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Speech language pathology teaching-clinic service: users' perception

Atendimento fonoaudiológico em uma clínica-escola: percepção de usuários

Viviane Alessandra Rozário[1], *Giselle Massi*[1], *Ana Paula Berberian*[1], *Rita Tonocchi*[1], *Israel Bispo dos Santos*[1], *Cláudia Moretti*[1], *Ana Cristina Guarinello*[1]

ABSTRACT

Purpose: to investigate users' or parents' perception about the service and care delivery of a speech-language pathology teaching clinic accredited by the Brazilian Unified Health System (SUS), extended to its facilities and staff performance. **Methods:** across-sectional quantitative, qualitative field survey, in which participants and/or their family members of a Speech Language teaching clinic, located in a city in Southern Brazil, answered a questionnaire about the speech and hearing services, as well as other services deliveredby the clinic. **Results**: most users demonstrate to know the actions and practices performed by the speech-language therapists and also assessed the therapy as very good and excellent, thus meeting their expectations regarding the service. In addition, most participants assessed the teaching clinic in a positive way regarding the receptionists´ service and physical facilities. Some suggestions for improving the clinic were: extending therapy time length, better spread of the work developed there and lectures to users. **Conclusion**: despite the satisfaction of most users with the speech-language and clinical services, there are some issues that need to be considered, such as: family dialogue with the speech-language therapist, fostering listening and considering their complaints. Those factors should be taken into account by the professionals who work there, since users'assessment of the speech-language therapy services, accredited by the SUS, is essential to promote the improvement of the health care system as a whole.

Keywords: Health promotion; Unified Health System; Speech language and hearing sciences; Health policies; User

RESUMO

Objetivo: investigar a percepção dos usuários e/ou responsáveis a respeito dos atendimentos e da atuação fonoaudiológica de uma clínica-escola credenciada no Sistema Único de Saúde, bem como das instalações e da equipe responsável por esse serviço. **Métodos:** pesquisa de campo quantiqualitativa, transversal, na qual os participantes e/ou familiares de uma clínica-escola de Fonoaudiologia, localizada numa cidade no Sul do Brasil, responderam a um questionário sobre os atendimentos fonoaudiológicos e os serviços realizados na clínica. **Resultados:** a maioria dos usuários demonstrou conhecer as ações e práticas realizadas pelo fonoaudiólogo, avaliou o atendimento fonoaudiológico como ótimo e excelente e referiu que as expectativas com relação ao atendimento foram correspondidas. Além disso, grande parte dos participantes avaliou de forma positiva a clínica-escola, com relação ao atendimento das recepcionistas e as instalações físicas. Algumas sugestões para melhoria do atendimento foram aumento do tempo de terapia, maior divulgação do trabalho e palestras para usuários. **Conclusão:** apesar da satisfação da maioria dos usuários com relação aos atendimentos fonoaudiológicos e da clínica-escola, há questões que necessitam ser consideradas, tais como o diálogo da família com o profissional fonoaudiólogo, a ampliação da escuta e o acolhimento das queixas. Tais fatores devem ser levados em conta pelos profissionais que ali trabalham, pois se entende que a avaliação dos usuários quanto aos serviços fonoaudiológicos vinculados ao SUS é fundamental para promover a melhoria do próprio sistema de saúde.

Palavras-chave: Promoção de saúde; Sistema Único de Saúde; Fonoaudiologia; Políticas de saúde; Usuário

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[1]Universidade Tuiuti do Paraná – UTP – Curitiba (PR), Brasil.

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Corresponding author: Ana Cristina Guarinello. E-mail: ana.guarinello@utp.br

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INTRODUCTION

The Unified Health System (SUS) was implemented in Brazil in 1988, enacted in the Federal Constitution[1]. Thus, the Brazilian population has had the access to free health care services. In addition, health has been defined as a right of all and duty of the State. Formerly, Brazilian health care model used to be organized as follows: private health care, that is, for those people who could afford to pay for health care services; public health care ensured by the social security to formally registered workers, while the unemployed were treated as the needy ones, without any means or rights.

The Federal Constitution of 1988 also embodied new dimensions to the health conception at the time, based on the biomedical model, declaring that a range of factors was necessary for individuals to be considered healthy, such as, food, housing, employment and education. Article 196 from the Constitution states that the right to health is for all, and must be ensured by social and economic policies, aiming at reducing the risk of diseases, as well as the universal and egalitarian access to health actions and services for its promotion, protection and recovery[1]. Under these tenets, each person is understood within their uniqueness.

Almost 20 years after the Federal Constitution had come into effect, the National Policy of Health Promotion[2] was implemented in 2006, expanding the actions around Brazilian health, relating it to its determinants and conditioners, in a way that the organization of the health care entails not only the actions and services, which operate on the effects of the disease, but also those which work on the life conditions and possibilities of healthy choices on the part of individuals and communities in the territory where they live and work.

Health promotion is understood here as a set of strategies and ways to produce health within the individual and collective scope, characterized by the articulation and cooperation among the sectors, and the creation of Health Care Networks. Therefore, equity and quality of life are determinants for the reduction of vulnerabilities and life hazards evolving from social, economic, political, cultural and environmental agents.

In that sense, the integrality of the health promotion turns out to be a strategy for health production, complying with the specificities and potentialities, in order to build therapeutic, life projects and organization of the health care from qualified listening to professionals and users, considering their life stories and conditions[2].

With the creation of the SUS and the health care policies based on the social welfare, users, autonomy promotion and quality of life have taken on a central role. Thus, users have been perceived as leading actors, unique beings, with unique life stories, who must participate in the assessment of this health care system[3]. The social participation, as a tenet of the SUS, has stressed the protagonism of the users of health care services, acknowledging that their steady assessment and reassessment are fundamental for the improvement of service rendering and the quality of the services. Additionally, assessment and reassessment of the services are also essential for the planning of actions and activities developed by the public health, in order to deliver more humanized, friendly and stable services.

Assessing users' perception on the public services is, undoubtedly, a necessary tool to improve such services[4]. Users' assessment is also fundamental for them to join discussions entailing aspects regarding their quality of life and the quality of the offered services. Thus, it is relevant to assess users' perception on the therapeutic speech-language services accredited by the SUS. In the current study, the teaching school[5], with the Speech-Language Course, was assessed. It offers services comprising academic training, research development and population care delivery. The services offered in such facilities play relevant social role, once they are free or at low financial cost, enabling the access of the needy population to the speech-language therapy service.

Considering the relevance of the quality of the public services rendered to SUS users, this study aims to investigate users and/or their legal guardians' perception on the speech-language therapists' performance and speech-language care of a teaching school, accredited by the Unified Health System (SUS), and also the assessment of its facilities and staff.

METHODS

It is a cross-sectional, quantitative and qualitative study, approved by the Ethics Research Board of the University Tuiuti of Paraná, opinion number 88408718.8.0000.8040.

It was conducted in a teaching clinic, accredited by the SUS, located in Southern Brazil. Users are screened by trainees, undergraduates from the seventh and eighth terms of the Speech-Language Therapy Course, monitored by a speech-language pathologist, responsible for each area of impairments: language, hearing, voice, dysphagia and orofacial motricity (OM).

The research inclusion criteria were: to be a user of the Speech-Language teaching clinic, to be 18 years of age or older, and to have undergone therapeutic speech-language care in the areas of language, voice, dysphagia and OM during 2018, or to be the legal guardian of an under-aged or cognitively-impaired user, undergoing treatment in the Speech-Language teaching clinic in the areas mentioned above.

The participants responded a questionnaire with 26 questions, comprising 12 closed and 14 open questions. They aimed to know the users' perception on the speech-language care held at the clinic, its work and the users' knowledge on the therapeutic speech-language interventions. This instrument had been formerly used by another author[5].

The rating of the closed questions ranged from 1 to 5, as follows: 1, poor; 2, reasonable; 3, good; 4, very good and 5, excellent.

For data collection, the users or their legal guardians were invited to respond the questionnaire on the day assigned for the therapy in the teaching clinic. Those, who accepted to participate, signed the Free Informed Consent Form, read by the head researcher. Due to overlapping in the head researcher's schedule, the questionnaire was applied by the trainee responsible for the speech-language intervention. Each participant responded the questionnaires individually and orally, and the researcher took down the responses, without interfering in their elaboration.

At the time of the data collection, there were 105 users undergoing treatment in the clinic. Among those, the questionnaire was responded by 79 subjects.

The statistical analyses were performed by means of descriptive (tables of absolute and relative frequencies) and inferential (Fisher's exact test, significance level of 0.05) methods.Excel and Statistica 13.2 softwares were used in those analyses.

Qualitative analysis was performed by means of Bardin's Content Analysis[6], which is a set of techniques of communicative analysis. The category analysis was used in this study, which clusters the responses of the research participants, after the analysis of all responses. The data were divided in four axes: 1) Participants' profile, 2) Knowledge on the speech-language intervention, 3) General assessment of the teaching clinic, 4) Specific assessment of the speech-language services in the clinic.

The research participants were identified by the letter P (for participant) and numbers from 1 to 79.

RESULTS

Axis 1 – Participants' profile

The study sample comprised 79 participants: 68.1% (n=53) were the legal guardians of the under-aged users, 2.6% (n=2) were the legal guardians of the cognitively impaired users, and 30.3% (n=24) were the users of 18 years of age or older, who responded the questionnaire.

The studied population's salary ranged from 1 to more than 4 minimum salaries: 24.1% (n=19) earned up to 1 minimum salary; 29.1% (n=23) earned from 1 to 2 minimum salaries; 35.4% (n=28) earned from 2 to 4 minimum salaries. Only 11.4% (n=9) of the sample earned over 4 minimum salaries.

As for the users' age, 51.9% (n=41) were between 2 and 10 years old; 11.4% (n=9), from 11 to 17 years old, and the remaining 36.7% (n=29) were between 18 and 69 years old. Concerning the users' gender, 40.5% (n=32) were females, and 59.5% (n=47) were males. From the users who underwent speech-language care, 40.5% (n=32) lived with their father, mother and another relative, that is, a brother or sister, uncle or aunt, grandfather or grandmother.

Concerning the users' schooling, 40.5% (n=32) were attending elementary and middle school, 15.2% (n=12) were attending kindergarten, and 8.9% (n=7) were attending a special school. The users with incomplete middle school, complete middle school and complete high school accounted for 7.6% (n=7) of the total sample; graduated users from Higher Education accounted for 6.3% (n=5); 3.8% (n=3) had incomplete high school; 1.3% (n=1) were attending high school, and 1.3% (n=1) had incomplete Higher Education.

Most users (73.4%, n=58) were referred by Health professionals, among them, doctors and speech-language pathologists, while 26.6% (n=21) were referred by professionals from the Education area.

Most users (60.8% n=48) had oral-language related complaints, followed by orofacial motricity (OM) (13.9%, n=11); 11.4% (n=9) reported voice-related complaints; 7.7% (n=6) of the users reported written language-related complaints, and 6.3% (n=5) were under treatment in the dysphagia sector.

Table 1 shows data regarding users' gender and their complaints.

By means of the odds ratio test, significance level of 0.05 (5%), users' gender-related odds and complaints, regarding oral language, were compared, resulting in p=0.2533, that is, the odds ratio was not significant. The test was not conducted for the other complaints due to the small number of cases, which did not justify its application. However, in the results shown in Table 1, ratio for complaints on oral and written language was higher among males, while complaints about OM and voice were higher among females, even though the odds ratio was not significant.

Table 1. Relation between gender and complaints

COMPLAINTS	GENDER	
	Female	Male
Oral language	17 (53.1%)	31 (66.0%)
Written language	1 (3.1%)	5 (10.6%)
Orofacial motricity	6 (18.8%)	5 (10.6%)
Voice	6 (18.8%)	3 (6.4%)
Dysphagia	2 (6.2%)	3 (6.4%)
TOTAL	32 (100.0%)	47 (100.0%)

Source: elaborated by the authors

Axis 2 – Knowledge on the speech-language intervention

In this axis, respondents were asked about their knowledge on the speech-language intervention. Initially, it was asked about the users' age for speech-language therapists to start the intervention. Most respondents (89.9% n=71) answered that the speech-language therapist may work with all age ranges; the remaining 10.1% (n=8) responded that such professionals may only work with individuals at a certain life cycle: children, adolescents, adults and the elderly.

Regarding speech-language pathologists' areas of intervention, most respondents mentioned language/speech, followed by voice, reading/writing, orofacial motricity (OM), audiology and impairments.

When the participants were asked if speech-language services were beneficial for the patient, all of them answered affirmatively. Most of them justified their answer according to their improvement in their speech-language complaint. Subsequently, some of the respondents' answers:

> (The therapist) *helped recover speech, and also helped with writing, ending bullying at school* (P4).

> *My son developed here, he stopped signing and also improved his chewing, providing him with better quality of life* (P11).

When asked about the areas, which could perform joint work with Speech-Language Pathology, most of them responded that the speech-language pathologist could work with Health professionals, followed by Education professionals.

Axis 3 – General assessment of the teaching-clinic

In this axis, answers were collected on the users' perception of the teaching clinic. Initially, when asked about the difficulties in getting to the clinic, most of them (72.2% n=57) responded negatively; 21.5% (17) responded that distance hindered their treatment, and 63% (5) claimed financial difficulties to pay for the transport.

In the general assessment of the teaching clinic, questions were asked regarding its facilities and secretaries'/receptionists' service. Their answers are shown in Table 2.

The participants' responses showed that the clinic facilities were highly rated by the users. The highest rates were good, very good and excellent. Regarding the secretaries' service, only 1 respondent rated it poor; most of them rated their service as very good or excellent. Subsequently, some of their responses regarding secretaries'/ receptionists' service and the clinic facilities:

The secretary wasn't nice to me, I called to let them know that I couldn't come, and she was rough, I know how it is, it was just one absence because I couldn't come, she should be kinder to the users (P75).

Their service is always good, they solve everything you need, are polite, always greet you, and I also find it nice when they call to cancel an appointment (P10).

The rooms need improving, more space and ventilation, you feel locked up, a bad feeling. There should also be mirrors in every room, for not wasting time by changing rooms all the time (P78).

There's everything you need, wheelchair ramp, it's excellent (P24).

Regarding the time length to make an appointment at the clinic, 31.7% (n=25) of the participants responded that they waited until 3 months; 25.3% (n=20) did not have to wait; 17.7% (n=14) did not remember how long they had waited; 13.9% (n=11) responded that they waited over 9 months for an appointment; 8.9% (n=7) waited until 6 months, and only 2.5% (n=2) waited until 9 months.

Participants, who waited until 6 months for the appointment, did not report any dissatisfaction with the time length to start the therapy, but the ones, who waited 9 or more months for it, expressed their dissatisfaction with that. Subsequently, some responses about the waiting time for an intervention:

It was good, compared with other waiting lists, I thought it would take a year or longer (P12).

I didn't have to wait, I was helped by a professional here, I had an acquaintance here, it was good for my daughter, although I think I cut the line, I don't think it's fair. But it was good (P64).

Table 2. General assessment of the teaching clinic

GENERAL ASSESSMENT OF THE SPEECH-LANGUAGE PATHOLOGY CLINIC	USERS OF THE SUS % (N)
How do you assess the clinic facilities?	
Poor	0
Reasonable	1.3% (1)
Good	29.1% (23)
Very good	29.1% (23)
Excellent	40.5% (32)
How do you assess the secretaries' service?	
Poor	1.3% (1)
Reasonable	1.3% (1)
Good	7.6% (6)
Very good	34.2% (27)
Excellent	55.7% (44)
TOTAL	100% (79)

Source: elaborated by the authors
Subtitle: N = number of subjects

It's a long time, it must be improved, it's inhuman. Lack of structure on the part of the SUS, and I also think that the special children should have the priority (P18).

Axis 4 – Specific assessment of the speech-language services in the clinic

In this axis, questions were asked about the speech-language services in the clinic. When asked about the reason to search for these services, most participants responded that it was SUS referral, followed by a friend's recommendation, and by a professional's referral.

In Table 3, data about the time length of the therapy and users'/legal guardians' assessment concerning the service were crossed.

By means of the Fisher's exact test, significance level of 0.05 (5%), there was no significant correlation (p = 0.0742) between the length of therapy and the users' assessment on the service. However, a tendency was verified, among those who underwent therapy in the clinic longer, towards a more positive assessment of its service. To enable the test application, 2 categories of time length were considered: until 9 months, and from 9 months to over 36 months.

Table 4 shows the correlation between the users' assessments regarding the speech-language therapy service and the job expectation.

The assessment of the speech-language care had a high rate of approval among the respondents, and the majority rated it as very good or excellent, specially due to the users' improvement in the aspects related to the speech-language treatment.

In general, the item regarding the explanations given by the speech-language therapist during the treatment was highly rated. Some speeches, as follows:

The current therapist is very unfriendly, doesn't talk to me, the others were more receptive, they were always talking to me, this one falls short (P54) (a patient's mother report).

I can't complain, I always understand, if I don't, I ask her and she explains in a way that I can understand (P51).

They always explain well, but I think it should be more often, they call us to talk to them few times, we don't know how our child is doing, it should be done more frequently (P12).

When respondents were asked whether "they would recommend the clinic for speech-language care", 98.7% (78) responded "yes", and only 1.3% (1) responded "no".Asked

Table 3. Relation between the time length of therapy and assessment of the speech-language intervention

TIME LENGTH OF THERAPY	ASSESSMENT		
	Good	Very good	Excellent
Until 3 months	5	1	6
Until6 months	1	3	9
Until 9 months	-	1	1
From 9 to 12 months	-	1	3
From 12 to 24 months	1	5	7
From 24 to 36 months	3	9	9
Over 36 months	-	5	9

Source: elaborated by the authors

Table 4. Specific assessment of the speech-language therapy services

SPECIFIC ASSESSMENT OF THE SPEECH-LANGUAGE SERVICES	SUS USERS % (N)
How do you assess the speech-language therapy service delivered by this clinic?	
Poor	0
Reasonable	0
Good	12.7% (10)
Very good	31.6% (25)
Excellent	55.7% (44)
Was your expectation on the service delivered here met?	
Totally	62.0% (49)
Partially	35.4% (28)
It was not met	2.5% (2)
How do you assess the explanations given by the speech-language therapist? (in all occasions that you talked to him/her, in the initial interview, in the periodical feedback, clearing your doubts...)	
Poor	0
Reasonable	0
Good	15.2% (12)
Very good	27.8% (22)
Excellent	57.0% (45)

Source: elaborated by the authors
Subtitle: N = number of subjects

about the reason, he said: "*No, I can't say, I can't explain*." This patient was aphasic.

When respondents were asked about the therapy time length, 68.3% (54) responded that 40 minutes a week was enough; 21.6% (17) responded that the therapy session could last one hour; 6.3% (5) suggested that the therapy session should last one hour 30 minutes, and 3.8% (3) claimed that the therapy time length was enough, but it could ideally be held twice a week.

Participants were asked about the positive points of this teaching clinic. Despite differing responses, most of them mentioned the quality of the speech-language service, the good results of the therapy and the secretaries'/receptionists' service.

In relation to the negative points of the clinic service, most participants responded that there were not any. Some mentioned, as negative points, the small size of the therapy rooms, their poor ventilation, time in the waiting list, and the short time for the therapy.

As for the users' suggestions to improve the clinic, most of them said that they did not have any suggestions. Among the suggestions given by some users are: longer therapy sessions, lectures for the users, spread of its speech-language service, etc. Below, some respondents' answers:

> *Space for 'voice fairs', places where people with similar conditions could gather, with lectures for the target public* (P32).

> *Spread the speech-language careby means of posters, folders* (P51).

> *Increase therapy time length for twice a week, or longer sessions of over an hour* (P29).

DISCUSSION

In the Axis 1 – Participants' profile – most users were 2 to 10 years old, that is they were preschoolers or schoolers. Similar data had already been evidenced in Brazilian studies, with higher incidence of speech-language interventions in this age range[7-10].

Research in Brazilian literature has shown greater incidence of speech-language pathology interventions among males[5,7,9,11,12]. In the current research, this higher prevalence corroborated the literature findings. Consequently, higher complaints in the oral language area was prevalent among male users[5,13,14]. Studies have pointed that prevalence can be related to neurological factors (brain maturity is slower in males), social and genetic factors (social demands are more frequent and intense towards the boys, always requiring correct speech on their part[11]).

Considering the complaints, there was greater demand for speech-language pathology treatment in oral language, which also corroborates literature[5,9,15,16].

In the current study, 68.1% (52) of the respondents were the legal guardians of the clinic users, once they were mostly children. Literature has also evidenced that the greatest part of the population undergoing therapy in a speech-language pathology clinic is taken by their legal guardians[5]. These legal guardians were mostly females.

Findings in this study also meet the ones in the studied literature in relation to the users' referral, as most referrals to the clinic were performed by Health professionals[5,9].

There was also a correlation between complaints and referrals, that is, most referrals to the language areas were conducted by Education and Health professionals. Data showed that only Health professionals had performed the referrals to the other Speech-Language Pathology areas, such as OM, dysphagia and voice. Literature points to a tendency for school professionals to refer students to the language area. This possibly happens because school activities are usually related to the oral and written languages[5].

In addition, during the past years, there has been an increase in the referrals of children and adolescents, who are assumedly suffering from "disorders" or "difficulties" in reading and writing, once they do not meet the school expectations. When assessed by Health professionals, mainly doctors, many subjects have had diagnoses justified by organic-related causes[17]. Opposing to that view, there are researchers who perceive a medicalization

process within the education, that is, the transformation of non-medical issues – social, cultural, educational and political ones – into medical issues. Medicalization understands the health/disease process as centered in the individual, which makes social issues lose their collective dimension[17].

As for Axis 2 – Knowledge on the speech-language intervention – most users and participants responded that the speech-language therapist may treat all ages, which corroborates the studied literature[18]. The most frequent justification, provided by the respondents, was that they noticed, while waiting in the clinic reception, that the therapist treated users from all age ranges.

Concerning the area that a speech-language therapist can perform, results showed that the greatest part of the sampling had knowledge of the areas that a speech-language therapist performs. These results differ from the studied literature[18], which observed that users from a speech-language pathology clinic had restricted knowledge of the areas, in which a speech-language therapist may intervene, and they believed that a therapist's intervention was only related to speech disorders, ignoring speech-language pathology intervention in other areas.

The results of the current study seem to evidence that the users of the clinic had knowledge about a speech-language pathologist's actions and practices. This finding corroborates actions for health promotion, which claim that users must participate in the identification of problems and solution of needs, as well as the knowledge of the job of the professionals that they have contact with, such as the speech-language therapist[2].

When asked whether speech-language pathology services may benefit users, all respondents answered affirmatively. In the justifications for that question, (P4) and (P11), clearly showed their satisfaction with their improvement in aspects related to their speech-language pathology treatment.

In Axis 3 – General assessment of the teaching clinic – most participants evidenced their satisfaction, data which corroborate the literature[9].

The respondents, who stated that the secretaries were always willing to help them, recurrently mentioned receptionists' friendliness and problem-solving ability. Those professionals' job is claimed to be essential, once they are the first people that users have contact with when they get to the clinic. Such data also match those from the studied literature[19]. A study evidenced that satisfied users with the service may get more interested in the procedures performed by the professionals[19].

Despite the positive assessment of the clinic by most users, studies[19,20] have shown that it is common for users to demonstrate their satisfaction with the services for the fear that unfavorable responses may hinder or result in some harm to their treatment.

The low rate of waiting lines was also mentioned by the respondents as one of the positive points of the clinic. In this aspect, part of the studied literature[21] evidenced that, in general, primary health care units face high rate of waiting lines, and more professionals should be hired to meet the high demand, thus solving this problem. Another study, also held in a teaching clinic[9], evidenced, similarly to the current study, that there is a low rate of subjects in the waiting list.

Users may find it strange the fact that they do not stay in the waiting list for very long, as shown in the response by P12, who pointed out that many users are not used to fast care delivery in the SUS services.

The explanation for that is probably related to the number of trainees available for the speech-language therapeutic treatment.Thus, the higher the number of trainees in a period, more vacancies in the speech-language pathology services.

Regarding Axis 4 – Specific assessment of the speech-language pathology services in the clinic -, when asked about the correlation between therapy time length and assessment of the speech-language pathology service, users' responses pointed to a tendency of positive assessment among those who undergo the treatment longer.

In this study, great part of the users assessed speech-language pathology service as very good and excellent. This was mostly justified by the fact that the trainees are monitored by the professor who advise them, and also by the improvement in the complaints after the users undergo the therapy.

Few users assessed the therapy negatively. An example is P54's response, a dissatisfied mother with the current therapist, mentioning the difference from the other therapists who had formerly treated her son (daughter), who were more accessible. Actually, there is a yearly turnover among the trainees, which some users may consider negative. In addition to P54's response, other users reported that trainees' turnover hinders the course of the therapy.

Another complaint related to the specific assessment of the speech-language pathology services, mentioned by some users' legal guardians, was the restricted contact with the therapist. Some families perceive that talking to the therapist is important for the user's improvement, and they used to ask how they could help. In P12's response, for example, his/her dissatisfaction towards this issue is clear. P12 suggested that the contact with the therapist should be more frequent, so that the legal guardian can keep track of the therapeutic process.

Literature evidenced that listening practice in the clinic enables parents to take a stand and be aware of their children's problems. Thus, being aware of the child's problem has a therapeutic effect over parents[22,23]. Therefore, it is the therapist's task, who works in a perspective of health promotion, to think critically about the complaint and take the family in, acknowledging that it is by means of a complaint that patients and their families identify the need of a therapeutic intervention, enabling the professional to listen to them and redefine that request for help, not only on the patient's behalf, but also on his/her family's behalf. When the complaint is acknowledged, the speech-language therapist may summon up the family, so that they can actively participate in the therapeutic process, helping them understand their importance in this process, considering that many behaviors and individual responses of the subjects evolve from the way their families work and sense them [24].

Based on a perspective grounded in the dialogical interactions, the contact between family and therapist is fundamental. Therefore, it is by means of the dialogue that the therapist may understand symptom-related situations and help to redefine them. P12's complaint – *"They always explain me well, but I think this should be done often, they just call me a few times to talk to, we end up not knowing how our son is doing, it's necessary to be done more frequently"* – showed that more interaction with the professional is necessary, who must listen to the family.

Thus, the frequent contact with the family is important for the satisfactory course of the users' therapy. Parents' or legal guardians' role in their children's therapeutic process is relevant, once a new meaning for the child's complaint, as well as a new position within the family environment may evolve from more effective interactions with the family, consequently, enabling changes. Therapy should also be the place for dialogue as

well as for taking in not only the users, but also their families. In this sense, it is important for professionals to understand such aspects and interact with the families.

Therefore, speech-language pathologists must establish more accessible interactions in order to meet users' expectations, explaining them what is being done during the treatment and, consequently, getting reassurance and confidence across. In addition to the therapeutic procedures, the professionals must discuss their approaches with the users and their families, meeting users' needs[18], and fostering the promotion of their autonomy and protagonism[3].

A good service, based on listening to the users and satisfactory professional performance, fosters the bonding user-health care service, which enhances the care process, enabling professionals to get to know their patients and their priorities, facilitating them the access[20].

As a suggestion to improve the speech-language pathology service in the teaching clinic, some people responded that some actions should be held in that setting, such as speech groups, chats, and spread of their speech-language pathology services. However, the actions to be carried out in the clinic should evidence subjects' autonomy and uniqueness, and assure their active participation. In this perspective, experience and knowledge exchange, by means of the dialogue, should be considered, thus enabling the interaction. This way, it is fundamental for professionals, who work in the speech-language pathology clinic, to consider the individual and collective well-being, that is, one should learn with the other, consequently, enhancing individual potentialities[25].

Considering the negative points mentioned by the research participants, one may conclude that they did not refer to the speech-language pathology service itself, but to the clinic facilities and service organization.

Data collection led to the conclusion that the assessment of users' satisfaction is essential for the management of service delivery; its understanding may provide a performance assessment to the speech-language pathology clinic in the users' perspective, and guide decisions that may enhance quality level of its services.

Regarding the study limitations, once it is a cross-sectional research study, new periodic surveys are necessary so that users' assessment be permanent. In addition, the fact that the users did not respond the survey anonymously, and some questionnaires were applied by the trainees, who cared for them, may have influenced the findings.

CONCLUSION

Despite most users' satisfaction with the speech-language therapy services in the teaching clinic, there are issues to be considered and solved in order to deliver more humanized speech-language therapy practices, ultimately regarding the family interaction with the speech-language therapist, the expansion of the listening, and the reception of the complaints by the professionals of the clinic. Therefore, users' assessment on the speech-language pathology service accredited by the SUS is very important to improve the health care systemas a whole.

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