INVESTIGATING THE COMPLIANCE WITH SPEECH THERAPY SERVICE IN THE CONTEXT OF PRIMARY CARE

Investigando a adesão ao atendimento fonoaudiológico no contexto da atenção básica

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ABSTRACT

Purpose: to analyze the reasons related to non-compliance of patients with speech therapy in a Health Center Primary Care in Campinas. **Method:** an *ex-post facto* exploratory study with qualitative characteristics, developed with patients or people responsible for them, seen at a health service and who did not comply with speech therapy. Semi-structured interviews were conducted, with semi-directed questions, so as to catch the reasons and attitudes exposed by patients or people responsible for them, regarding the non-compliance with the Speech, Language and Hearing Therapy. The interviews were transcribed and systematized considering the assumptions of Thematic Analysis, a technique of Analysis of the Content. **Results:** ten people were interviewed. During the analysis, a variety of themes and subthemes raised, from the ones related to the reason for the abandonment up to the assessment of speech therapy service in the view of users, plus the familiar organization dynamics to attend the visits. This study indicated that there are different reasons for quitting speech therapy in the context of Primary Care, such as: incompatibility of time, the dynamics of the visits, observation of improvement/solution of the case, patient's lack of interest and the need to have a previous treatment in another area. **Conclusion:** it was possible to observe the presence of different reasons related to an abandonment in the same interview, aspect that corroborates with the one discussed by the national and international literature, which characterizes the process of compliance/non-compliance as complex and multifactorial.

KEYWORDS: Patient Compliance; Speech Therapy; Primary Health Care; Qualitative Analysis; Speech, Language and Hearing Sciences

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INTRODUCTION

The Unified Health System (SUS) is an organizational arrangement of the Brazilian Government that supports the realization of the health policy in Brazil and translates into action the principles and guidelines of this policy[1]. The creation of this system was the result of the implementation of Health Reform ideals, being legitimized in the Federal Constitution and in the Organic Laws of Health.

The actions and services of SUS integrate a regionalized and hierarchical network, in the form of a single, organized and decentralized system, with a single management in each sphere of government, providing comprehensive care, with services that make up what is called Primary Care (AB) up to the Medium and High Complexity[1].

AB represents "a group of health actions, both in the individual and collective spheres, covering the promotion and protection of health, disease prevention, diagnosis, treatment, rehabilitation, harm reduction and health maintenance" (p. 3)[2], which has the role of being the pole irradiating the actions of communication in the care networks, in addition to solving most health problems, organizing the flows of subjects in the various health care services, taking care, bonding and accounting for the health of the population of its area.

The speech therapist can be inserted in AB through various arrangements[3-6]. The organization of most speech therapy services in AB is given through the reception, assessment and rehabilitation[7]. The availability of these services and the indication of the need for speech therapy alone do not ensure patient compliance. Practice has shown that a portion of patients seeking speech therapy, either through referrals from other professionals or spontaneously, does not adhere to the therapy.

The term compliance refers to many different meanings, and there is no consensus yet about its concept[8]. In the literature, there are studies that consider the patient as passive subjects in the treatment, disregarding them as social beings endowed with expectations, knowledge, interests and socio-cultural values that produce meanings and senses about the treatment of their illness[8], up to studies that give the subject an active role in the process of living with the disease and the treatment[9,10]. Moreover, Bertolozzi *et al.*[9] mention that the concept compliance consists of three aspects: the concept of health and disease presented by the carrier of the disease, the social position occupied by the sick person and the health production process[9].

Treatment compliance can be defined as a means to an end, an approach to the maintenance or improvement of health, to reduce the signs and symptoms of a disease[11]. However, there is a tendency to give a greater load of responsibility for the compliance/non-compliance to the patient, which is a misconception[12], since professionals and health services should be co-responsible in the process[10]. For the World Health Organization[13], compliance is a multidimensional phenomenon determined by the interaction of five dimensions: patient-related factors, disease-related factors, therapy-related factors, social and economic factors and health care system and team.

Low compliance may be related to the characteristics of the treatment, disease, patient and even the relationship between the health professional and the patient[14]. With regard to this last factor, Subtil *et al.*[15] point out that the aspects of the relationship between the care giver and the patient are essential, since the quality of the relationship established between them will have direct implications on the treatment compliance process.

Although the literature on the compliance to therapy is growing, such as the investigations on treatment compliance in HIV/AIDS[16], tuberculosis[17], hypertension[18], diabetes[19], physiotherapy[15], among others, there is still a paucity of studies investigating the patients' compliance to speech therapy. Apparently, compliance has been investigated particularly in relation to chronic diseases, and as speech therapy is related to the treatment of changes in orofacial motricity, language, speech and hearing, which can often turn into chronic conditions, it becomes essential to treat these patients' compliance based on this focus.

The few existing studies in the Speech Therapy field study the compliance to services of secondary and/or tertiary care, such as compliance to orofacial motricity therapy in a university hospital[20], vocal treatment in a university hospital[21], phonotherapy care of children with special needs in philanthropic institutions[22] and the program of Universal Newborn Hearing Screening in specialist rehabilitation center[23] and in maternity[24]. Therefore, we identified that there are no further studies investigating compliance to speech therapy in the context of AB, a fact that, as pointed by Reiners *et al.*[10], signals that the scientific literature production on compliance/non-compliance needs to grow, with contributions from academic faculties as well as from health care professionals.

This research aimed to analyze the reasons related to the non-compliance of patients to speech therapy services in a Primary Health Care Center (CS) of the Municipal Health Network of Campinas.

METHOD

This study was approved by the Municipal Secretariat of Health of Campinas and by the Research Ethics Committee of the School of Medical Sciences, under Certificate of Presentation for Ethical Consideration (CAAE) number 02914212.0.0000.5404.

This is a qualitative *ex-post facto* exploratory investigation [25] that had, as its subjects, patients or their guardians, in the case of minors, who were treated at a CS of Campinas and who did not comply with the therapy.

The starting point for non-compliance was when the patient failed to appear with frequency, i.e., from three consecutive absences without justification, to the speech therapy, being then removed from the sessions. It is important to highlight that, in all cases,

there was attempted contact, either by phone or by sending a written message via community health agent. They were only removed when, even after this contact, there was no return of the patient, whether or not to continue the service.

The subjects researched were received service at the CS by interns of the speech therapy course at the University of Campinas (Unicamp), since this unit is established as a graduation training field. This internship takes place twice a week at this health service, being developed in each of these days by a different team of interns under the supervision of a speech therapist, professor at the university. The activities of internship include situational analysis, conducting of activities to promote health, prevention and speech therapy.

The internship exists in this service since 2002. All patients starting speech therapy services are included in a database organized by the undergraduate course for academic purposes, in which it is possible to obtain identifying information, as well as whether the patient was discharged from the service, or if they did not comply with the therapy. From this database, we identified patients who did not comply with treatment, and among these, we draw some to be invited to participate in the research. The draw and inclusion of subjects stopped when we noticed the saturation of the sample[26].

We included subjects belonging to the three teams of the Family Health existing in the CS. The participants of the study were the former patients themselves, in the case of individuals who were of legal age, or their guardians, in the case of individuals who were minors.

The invitation to be part of the survey was conducted via telephone call or letter delivered by Community Health Agents (CHA) to potential research subjects. The researcher, at the invitation and before the interview, explained the procedures that would be taken, clarifying doubts and gathering the Informed Consent Form (ICF) signed.

The criteria for inclusion of subjects in the study were: i) to have received care or be responsible for a family member who received care in speech therapy in CS, ii) voluntary inclusion and iii) agreement and signing of the ICF. The exclusion criterion of the subjects was: i) to not agree to participate in the research.

Semi-structured interviews were conducted from a script of semi-structured questions that was developed by the researchers, in which the questions were made so that respondents could freely express the content of their answer[26].To this end, we adopted, during the interviews, a strategy of interaction aimed at the establishment of a bond between the researcher and the users or their guardians so that inquiries about treatment dropout could be addressed in a non-forceful or coercive way.

The script was developed with questions that focused on the exploration of the reasons for the non-compliance to speech therapy in order to understand the reasons and attitudes[27,28] given by the patients or their guardians in relation to speech therapy dropout. The questions guiding the interview were about how the patient went to the CS for the speech therapy, what was the reason they stopped going to the speech therapy at the time, how was the relationship between patient and professional who attended them, if they searched for some other service and what suggestions the patient would give to improve the service.

The interviews were conducted in the premises of CS, being recorded for later transcription and analysis.

The data collected through the interviews were transcribed and systematized considering the assumptions of Content Analysis[28]. The Content Analysis is a set of analysis techniques of communication that seeks to unveil the meanings of different types of speeches, based on inference or deduction, but that simultaneously respects specific criteria enablers of data in frequency, thematic structures, among others[28].

Among the techniques of the Content Analysis, we used the Thematic Analysis. “The notion of Theme is linked to a statement about a certain subject. It comprises a series of relationships and can be presented graphically by means of a word, a sentence, an abstract” (p. 208)[28]. The thematic analysis is about discovering the units of meaning that make up the communication whose presence means something to the analytical objective pursued.

The process of data treatment was started with the pre-analysis a phase in which we performed the preparation of the material and readings of the findings in order to provide comprehensive contact with the data and consequent impregnation by content. Subsequently, we made the exploration of the material through the encoding operation, with the cutout of the data and compilation into units of meaning (themes and subthemes), to, finally, describe and interpret the data [28].

The presentation of results will be performed descriptively, along with the discussion. The participants are identified by the letter S followed by a number one through ten.

RESULTS

We invited to participate in the study 18 subjects, and we conducted approximately 50 calls prior to the interview, in addition to sending written invitation by CHA for two users. Of these 18 former patients/families invited, ten did not participated in the survey for various reasons, such as: refusal to participate in it, change of address (neighborhood farther in the same city or even moving to another city), said to not recall more on the information that would be required in the research and non-attendance at the scheduled time for the interview.

We held, therefore, eight interviews, stopping up the invitation of more subjects belonging to the database due to the saturation of answers. Among these interviews, one was held with the former patient herself and the others with relatives of former patients. Figure 1 shows the data of participants of the research.

	Interviewee(s)	Purpose of the speech therapy	Patient age at the time
1	Grandmother (S1)	Articulation Disorder	4 years
2	Mother (S2) and father (S3)	Articulation Disorder and Change in Orofacial Motricity	8 years
3	Mother (S4)	Reading and Writing Difficulties	8 years
4	Mother (S5)	Change in Orofacial Motricity	9 years
5	patient herself (S8)	Change in Orofacial Motricity	57 years
6	Mother (S6) and father (S7)	Change in Orofacial Motricity	9 years
7	Mother (S9)	Articulation Disorder	5 years
8	Mother (S10)	Change in Orofacial Motricity	8 years

Caption: S – subject.

Figure 1- Data of the participants of the research

The themes and sub-themes that emerged from the analysis of the interviews can be seen in Figure 2. In the discussion section, examples will be given of the subjects' speech for each of the themes found, articulating with what the academic-scientific literature points on these issues.

As can be seen, the interviews brought a multitude of topics. In the discussion of this work, we will focus on the aspects related to the reason for the dropout, using the other findings when necessary.

Theme	Theme
Reason for dropout	Incompatibility of time
	The dynamics of speech therapy visits
	Noted improvement/resolution of the case
	The need for pretreatment in another area
	Patient's lack of interest
Evaluation of the speech therapy visits in the view of users	Ease of access to health services
	Relation of patients with the speech therapy intern
	Fragile teaching-service integration
Organization of the family dynamics to attend the service	-
Interdisciplinary contacts	-
Search for private speech therapy services	-
Satisfaction with the research	-
Suggested improvements to the service	-

Figure 2 – Themes and subthemes analyzed

DISCUSSION

In the AB services, the speech therapist works on the border of the clinical field and social field, fulfilling their role in the network of health care. Their performance should provide partnerships between other social institutions in the territory and the community, stimulating the creation and strengthening of social networks, relationships, acceptance and autonomy, besides the development of projects that deal with the size of the plurality of life[29].

According to the results, we observed that one of the factors that most hindered the compliance of the interviewees in the service was the incompatibility of schedules between school and the speech therapy sessions, a theme that emerged in five of the eight interviews:

> S6: *He [their son, former patient] changed schools and had to start studying in the afternoon. So, we couldn't attend the therapist because of the school hours.*

> S9: *[...] he [their son, former patient] was doing the therapy and, this year, when he returned from vacation, he began to study in the afternoon. And then I could not reconcile the therapist!*

The incompatibility of schedules has also been found in other studies as a cause of non-compliance, accounting for 4.4% of therapy dropouts on an Orofacial Motricity clinic in a tertiary service care[20] and for 21.7% of dropouts of patients with vocal disorders treated at a university hospital[30].

The speech therapy interns of a public university located in a region close to the one surveyed are presented in this CS only two times during the week, doing other internships in different institutions in the other periods. When the patient presented any impediment to attend at the times available, it was difficult to refer them to another service, as in the city of Campinas there is a shortage of speech therapists in public services, especially in Primary Care. This difficulty in the supply of speech therapy services was also found in a survey conducted in the city of Salvador, Bahia[31].

We could verify that a noted improvement from the complaints by patients also had an important role in the dropout process, as often the subjects/their family considered as sufficient the gains already achieved:

> S5: *[...] I talked with the dentist [orthodontist] after he [their son, former patient] was doing it for some time and she said that the exercises had helped him a lot – because he had no muscles, you know? So, all the exercises they [the speech therapy interns] gave him there were helping. So I believe he stopped for two reasons: because he was already kind of tired from the exercises and because he got better.*

> S1: *And the last time I talked to the ladies [the speech therapy interns] that took care of her [their granddaughter, former patient], I*

told them she was speaking well, she was no longer confusing the letters.

This aspect of dropout due to the evolution of the complaints was also observed in a study that discusses compliance to physiotherapy treatment[15], in which one of the reasons found for the non-compliance process was the relative improvement in signs and symptoms of the disease, coupled with the lack of persistence to continue until the end. This may be related to the prospect that some users of health services have on the process of health and illness, which can be a linear design, based on the restrictive, reductionist and curative interpretation, which is reflected in the dropout due to non-visualization of the complexity of the health-disease[32] and health care process.

Another aspect that can be observed in relation to the dropout was the patient's lack of interest to attend the speech therapy sessions:

S4: *The first few times he [their son, former patient] went, he liked it. But then I think that, well, because the exercises [given at the speech therapy] were more or less the same, he would say: "Oh, mom! But I do not want to go, because what I do there I can do at home. "[...] The only problem was this: he did not continue to go because he got discouraged. He did not want to go anymore, and I did not want to impose.*

The therapeutic process in the rehabilitation of orofacial motricity changes often requires the fulfillment of certain exercises to suit the standard muscle. When patients are children, there is the challenge of linking exercises with fun activities to achieve the therapeutic goals. However, the literature indicates that a prolonged time of therapy contributes to the patient's lack of interest[33], being a contributing factor for the non-compliance, as found in this investigation.

However, non-compliance due to the lack of interest should not be seen as the sole responsibility of the patient. We have to consider that the health care service and professional have an important role in providing the patient the means to exercise their role on equal terms with a view to affecting the compliance process[10]. The speech therapist must therefore be envisioned as co-responsible in the compliance/non-compliance of the patient to the therapy and needs to promote a deeper understanding on this subject to be able to subsidize their care practice.

The literature on the compliance process shows that the difficulty in the communication between the therapist and the patient/their family covers aspects of the relationship between them, and, in addition to technical issues, compliance involves the continued development and improvement of the communication and relationship established at all interpersonal levels of the treatment[15]. When patients are children, the contact with family and a partnership are essential to the progress of speech therapy, whereas the opposite may be one of the reasons for non-compliance, as noted in the following statement:

S4: *[...] here I didn't know what he [their son, former patient] had to do, what exercise he did... So he would come here, to do it, and I didn't see, didn't know what was going on. [...] I didn't know what was going on, because besides not having much contact with the people [professionals] here, he didn't speak, because he didn't say what he did here, understand? [...] Because I wanted to know what was going on, his evolution, and we didn't have it! Because there in the speech therapy [particular sought after abandoning treatment in the CS] [...] he would go, do the exercises with her and then she called me, explained what he had to do and gave, you know, her opinion of it, understand?*

On the other hand, when there was a good relationship and communication of the therapist with the patient and/or their family, this was a positive aspect, well-rated by the subjects:

S2: *They [the speech therapy interns] were very thoughtful, they guided us a lot, and he loved to come [...], he was pleased to come [...] when we were out there, they guided us at the end [...]. So, well, this was not a problem.*

S5: *I found excellent the care because they guided us there [...]. They gave me a syringe, probe, taught exercises that helped very, very much. For my part, he would continue.*

S9: *[...] and he [their son, former patient] even asked me: "Oh Mom! I wanted to put go to that girl's center [speech therapy intern] where I played!" Then I told him: "R., your mom can't reconcile the time, but mommy will try to talk to them so you can go back." But he asked, he liked what he was doing here and such [...].*

The dropout related to the need for intervention of other treatments was also one of the reasons for the non-compliance to the speech therapy:

S8: *I stopped because I had to wear braces on the teeth, because my teeth are*

separated, then the tongue doesn't stay inside. So the speech therapists recommend the braces. But until today I haven't put it, I even tried to go after it, but at the time it was very expensive and I had no money to do it, and it is very expensive. Maintenance is also expensive. I came here and talked to one of the girls who coordinated the group here at the health center and I told her I would stop for a while until I got the braces. Only until now I have not made it [...].

The intervention of other fields (orthodontic, otorhinolaryngology, psychological, etc.) is often necessary for the realization of the speech therapy, which are essential for the successful development of speech aspects. Due to the cost of orthodontic treatment and the fact that this is still not a treatment offered by the public health of the city, some patients discontinue their speech therapy. This same point was also observed in another study[20], where 5.5% of the speech therapy dropouts were related to the need for further treatment prior to speech therapy.

Unlike other studies that point to the difficulty in the access to health services as a limiting factor for treatment compliance[22-24,31], the participants of this study reported no problems with this aspect, as the services occurred on a CS of their territory:

S1: It was not difficult [to bring her to the service], I live near here.

S9: I did not come [to seek speech therapy elsewhere]. I chose to look here first. Here is easier; it is near!

One of the fundamental aspects of Primary Care is the decentralization, with units spatially distributed closer to the lives of people[2], which favors the population access, favoring compliance.

During the research, some participants expressed the wish that their son/daughter would return to the speech therapy, as they realized the importance of continuing the intervention in the area. The researchers accepted this demand and, in total, there were four referrals, so that these children could return to the speech therapy.

CONCLUSION

There are several reasons for speech therapy dropout in the context of Primary Care, including the incompatibility of schedules, the dynamics of the service, the family observing an improvement of the case, the patient's lack of interest and the need for additional treatments.

Furthermore, we observed the presence of different reasons related to the dropout, which characterizes the process of compliance/non-compliance as complex and multifactorial.

Finally, we emphasize the importance of providing, along with speech therapy, a comprehensive health care to the service users. Therefore, it is necessary to be aware of the uniqueness of each subject who is the target of the therapists' practice, giving special support to those who represent low compliance expectations, always taking into account their responsibility in the compliance with the therapeutic process.

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RESUMO

Objetivo: analisar os motivos relacionados a não-adesão de pacientes à terapia fonoaudiológica em um Centro de Saúde de Atenção Básica do Município de Campinas. **Método:** estudo exploratório do tipo *ex-post facto* de caráter qualitativo desenvolvido com os pacientes ou seus responsáveis, atendidos em um serviço de saúde e que não aderiram à fonoterapia. Foram realizadas entrevistas semiestruturadas, com questões semidirigidas, a fim de apreender os motivos e atitudes enunciados pelos pacientes ou seus responsáveis em relação a não-adesão à terapia fonoaudiológica. As entrevistas foram transcritas e sistematizadas considerando-se os pressupostos da Análise Temática, técnica da Análise do Conteúdo. **Resultados:** foram entrevistados dez sujeitos. Na análise, emergiu uma diversidade de temas e subtemas, desde relativos ao motivo do abandono, até a avaliação dos atendimentos de fonoaudiologia na visão dos usuários e organização da dinâmica familiar para comparecer ao atendimento. Este estudo indicou serem diversos os motivos do abandono à terapia fonoaudiológica no contexto da Atenção Básica, tais como: incompatibilidade de horário, dinâmica dos atendimentos, observação de melhora/resolução do caso, desmotivação do paciente e necessidade de realizar tratamento prévio em outra área. **Conclusão:** foi possível observar a presença de distintos motivos relacionados ao abandono numa mesma entrevista, aspecto que corrobora com o apontado pela literatura nacional e internacional, que caracteriza o processo de adesão/não-adesão como complexo e multifatorial.

DESCRITORES: Adesão do Paciente; Fonoterapia; Atenção Primária à Saúde; Análise Qualitativa; Fonoaudiologia

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