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MENTAL THERAPEUTIC ITINERARY OF INDIVIDUALS SUSPECTED OF COMMON MENTAL DISORDER

ITINERÁRIO TERAPÊUTICO DE INDIVÍDUOS COM SUSPEITA DE TRANSTORNO MENTAL COMUM

ITINERARIO TERAPÉUTICO DE INDIVIDUOS CON SOSPECHA DE TRASTORNO MENTAL COMÚN

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ABSTRACT

Objective: to describe the therapeutic itinerary of individuals suspected of common mental disorder in a Family Health unit. **Method:** this was a sectional, observational, and analytical study. A questionnaire with socioeconomic-demographic characterization and a tracing instrument of non-psychotic mental disorders were used. The data collection was performed between July of 2011 and February of 2012. In the univariate association analysis, individuals with score ≥ 7 who seek for health services in the past six months were considered the outcome variable and socio-demographic conditions were considered as predictor variables. The research project was approved by the Committee of Ethics in Research, Protocol 028/2009. **Results:** common mental disorder was associated with the variables of being single, unemployed, and retired. The most sought-after health service was the ER. **Conclusion:** the seeking of health care was prevalent in the secondary care level demonstrating the distance of Primary Care, which should be the population's first choice. **Descriptors:** Mental Health; Access to Health Services; Primary Health Care; Nursing.

RESUMO

Objetivo: descrever o itinerário terapêutico dos indivíduos com suspeita de transtorno mental comum cadastrado em uma unidade de Saúde da Família. **Método:** estudo seccional, observacional, analítico. Aplicou-se um questionário com caracterização socioeconômico-demográfica e o instrumento de rastreamento de transtornos mentais não psicóticos. A coleta de dados aconteceu entre julho/2011 e fevereiro/2012. Para análise de associação univariada consideraram-se os indivíduos com escore ≥ 7 e que procuraram pelo serviço de saúde nos últimos seis meses como uma variável desfecho; as condições sociodemográficas foram consideradas como as variáveis preditoras. O projeto de pesquisa teve a aprovação do Comitê de Ética em Pesquisa, Protocolo 028/2009. **Resultados:** o transtorno mental comum foi associado às variáveis solteiro, desempregado e aposentado. O serviço de saúde mais procurado foi o Pronto-Socorro. **Conclusão:** há prevalência de busca de atendimento à saúde no nível de atenção secundária, demonstrando o distanciamento da Atenção Primária que deveria ser a primeira escolha da população. **Descritores:** Saúde Mental; Acesso ao Serviço de Saúde; Atenção Primária à Saúde; Enfermagem.

RESUMEN

Objetivo: describir el itinerario terapéutico de los individuos con sospecha de trastorno mental común registrado en unidad de Saúde da Família. **Metodología:** estudio seccional, observacional y analítico. Un cuestionario de características socioeconómico-demográficas fue aplicado, también el instrumento de rastreo de trastornos mentales no psicóticos. La recolección de datos ocurrió entre julio/2011 y febrero/2012. Para el análisis de asociación univariada se consideraron los individuos con escore > 7 y que buscaron el servicio de salud en los últimos seis meses como variable de desenlace; las condiciones sociodemográficas fueron consideradas como las variables preditoras. El proyecto de investigación fue aprobado por el Comitê de Ética em Pesquisa, Protocolo 028/2009. **Resultados:** el trastorno mental común fue asociado a las variables soltero, desempleado y jubilado. El servicio de salud más buscado fue el Pronto-Socorro (Centro de Atención Primaria). **Conclusión:** hay prevalencia de búsqueda de atención de salud en el segundo nivel de atención, lo que demuestra el alejamiento de la atención primaria, que debería ser la primera opción de la población. **Descritores:** Salud Mental; Acceso al Servicio de Salud; Atención Primaria a la Salud; Enfermería.

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INTRODUCTION

Mental health is responsible for a large percentage of disability and mortality in the general population. One in four people will suffer from some mental health condition throughout life. Depression will be the second most common incident cause of diseases in middle income countries, and the third largest in low-income countries until 2013.¹

In this perspective, mental disorders account for four out of ten leading causes of disability worldwide and affect 25% of the population in some stage of life. In Brazil, around 31% to 50% of the population tends to present at least one episode of some mental disorder during life. Professional help is around 20% to 40% as the result of these disorders, which indicates the social relevance of these problems.²

This information is corroborated by researchers who have studied specific populations in distinct regions. Greece is an example, in which 14% of the studied population suffered from some psychiatric morbidity.³

Among the types of mental suffering, this study was interested in Common Mental Disorders (CMD). These are types of mental suffering classified as non-psychotic, in which the person presents symptoms that produce functional incapacity; however, they generally do not meet formal requirements for the formulation of diagnoses. These symptoms are identified as insomnia, fatigue, depressive symptoms, irritability, forgetfulness, difficulties to concentrate, and somatic complaints.⁴

In Brazil, the prevalence of CMD is oscillating. In a municipality of Rio Grande do Sul it reached 51.1% of all individuals who seek help in the primary health care (PHC); depression, generalized anxiety, and dysthymia are the most frequent diagnoses. It is precisely this population that mostly uses health services seeking appointments with clinicians, specialists, and emergency services. These individuals are also responsible for increased uses of pain medication.⁵

Internationally, the PHC is a strategy of the health care organization, which aims to provide care to the population's needs in a regionalized, continuous, and systematized way with preventive and curative actions. The PHC in Brazil groups the principles of the Sanitary Reform constituent of the Unified Health System (UHS), and is composed of two basic features: the regionalization, in which

health services should be organized to suit the various national regions, identifying the health needs of each region; and integrality in order to strengthen the union between curative and preventive actions.⁶

Thus, the importance of the PHC in the care to a population is relevant. It is known that 56% of Family Health teams (FH) perform some action on mental health, configured as part of the basic health care network and gateway to the system. At all levels, it is clear that there is a close contact between FH teams and mental health problems.⁷

With respect to the FH teams, it is crucial that mental health and CMD be considered their priorities. The inclusion of these priorities in the strategies of promotion, prevention, and therapy, along with other existing ones such as diabetes and hypertension, will allow reaching goals to ensure full service to users. Therefore, the promotion of well-being and quality of life for the population for which FH is responsible will take place with increased efficaciousness and effectiveness of the already existing health resources.⁵

Considering these facts, it appears that CMD has been expressive in the population, which justified the need to study it in the PHC. By virtue of the attendance, one wonders where this population in mental distress seeks help, how does it happens, and where are them being tended.

The identification of the itinerary of people seeking health care services helps to understand how these individuals behave in relation to using these services. Such knowledge reveals the choice of appropriate strategies that will ensure access at the necessary time and in a continuous fashion, promoting the creation of a link between health staff and community, and with it, improving treatment adherence.⁸

The knowledge about the therapeutic itineraries can subsidize the organization and management of health services and build comprehensive integrated assistance practices. Moreover, it can serve as a support for the evaluation of the effectiveness of assistance networks to ensure access, detection of the real needs for the development of educational programs, professional training, and adequacy of service flows.⁸

Thus, the present study aims to describe the therapeutic itinerary of individuals suspected of common mental disorder and registered in a FH unit.

METHOD

This was a sectional, observational, and analytical study conducted in the population served by a FH team in a medium-sized municipality in the Brazilian Central-Western region with a significant economic and social regional representativeness. The choice of the Family Health Strategy (FHS) came about its representation of the insertion of the Nursing Course from the Federal University of Goiás, Catalão Campus, and expressive attendance of 1,440 registered families, comprising about 4,810 people, and a site where 8 community health agents (CHA) act in their micro areas.

The study population comes from the database from a previous research project that used the trace instrument of non-psychotic mental disorder Self Report Questionnaire 20 (SRQ-20) in 607 individuals served by the FH unit and selected by convenience.

Individuals who presented a score ≥ 7 and fully replied the questions about the demand for health services and attendance at the various levels of health care were selected from this database. Those who presented serious and persistent mental disorder, reported or observed cognitive deficit, were under the effect of alcoholic substance and other drugs, had incompatible address, and showed absence of a family member until the third researcher visit were excluded from the study. All participants were informed about the objectives of the study and those who agreed voluntarily signed an informed consent (VSIC).

The data collection procedure was initiated through meetings with the FH team, project presentation, and collaboration commitment by the CHA in order to introduce the researchers in the field. Data collection was performed between the months of July of 2011 and February of 2012.

The structured questionnaire and the tracing instrument of non-psychotic mental disorders, SRQ-20, were applied in a separate room; the questionnaire allowed for socio-economic and demographic characterization. Participants with score ≥ 7 received questions pertaining to their demand for health services and care.

The SQR-20 was translated, adapted, and validated for the Portuguese language. It contained 20 questions related to mental health condition in the past 30 days, the answers were "Yes" or "No"; each Yes answer was equivalent to one point. The result could range from 0 (zero) representing no probability, to 20 (twenty) representing

extreme probability. The cutoff was considered as equal to or greater than 7 for both genders.⁹

The data were entered in the Excel for Windows® 2003-2007 program and double checked. Cleaning and checking for database inconsistencies was performed after data entering. The analysis of the data consisted of absolute and relative frequency, mean values, and standard deviation using the software Statistical Package for Social Sciences (SPSS) for Windows version 15.0.

The univariate association analysis considered individuals with score ≥ 7 who searched for health service in the past six months as the outcome variable, and demographic conditions as the predictor variable.

The Chi Square test (χ^2) or Fischer test were used at the significance level of 5%. The Prevalence Ratio (PR) was used as the effect measure. The value of $p < 0.05$ was considered for factors associated with the outcome variable.

The ethical care governing research involving human beings were protected. This study integrates a matrix research that studied the health care process articulated to the formation of the professional nurse. Approved by the Research Ethics Committee of Federal University of Goiás (UFG/COEP) 028/2009.

RESULTS

The search for health services in the last six months by people with score ≥ 7 was analyzed in this study to identify the therapeutic itinerary of the studied individuals.

A total of 607 individuals were studied, of which 181 (29.81%) presented suspicion of CMD and scores of SRQ ≥ 7 , most of them were females (91.16%). Out of the 181 individuals suspected of CMD, 115 (63.53%) reported having sought a health service in the past six months, most of them were females (64.2%).

The interviewed individuals had several reasons to justify the search for health services, which resulted in a total of 137 events. The motivations were grouped into classes to provide a more objective presentation in the study. Among them, we highlight cardiovascular problems (20.43%) expressed by arterial hypertension, arrhythmias, heart attacks, and heart diseases in general, followed by orthopedics (10.94%), pain (9.48%), gynecological problems (9.48%), endocrine alterations (7.29%), neurological (6.56%), gastrointestinal (5.10%), infections in general (3.64%), kidney problems (2.91%),

consultations and routine exams (2.91%), and other reasons (12.4%). With regard to issues related to mental health, some reported depressive crisis and consultations with psychologists (8.75%).

The majority of participants sought health services directly into the ER by the SUS (26.66%), followed by health units and FH (21.48%), clinics with health plans (13.33%), private clinics (11.85%), Hospital outpatient

clinics (11.85%), private practices/practices with health plans (8.88%), specialty centers (2.22%), pharmaceutical care (2.22%), and other locations (1.48%).

Table 1 shows the socio-demographic conditions of participants who sought health services over the past 12 months, including individuals suspected of CMD considering as those with SQR-20 score ≥ 7 as the outcome variable.

Table 1. Demand for health services in the last 12 months by individuals suspected of CMD. Catalão, Goiás, Brazil, 2012

	N (%)	Yes ≥ 7	No ≤ 7	RP	IC 95%	p value
Sex		n (%)	n (%)			
Female	165 (91.2)	106 (64.2)	59 (35.8)	1.14	-1.79 0.73	0.525
Male	16 (8.8)	9 (56.3)	7 (43.8)		1.00	
Age group						
> or = 18 years and < 60 years	154 (85.1)	94 (61.0)	60 (39.0)		1.00	
60-69 years	17 (9.4)	13 (76.5)	4 (23.5)	1.23	0.92 -1.64	0.244
70-79 years	9 (5.0)	7 (77.8)	2 (22.2)	1.24	-1.79 0.86	0.298
80 or more	1 (0.6)	1 (100.0)	0 (0.0)	1.58	-1.76 1.41	0.635
Ethnicity referred to						
White	93 (51.4)	61 (65.6)	32 (34.4)	1.07	-1.33 0.86	0.554
Black	14 (7.7)	10 (71.4)	4 (28.6)	1.14	0.80 -1.61	0.522
Brown	65 (35.9)	40 (61.5)	25 (38.5)	0.95	0.75 -1.20	0.676
Asian	9 (5.0)	4 (44.4)	5 (55.6)		1.00	
Marital status						
Lives with a partner	129 (71.3)	83 (64.3)	46 (35.7)	1.05	-1.34 0.81	0.722
Widower	15 (8.3)	13 (86.7)	2 (13.3)	1.41	1.12 -1.78	0.051
Single	21 (11.6)	9 (42.9)	12 (57.1)	0.65	-1.07 0.39	0.036 *
Divorced	16 (8.8)	10 (62.5)	6 (37.5)	0.98	-1.46 0.66	0.928
Education						
Illiterate	8 (4.4)	6 (75.0)	2 (25.0)	1.19	-1.80 0.79	0.389
Read/write	14 (7.7)	12 (85.7)	2 (14.3)	1.39	-1.78 1.09	0.072
Elementary	63 (34.8)	38 (60.3)	25 (39.7)	0.92	-1.17 0.73	0.510
High school	84 (46.4)	54 (64.3)	30 (35.7)	1.02	-1.27 0.82	0.845
College	12 (6.6)	5 (41.7)	7 (58.3)		1.00	
Children						
Yes	169 (93.4)	108 (63.9)	61 (36.1)	1.10	0.67 -1.79	0.459
No	12 (6.6)	7 (58.3)	5 (41.7)		1.00	
Occupation						
Student	6 (3.3)	3 (50.0)	3 (50.0)	0.78	-1.75 0.35	0.381
Officially registered employment	21 (11.6)	16 (76.2)	5 (23.8)	1.23	-1.61 0.94	0.200
Self-employed	49 (27.1)	26 (53.1)	23 (46.9)	0.79	-1.05 0.59	0.074
Unemployed	3 (1.7)	0 (0.0)	3 (100.0)	0.00	0.00 -1.27	0.047 *
Retired/pensioner	28 (15.5)	23 (82.1)	5 (17.9)	1.37	1.10 -1.69	0.026 *
Housewife	73 (40.3)	46 (63.0)	27 (37)	0.99	-1.24 0.79	0.904
Retired/Self-employed	1 (0.6)	1 (100.0)	0 (0.0)	1.58	-1.76 1.41	0.635

PR: Prevalence Ratio; 95% confidence interval, CI; * significance level: $p < 0.05$

The univariate analysis revealed association between the outcome and predictor variables: being single ($p = 0.036$; PR: 0.65; 95% CI: 0.39-1.07), unemployed ($p = 0.047$; PR = 0.00; 95% CI: 0.00-1.27), and retired/pensioner ($p = 0.026$; PR: 1.37; 95% CI: 1.10-1.69).

DISCUSSION

The studied population showed SRQ score ≥ 7 , which suggests indication of CMD. Although these individuals showed results suggestive of CMD they referred to several other reasons to justify their search for health services.

The results of this study can be justified by the fact that mental disorders interact with other health conditions causing somatic symptoms including pain, fatigue, and dizziness. Other conditions that also affect health are the specific syndromes of organs

and systems, sometimes without a specific cause, such as irritable bowel syndrome, fibromyalgia, chronic fatigue syndrome, chronic pelvic pain, mandibular joint dysfunction, and sexual syndromes.¹⁰

Prior research has shown that somatic symptoms are strongly associated with CMD in about 15% of patients seen in the PHC.¹⁰

Women presented higher prevalence of CMD than men. Our results corroborate the results of the study conducted in Greece between 2009-2010 with 4,894 individuals, which revealed that 14% of the studied population had some CMD; women showed higher percentage of disorders (17%) compared to men (11%), and anxiety disorder (4.1%) and depression (2.9%) were highlighted.

3

The association between outcomes and some socio-demographic conditions are relevant factors to be considered because being single and unemployed represent decreased chances to seek some health service, and being retired represent increased chance to seek health service.

On the other hand, the labor activity can reflect on the quality of life of people, therefore, on the individual's health. Work is regarded as a moral obligation of individuals and is understood as an essence of life, both in the economic and psychosocial perspectives; moreover, it expresses activity and dignity.¹¹

The expressive number of "housewives" reported by the participants may be related to the condition of unemployment at the time of data collection, and possibly by a decreased search for health services. The unemployed refers to the economically active population, in the absence of work, while for the elderly and retirees it means that they are no longer part of the economically active population, being inactive in the socio-economic perspective.¹¹

The condition of being or not employed generates controversial feelings according to the age group, i.e., while it is seen as an exhausting activity for those active in the labor market, it is seen as the realization of life itself for the elderly who are retired and away from work leading them to feel stray, incomplete, and useless. It is in the workplace that individuals carry out contacts with other people and, through it, they get social recognition.¹¹

In addition, being unemployed reflects on the life of a worker as a whole and can trigger characteristic mental suffering such as low self-esteem, stress, anxiety, low mood and humor, feelings of shame, humiliation, and sleep disturbances, conditions that are susceptible to mental suffering.¹²

This study revealed that single and unemployed individuals suspected of CMD did not seek care in health services in the same relevancy than those who are retired. Retirement is a time that involves several critical situations that when interconnected with each other they directly influence on quality of life. In this perspective, retirement can be visualized under two views: a positive and a negative. The positive view represents the completion of a phase, a period of rest; the negative view represents a decrease in the family income and feelings of being uselessness.¹³

The way as the individual will face retirement is related to his perceptions and

life story because work also involves social relations. When retirement relates to a negative view including an unfit economic condition it results in decreased quality of life and may compromise the subject's psychic structure reflecting a prevalence of depressive symptoms, particularly in the age groups between 50-59 and 60-70 years of age.

¹³ Anxiety disorders are also expressive in the elderly population, especially in the age group between 60-70 years of age.³

The suspicion of an individual with CMD, who sought after some health service in the past six months revealed in this survey (63.53%), is superior when compared to other available data in the scientific literature (32%)³ demonstrating that the studied population had interest and wanted health services, whether in the PHC or not.

Considering the proposal of the current public health system in the country, the PHC is the gateway to strategic health services, decentralized, and constituent of health care networks.¹⁴ Thus, it was expected that the studied individuals seek health services in the primary level of attention. However, it was noted that the secondary level of attention (emergency room) was the most sought after service by the studied population, followed by the PHC (Health Centers, and Family Health Strategies-FHS).

In order to meet the three key roles in health care networks, identified as resolution, coordination, and accountability, the PHC needs to solve 85% of health problems in the population, directing flows and counter flows among members of the networks in addition to train health professionals in the receiving and communication steps in the health care networks consisting of primary health care unit or FH team.¹⁵ Thus, for the FH unit to become an agency of resolution power, it must include mental health care in their programs assisting the individual in mental distress, referencing, and counter-referencing within health care networks, consisting of FH strategies, Center for psychosocial care (CPSC), and general hospitals among others.¹⁶

In theory, the FH strategy would perform an integral follow-up given its proximity to the community, with approaches of more complex issues including mental health issues because assistance practices to mental disorders, suggested as the result of the paradigm shift through the psychiatric reform, have the de-institutionalization, reduction of psychiatric beds, and insertion of a service network in health services for people with mental disorders as their main goal.¹⁷

In the meantime, the focus on people with less serious mental disorders was unattended. The focus is well delineated regarding attention to patients with severe disorders. This demand for mental health highlights the deficiencies in the services with respect to insufficient training of teams and lack of tools and organizational support in addressing or routing identified problems. The professionals involved rely on biological aspects of health problems because they have greater capacity to intervene along these dimensions.¹⁷

This reality denotes that psychosocial issues are not a priority in the PHC services, which is reinforced by complaints of lacking physical structures and prepared teams to act facing the demands, in addition to the disarticulation between health services. These aspects reflect negatively on the integral attention to health and liability with respect to the promotion of health and effectiveness of health care services in meeting health needs in the population.¹⁶

CONCLUSION

In an attempt to describe the therapeutic itinerary of individuals with the possibility to develop CMD, it was observed that these people seek, above all, secondary level care services denoting the disarticulation between health services in the sense that they cannot meet the expressive demands for healthcare, as advocated by the Sanitary Reform and Health System implemented over twenty years ago.

Associated with this disarticulation, the reason for health care demand was mostly linked to cardiovascular, orthopedic, pain, and gynecological problems evidencing that the FH service with emphasis on attention to mental health, happens based on reported biomedical basis alterations with indications of symptomatic medicines to reported complaints, stressing that the origins of the various presented problems can relate to the scope of emotions, relational or psychic.

This featured punctual and emergency service care, with little possibility of continuity in the attention to health needs in the community. In addition, it reinforced the PHC distancing, which should, in general, be the first choice of the population. The search for services for mental health related issues was little expressive and in some cases it was what determined the search for a particular service in the area, such as the CPSC and not in PHC.

The methodological design was a limitation in this study because sectional studies represent a given phenomenon in a

determined time, making it impossible to infer causality between outcomes and predictors. Studies with diversified methodological approaches would be necessary for better analysis of the object of study and its complexity. However, the results will help in identifying the itinerary used by people with CMD enabling the review of health care practices with a view to modify conducts and customer care services to individuals with mental distress that will be extensive to family members and the community in which he is inserted.

The effective FH embracement and the development of practices that are necessary for mental health care in the FH with focus on the family relationships are necessary to attain the object image that is integral care for individuals in mental distress.

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