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EVALUATION OF PATIENTS WITH ANXIETY AND DEPRESSION USING PSYCHODRUGS IN A MUNICIPALITY IN THE INTERIOR OF PARAÍBA

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Abstract: Introduction: The use of psychotropic drugs deserves investigation and intervention. Objective: to evaluate patients with a clinical diagnosis of anxiety and/or depression using psychotropic drugs in the city of Paraíba. Method: field study, cross-sectional, quantitative, with 2126 users of the health system. 22 patients were included after applying inclusion and exclusion criteria to 114 individuals using psychotropic drugs. Three instruments were used: individual questionnaire; Hamilton Anxiety Scale (HAM-A) and Hamilton Depression Scale (HAM-D). The data were tabulated in SPSS (version 25) and descriptive and inferential statistics were adopted, with a significance of $p < 0.05$. Results: female (95.5%), 14 (63.3%) individuals diagnosed with depression and 11 (50.0%) with anxiety; approximately 63% had a depression score (HAM-D) and 54.5% had an anxiety score (HAM-A). Around 87% of those who had not been diagnosed with depression were assessed with depression using the HAM-D, 50% of those who had already been diagnosed with depression maintained a score for depression using the HAM-D and around 64% of those diagnosed with anxiety maintained a score for depression. Anxiety in HAM-A. Conclusion: Drug treatments, as prescribed, were not effective; Mental health management regarding these diseases needs to be improved in primary health care.
Keywords: Pharmacological treatment. Therapy. Primary Health Care. Mental Health.

INTRODUCTION

The use of psychotropic drugs has increased in recent decades. It is believed that this factor is due to the increased incidence and diagnosis of psychiatric pathologies, as well as the indiscriminate use of these drugs, often prescribed without criteria. (COSTA; OLIVEIRA, 2017; MOURA et al., 2016; RODRIGUES et al., 2006). The risks that these medications pose in the short and long term make this subject worthy of investigation and intervention. (ANDRADE et al., 2004; FIRMO et al., 2013; GRÉGIO et al., 2011).

Psychotropic drugs act on the Central Nervous System (CNS), which can produce changes in mood, behavior and cognition. (ARRUDA et al., 2012; RODRIGUES et al., 2006). They are medications that are easy to self-administer and some of them are highly addictive. Consequently, abruptly stopping its use can lead to withdrawal syndrome. (COSTA; OLIVEIRA, 2017; PADILHA et al., 2014; RODRIGUES et al., 2006). They act by altering communication between neurons and can produce different effects depending on the type of neurotransmitter involved and the way the drug acts. (COSTA; OLIVEIRA, 2017; CARLINI et al., 2001).

The new version of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) defines the Depressive Episode as part of the Mood Disorder category. Generally, these episodes are characterized by the presence of a sad and/or irritable mood, associated or not with anhedonia, which is characterized by the loss of pleasure or interest in previously pleasurable activities. One of these two symptoms must be accompanied by somatic and cognitive changes that significantly affect the individual's ability to function. Meanwhile, anxiety disorders are defined as disorders that share characteristics of excessive fear and anxiety and related behavioral disturbances. Fear is the emotional response to real or perceived imminent threat, while anxiety is the anticipation of future threat. (APA, 2014).

Evaluating diagnosis and monitoring of depressive patients, Freire and collaborators (2014) investigated the psychometric properties of the 17-item Hamilton Depression Scale (HAM-D-17) in 231 subjects from the Southern Region of Brazil. According to the SCID interview, 105 were diagnosed with

depression. The results indicated that the scale's cutoff point of 9 was able to discriminate individuals according to their diagnosis, with sensitivity of 0.90 and specificity of 0.91.

Assessing that the main prescriber in Brazil today in the health unit is the general practitioner, who often only keeps one previous prescription, contributing to the decline in coping capacity, regardless of illnesses and daily pain, while doctors with specialization in psychiatry, they detect symptoms and make a diagnosis more quickly and accurately. (BORGES et al., 2015; KARTAL et al. 2010; MORAL et al, 2010; WANDERLEY et al, 2013).

Regarding medical self-perception, an Ibero-American study with family doctors demonstrated that the vast majority of FCMs said they had good or very good ability to resolve common cases linked to psychiatry. (MORAL et al, 2010). This effectiveness is questioned in some articles. (FORTES et al., 2014; BORGES et al, 2015; MORAL et al, 2010). The study by Moral and collaborators (2010) questions medical training in PHC services regarding the SM approach. For the authors, training and training for these services are unsatisfactory, not allowing an adequate response to this problem. The integration of SM and PHC services by generalists is still limited, considerably restricting the ability of PHC to fulfill its functions in relation to SM at the level of resolution entrusted to it in the context of a community mental health model.

Therefore, this study aimed to evaluate patients with anxiety and depression using psychotropic drugs in the municipality of Areia de Baraúnas - PB. The profile of users of psychotropic drugs and the most prescribed psychotropic drugs in the Family Health Strategy (ESF), depressive and anxious symptoms through the application of scales, therapeutic efficiency and the rational use of psychotropic drugs were also evaluated.

METHOD

This is a field study, cross-sectional and with a quantitative approach carried out in the only Basic Health Unit (UBS) in the municipality of Areia de Baraúnas - PB. The population included in the study was 2126 users registered in the local Unified Health System (SUS). Data collection was carried out for 120 calendar days, following the approval of the Ethics and Research Committee of Faculdades Integradas de Patos with the substantiated opinion number 2.676.803/2018 and CAAE 88828818.2.0000.5181.

The sampling was constituted in a non-probabilistic way, determined by the inclusion and exclusion criteria. 114 individuals using psychotropic drugs were included, followed at the Basic Health Unit of Areia de Baraúnas - PB. Of which 106 were aged 18 or over, only 83 of these were regularly monitored. 11 individuals who had changed their medication or dose in the last two months were excluded; 39 people with psychotic disorders (schizophrenia, schizoaffective, etc.) and neurological disorders (epilepsy, dementia, etc.); 11 individuals for refusing to sign the Informed Consent Form. In the end, a sample of 22 individuals was obtained.

Three instruments were used for the research: an individual questionnaire designed for this study; the Hamilton Anxiety Scale (HAM-A); the Hamilton Depression Scale (HAM-D). Initially, the questionnaire prepared with personal, sociocultural, health and therapeutic data of each individual was filled out during an individual interview; Afterwards, the Hamilton scales were applied individually, starting with the HAM-A scale and followed by the HAM-D scale, for symptoms in the last week. Both scales have been used for over 50 years as a gold standard for assessing symptom intensity, being validated in numerous languages around the world. (HAMILTON, 1959; HAMILTON, 1960).

The HAM-A, validated for Portuguese, consists of 14 items of psychic and somatic symptoms answered by the research subjects in a sequential, objective manner, with numbers from zero to four, where zero is zero intensity and graduates to four, which means maximum intensity (disabling), at the end the score determined by the individual's responses was added. Subsequently, the HAM-D was applied, validated for Portuguese, consisting of 17 items of psychic, somatic and cognitive symptoms answered by the research subjects in a sequential, objective manner, with numbers from zero to four, according to the intensity at which zero is null intensity and gradually rises to maximum intensity (variable in each item), patients with a score greater than or equal to 9 on this scale were considered to be in a depressive episode. (MORENO; MORENO, 1998)

Data were analyzed using SPSS (version 25). In addition to descriptive statistics of relative, absolute frequency, mean and standard deviation, Pearson's Chi-square tests and one-way ANOVA were also adopted. The adopted significance was $p < 0.05$.

RESULTS

The data show the demographic assessment of psychotropic drug users with depression and/or anxiety in the municipality of Areia de Baraúnas - PB. As shown by the drug therapies used, the symptomatological assessments using the Hamilton Anxiety and Depression scales and the associations between diagnosis and symptomatological assessment using these scales.

The sample of 114 individuals shows us a prevalence of 5.32% of psychotropic users in the population of the city studied. Based on this, the final sample evaluated consisted of 22 individuals, of which 21 (95.5%) were female. 17 (77.3%) live with a regular partner, 15 (68.2%) did not complete high school, six (27.3%) are farmers and five (22.7%) are retired and only three (13.5%) have a job with a formal contract and fixed hours, on active civil service examinations. An average of three people living at home was also observed (Table 1). The average age found was 50.0 years (SD= 12.49); minimum 27, maximum 74 years old. 13 (59.1%) patients were found over 50 years of age, of which four patients were over 65 years of age, accounting for 18.2% of the total number of patients evaluated.

Variables	Absolute frequency	Relative frequency
Gender		
Female	21	95,5
Male	1	4,5
Marital status		
Divorced	4	18,2
Married / Stable Union	17	77,3
Single	1	4,5
Education		
Illiterate	2	9,1
Elementary School *I (incomplete)*	5	22,7
Elementary School *I (complete)*	3	13,6
Elementary School *II (incomplete)*	2	9,1
Elementary School *II (complete)*	1	4,5
Incomplete high school	2	9,1
Complete high school	7	31,8
Occupation		
Farmer	6	27,3
Retired	5	22,7
Home maid	4	18,2
Absent	1	4,5
Unemployed	3	13,6
Active candidates	3	13,6
Domiciled		
1	3	13,6
2	6	27,3
3	4	18,2
4	7	31,8
5	1	4,5
8	1	4,5

Table 1. Description of the sample's sociodemographic variables (N=22)

EF – Elementary School; EM – High School.

In study patients, 33 pre-research diagnoses had been established in clinical evaluations. Among them are 14 (63.6%) of individuals diagnosed with depression and 11 (50%) of individuals with a diagnosis of anxiety, and there may be individuals with more than one diagnosis. 40 medication prescriptions were found. The most prescribed medications were from the Benzodiazepines (BZDs) class, followed by Selective Serotonin Reuptake Inhibitor Antidepressants (SSRIs) and later Tricyclic Antidepressants (AT), and their respective most prescribed active ingredients were Clonazepam, Fluoxetine, Amitriptyline.

Only Escitalopram was used at the maximum dose recommended in the leaflet for drug treatments, ATs were used in subdoses and the other antidepressants were kept close to the minimum therapeutic dose recommended in the leaflet. The majority of patients had more than 10 years of treatment and had depression as a therapeutic indication (Table 2).

Variables	Absolute frequency	Relative frequency
Diagnosis		
Anxiety	11	33,3
Depression	14	42,4
Dep BZD	7	21,2
Fibromyalgia	1	3,0
Total	33	100,0
Medications		
Tricyclic antidepressant	9	22,5
Amitriptyline 10mg	1	2,5
Amitriptyline 25mg	4	10,0
Amitriptyline 50mg	3	7,5
Clomipramine 75mg	1	2,5
SSRI antidepressant	11	27,5
Fluoxetine 20mg	5	12,5
Fluoxetine 40mg	1	2,5
Citalopram 20mg	4	10,0
Escitalopram 20mg	1	2,5
SNRI antidepressant	2	5,0
Venlafaxine 75mg	1	2,5
Desvenlafaxine 50mg	1	2,5
BZD	13	32,5
Clonazepam 1mg	3	7,5
Clonazepam 2mg	4	10,0
Clonazepam 4mg	1	2,5
Alprazolam 2mg	3	7,5
Diazepam 10mg	2	5,0
Antipsychotic	5	12,5
Risperidone 1mg	1	2,5
Chlorpromazine 25m	1	2,5
Quetiapine 25mg	3	7,5
Total	40	100,0
Period of treatment		
Less than 1 year	10	25,0
Between 0,6 and 1,5 year	7	17,5
Between 1,5 and 3,0 years	3	7,5
Between 5 and 10 years	6	15,0
> 10 years	14	35
Total	40	100,0
Indication		
Anxiety	6	15,0
Depression	17	42,5
Unrest	1	2,5
Somatization	3	7,5
Psychosis	3	7,5
Phobia	1	2,5
Tremors	4	10,0
Fibromyalgia	1	2,5
Weaning from BZD	2	5,0
Insomnia	2	5,0
Total	40	100,0

Table 2. Description of diagnoses, classes and medications, time and indication of treatments.

Note: The total number of diagnoses and medications does not represent the total number of patients

Of the users undergoing drug treatment, only five (22.7%) were undergoing complementary treatment, with psychotherapy being the only complementary practice used. Thus, 17 users (77.3%) only took medications. When evaluating the practice of bodily activities (physical exercises), only two users (9.1%)

practiced them regularly. Of the patients undergoing psychotherapy, 40% were in remission of anxiety symptoms and also 40% were in remission of depressive symptoms; Of the patients who performed physical activities, 100% of them were in remission of anxiety symptoms and 50% were in remission of depressive symptoms, the individual who was not in remission had mild symptoms of depression.

Evaluating users after applying the Hamilton Depression (HAM-D) and Anxiety (HAM-A) scales, 14 of the 22 patients (63.6%) had a score for the presence of Depression on the HAM-D Scale. On the other hand, 12 of the 22 patients (54.5%) had a score for the presence of anxiety according to the HAM-A scale. Among these diagnoses and based on the Hamilton scales, 40.9% of the sample had moderate to severe depression symptoms, the same result was repeated for moderate to severe anxiety symptoms (Table 3).

	Absolute frequency	Relative frequency
HAM Depression		
Negative	8	36,4
Positive	14	63,6
HAM Anxiety		
Negative	10	45,5
Positive	12	54,5
HAM Depression		
Absent	8	36,4
Light	5	22,7
Moderate	2	9,1
Serious	7	31,8
HAM Anxiety		
Light, without anxiety	10	45,4
Light to moderate	3	13,6
Moderate to serious	3	13,6
Serious	6	27,3

Table 3. Description of cases and assessment of depression and anxiety using the Hamilton scales

When applied to the HAM-D scale and compared to pre-research diagnoses, we noticed that 7 of the 14 people (50%) diagnosed with depression continued to score for Depression on the HAM-D; that 7 of the 8 people (87.5%) who were not diagnosed with depression were assessed as having depression by the HAM-D ($p > 0.05$). Furthermore, 9 of the 11 people (81.8%) with anxiety diagnoses also had a Depression score on the HAM-D. When applying the HAM-A scale, it was observed that 7 of the 11 people (63.7%) diagnosed with anxiety have an Anxiety score on the HAM-A and that 5 of the 11 people (45.5%) who did not have a diagnosis of anxiety and were assessed as having anxiety using the HAM-A ($p > 0.05$). We can still infer that 7 of the 14 people (50%) diagnosed with depression had an Anxiety score on the HAM-A. (Table 4).

	HAM Depression		$p(\chi^2)$
	Without	With	
Depression (diagnosis)			
No	1 (12,5%)	7 (87,5%)	0,17*
Yes	7 (50,0%)	7 (50,0%)	
Anxiety (diagnosis)			
Yes	2 (18,2%)	9 (81,8%)	
	HAM Anxiety		
	Without	With	$p(\chi^2)$
Anxiety (diagnosis)			
No	6 (54,5%)	5 (45,5%)	0,37*
Yes	4 (36,4%)	7 (63,6%)	
Depression (diagnosis)			
Yes	7 (50,0%)	7 (50,0%)	

Table 4. Association between diagnosis of depression or anxiety and assessment using Hamilton scales.

Note: *Fisher's exact test

To understand the relationship between medications and their effectiveness in treatments, the data in table 5 were presented, with treatments in the "Without" column being effective and those in the "With"

column not being effective. Thus, it can be seen that ATs and BZDs were not effective in treating depression in 88.9% and 76.9%, respectively, and that ATs were used entirely in subdoses, it is possible to infer that BZDs may be a promoting factor for this disease, as patients who used them had more depressive symptoms than anxious symptoms.

The use of antipsychotics appears to stabilize depressive symptoms by 80%, but in all cases, they were used in association with antidepressants in therapeutic doses. SSRI and SNRI antidepressants were effective in 45.5% and 50%, respectively, at minimum recommended therapeutic doses in 10 of the 13 situations used. In relation to anxiety, it is clear that SNRI antidepressants were not effective in 100% of the times used, ATs were not effective in 77.8% and BZDs were not effective in the treatment in 61.5%. The use of antipsychotics appears to stabilize anxiety symptoms, also in 80%, in association with antidepressants. SSRI antidepressants were effective in 54.5%.

DISCUSSION

As the study was carried out in the only health center in the city, the UBS, it becomes, as recommended by the Ministry of Health, the main gateway for patients with psychological complaints. (FORTES et al., 2014; MINISTRY OF HEALTH, 2011).

In this context, the prevalence of psychotropic drug use in monitoring by the UBS team in the studied population was 5.36%. This prevalence is lower than that commonly found in national articles, which range from 9% to 13% in the general population and 27.1% among women (BORGES et al., 2015; LIMA et al., 2008; RODRIGUES et al., 2006), however, closer to the values found in research carried out in primary care with a prevalence varying between 5.7% and 7.3%. (BORGES et al., 2015; NETTO et al., 2012; ROCHA; WERLANG, 2013). Regarding the prevalence related to the diseases initially addressed (depression and anxiety), it was not possible to estimate them, a fact resulting from the exclusion and inclusion criteria, which removed users with associated pathologies or recent medication changes from the research.

Therefore, when considering the profile of the sample, it was possible to observe an average age of around 50 years, with almost 60% of patients being over 50 years old and around 20% of all patients being over 50 years old. of 65 years. The finding warns about the importance of mental health in the elderly. The same could be seen in Portuguese research, in which elderly people showed higher levels of depression, anxiety and stress. However, no studies were found that identified the average age of psychotropic users. (APOSTOLO et al., 2011)

The intensity of women, both in relation to prevalence and in relation to symptoms, in proportion to men also draws attention in the present investigation. Even though it is consolidated data in national and international literature; the magnitude of 21:1 found is discrepant from the commonly seen in literature 2:1. Although a magnitude greater than the standard in scientific studies for the local reality was expected; in which women are more concerned about their own health, reaching 62% of care at the UBS, while men make up "only" 8% and 30% are for children (service data from the unit under study); The discrepancy found in this study makes us question the severity of men's lack of seeking health services, especially in relation to mental health. (APOSTOLO et al., 2011; BORGES et al., 2015; LIMA et al., 2008; REIS et al., 2017; ROCHA; WERLANG, 2013; WANDERLEY et al., 2013; WHO, 2001).

In this context, it is important to reinforce the need for the effectiveness of the National Policy for Comprehensive Men's Health Care

	HAM Depression		HAM Anxiety	
	Without	With	Without	With
Tricyclic antidepressant	1 (11,1%)	8 (88,9%)	2 (22,2%)	7 (77,8%)
Amitriptyline 10mg	1 (12,5%)	0 (0,0%)	1 (12,5%)	0 (0,0%)
Amitriptyline 25mg	0 (0,0%)	4 (50,0%)	1 (12,5%)	3 (37,5%)
Amitriptyline 50mg	0 (0,0%)	3 (37,5%)	0 (0,0%)	3 (37,5%)
Clomipramine 75mg	0 (0,0%)	1 (100,0%)	0 (0,0%)	1 (100,0%)
Antidepressive ISRS	5 (45,5%)	6 (54,5%)	6 (54,5%)	5 (45,5%)
Fluoxetine 20mg	3 (50,0%)	2 (33,3%)	3 (50,0%)	2 (33,3%)
Fluoxetine 40mg	0 (0,0%)	1 (16,6%)	0 (0,0%)	1 (16,6%)
Citalopram 20mg	1 (25,0%)	3 (75,0%)	2 (50,0%)	2 (50,0%)
Escitalopram 20mg	1 (100,0%)	0 (0,0%)	1 (100,0%)	0 (0,0%)
Antidepressive IRSN	1 (50,0%)	1 (50,0%)	0 (0,0%)	2 (100,0%)
Venlafaxine 75mg	1 (100,0%)	0 (0,0%)	0 (0,0%)	1 (100,0%)
Desvenlafaxine 50mg	0 (0,0%)	1 (100,0%)	0 (0,0%)	1 (100,0%)
BZD	3 (23,1%)	10 (76,9%)	5 (38,5%)	8 (61,5%)
Clonazepam 1mg	1 (10,0%)	2 (20,0%)	2 (20,0%)	1 (10,0%)
Clonazepam 2mg	2 (20,0%)	2 (20,0%)	2 (20,0%)	2 (20,0%)
Clonazepam 4mg	0 (0,0%)	1 (10,0%)	0 (0,0%)	1 (10,0%)
Alprazolam 2mg	0 (0,0%)	3 (33,3%)	1 (33,3%)	2 (66,6%)
Diazepam 10mg	0 (0,0%)	2 (100,0%)	0 (0,0%)	2 (100,0%)
Antipsychotic	4 (80,0%)	1 (20,0%)	4 (80,0%)	1 (20,0%)
Risperidone 1mg	1 (100,0%)	0 (0,0%)	1 (100,0%)	0 (0,0%)
Chlorpromazine 25mg	1 (100,0%)	0 (0,0%)	1 (100,0%)	0 (0,0%)
Quetiapine 25mg	2 (66,6%)	1 (33,3%)	2 (66,6%)	1 (33,3%)

Table 5. Comparison of HAM-A and HAM-D assessments and use of psychotropic drugs

(PNAISH). To achieve this, it is essential to understand the vulnerabilities of this gender, to implement strategies to expand access and support men with resolving demands. A study carried out by the Ministry of Health demonstrated that, despite men's interest in participating in health promotion activities, the commitment of municipal management to strengthening PNAISH is still quite timid.

It was found that only 23.3% of men interviewed reported having been invited for a consultation and that only 7% of men reported being unable to do so due to time/ time. Therefore, the active search initiative of this group for primary, secondary or tertiary prevention is a fundamental strategy of PNAISH, mainly by making men co-responsible for their own health and, consequently, that of the environment in which they participate. (COELHO et al., 2018; MINISTRY OF HEALTH, 2013)

This research also elucidates that 77% of the sample live with a steady partner, however, research in Greece found that married marital status was a protective characteristic for depression. What must be a protective factor, however, may be part of the illness process. This leads to the question of whether the marriage relationship in this population is healthy or not, that is, whether it would enhance the harmful effects of Brazilian culture in which machismo and female submission still operate. (PAPADOPOULOS et al., 2005).

No other major differences were observed in relation to sociodemographic factors, since

the entire community is demographically in the same social classification, at the same time that this study was carried out mainly on women. And it is believed that in this group other factors can have a greater impact on the predisposition or not to mental suffering, such as: presence of a consolidated social support network (church, sporting and artistic activities and human support) which is inversely associated with these conditions, by triggering protective factors. (FORTES et al, 2011; FORTES et al., 2014; LIMA et al., 2008).

When evaluating the symptoms of the diseases studied, it was noticed that 63.6% of the participants had a score for non-remission of Depression by HAM-D and 54.5% had a score for non-remission of Anxiety by HAM-A. Among these individuals, 40.9% had moderate and/or severe symptoms for both HAM-A and HAM-D. Research carried out in Portugal evaluated that 72% of the general population with symptoms of depression had moderate to severe symptoms and when related to anxiety this percentage was 82.58%.19 This shows that the population in question has a greater tendency to depression than for anxiety and a lower percentage of serious cases, in relation to the international study. It is worth noting, however, that the sample group had been using psychotropic medications without change for more than three months, and must have been in remission with a minimum score on these Anxiety and Depression scales.

Regarding drug treatment, it was observed that the most prescribed medications were from the Antidepressant classes, followed by Benzodiazepines, in line with national articles on prevalence in the general population. (BORGES et al., 2015; NETTO et al., 2012; ROCHA; WERLANG, 2013). Among those surveyed, 50% of the times the medication had been used for more than five years. Whether due to the diagnosis of Depression or Anxiety, when evaluating the scores on the Hamilton scales, it can be inferred that the medications used seem to have low therapeutic effectiveness, probably related to underdoses of ATs and low doses of most of the other antidepressants used. This probably explains why the therapy used is not effective in 54.5% to 63.6% of diagnosed users, who maintain treatment for more than three months without beneficial clinical changes.

On the other hand, 81.8% of individuals diagnosed with anxiety had a score for Depression on the HAM-D and 50% of those diagnosed with depression had a score for Anxiety on the HAM-A. Just as in the study by Borges and collaborators (2015), carried out with women at the UBS in an urban Brazilian center, there is evidence that psychotropic drugs are not being effective, indicating dissonances in relation to the use and correct recognition of symptoms of mental suffering. This is a worrying fact, given that the scientific literature advises making changes in dosage and/or active ingredients every four to eight weeks until total remission of symptoms and subsequent maintenance therapy with asymptomatic patients, which can vary from six to 24 months in general. majority. In view of the findings, the rational and effective use of psychotropic drugs today and in PHC services is questioned. (APA, 2014).

The results showed that the use of antipsychotics improved symptoms of anxiety and depression and the use of antidepressants was not effective in most cases, which is inconsistent, given that antidepressants are the first-line medications for the treatment of these illnesses. Therefore, the question to be asked may not be which medication to use, but rather, how the patient is monitored, in relation to adherence to treatment, effective dose and use of complementary therapies, neglected by patients and the healthcare team. (FORTES et al., 2011; LIRA et al.,

2014; PAPADOPOULOS et al., 2005; REIS et al., 2017; ROCHA; WERLANG, 2013; SARACENO et al., 2007; WANDERLEY et al., 2013).

The application of the Hamilton scales highlights flaws in pre-research diagnoses, especially regarding Depression. Therefore, it is clear that 87.5% of people who were not diagnosed with Depression had a score for Depression on the HAM-D. While 5 of the 11 people (45.5%) of those who did not have a diagnosis of anxiety were assessed with anxiety by the HAM-A. The probability of underdiagnosis of pathologies in this population is inferred, possibly because this clinical picture does not make people seek the necessary assistance and, when they do, they receive inadequate diagnosis and treatment due to the lack of technical training of the teams for better intervention in people in distress. psychic. Therefore, the idea of screening for depression and anxiety in users of psychotropic drugs and those with symptoms of somatization and sadness is pertinent; since a large proportion of patients with anxiety and/or depression disorders are not diagnosed, as assumed in a national study by the ESF. (BORGES et al., 2015; FORTES et al., 2014; SARACENO et al, 2007).

This is a paradox, since PHC has the potential to develop mental health promotion actions, conduct tracking, referral and monitoring of these patients28 and that the doctor responsible for the area carries out longitudinal monitoring based on constant scientific updating, due to the MFC training process. The reasons for ineffective therapeutic maintenance are then questioned. Clinical experience in medical practice responds to most of these cases as resistance to therapeutic change, whether due to the unavailability of medication in the public network and lack of conditions to purchase it in the private network; whether due to lack of adherence due to side effects and others. This seems to be the biggest obstacle for doctors in mental health clinical practice in PHC to adapt drug therapy, but more studies are needed to raise this question. (MORAL et al., 2018)

Therefore, assuming that there is weakness in the recognition and support for people with this condition in the PHC setting, and that 77.3% of users only underwent drug treatment, which was not effective in more than 54% of cases, this is a worrying fact. Assuming that the medicalization of psychological suffering remains the most used, it is understood that non-pharmacological interventions can have the power to promote health and, above all, comfort in the lives of patients, without neglecting the potential of pharmacology. Therefore, these patients improve when supported by PHC teams, individually or in groups, which justifies the possibility of developing other therapeutic interventions in addition to medicalization, as they are low-cost strategies, easy to implement and proven to be effective. This corroborates the data found in the research in which individuals in the group that underwent psychotherapy or physical exercises had, respectively, a 40% and 75% remission rate of symptoms of depression and/or anxiety, regardless of the pharmacological therapy they were using. subject. (CHAVES et al., 2019; EJEBY et al., 2014; FORTES et al., 2014).

However, the present study found that 9.1% practiced physical exercise among participants. Brazilian and Icelandic research observed that the practice of resistance physical exercise in middle age reduced symptoms of depression and anxiety. Therefore, a sedentary lifestyle may be associated with the lack of success in mental health therapy in the researched group. This fact is possibly due to the lack of social support for the practice of physical activities. (ARAÚJO et al., 2017; CHANG et al., 2016; AGOSTINHO et al., 2020).

With the ESF acting as the main gateway for complaints of mental suffering, being a scenario for resolution, prevention and rehabilitation in SM, a new form of articulation between the primary and specialized levels is essential. The integration of psychiatry and PHC through matrix support can provide for the organization of the flow of users between the primary and specialized care levels.

This interaction and integration are still scarce and limited in national and international medical practice. Matrix support is a crucial tool for improving MH care in PHC. It is proposed to be a new form of relationship between primary care and specialized care, through a matrix of interaction of different knowledge, incorporating the general practitioner as a resolving agent. In 2008, the publication of Ordinance No. 154, which regulates the creation of Family Health Support Centers (NASF) with the recommendation that there be at least one MH professional, standardized the practice of matrix support, defining it as a model of care collaboratives in the Brazilian SUS. However, this is not the reality we see in practice. It is still a utopian scenario in many Brazilian regions, but it is possible to achieve and deserves support and encouragement. (MORAL et al., 2018; FORTES et al., 2014).

Finally, the data found in the article are limited due to the small sample size, possibly due to the incidence found of use of psychotropic drugs, below the average, of only 5.36%, corroborated by the exclusion of 11 patients who were undergoing changes in medications in the last two months, and 11 participants for refusing to sign the informed consent form, which represented 50% of the total eligible participants excluded from the research. However, despite being a study restricted to a specific population in a city in the interior of Paraíba, with less than three thousand inhabitants, the results found confirm the idea that generalist doctors in UBS do not have sufficient training to manage health cases. mental, whether simple or complex. Therefore, this study becomes of extreme academic relevance, as it highlights the need to improve matrix support in the training of Family and Community Doctors, as well as in the overall functioning of PHC services, especially regarding failures in the diagnosis of depression and anxiety and in therapeutic monitoring using subdoses of ATs and ineffective doses of SSRIs or SNRIs.

CONCLUSION

When evaluating users with anxiety and depression using psychotropic drugs in the municipality of Areia de Baraúnas - PB, it was noticed that a large percentage did not show improvement and were only undergoing medication treatment in subdoses or long-term low therapeutic doses. At the same time, the diagnostic failure in these patients was relevant, as many presented only one diagnosis and scored for both clinical conditions.

Therefore, mental health management of depression and anxiety needs to be improved in primary health care. This requires an emphasis on non-pharmacological therapies, with the aim of promoting quality of life and enhancing drug treatment, consolidating the quality of the PHC service.

In addition, a well-structured network is necessary in Brazil, and matrix support must be put into practice. Therefore, the main protagonists in the construction of these new practices must be general practitioners, specialists in Family and Community Medicine and the multidisciplinary team of the ESF, always with the help of psychiatrists and other MH professionals who work in PHC.

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