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Access to psychological care and the prevention of cases of self-caused violence in Bom Jesus do Itabapoana/RJ

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ABSTRACT

The Course Completion Work focuses on analyzing the National Policy for the Prevention of Self-Mutilation and Suicide, as established by Law No. 13,819, through evaluating outpatient care coverage provided by clinical psychologists in Bom Jesus do Itabapoana, from 2010 to 2020. Self-inflicted violence poses a significant public health challenge, complicated by stigma and underreporting, hindering effective policy development. Motivated by firsthand experience in Primary Care Psychology in Apiacá/ES, the research aims to understand the effectiveness of psychological care in addressing self-inflicted violence in Bom Jesus do Itabapoana. The study is structured to characterize the profile of self-inflicted violence cases, assess psychologists' workload and outpatient production, and estimate the coverage of psychological services. Ultimately, the research aims to inform better mental health promotion and violence prevention strategies in the municipality.

Keywords: Self-inflicted violence, Clinical psychologists, Public health, Mental health promotion, Policy analysis.

INTRODUCTION

The bias chosen for this Course Completion Work was the analysis of the National Policy for the Prevention of Self-Mutilation and Suicide, established by Law No. 13,819, of April 26, 2019, through the evaluation of the coverage of outpatient care provided to residents of Bom Jesus do Itabapoana that fit the epidemiological profile of cases of self-inflicted violence in this territory by clinical psychologists, during the years 2010 to 2020, in establishments in the municipality that serve the Unified Health System (SUS).

Self-inflicted violence is a public health problem that has a strong presence in the country and around the world, being characterized by its complexity and diversity of factors. The stigma surrounding this issue not only interferes with awareness, prevention and treatment, but also with obtaining statistical data on cases. Underreporting interferes with the visualization of the dimension of the problem and, consequently, with the development of more effective public policies and programs.

The initial interest in this subject arose from the experience in the Psychology sector in Primary Care in Apiacá/ES, during 2017. During this period it was possible to realize how serious the problem is in the region, despite being invisible. Taking into account the proximity to different social actors and knowledge and the direct contact with the community of professionals who work in the SUS and the importance of psychological support for the prevention of self-inflicted violence, this research was guided

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by the following question: psychological care provided in Do health establishments that serve the SUS in Bom Jesus do Itabapoana/RJ benefit citizens who fit the epidemiological profile of cases of self-inflicted violence registered in the municipality?

This work seeks to contribute to better planning of actions to promote mental health and prevent self-inflicted violence developed in the municipality of Bom Jesus do Itabapoana/RJ and reflect on the quality of available health data. For a better understanding of the proposed topic, the contextualization of the theme was briefly presented in this introduction. The remainder of the article is organized neatly into theoretical framework, methodology and public policy analysis, which is divided into 2 sections. The first addresses a reflection on the National Policy for the Prevention of Self-Mutilation and Suicide and the profile of cases of self-inflicted violence in Bom Jesus do Itabapoana. And the second reports the results of the analysis of the potential and actual coverage of psychological care provided to residents who are in the profile of cases in the municipality. At the end, the final considerations item was set out, where the conclusions and observations on the subject will be demonstrated.

GOAL

The general objective of the research was to analyze the coverage of care provided by clinical psychologists in health establishments that serve the SUS in Bom Jesus do Itabapoana/RJ to residents who fit the epidemiological profile of cases of self-inflicted violence in the municipality during 2010 to 2020. The specific ones were:

- Characterize the profile of cases of self-inflicted violence that occurred in the municipality between 2010 and 2020;
- Investigate the workload and outpatient production of clinical psychologists in establishments that serve the SUS in the city, from 2010 to 2020;
- Estimate the potential coverage and actual coverage of these services.

THEORETICAL REFERENCE

Violence is present at different moments in human history, whether reprehensible or not depending on the laws and values of society in a given time and space. Before learning about the National Policy for the Prevention of Self-Mutilation and Suicide, it is important to understand what self-inflicted violence is and the main measures taken by the State to combat its impact on public health.

According to the World Health Organization (2002), violence is defined as the threat or intentional use of force and power against a person, a group, a community or oneself that causes or may cause physical and psychological harm, death, developmental problems or deprivation. It is divided into three types that are subdivided into more particular subtypes. Among them, there is self-inflicted violence,

which can be physical, psychological and/or deprivation or neglect and includes suicidal behavior and self-abuse .

To clarify these concepts, Minayo (2006) divides suicidal behavior into suicide, suicidal ideation and attempted suicide and self-abuse into self-aggression and self-mutilation. Suicidal ideation is manifested through thoughts related to death, accompanied or not by plans that can be put into practice immediately or not (PORTO, 2019). Suicide attempts are also called non-fatal suicidal behaviors and are marked by offensive acts against oneself in which there is no conviction of survival and based on the intention of self-annihilation and little perception of risks to life that do not result in death (KOVÁCS, 1992).

Self -abuse can be explained as several acts against oneself with the aim or not of a fatal outcome (PORTO, 2019). One manifestation of this behavior is self-mutilation, defined by the World Health Organization (2002) as the direct and deliberate destruction of parts of the body even without the intention of dying, which can be divided into severe, stereotyped and superficial.

The serious one involves more extreme acts, such as blinding oneself and self-amputating fingers, hands, feet, arms, legs or genitals. While the stereotypical type is related to frequent behaviors such as hitting one's head, biting oneself, hitting one's own arm, cutting one's eyes or throat, or pulling out one's hair. Superficial, also called moderate, is considered less serious and may go unnoticed, such as cutting, scratching, burning or sticking needles into the skin or compulsively pulling out hair.

Suicide is the most well-known and easily identifiable type as it is a fatal suicidal behavior. It is not a diagnosis or mental disorder, but rather a multifaceted conduct related to biological, psychosocial and cultural issues of each individual, which comprises idealization, planning and the act itself, which is intentional and conscious (PORTO, 2019).

According to Brasil (2005), the main factors that contribute to the persistence and increase of violent behaviors, especially self-inflicted violence, are biological and personal, relational, community and social. The characteristics of each of them are shown below in Table 1.

Table 1– Factors that contribute to the persistence and increase of violent behaviors

Biological and personal factors	The behavioral characteristics of each person that increase the likelihood of a person being a victim or perpetrator of a violent act.
Relational factors	Factors that point to the existence of people who, in social interactions, encourage individuals to practice or suffer violence.
Community factors	Spaces (the work environment, the educational institution and the neighborhood), problems (unemployment and drug and weapons trafficking) and interpersonal relationships (social isolation) that influence the occurrence of violence.
Social factors	Those who justify violence, with values that place violence as the answer to resolving disagreements, consider suicide as a right to choose, encourage machismo and adult-centric culture, validate police violence and support political conflicts.

Research source: (BRASIL, 2005)

Many authors dedicated themselves to studying the topic and bringing different enriching views to this debate. Levy (1979) characterizes suicide as the voluntary and conscious intention to eliminate oneself, which in a broader sense can include unconscious, persistent and long-lasting acts against one's own life.

Despite defining it as an individual and desperate act that aims to end one's own existence, Durkheim (2000) relates suicide to the social sphere and classifies it according to the victim's level of connection with others, which are explained in Table 2. All three types are marked by the influence of society, ranging from a situation of total integration with the group, erasing any personal mark, to total helplessness and social distancing.

Table 2– Types of suicide

Selfish suicide	Based on personal desire and influenced by society's individualism and the lack of institutions that generate the feeling of interaction, such as church and family. Thus, the feeling of loneliness, despair and lack of reasons to live makes death seem like the only way out.
Altruistic suicide	Related to intense integration into a group and the feeling of being impossible to stay alive after losing the appreciation of its members. In these societies, non-individuality and self-denial prevail, with no inclination towards the person, and suicide is part of the rituals of sacrifice, martyrdom and heroism.
Anomic suicide	Result of the influence of situations of disorganization and crisis, in which society fails and causes the subject to lack of basis, guidance, parameters, certainty.

Research source: (DURKHEIM, 2000)

Kalina and Kovadloff (1983) also discuss the responsibility of society, which they define as thanatotoxic, ruined and crumbled. Life represents a constant self-destruction that reaches its objective with the death of the individual. Therefore, suicide is socially induced and represents a way of dominating or rebelling against the social environment.

Even though it is not a public health problem, violence was included on this agenda due to its influence on the population's quality of life. According to Minayo (2006), violence is responsible for deaths, physical, mental, emotional and spiritual trauma, a drop in quality of life, demands restructuring of the organization of traditional health services, creates problems in preventive or curative medical care and demonstrates the lack of of interdisciplinary, multidisciplinary and intersectoral action that is more focused and involved.

Political and social discussions about violence began in 1980 and in the following decade the Pan American Health Organization (PAHO) and the World Health Organization (WHO) began to address violence, through conferences and international assemblies with ministers of health, experts and researchers from the Americas and different countries (MINAYO, 2006).

In Brazil, the first step towards establishing strategies and interventions in the area of health occurred with the publication of Resolution nº 309, of March 8, 2001, which approved the proposal of the

Ministry of Health and Ordinance MS/GM nº 737, of May 16, 2001, which approved the National Policy for Reducing Morbidity and Mortality due to Accidents and Violence and influenced the development of other documents that expanded the collection capacity and improved information on accidents and violence in the SUS.

Until now there was no specific initiative for suicide prevention, which changed with Ordinance No. 2,542, of December 22, 2005, which established the Working Group for the elaboration and implementation of the National Suicide Prevention Strategy and resulted in in the National Guidelines for Suicide Prevention, which were established with the publication of Ordinance No. 1,876, of August 14, 2006 (BRASIL, 2006). The guidelines established the obligation for their implementation and respect throughout the country and the need for their organization in an articulated manner between the Ministry of Health, the State and Municipal Health Secretariats, academic institutions, civil society organizations, governmental and non-governmental bodies. governmental, national and international (BRASIL, 2006).

Some policies dealt with minority groups, whose violence rates are higher. The National Health Care Policy for Indigenous Peoples, approved by Ordinance No. 254, of January 31, 2002, included suicide in special situations, whose actions must be a priority (BRASIL, 2002). Another example is the National LGBT Comprehensive Health Policy, created by Ordinance No. 2,836, of December 1, 2011, which states one of its objectives is to “reduce problems related to mental health, drug addiction, alcoholism, depression and suicide among lesbians, gays, bisexuals, transvestites and transsexuals, working in the prevention, promotion and recovery of health” (BRASIL, 2011, np).

Self-harm began to be considered a health problem and entered the National Compulsory Notification List as of Ordinance No. 1,271, of June 6, 2014. It was revoked with the publication of Ordinance No. 204, of February 17, 2016 (BRAZIL, 2016). It is important to highlight that the term is used to designate suicide attempts in some studies. Self-inflicted injury is considered a health problem subject to mandatory notification to doctors and other health professionals or those responsible for public and private services, who must notify the Municipal Health Department of the patient's place of care of the suspicion or confirmation of this problem within twenty four hours from the first service.

To prepare a National Suicide Prevention Plan in the country, Ordinance No.3,479, of December 18, 2017, which establishes a committee formed by representatives, principals and alternates of the Ministry of Health and the Pan American Organization (PAHO/WHO) with the following competencies:

> I - coordinate the construction of situational diagnoses on the scenario relating to suicide in Brazil; II - prepare the proposal for the National Suicide Prevention Plan in Brazil in line with the National Guidelines for Suicide Prevention and the Organizational Guidelines for Health Care Ne2rks; III - articulate the implementation and implementation of the National Suicide Prevention Plan in Brazil; IV - carry out monitoring and evaluation of the National Suicide Prevention Plan in Brazil (BRASIL, 2017a, np).

The financial resources for financing projects that address health promotion, surveillance and comprehensive health care for suicide prevention in the SUS through RAPS were constituted with Ordinance No. 3,491, of December 18, 2017, with the beneficiaries being all federated entities that develop projects in accordance with the National Guidelines for Suicide Prevention, Strategies for Suicide Prevention and Health Promotion in Brazil and that take into account the relationship between Health Care Ne2rks, Health Surveillance and Care to the Health of Indigenous Peoples in the Unified Health System. (BRASIL, 2017b). The document determines values related to the number of Health Regions served by the project, the receiving priorities and additions provided according to specific aspects.

The National Policy for the Prevention of Self-Mutilation and Suicide (PNPAS) was established by Law No. 13,819, of April 26, 2019, which included in the definition of self-inflicted violence completed suicide, attempted suicide and the act of self-mutilation with or without suicidal ideation. (BRAZIL, 2019a). The Steering Committee for this policy was established by Decree No. 10,225, of February 2020, which also defined the rules regarding compulsory notification of self-inflicted violence (BRASIL, 2020). To better understand the impacts of this policy, it was necessary to choose a methodology that would allow reconciling the rates of self-inflicted violence and the care provided in the municipality, which will be presented below.

METHODOLOGY

This research is classified, in terms of its objectives, as descriptive research, defined by Gil (2008) as studies on aspects of a population and the level of performance of public sectors in meeting their needs. Research that seeks to evaluate a public policy result in the formulation of an opinion that may influence its follow-up, reformulation or interruption (CEBRAP, 2016).

The procedures used for its preparation were bibliographical research and documentary research. The bibliography is created through the use of sources originating from research on the same subject produced by other authors, such as articles, magazines and works, and allows the researcher to investigate more facts within the defined scope (GIL, 2008; SEVERINO, 2013). Documentary differs from bibliographical in that it encompasses a range of documents that go beyond printed works, such as audiovisual material, legislation and newspapers, and that have not yet been subject to interpretation (SEVERINO, 2013).

> While bibliographic research fundamentally uses the contributions of different authors on a given subject, documentary research makes use of materials that have not yet received analytical treatment, or that can still be reworked according to the research objectives (GIL, 2008, p. 51).

The main documentary sources used for data collection were statistical records and written institutional records. Our society has a range of statistical data that reflects aspects of individuals and that

meets the tastes of organizations (GIL, 2008). Although they facilitate data collection, they require clarity in determining what type of data the researcher wants to obtain and what are the best sources for this purpose.

The characteristics of these data represent the objectives of those who collected and organized them (GIL, 2008). The secondary data used in this research brings sociodemographic information and health information of the population of Bom Jesus do Itabapoana obtained from public domain information systems, such as the National Registry of Health Establishments (CNES) and the Department of Information and Informatics of the SUS (DataSUS).

Written institutional records are documents written by government institutions (GIL, 2008). In the case of this work, publications related to public health policies, reports, ordinances, laws, decrees and studies that address the topic of self-inflicted violence were selected. To evaluate access to psychological care and prevention of cases of self-inflicted violence in Bom Jesus do Itabapoana, the coverage assessment was used, which measures the portion of the target population of a program that benefits from its actions (VIEIRA-DA-SILVA, 2014).

PUBLIC POLICY ANALYSIS

SECTION 1 – THE NATIONAL POLICY FOR THE PREVENTION OF SELF-MUTILATION AND SUICIDE

Although it has been recognized as a health issue under discussion since the 1980s, the institution of a public policy that addressed the prevention of self-inflicted violence only occurred in our country in 2019. Even so, it represented a major advance in establishing continuous health actions. prevention and treatment to reduce cases of self-inflicted violence.

The National Policy for the Prevention of Self-Mutilation and Suicide has as a social problem self-inflicted violence and its main target audience is people in psychological distress, mainly with a history of suicidal ideation, self-mutilation and suicide attempts and their peers (BRASIL, 2019a). Its main objectives are:

> I – promote mental health; II – prevent self-inflicted violence; III – control the determining and conditioning factors of mental health; IV – guarantee access to psychosocial care for people in acute or chronic psychological distress, especially those with a history of suicidal ideation, self-mutilation and attempted suicide; V – adequately approach family members and people close to suicide victims and guarantee them psychosocial assistance; VI – inform and raise awareness in society about the importance and relevance of self-harm as preventable public health problems; VII – promote intersectoral coordination for suicide prevention, involving health, education, communication, press, police entities, among others; VIII – promote the notification of events, the development and improvement of methods for collecting and analyzing data on self-mutilation, suicide attempts and completed suicides, involving the Union, the States, the Federal District, Municipalities and health establishments and of legal medicine, to support the formulation of policies and decision-making; IX – promote ongoing education of managers and health

> professionals at all levels of care regarding psychological distress and self-inflicted injuries (BRASIL, 2019a, np).

The indicators for evaluating this policy are the data generated from the Notification of Interpersonal and Self-Inflicted Violence, addressed in this study, and Deaths due to external causes. The notification is a sociodemographic information instrument that allows understanding profiles and risk and protective factors. Thus, they help in planning global or local actions aimed at the general population or vulnerable groups and in linking victims to health establishments that care for them.

The main strategies addressed by Law No. 13,819/2019 are the creation of a telephone service for free and confidential assistance to this public, compulsory notification of suspected or confirmed cases of self-inflicted violence by health and educational establishments, both public and private, and investment in information and training of these professionals regarding notification.

According to the Vita Alere Institute of Prevention and Postvention (2019), public and private educational establishments are responsible for notifying cases and training their professionals for this role, but it is clear that it is limited to Basic Education by mentioning that this notification will be made to the Guardianship Council. This excludes Higher Education and directly influences the contact of health and education professionals in training on the topic. Furthermore, training needs to cover not only notification, but also other topics related to mental health care for both students and teachers.

The procedures to be taken by the Guardianship Council after receiving notification from educational establishments need to be determined, especially with regard to dealing with the victim and their family (INSTITUTO VITA ALERE DE PREVENAÇÃO E POSVENAÇÃO, 2019). The notification is not a police report, therefore, punishing and blaming the family and exposing the victim must be avoided so that suicidal and/or self-abusive behavior is not criminalized.

The Vita Alere Institute of Prevention and Postvention (2019) draws attention to the use of concepts without their meanings and examples being explicit, as is the case in item III of Article 3 when addressing the “determining and conditioning factors” without informing which would be. As well as the lack of identification of the most affected groups so that they can be targeted with more specific actions.

Even though other factors are referenced, the emphasis on biomedical thinking is noted through the emphasis given to mental disorders. The family is also seen as essential for the fight, with family problems related to the need for protection and psychosocial care (BRASIL, 2019b). This moralizing discourse excludes the social dimension of health, which encompasses food, housing, income, work, transport, leisure, health, safety, education and other conditions. The State's responsibility is transferred to the family, without considering offering psychosocial support to them as a strategy.

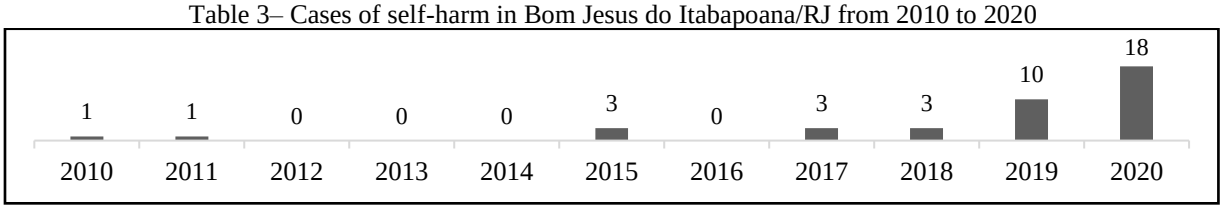
The crisis of family authority is seen as something serious and, in the social dimension, its valorization is included in the necessary initiatives for public policies, along with voluntary work and

access to the job market and study (BRASIL, 2019b). Other initiatives would include collaboration with religious institutions, promotion of physical exercise and sports, quality of health services, study of cases of suicide and self-mutilation and analysis of data on self-inflicted violence.

For the Vita Alere Institute of Prevention and Postvention (2019), it is important to raise awareness and qualify health professionals on the topic, continuity of care and the establishment of reception, assistance and specific health practices for this public. target, regardless of the scope of the establishment or professional. Likewise, the use of different perspectives in suciodology and the involvement of professionals from different areas is crucial as it is a complex phenomenon. The Institute expresses a view against facilitating the use of firearms in the country.

The research location was the city of Bom Jesus do Itabapoana, located in the State of Rio de Janeiro. The municipality served as a context for observing and studying the guarantee of access to care with clinical psychologists in establishments that serve the SUS. The data pointed to a total of 39 cases of self-inflicted violence during the period from 2010 to 2020 (Table 3). The year 2019 stands out, with an increase of 233.3% compared to the previous year, and the year 2020, with an increase of 80% compared to the previous year. The increase in notifications does not necessarily mean an increase in occurrences and may represent an improvement in the identification and recording of cases and greater demand by victims for health services.

Table 3– Cases of self-harm in Bom Jesus do Itabapoana/RJ from 2010 to 2020



Research source: (SUS INFORMATION AND IT DEPARTMENT, [sd])

According to data from the SUS Information and IT Department ([sd]), self-inflicted injuries are prevalent among female residents (69%), between fifteen and nineteen years old (26%), white people (46%) and those with secondary education. complete (10%). The most used method is poisoning (26%), with residence as the main scenario (54%). This profile follows the State and Country standard with regard to sex/gender, place of occurrence and means used (RIO DE JANEIRO, 2020; RIO DE JANEIRO, 2021; BRASIL, 2021). The education and color/race variables are similar to those found at the national level.

Regarding the age group, the profile differs from the state and national ones, which present more cases among people aged twenty to thirty-nine (RIO DE JANEIRO, 2020; RIO DE JANEIRO, 2021; BRASIL, 2021). However, the age group between fifteen and nineteen years old is in second place,

representing around 22% of cases in the State and 23.3% in the Country. In Rio de Janeiro there are more cases among people with incomplete primary education and self-declared as mixed race.

According to D'Albuquerque (2018), taking into account that the notion we have about self-extermination permeates the social sphere, we can understand that our understanding of this act, from ideation to the end itself, is also influenced by the idea of gender and sex. Including the social representation of which acts will be considered serious or ways of capturing attention.

> Commonly, what is considered serious are cases related to male bodies, while episodes seen as manipulative and less worrying are associated with female bodies. This occurs, according to Jaworski (2010), not only due to the materialization of the acts themselves, as the methods used by men tend to be more lethal and violent, but also due to the social reading of these acts, which perpetuate binary patterns in the face of voluntary death (D'ALBUQUERQUE, 2018, p. 16).

Some researchers name this phenomenon the Gender Paradox of Suicidal Behavior. Explanations include men's difficulty expressing their own feelings and, consequently, reporting possible suicide attempts, the lack of official records of men's unsuccessful attempts due to a feeling of personal failure and omission, possible errors of interpretation in women's death records caused by the view of intentional acts as accidental, alcohol and drug abuse by men that would influence the search for more lethal means of self-extermination and a greater incidence of concealment of cases of death by suicide of women by the victims' family (D'ALBUQUERQUE, 2018) . Exposure to gender-based violence and excessive duties, historically imposed, such as caring for the home, family and children, in line with their work duties also contribute to women's vulnerability (RIO DE JANEIRO, 2021).

In Petter's view (2021), adolescence represents a period of transition between childhood and adulthood that begins at the age of ten or eleven, being marked by biopsychosocial changes that will continue until the age of nineteen. These changes have a major impact and when associated with other transformations, such as loss and grief, can make young people more fragile and vulnerable. According to D'Albuquerque (2018), this age group corresponds to the period in which the individual does not work, which can cause great concern about their professional occupation and fragility due to not being included in the job market.

According to Silva (2019), there are several risk conditions for suicidal behavior in children and adolescents. This includes impulsivity, fights with colleagues, breakups, social isolation, bullying, influence of social ne2rks, performance problems, family problems, among others. In addition, socioeconomic issues, dilemmas regarding social insertion and the search for autonomy and consumption of alcohol and other drugs must also be taken into consideration as determinants.

When we analyze the education variable, we need to understand that it impacts men and women differently. A shorter period of schooling for men makes it difficult to enter the job market and professional success (D'ALBUQUERQUE, 2018). In the case of women, investing in a profession

represents a challenge for their married life, resulting in their decision to invest in a romantic relationship and motherhood or in an attempt to reconcile all activities, leading to a state of exhaustion and psychological fragility.

Due to the existence of ignored or blank fields in many of the variables analyzed in the notifications and the lack of descriptions about education and color/race of the population served in the service data carried out by clinical psychologists, the research only collected rates related to sex/gender and age group for constructing the epidemiological profile (Table 4 and 5).

Table 4– Self-inflicted injuries according to sociodemographic characteristics – sex

Sex	2010	2011	2015	2017	2018	2019	2020	Total	%
Masc.	-	1	2	2	-	2	5	12	31
Female.	1	-	1	1	3	8	13	27	69
Total	1	1	3	3	3	10	18	39	100

Research source: (SUS INFORMATION AND IT DEPARTMENT, [sd])

Table 5– Self-inflicted injuries according to sociodemographic characteristics – age group

Age Range	2010	2011	2015	2017	2018	2019	2020	Total	%
<1 Year	-	-	-	-	-	-	1	1	3
Oct/14	1	1	-	-	1	-	-	3	8
15-19	-	-	-	1	2	3	4	10	26
20-29	-	-	-	1	-	2	2	5	13
30-39	-	-	2	1	-	2	1	6	15
40-49	-	-	-	-	-	1	5	6	15
50-59	-	-	-	-	-	-	3	3	8
60 and over	-	-	1	-	-	2	2	5	13
Total	1	1	3	3	3	10	18	39	100

Research source: (SUS INFORMATION AND IT DEPARTMENT, [sd])

Based on these characteristics, it is possible to understand the profile of the majority of victims and analyze the efficiency of coverage of psychological care in the municipality in cases of self-inflicted violence, which will be demonstrated in the next section.

SECTION 2 – COVERAGE OF PSYCHOLOGICAL CARE IN BOM JESUS DO ITABAPOANA/RJ

To evaluate the coverage of psychological care for residents who fit the epidemiological profile of self-inflicted violence in the municipality, potential coverage (PC) and actual coverage (CR) were calculated (VIEIRA-DA-SILVA, 2014). Potential coverage is related to the concept of service availability and measures the resources available to carry out actions. While real coverage is related to the use of services and measures the portion of the population that was actually benefited. Disparities between potential and actual coverage point to problems in the implementation of the program or policy. The calculation of potential coverage is presented in Equation 1.

Equation 1– Calculation of potential coverage (CP)

$$CP = \frac{\text{"resources available in a given year"}}{\text{"target audience in a given year"}} \times 100$$

Research source: (VIEIRA-DA-SILVA, 2014)

To determine the available resources (Equation 2), data on the outpatient workload of all clinical psychologists from health establishments in the city that served the SUS from 2010 to 2020 were used, which were added together and resulted in the total workload. This value was multiplied by the number of weeks in the month (four), number of months worked (eleven) and the number of consultations performed per hour. The average daily service time of thirty minutes was taken into account, which results in 2 consultations per hour. The number of clinical psychology professionals and the respective weekly outpatient workload carried out in establishments that serve the SUS were obtained from the National Registry of Health Establishments (CNES).

Equation 2– Calculation of available resources (RD) per year

$$RD = \text{total workload for a given year} \times 4 \times 11 \times \text{number of appointments per hour}$$

Source: (VIEIRA-DA-SILVA, 2014)

The target audience in a given year was defined based on the construction of the epidemiological profile of cases of self-inflicted violence in Bom Jesus do Itabapoana/RJ in 2010 to 2020 based on secondary data from SINAN violence notifications available at the Department of Information and IT from SUS (DataSUS).

The calculation of real coverage (CR), present in Equation 3, takes into account the number of target audiences in a given year and the number of services provided to this target audience through detailed information on outpatient production data carried out in establishments in the state of Rio. of January. The information was filtered so that only services provided to Bonjesuenses by clinical psychologists in Bom Jesus do Itabapoana, during the years analyzed by the research, were shown. For this, the competencies related to each year analyzed were chosen, clinical psychologist in the professional-group field and Bom Jesus do Itabapoana in the municipality of residence and municipality of service.

Equation 3– Calculation of real coverage (CR)

$$CR = \frac{\text{"number of services to the target audience in a given year"}}{\text{"target audience in a given year"}} \times 100$$

Research source: (VIEIRA-DA-SILVA, 2014)

Data on the establishments that serve the Unified Health System available in the municipality and information on the outpatient workload of its psychology professionals were obtained through the professional data extraction consultation. The type of management selected was 'All' and the competencies considered were those corresponding to the months of January of each year covered by the research,

January 2010 to January 2020. In the *Excel file* generated, 'CLINICAL PSYCHOLOGIST' was filtered in the description CBO and 'S' in SUS so that only data could be collected from professionals who serve the SUS. Only the weekly outpatient workload of each professional was used, being added and used in the calculation of Available Resources (RD) for each year, which can be seen in Table 6.

Table 6– Weekly outpatient workload and available resources (RD) from 2010 to 2020

YEAR	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
WEEKLY OUTPATIENT HOURS	10	8	20	20	20	20	20	20	20	20	20
	40	0	8	8	8	8	8	8	8	8	8
	15	40	40	20	20	20	20	20	30	12	8
	15	20	12	6	6	40	40	40	20	8	12
	12	12	20	40	40	30	30	30	8	20	20
	20	20	0	20	20	12	20	12	20	20	8
	20	0	20	20	20	20	12	20	40	40	20
	10	20	20	12	12	0	0	0	20	20	40
	10	20	20	0	0	20	20	20	16	16	4
	12	10	20	20	20	20	20	20	0	0	4
	20	12	12	20	20	20	20	20	20	20	10
	30	10	8	20	20	12	12	12	20	20	20
	0	8	30	12	12	20	20	20	8	8	16
	0	30	0	20	20	8	8	30	20	20	0
	0	0	0	8	8	30	30	8	8	8	20
	0	0	0	30	30	0	0	0	30	30	20
	0	0	0	0	0	0	0	0	0	0	8
	0	0	0	0	0	0	0	0	0	0	20
	0	0	0	0	0	0	0	0	0	0	8
	0	0	0	0	0	0	0	0	0	0	20
TOTAL	214	210	230	276	276	280	280	280	288	270	286
RD	18832	18480	20240	24288	24288	24640	24640	24640	25344	23760	25168

Source of research: (NATIONAL REGISTRATION OF HEALTH ESTABLISHMENTS, [sd])

The number of services performed was found through health information on outpatient production carried out in the state of Rio de Janeiro - complete data, which were filtered in the options competence, professional-group, municipality of service and municipality of residence so that they only presented information on the years, professionals and population covered by the research. Some selected years do not present service records, which points to problems or changes in sending data to health information systems.

When analyzing the data to prepare the target audience item, race/color and education were not considered, as this information is not available in the outpatient production. The target audience was obtained from population estimates by municipality from the SUS Information and IT Department (DataSUS) and the number of services to this profile is present in the data in Tables 7 and 8.

Table 7– Estimated resident population of Bom Jesus do Itabapoana/RJ from 2010 to 2020 by age group

Range Age 1	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
15 to 19 years old	2967	2928	2899	2880	2837	2763	2681	2565	2439	2324	2221
Total	36078	36186	36298	36410	36526	36648	36760	36870	36985	37096	37203

Research source: (SUS INFORMATION AND IT DEPARTMENT, [sd])

Table 8– Estimated resident population of Bom Jesus do Itabapoana/RJ from 2010 to 2020 by sex

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Feminine	18542	18607	18662	18723	18791	18849	18911	18970	19027	19086	19140
Total	36078	36186	36298	36410	36526	36648	36760	36870	36985	37096	37203

Research source: (SUS INFORMATION AND IT DEPARTMENT, [sd])

The result of calculating potential coverage and actual coverage (Table 9) points to a large discrepancy between the number of services that could be provided, given the resources available, and the number of services provided. The results for the period 2019 and 2020 may be related to the Covid-19 Pandemic, which caused a stoppage and reduction in public services in establishments and a reduction in searches for health services.

Table 9– Potential and actual coverage of psychological care for citizens who fit the profile of cases of self-inflicted violence in Bom Jesus do Itabapoana/RJ, between 2010 and 2020

	POTENTIAL COVERAGE		REAL COVERAGE	
	AGE	GENDER	AGE	GENDER
2010	634.71	101.56	No informations	No informations
2011	631.14	99.31	2.04	No informations
2012	698.17	108.45	No informations	No informations
2013	843.33	129.72	0.31	12.19
2014	856.11	129.25	0.1057	0.13
2015	891.78	130.72	0	0.03
2016	919.06	130.29	0.11	0.45
2017	960.62	129.88	0.42	1.36
2018	1039.11	133.20	0.20	1.30
2019	1022.37	124.48	0.17	0.47
2020	1133.18	131.49	0	0

Research source: (NATIONAL REGISTRATION OF HEALTH ESTABLISHMENTS, [sd]; DEPARTMENT OF INFORMATION AND INFORMATICS OF THE SUS, [sd]; RIO DE JANEIRO, [sd])

Furthermore, the lack of information on outpatient production in some years and the failure to complete certain fields on the notification forms prevented a more in-depth analysis of the epidemiological profile of cases in the municipality. This demonstrates great inefficiency in handling cases and difficulty in obtaining accurate data on health information, which could facilitate the preparation and evaluation of combat and prevention plans and strategies.

The problem in filling out the forms is also noted at the state level (RIO DE JANEIRO, 2020). A proportion above 30% of notifications with blank/ignored fields was observed, especially in the variables sexual orientation, gender identity, motivation, education, race/color, presence of disorder/disability,

recidivism and marital status. Completing the form completely would allow greater reliability in the diagnosis and precision in the planning and evaluation of coping policies. Some of these items would point out issues related to stigma and discrimination, such as sexual orientation and race/color.

Data on self-inflicted violence is a social construction. Until it becomes an official statistic, it is influenced by the peculiarities and interests of the institutions that pass through and by the ideologies of the people who notify and process the notification and the adversities and successes of technology and operation of systems and sources of information (BRASIL, 2005). For this reason, the filling out and processing of notification data is directly influenced by professionals' conceptions.

Despite the search for improving data quality, there is concern about validity and reliability (BRASIL, 2005). The very understanding of what violence is affects the situation, since there is violence that society sees with greater fanfare (homicides and robberies) and others that are ignored (intra-family violence, racial and gender discrimination).

The real numbers are higher than the official data, due to religious, cultural and moral values. Some episodes that demonstrate the influence of these values in Brazil, a country with a strong influence of Judeo-Christian culture, are:

> (a) family members often try to hide it, negotiate with those who notify, revealing the microsocial difficulties that dealing with this fact reveals; (b) on a broader level, society is also usually perplexed by this type of event, making it difficult to obtain knowledge that is less involved in prejudice, in feelings of guilt towards the suicidal person, in the stigmatization of the family and the person who committed suicide; (3) in addition, underreporting also occurs due to inadequacy of records; due to inaccurate completion of data capture instruments; due to the existence of clandestine cemeteries and the destruction of corpses (BRASIL, 2005, p. 208).

Another obstacle is the deficiency in discriminating some forms of self-inflicted violence from other events that generate deaths or injuries, an example are traffic accidents in which the victim intentionally threw the car against a pole or another vehicle, and natural deaths, such as death from starvation purposefully in elderly people who lost their spouse (BRASIL, 2005). In the case of a suicide attempt, there is also an increase in the health authorities' lack of knowledge about the case (BRASIL, 2005). Since only 25% of people who commit suicide go to public hospitals to seek care.

The study pointed to the deficiency in assistance to citizens who fit the profile of cases of self-inflicted violence in Bom Jesus do Itabapoana and a major impasse in the analysis of data on the topic due to the inadequate completion of violence notification forms and outpatient production. This situation demands improvement in the production of health information and identification, evaluation and communication of cases for the development of contextualized public policies for the prevention and treatment of self-inflicted violence.

These are fundamental ways to reduce the myths and beliefs that encourage invisibility and the increase in cases: the introduction of preventive health actions in partnership with other bodies and sectors

of society, for the sharing of information to the general public and the dissemination of services available in the municipality; the development of a flowchart and procedures to be followed for reception, information collection, notification, referral to necessary services and monitoring of the victim; organization of coordinated actions in locations with greater circulation of people who fit the profile of the cases; specific actions in stores where the substances most used in poisoning are sold.

FINAL CONSIDERATIONS

The research sought to analyze the National Policy for the Prevention of Self-Mutilation and Suicide, mainly with regard to psychological assistance from the Unified Health System aimed at citizens who fit the epidemiological profile of self-inflicted violence in Bom Jesus do Itabapoana/RJ, during the years from 2010 to 2020. For this, official and statistical material was used, which was analyzed based on several publications that conceptualize and bring different views on the interference of violence, especially self-inflicted violence, in social life.

It was possible to construct the epidemiological profile of cases of this type of violence in the municipality, noting that the majority are white women aged fifteen to nineteen with complete secondary education who use poisoning as a method and practice it in their own homes. This is no different from what is observed in research at state and national level when it comes to sex/gender, place of occurrence and method used. Explanations for this profile focus on understanding the changes and transformations suffered by adolescents, socioeconomic issues and the concept of the Gender Paradox of Suicidal Behavior.

Information was collected on the workload per week completed by clinical psychologists in SUS health establishments and the number of services provided by them, between 2010 and 2020. From this, the potential coverage (PC) and coverage were calculated. real (CR) of psychological care. In other words, the value that the available resources (RD) to guarantee this right made possible and the value that was actually possible.

Providing psychological care to groups most vulnerable to the problem is one of several action strategies, but it requires actions, focused on the general and specific public, that are contextualized to the local reality. In the case of the city of Bom Jesus do Itabapoana, there was a big difference between the numbers that represented what could happen and what actually happened. The data for the period 2019 and 2020 were justified by the Covid-19 pandemic, but the other years indicate the inefficiency of public policy coverage.

The incompleteness of health information was the main adversity faced in interpreting the material, because it did not guarantee a deeper understanding of the city's reality. The incidence of fields being

ignored or left blank is a behavior addressed in several epidemiological bulletins and directly interferes with the planning of policies to combat violence. More empty fields, less knowledge about the problem.

It is concluded that the implementation of the National Policy for the Prevention of Self-Mutilation and Suicide in Bom Jesus do Itabapoana is ineffective in the practice of actions that result in reaching the public that meets the trend of cases registered in the municipality and in the quality of information originating from the production outpatient and notification of interpersonal/self-inflicted violence.

The study contributes to the discussion about the quality of health information and the configuration of strategies to prevent self-inflicted violence in accordance with the population's reality. Furthermore, it demonstrates the relevance of developing movements focused on ne2rking, demystifying taboos, sharing information, planning work processes, communicating cases and assisting the general public and risk groups.

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