many responsibilities of PHC, there is still a lack of integration, both due to deficiencies in the training of professionals and in the structuring of the network, including therapeutic resources²². The fragility in the relationship between PHC services, professionals, users, family and care networks makes it impossible to provide comprehensive care and continuity of care, which are essential for the quality of life and health of users.

The articulations between services allow the exchange of knowledge, experiences and different fields of action in health. Based on shared care and integrated actions for people with mental suffering and/or users of alcohol and other drugs, care can expand to other areas necessary to improve the subject's quality of life²⁴.

The FHS and the CAPS are mechanisms that unite the mental health care network, as they have become strategic services to break with institutionalization. For effectiveness, the CAPS must rely on matrix support for PHC teams, conducting mental health cases, supporting the work of teams, favoring them to guide interventions effectively, in addition to avoiding referrals to more complex levels¹¹. In addition, the NASF enable the evolution to a longitudinal monitoring process under the responsibility of the PHC/fhs team, working to strengthen its attributes and the role of coordinating care in the SUS²⁴.

It is essential to work from the perspective of the integration of services, building horizontal links between professionals and other sectors, allowing the different knowledge to coalesce, in the search to overcome the fragmentation in health care. Integrated and collaborative work becomes a basic strategy for improving the quality of health offered to users in chronic use of BZD, promoting comprehensiveness and continuity of care.

Also, communication is an important tool in the health production process, and it is necessary that professionals who work in the FHS properly appropriate the use of light

technologies, so that intersubjective relationships are established effectively and efficiently, considering its potential in offering quality care, positively impacting the health status of users/family/community²⁵. So, in the different health facilities, health professionals and managers must strengthen the communication process to provide quality care, prioritizing continuous reception and monitoring, offering collective spaces for the sharing of knowledge and workshops that expand the new network concepts, aiming to provoke changes in the work process of the health teams and to produce improvements in the effectiveness and quality of the mental health policy.

CONCLUSION

In this research, mental health care practices were conditioned to medication and to the medical professional, with indiscriminate use of BZD and the professionals' difficulty in their role, due to a deficient knowledge about these drugs. In addition, a fragile network, with misunderstandings of intersectoral competences, leading to erroneous referrals and fragmentation of care.

Strengthening mental health care in health services is a challenging process, specifically in PHC, which has a strategic position in the assigned territories. It is essential to plan and organize care for users and their families in an integral, resolute and interdisciplinary way, permeated by effective communication that allows an approach with greater interpersonal interaction that promotes the guarantee of assistance at all levels of health care.

The research has limitations, due to the small sample and the non-inclusion of patients, which reduces the deepening of the understanding in question. In turn, it brings a clipping of a reality that possibly portrays the complexity of mental health action in PHC. This fact suggests further studies involving patients, work processes and also mental health specialists.

This work points to the defragmentation of care for the continuity of health production, the need to sensitize professionals in the field of the FHS, the resignification of practices, the adoption of strategies that enhance the accountability of the teams for the cases.

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