

## LIBRAS AS A TOOL FOR CARE IN MENTAL HEALTH: FROM BARRIER TO ACCESS

Libras como ferramenta de cuidado em saúde mental: da barreira ao acesso

LIBRAS como herramienta de cuidado en salud mental: de la barrera al acceso

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### ABSTRACT

**Objective:** The study's purpose has been to identify the concept of Comprehensive Health Care regarding the idea of Access and Barrier; furthermore, to validate the use of *Língua Brasileira de Sinais (LIBRAS)* [Brazilian Sign Language, BSL] as a tool for providing Comprehensive Care in a Mental Health ambulatory. **Methods:** It is a descriptive-exploratory research with a qualitative approach, type of Experience Report, which is supported by the data collection of a Field Diary of the trajectory of a Guide-User as a way of mapping and analyzing the service that provides care in Mental Health, regarding the concepts of Access and Barrier. **Results:** In the care service, the user and his/her caregiver communicated through *LIBRAS*, but the professional was unaware of that language. It was observed that the non-appropriation of *LIBRAS* resulted in a communication barrier during the care service. **Conclusion:** The health care services should develop practices that allow building drives, meetings and production of different ways of being in the world.

**Descriptors:** Health services accessibility, mental health, sign language, integrality in health, equity.

### RESUMO

**Objetivo:** Identificar o conceito de Cuidado Integral em Saúde na relação com a ideia de Acesso e Barreira; Validar o uso da LIBRAS como ferramenta para a produção de Cuidado Integral em um ambulatório de Saúde Mental. **Métodos:** Pesquisa descritiva, exploratória, com abordagem qualitativa, do tipo Relato de Experiência, sustentada pela coleta de dados de um Usuário-Guia como forma de mapear e analisar o serviço que promove cuidado em Saúde Mental. **Resultados:** No atendimento, o usuário e sua cuidadora comunicavam-se pela LIBRAS, porém o profissional desconhecia essa língua. Observou-se que a não apropriação da LIBRAS resultava em uma barreira comunicacional no atendimento. **Conclusão:** Os serviços de saúde devem elaborar práticas que possibilitem construir acionamentos, encontros e produção de diferentes formas de estar no mundo.

**Descritores:** Acesso aos serviços de saúde; Saúde mental; Linguagem de sinais; Integralidade em Saúde, Equidade.

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## RESUMÉN

**Objetivo:** Identificar el concepto de Cuidado Integral en Salud en la relación con la idea de Acceso y Barrera; Validar el uso de la LIBRAS como herramienta para la producción de Cuidado Integral en un ambulatorio de Salud Mental. **Métodos:** Investigación descriptiva, exploratoria, con abordaje cualitativo, del tipo Relato de Experiencia, sustentada por la recolección de datos de un Usuario-Guía como forma de mapear y analizar el servicio que promueve cuidado en Salud Mental. **Resultados:** En la atención, el usuario y su cuidadora se comunicaban por la LIBRAS, pero el profesional desconocía esa lengua. Se observó que la no apropiación de la LIBRAS resultaba en una barrera comunicacional en la atención. **Conclusión:** Los servicios de salud deben elaborar prácticas que posibiliten construir accionamientos, encuentros y producción de diferentes formas de estar en el mundo.

**Descriptorios:** Accesibilidad a los Servicios de Salud; Salud Mental; Lenguaje de Signos; Integralidad en Salud; Equidad.

## INTRODUCTION

The Psychosocial Care Network from the Rio de Janeiro city is composed of a diversity of services with different entry points, as a way of guaranteeing access to mental health care. The present study, which was performed in an ambulatory of a Psychiatric Hospital in the aforementioned municipality, carried out a welcoming experience that, in turn, is understood as one of the care strategies used to ensure a risk assessment that considers, not only the order of arrival, but, above all, the priority of care, then corroborating the severity of psychological suffering.<sup>1</sup>

The welcoming has no place to happen, and can be performed at any time, by any health professional on the team, guided by the ethical posture, which implies listening to users' complaints, recognizing their role in the health and illness process. It is at this moment that attention is offered to the most varied degrees of physical and psychological suffering, validating the principle of Equity in the *Sistema Único de Saúde (SUS)* [Brazilian Unified Health System].<sup>1</sup> In this unit, the average number of hospitalizations was thirty people per week.

Considering the above-mentioned, the practice in the unit took place in all service activities. Nevertheless, as a way to assure the arrival of new users, formally, it was defined that the welcoming event would be held in two rooms in the hospital's ambulatory, with the presence of a multiprofessional team, composed of an occupational therapist and two psychiatrists. In addition to those, psychiatric residents and interns from the Academic Scholarship Program of the City Hall of *Rio de Janeiro* city have also participated.

In this trajectory, it was observed that qualified listening constituted an important tool for providing care, given the proposal to fully understand the subjects and refer them to therapies that were more in line with their needs. Nonetheless, it was also noticeable that, in some consultations, the focus was on giving medicines to reduce the suffering, without having the sensitivity of better listening by the professionals according to the demands of each case. Hence, there was a framework for the welcoming:

situation of the multiprofessional approach, listening and language as instruments of access to health care services.

At the time, the sector addressed had already welcomed deaf people, however, accompanied by family members or listening friends, who knew the language, translating the needs presented by the users into Portuguese. Following the institutional flow, after welcoming, these users were referred to an ambulatory care, performed individually. In the ambulatory care, it was possible to observe the absence of interpreters, since in the unit there was no professional with the knowledge of *Língua Brasileira de Sinais (LIBRAS)* [Brazilian Sign Language, BSL]. For this reason, communication was being carried out through writing in Portuguese, impairing access to care, due to the noise generated in different languages. Thus, the present study takes as an object the use of LIBRAS in the care of the deaf user, as a way of guaranteeing access to care in health services.

The come and go of users, as well as the encounters produced by them, build networks of connections with services and their workers who, in micropolitics, operate interdiction devices or facilitate access to care. By understanding care as something produced in the caregiver's body and in the person receiving this care, it must be considered that the quality of what is produced is directly related to the scope of affective and technical instrumentalization, as forces that promote well-being.<sup>2</sup>

Bearing in mind the aforesaid, this study is justified by the contribution to the understanding of nursing professionals, and the other specificities of health, about the benefits and importance of the knowledge of LIBRAS for the effective care of users, contributing to their therapy and corroborating the understanding of Access health and Integrality in the SUS.

Few articles discuss the relationship between care, nursing and LIBRAS, and it is necessary to expand studies in this area, since the communication of deaf users in health care services, through LIBRAS, is ensured by Decree No. 5626/05.<sup>3</sup> Therefore, the non-fulfillment of what is legally provided can produce a communication barrier towards care practices, since users produce their demands from a network of existential connections built, in a micropolitical way, by the encounter between deaf and the health professional.

## OBJECTIVES

Hence, this study aims to:

- Identify the concept of Comprehensive Health Care concerning the idea of Access and Barrier;
- Discuss the use of LIBRAS as a tool for the provision of Comprehensive Care in a Mental Health ambulatory;

## METHODS

It is a descriptive-exploratory research with a qualitative approach, type of Experience Report, which is supported by the data collection of a Field Diary of the trajectory

of a Guide-User as a way of mapping and analyzing the service that provides care in Mental Health, regarding the concepts of Access and Barrier.

The experience report occurs through the capture of reality characterized as the stage of knowledge of reality, which is an approximation and not a total knowledge of it, since it is dynamic and, therefore, there is a need to always be revisited.<sup>4</sup> In turn, using the logic of the User-Guide is to consider a research idea that brings the user to the centrality of production, not only through his eyes but, above all, through his perspective, accessing his paths. In this way, we let ourselves be carried away by him, due to his demands and trajectories in the care network, as a way to go beyond the “clinical case” and quantitative methodologies, then causing a displacement of the researcher’s place.<sup>5</sup>

Data collection took place over the period from March to April 2016, during the internship period of a Nursing undergraduate student from the *Universidade do Estado do Rio de Janeiro (UERJ)*, related to the Academic Scholarship Program of the City Hall of *Rio de Janeiro* city. The internship included the participation of students in monitoring the welcoming of new users, together with a professional. At the end of the internship period, a theoretical work is carried out describing the experience from the perspective and experience of the academic in this period. The setting was an ambulatory of a Psychiatric Hospital, located in the *Rio de Janeiro* city, which is responsible for Programmatic Area 4.0 and covers the neighborhoods of *Barra da Tijuca, Camorim, Cidade de Deus Grumari, Itanhangá, Jacarepaguá, Joá, Recreio dos Bandeirantes, Vargem Grande, and Vargem Pequena.*

## RESULTS

### Providing comprehensive care under the logic of access and barrier

According to the *SUS* Principles, nursing care must be Universal, Equal and Integral. By Universality, it is understood the guarantee of full access to health actions and devices at all levels of complexity, without any barrier, aiming to guarantee the promotion, protection, and recovery of the subjects’ health and well-being.<sup>6</sup> It is through this accessibility that the ease or difficulty with which subjects obtain health care in the service network is measured.<sup>7</sup> In turn, valuing equality of care means paying attention, according to Equity, to provide access for all people without discrimination, enabling the welcoming and attendance of inequalities.<sup>6</sup> In this sense, guaranteeing Equity, as a principle applied to health actions and services in the network, makes it possible to obtain more effective results in care.<sup>7</sup>

The principle of comprehensive care encompasses the articulation in the network, the continuity of care in actions and devices, and the observation of what is determinant in each case, at different levels of complexity.

This principle encompasses all dimensions that cross care, namely: biological, psychological and social, promoting the strengthening of the subjects’ autonomy in care.<sup>8</sup> So, this principle proposes that meeting the needs of the subject is not restricted to just to curative actions, but also those that can expand to other dimensions of comprehensive care.<sup>7</sup>

In this direction, the concept of Comprehensive Care is expanded, based on two approaches: one that deals with the various care and attendance of the individual needs of users and the other, as the main objective of the health system, obtained from the various devices of the network. From this, the idea of Integrality of Care is understood with equal importance, both as a guideline of the *SUS* and as a guide for the production of Comprehensive Care.<sup>9</sup>

In this setting, nursing acts in several aspects, as a professional who articulates, coordinates and conducts the care delivery.<sup>10</sup> However, the understanding that the care production process must necessarily transpose the execution of technical knowledge stands out, it is necessary to contemplate the political and organizational fields. So, in order to consolidate Comprehensive Care, it is necessary to consider aspects such as welcoming, bonding, accountability and resolvability.<sup>11</sup>

The provision of health care, as unique ways of building networks of existential connections, makes the encounters produced in the micropolitics of devices, ways of interdicting or facilitating these connections. Therefore, users of health establishments seek relational links with several possible territories in unique ways, being a protagonist of their care production, making this construction subjective. In this way, reflecting on the existence of accessibility and barriers to care, in the complex mental health network, brings understanding beyond a physical phenomenon of a person who demands health care to be included or not, both in a physical establishment and in a care modality.<sup>12</sup>

In the field of comprehensive health care, in favor of solidary care, with support, support and production of life, all the characters are active participants (workers and users), in a dialogical construction relationship, containing their own and many guidelines (im)possibility that we do not know. To this end, it is necessary to invest in accessing, listening to and producing new tools for the effective joint construction of Comprehensive Care. Accessing a health service does not mean accessing care. For this attention to be effective, it is necessary to access the subject’s demands and, with him, build his networks of existential connections. So, knowing how to use *LIBRAS* is to master a fundamental communication to guarantee the access of deaf users, according to the Equity principle from the *SUS*.

### **LIBRAS as a tool for enhancing access towards care provision**

Ensuring health care for all people is the responsibility of network service professionals, and it is necessary to reduce barriers to care. In the case of a deaf person, there are often barriers in communication that can compromise interaction during the meeting between the deaf user and

health professional.<sup>13</sup> In the group of people who have a common trait of hearing loss, some are considered hearing impaired and other people considered deaf, due to the degree of hearing loss. So, the main characteristic of deaf people is the use of the *Língua Brasileira de Sinais (LIBRAS)* [Brazilian Sign Language, BSL] for their communication with society.<sup>14</sup>

The social movement of deaf people started to raise the banner of struggle for the political recognition of deaf people, as well as sign language, culture, and deaf identity, being characteristics that make up the deaf community. Cultural values, feelings of group identity, author recognition and identification as deaf are shared in this community.<sup>14</sup>

Given this framework, the inclusion of the deaf has achieved institutional support from Federal Law No. 10436/02, in which the *Língua Brasileira de Sinais (LIBRAS)* [Brazilian Sign Language, BSL] is recognized as a legal means of communication and expression, being the second official language of Brazil. Decree No. 5626/05 guarantees the right to health for deaf or hearing impaired people to be served in the service network of the *SUS*, with at least 5% of the employees of these units trained for the use and interpretation of *LIBRAS*.<sup>15</sup> Nevertheless, despite the legal means, it is currently a challenge for the *SUS* to ensure care for the deaf without the need for intervention by an accompanying listener, experiencing situations of exclusion due to the communication barrier.<sup>14</sup>

The *SUS* still shows great inequalities regarding the accessibility to health care services, reinforced by historical social inequalities in the country. Equity in access to health care services is scarcely noticed in this regard, reflecting the social invisibility of people in situations of social vulnerability. The deaf community is in this portion of the population that is unable to provide equitable care in public health systems, being marginalized from society and services. The communication barrier is a challenge in assisting the deaf in health units, due to the lack of preparation of health professionals and lack of knowledge about this individual. Furthermore, the low knowledge of deaf people about the health-disease process and the difficult process of including them in society are barriers to access health care services faced by deaf people.<sup>16</sup>

The linguistic condition of deaf people presents daily challenges to access health care services, since deaf signers (who use *LIBRAS*) communicate using a visual-motor language, while health professionals communicate using an auditory-oral language. This barrier is corroborated by the absence of sufficient interpreters or people who are able to communicate effectively with the deaf. As a result, most deaf people need companions to obtain assistance in health care services.<sup>17</sup>

Deaf people communicate in various ways, through sign language, orality, lip-reading, others through writing and others through gestures. In the meeting between deaf people and health professionals, it is necessary to know which communication strategies enable better understanding and access to care. Professionals trained in these skills facilitate interaction, then reducing the communication barrier.<sup>17</sup>

Doing health involves relational aspects, in which the communication barrier between deaf people and health professionals can compromise the autonomy and independence of these subjects. Bearing this in mind, the ignorance of health professionals leads to distance from the bond with users, since information on health conditions is not reported directly to the subject who needs and seeks the service. Among these communication resources, the use of writing in Portuguese makes it difficult for the deaf to access health care, since Portuguese is their second language, and there may be difficulties in their domain, since barriers are also faced in accessing the educational system.<sup>17</sup>

The Portuguese language has vocabulary and grammar different from the Brazilian Sign Language, then making written communication an obstacle. So, health professionals are unaware of the basic differences between these two languages. *LIBRAS* does not have inflection, gender, and alphabetical writing. Moreover, there is topic-commentary structure, while in the Portuguese language it has linear syntax and alphabetical writing. Thus, attempts to communicate in writing may not be efficient. In this way, the deaf do not understand the information and there is no communication established with understanding, only unilateral transmission of what the other interlocutor tries to express.<sup>16</sup>

The mediation of care by an interpreter, whether by a family member, an acquaintance or a professional can be positive due to the viability of communication, but it can end up disturbing, since it can take away the privacy of the subject, not fully reporting his health situation. Additionally, interpreters are not always aware of health terms and can generate noise in communication.<sup>14</sup>

Hence, the visibility of the deaf community becomes one of the priorities in the social environment, reinforcing in this population its historical and political adherence, which opens the way for new statements and demands.<sup>16</sup>

### **The use of *LIBRAS* in a welcoming in mental health care**

To welcome is to recognize what the other brings as a legitimate and singular health need. The welcoming must *SUS*tain the relationship between the team and the users to build relationships of trust, commitment, and bond. With this tool it is possible to guarantee the access of these users to technologies appropriate to their needs, increasing the effectiveness of health practices.<sup>1</sup>

As previously mentioned, welcoming was the strategy used as a gateway to consultations at the aforementioned hospital's ambulatory. The service on screen counted on the participation of a deaf user accompanied by his listening mother, a professional and two academic nursing scholars. The user dialogued in *LIBRAS* with his mother, who mediated the service, interpreting the needs brought by him into Portuguese, with the purpose of enabling communication between the deaf and the listeners.

When asked about the reason for looking for the service, the user's mother reported that he had insomnia,

sadness and “willing to do nothing”. The user interrupted his mother’s speech several times, in an attempt to add something to his explanation, demonstrating the need to be telling his own story. The mother was very concerned with the user’s insomnia and sadness, asking the team about the possibility of offering drug treatment that would reduce her son’s insomnia. In the unsuccessful attempt to communicate, the sadness and anxiety presented by the user during the service were increasingly evident.

From the team’s perspective, a kind of anguish was also perceived, as there was a desire by workers to access the experience silenced by the user’s language. The care, as something produced by the team-user binomial, was impaired, generating anxiety not only in those who sought care services, but also in workers who performed welcoming that did not know sign language. In this way, the only access to the story was the mother’s partial report, which made the feelings experienced by the user invisible. This technological difficulty resulted in a barrier not only in communication, but, above all, in the care provision.

Therefore, having access to a health service did not mean having access to care provision, since the lack of sign language was configured with a communication barrier that did not produce networks of existential connections and quality of life. In this way, the issue of access/barrier, built in the daily care, brings about the following question: ensuring physical passageway, from outside to inside services, guaranteeing universal access to health, is not a guarantee that care will be produced from the validation of the users’ experience and demands, while the inability of language interrupts this construction process. In this sense, accessing a health service is building a barrier to the multiple possibilities of life in the subjects’ ways of existing.<sup>12</sup>

Given this, the scholarship scholar interrupted the consultation, explaining to the professional that she had some knowledge of *LIBRAS*, proceeding with the service, where she is the mediator, targeting to have a direct communication with the user so that he could express his feelings and needs. At this moment, the receptive user had more details about the experience that took him to the service. He reported that he previously lived with his uncle who sexually assaulted him, but this uncle was no longer there. After that, he started to have insomnia, he was worried and scared at home. Another question was related to its circulation network, which was also hampered by the non-existent relationships, given the difficulty of communication, since many friends were unaware of *LIBRAS*. The impoverished social network had only its official interlocutor: the mother.

During the service, the academic dialogued with the deaf by *LIBRAS* and translated it into Portuguese for the professional. This more confident user was able to report his needs to the academic aiming to help him look for the best solution. So, the professional could acquire more information about the subject’s life history, being able to redirect the medication conduct for referral to psychotherapy. It was also advised that in these subsequent consultations, the mother could not be present, in order to validate, even

with the difficulties presented, the understanding of the user’s history by himself.

There were no professionals in the unit who knew *LIBRAS*, so the referral took place to a listening professional who would communicate with the deaf subject by writing in Portuguese, in an attempt to get the user to express their anxieties. This fact is a breach of current legislation. Thus, it should be noted that, despite having a legal framework that supports the production of care, the daily scraping of health care services continues to breach the law and, consequently, producing barriers to the comprehensiveness of care.

Even though the welcoming was successful, using the *LIBRAS* tool, the continuity of this user’s trajectory through the care network continues to present itself as an issue. Referral to other services, including psychotherapy at the same institution, will be carried out by writing in Portuguese, which is a communication barrier, since *LIBRAS* and Portuguese are different languages. The referral decision was not made in conjunction with the user, in order to find out if he knew Portuguese, since this is the second language of the deaf, making a portion of the deaf community unaware of it. Therefore, communication in two different languages may not generate an effective service.

## DISCUSSION

In the strict sense, being attentive to the meetings and what they cause, means providing care that overflows the exposed by the binomial named user-mental health professional. The meetings, however brief they may be, have the potential to produce noise in health systems and in how these are placed as a barrier to access to psychosocial care. The demand for this view is urgent under the logic of producing existential connections and qualitatively richer ways of life.

This statement is based on the consideration of the *SUS* principles of Universality, understood as the duty of the State to guarantee access to health actions and services for all people, health as a right, and Equity, which places in the State the duty to reduce the differences between citizens, investing more in those who have more difficulties, so that everyone has the same quality of access.

The principle of Equity, within the scope of the *SUS*, is a fundamental reference for thinking about care, intending to guarantee access to all services and actions that are necessary to face health problems. Thus, acting in favor of Comprehensiveness means being available and sensibly prepared to understand the health needs of users, as a reference for the organization of health care.<sup>12</sup>

In this framework, the social movement of deaf people has produced certain achievements. It was created, from the Decree 5626/05, the mandatory organization of the *SUS* services to attend the deaf person. Nonetheless, the public health system still presents obstacles in providing care to these users, with regard to accessibility to *SUS*, mainly due to the communicative barrier and the difficulty of including them in the listening society.

From this perspective and aiming to ensure greater inclusion in the activities developed and offered by health care services, deaf users need professionals trained in Sign Language, since an interpreter, family member or not, will receive crucial information, others with character confidentiality which, if not respected, can lead to the embarrassment of the user in question.

Hence, the difficulty of communication between professionals and users due to the lack of knowledge of *LIBRAS*, in addition to creating barriers to access, impairs the professional-user relationship. So, the interaction between professional and user does not occur, then causing the non-identification of the care demands for each subject.<sup>18</sup>

In addition to confidentiality, other principles of health ethics, such as patient autonomy and individualization of the person's treatment, can be neglected when there is a bias of a third participant mediating information. Thus, the lack of knowledge of *LIBRAS* by health professionals can produce a fragility in the bond with users, since the recommendations or data regarding health conditions are not reported directly to those who need them and to those who seek the service.

It is essential to question whether care is expanding or decreasing the networks of existential connections. The expansion of this network produces more life, however, if the care built reduces its networks, it must be recognized that this trajectory produces more barriers for qualified living. Therefore, even with success in accessing the health service, the care produced can function as a barrier to the production of life, and it is necessary to understand access and barrier under the logic of making existential connections feasible/unfeasible.<sup>12</sup>

In this sense, the reported experience points out that the inability to communicate with the user, as well as the validation of the mother as the only authorized interlocutor for communication and the medicalization of the user's suffering, are behaviors that, even intending to care, crystallize barriers in the production of life and ways of existing in the world of deaf people.

It is noted that despite the current health scenario being marked by the use of modern technologies and the multiple activities of nurses, there is still a need to develop ethical and humane care, which is based on skills, competences, professional attitudes and valuing the subjectivity of each individual being taken care. Thus, nurses, by having care as the essence of being and their profession, need to take care with an attitude of occupation and concern. To this end, the aim is to combine technical competence with sensitivity, affection and respect.<sup>19</sup>

The Brazilian Sign Language is a fundamental tool to transpose the simple idea of access or barrier as a physical phenomenon, which guarantees whether or not someone outside of certain care can be included. Transposing this idea is to understand access through the complexity of care, in the sense of producing new encounters and better quality of life. Accessing a service does not mean that the individual (or community) will receive care, since being in a health institution does not guarantee providing care or ways

of life. It is natural to ponder upon someone that is being taken care, and upon how much they have either expanded or decreased their network of existential connections.

## CONCLUSION

It is understood that health care services can generate situations in which the clinical conduct might constitute either a barrier or access, being understood as interdiction or activation of networks of existential connections. With this, a meeting can redraw new connections with the multiplicity of ways of living.

Therefore, this study contributes to the reflection about mental health care services and their working tools, as places of interdiction or activation of care. Furthermore, through this research it is possible to foster evidence for the construction of a map of what is instituted in the devices and how they build their access mechanisms or barriers, as a social obligation, in other words, providing care to the population according to the principles of Universality and Equity from the *SUS*.

The presence of an interpreter to assist deaf people is not as effective as the presence of a health professional with the knowledge of *LIBRAS*. This tool, in addition to providing better communication between those involved, excluding the need for interlocutors, favors the bond with the user. The inclusion of *LIBRAS*, in compliance with what is determined by law, contributes to the development of a more just and inclusive society, demonstrating the importance of respect for deaf citizens.

Access to health care must transpose access to health care services, by understanding the potentializing access to care meetings to expand the networks of existential connections. The encounter that produces a barrier to access reduces these networks, not guaranteeing the provision of health care, thus reducing the possibilities of producing life for these subjects.

Access, and consequently care, cannot produce barriers to life qualification. Hence, the health care services must develop practices that can use assistance toolboxes that enable strategies to build drives, meetings and production of different ways of being in the world.

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