



## Quality of Life in Brazil's Family Health Strategy: Common Mental Disorders, Use of Psychotropic Drugs and Sociodemographic Factors



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### A B S T R A C T

The aim of the study was to evaluate the patients' quality of life in Brazil's Family Health Strategy and its association with sociodemographic factors, presence of common mental disorders, and use of psychotropic drugs. Were interviewed 442 patients. Tools were: World Health Organization Quality of Life Assessment-Bref and Self Reporting Questionnaire. Male and low education were strongly associated with higher quality of life. Use of psychotropic drugs and the presence of CMD were strongly associated with poor quality of life. There is a pressing need for primary health care professionals to invest in tracking, and in holistic interventions that are able to cover the healthcare needs of these vulnerable groups.

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It has been seen that the evaluation of quality of life provides a comprehensive and individualized perspective of the health and the wellbeing of general or specific populations (Muhwezi, Okello, & Turiho, 2010). In this way, health-related quality of life is increasingly used to analyze clinical and population-based outcomes in the health field (Lubetkin, Jia, Franks, & Gold, 2005), to identify the general healthcare needs (Frohlich, Zaccolo, da Silva, & Mengue, 2010), and to raise clinical and policy recommendations (Frick & Jones, 2008).

Thus, the assessment of the quality of life is particularly important in primary health care (PHC), where the majority of patients are attended in Brazil.

Besides, in Brazil, the Family Health Strategy (FHS) is a government strategy for the development of PHC in the public system. The aims are to coordinate and ensure universal access and comprehensive services in all levels of care, and implement inter-sectoral action for health promotion and disease prevention. Thus, the focus of FHS is on families and communities, integrating public health actions and health promotion with medical care (Paim, Travassos, Almeida, Bahia, & Macinko, 2011).

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Another peculiarity of FHS in Brazil is that many patients seen in these settings have common mental disorders (CMD), that defines conditions without specific diagnosis, where patients do not fit into the mental disorder diagnostic criteria but present symptoms of anxiety, depression or somatic symptoms (Bener, Dafeeah, Chaturvedi, & Bhugra, 2013; Walters, Buszewicz, Weich, & King, 2011). In addition, there is evidence that patients with CMD are more likely to use psychotropic drugs (Lima et al., 2008) and the presence of CMD and other comorbidities worsens the quality of life scores (Kroenke et al., 2013).

According to the literature, patients with CMD and/or in use of psychoactive drugs have a worse quality of life when compared with the general population (Jansen et al., 2011; Lima et al., 2008; Quintana et al., 2013; Walters et al., 2011) and greater amount of unhealthy days per month (Kopp et al., 2011). It is therefore necessary that mental disorders are considered one of the priorities in health care (Cook & Harman, 2008).

In Brazil, the FHS is the frontline settings where CMD patients will initially seek out care. However, many will encounter challenges such as lack of specific actions for people with CMD, and healthcare teams not equipped in the proper management of treatment. A study on this issue showed that only a small number of patients were treated in full compliance with the guidelines and manual treatment for CMD (Van Fenema, Van Der Wee, Bauer, Witte, & Zitman, 2012). In addition, studies have revealed inadequacies and inconsistencies in drug prescriptions for the treatment of mental disorders by general practitioners in PHC services (Bet, Hugtenburg, Penninx, Balkom, et al., 2013; Sirdifield et al., 2013).

Such challenges pose possibilities of functional impairment in the quality of life of CMD patients. Thus the variables explored in this study include; measuring the quality of life in FHS and its association

with sociodemographic data, presence of CMD and use of psychotropic drugs as valuable measures to define functional impairment that individuals may have. This analysis also allows identification of specific characteristics of individuals with impaired quality of life related to psychiatric symptoms and psychotropic use.

Therefore, the objectives were to evaluate the quality of life in patients treated in Brazilian FHS and its association with sociodemographic factors, presence of CMD and the use of psychotropic drugs.

## METHODS

### Setting and Participants

The study was conducted in ten FHS in Diamantina, Minas Gerais, Brazil, covering all the PHC system of that county. Each FHS is composed of a multi-professional team: a nurse, a doctor, a nurse technician, one administrative assistant, one general assistant, and six community health agents at least. The average number of medical appointments per month in each FHS varies from 167 to 445.

The sample met the following inclusion criteria: patients aged 18 years old and over that have passed through medical consultation, and Portuguese speakers. Exclusion criteria were patients aged less than 18 years, with cognitive impairment, with no access to the units, and patients with lack of a medical scheduled appointment.

A sampling plan for stratified sampling with proportional allocation by strata was adopted, each stratum formed by each of the ten FHS. The prevalence taken as a basis for sample size calculation was 50% of CMD (Lima et al., 2008), thus guaranteeing the largest sample size covering the estimation of the use of psychotropic drugs, since the prevalence reported in literature is less than 50%. The sampling tolerable error was 5%, and the significance level was 5%. No charge was added equivalent response to 15%, resulting in a sample size of 442 participants.

The study received approval from the Research Ethics Committee of the University of São Paulo at Ribeirão Preto College of Nursing (n° 24,259,113.2.0000.5393). Following the guidelines of the Brazilian National Research Council, Brasília, Brazil, researchers provided the participants with information about the aim of the study. Written, informed consent was obtained from all participants.

### Design and Procedure

The descriptive cross-sectional study was carried out and data collection took place from February to October 2014. The researchers remained at the FHS in private places, every day, every other time, in order to cover the entire opening hours of the units. Patients were approached while waiting for medical consultation and each interview lasted approximately 30–40 minutes.

### Measures

#### Demographic and Clinical Data

To obtain the demographic and relevant data to psychotropic drugs used, a structured questionnaire with the following questions was used: gender, age, education, marital status, religion, occupation, individual and family monthly income, number of household, presence of illness, and information about medications in use, including psychotropic drugs.

#### Quality of Life Assessment

To assess the quality of life, the *World Health Organization Quality of Life Assessment-Bref* (WHOQOL-Bref), a quality of life assessment tool was used (WHO, 1998). This instrument is composed of 26 questions, two general “How would you rate your quality of life?” (Question 1) and “How satisfied are you with your health?” (Question 2), and 24 representing four domains namely: domain I (physical: pain and discomfort, energy and fatigue, sleep and rest); domain II (psychological: positive feelings, thinking, learning, memory and concentration, self-

esteem, body image and appearance, negative feelings); domain III (social relations: personal relationships, social support, sexual activity); domain IV (environment: physical security and protection, home environment, financial resources; health and social care: accessibility and quality, opportunities for acquiring new information/skills and opportunities for recreation/leisure) (WHO, 1998).

#### Self Reporting Questionnaire

To identify the presence of CMD, the *Self-Reporting Questionnaire* (SRQ-20) was used (Mari & Williams, 1986). The questionnaire is composed of 20 questions, intended to screen for psychiatric conditions. The original questionnaire was developed by Harding et al. (1980) and it was composed of 30 items. The Brazilian version of the SRQ (SRQ-20) was validated in 1980 by Mari and Williams (1986) and has 20 items. Gonçalves, Stein, and Kapczinski (2008) evaluated the performance of the SRQ-20 as a psychiatric screening tool and recommended it for use in clinical practice for any professional, since their training can be done autonomously and with low cost. In addition, the cutoff points suggested by the SRQ-20 validation studies were used in this research. Thus, it was considered positive when female respondents answered “yes” to eight or more items, and when male respondents answered “yes” to six or more items.

#### Data Analysis

The Statistical Package for the Social Sciences, version 21.5, was used for data analysis. Statistical associations were investigated between quality of life (dependent variable) and the independent variables, namely: sociodemographic, use of psychotropic drugs and the presence of CMD.

Normal regression models and asymmetric regression models were used to verify the impact of independent variables on the dependent variable. For the likelihood ratio test, the normal model was used when the asymmetry was not significant; and standard model was used when the asymmetry was significant.

The analyses followed all the assumptions for regressions, such as multicollinearity, homoscedasticity and normality check. The regression model, which is shown in the results session, contain those variables that jointly expressed better quality of life prediction. A Fisher's test was also performed for the analyses of the two first questions of the WHOQOL-brief.

For each domain of the quality of life assessment tool, a standardized score that ranged from 0 to 100 points was built. The higher the score the better the situation of the domain related to the quality of life. Regarding the social relationships domain, the items were distributed into two categories (up to 50 and above 50, for the logistic regression) because the continuous distribution was not detected as normal.

## RESULTS

The sample consisted mostly of females (414/93.7%), age range of 41 to 59 years (186/42.1%), with secondary and higher education levels (373/84.4%), marital status with companion (338/76.5%), Catholic (300/67.9%), with an occupation (374/84.6%), individual monthly income of up to 3 times the minimum wage (365/82.6%), monthly household income of more than 3 times the minimum wage (227/51.4%), number of residents of the house up to four (427/96.6%), and with other illness (187/42.3%).

Table 1 shows the association of variables related to the questions of the Quality of Life Assessment Scale: How would you rate your quality of life? (Question 1) and How satisfied are you with your health? (Question 2). The questions have five possible answers and the highest score is related to better quality of life. Regarding the first question, there is association with all the variables studied, except with ‘gender’ ( $p = 0.458$ ). With regard to the question two, there was no association related to the variable ‘people living in the same house’ ( $p = 0.451$ ) and ‘number of medications in use’ ( $p = 0.720$ ).

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