

We live balancing dishes: perspectives on violence that interrogates the public mental health in the municipality of Rio de Janeiro, Brazil

A gente vive equilibrando pratos: olhares sobre a violência que interroga a rede pública de saúde mental do município do Rio de Janeiro

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Abstract

This article has sought to characterize the mental health network of the city of Rio de Janeiro and understand the ways, practices and discourses focused the attention given to persons in situations of violence that come to these services. We carried out an exploratory study of quantitative and qualitative approaches that tackled professionals and managers in 22 mental health units. As a result we identified the production of knowledge and strategies to deal with situations and intervene in effect as stopping the cycle of violence, however these actions have little visibility into the entire network of health and are poorly integrated guidelines of National Policy on Reduction of Morbidity and Mortality from Accidents and Violence (PNRMAV). We conclude that attention in the area of mental health for victims of violence is being held in a non-integrated meanwhile PNRMAV which exposes the gaps.

Keywords: Violence, Mental Health, Health Care, Prevention.

Resumo

Este artigo buscou caracterizar a rede de saúde mental do município do Rio de Janeiro e compreender os caminhos, práticas e discursos voltados à atenção prestada às pessoas em situação de violência que chegam a esses serviços. Realizou-se um estudo exploratório de abordagens quantitativa e qualitativa que abordou profissionais e gestores em 22 unidades de saúde mental. Como resultado identificou-se a produção de conhecimentos e estratégias para lidar e intervir nas situações tendo como efeitos a interrupção do ciclo de violência, entretanto estas ações têm pouca visibilidade em toda a rede de saúde e estão pouco integradas às diretrizes da Política Nacional de Redução da Morbimortalidade por Acidentes e Violências (PNRMAV). Conclui-se que a atenção na área da saúde mental às vítimas da violência vem sendo realizada, entretanto, de forma não integrada à PNRMAV o que expõe lacunas importantes.

Palavras-chave: Violência; Saúde Mental; Atenção à Saúde; Prevenção.

Departure point

Violence is a concrete phenomenon that causes deaths, wounds, traumas, and above all, loss of the quality of life in victims and in an incalculable number of people that suffer it (Minayo, 2009). The literature shows that loss of a family member or close friend to violence can lead to transitory or long-term psychological maladies. By a conservative estimate, some three people are directly affected by any event that results in death or hospitalization, which in turn burdens the public health network (Mello et al., 2007; Soares et al., 2006).

Although violence is not exclusively a health matter, the health-service networks receive the victims and function beyond mere treatment of injuries by bringing into the debate a whole set of social actors to address this complex phenomenon (Mattos, 2006). The idea of networks is based on communications theories and is understood to be a flexible social organization, adaptable and present in all societies, that allows expansion of creative capacity to achieve objectives and alter life's codes. All networks are made up of elements integrated into what are called "knots", that enable sharing of common values and objectives decipherable in a process of communication (Castells, 2005). Thus, synthetically speaking, networks can be defined as a set of "knots" that are interconnected and determine the flows of information and communication between these connections (Njaine et al., 2007).

In the health field, the idea of networks is manifest in structures (services and technology) organized around care and prevention and promotion of health. The actors of these actions are the health care workers and users of health services involved in care, which go from identification of health needs to being available to listen to users in the context in which they live; responding to their demands; intervening in their expressed reality, assuming a strategic character in seeking to overcome the challenges imposed by this reality (Silva Júnior et al., 2006).

In the mental health area, the network is formed from construction of therapeutic projects that require an interdisciplinary approach, represented by the set of general and specific knowledge from different health and social professions and services directed towards solutions to the problems

encountered (Silva Júnior et al., 2005). Care, from this perspective, is based on the characteristics and needs of people, promoting restructuring of teams and specialized services, offering services such as consultations and ambulatory treatment, intensive attention in day care, full hospitalization for short-periods guided by individualized therapeutic projects, amongst others (Pitta, 2001), provided in an articulate fashion seeking the optimization of results and avoiding overlapping or contradictions.

Mental health networks have an important role in regards to direct and indirect victims of violence, as it receives part of the social demands that exemplify the problem - causing tension in an area which traditionally has been called upon to assume and treat social maladies as pathologies, often "leading to psychiatrization of greater social problems" (Vasconcelos, 2010, p. 26). It is recognized that this psychiatrization is not the best solution for addressing the impacts of violence on health, from an ethical, political or even a scientific point of view. But it is important to recognize that there are these demands on the mental health network and that responses are being constructed in view of these demands. The purpose of this article is to characterize the mental health network in the municipality of Rio de Janeiro and view the ways, practices and discourses involved in providing services to people in violence situations.

The methodological way

This article is part of the study "*Análise diagnóstica da atenção às vítimas de violência nos Centros de Atenção Psicossocial do município do Rio de Janeiro*", from the Jorge Carelli Latin American Center for Studies of Violence and Health (*Centro Latino-Americano de Estudos de Violência e Saúde Jorge Careli*) (CLAVES/ENSP/FIOCRUZ -), 2010 to 2012, with the purpose, through Triangulation of Methods (Minayo, 2006), of building a comprehensive and interpretive view of mental health care for victims of violence in the Municipality of Rio de Janeiro, seeking to identify where there has been success or difficulties, from the point of view of professionals involved in this service (Deslandes et al., 2007). This article made an exploratory study to identify

and characterize the mental health network in the municipality of Rio de Janeiro and understand the care given to victims of violence in this network. Qualitative and quantitative approaches were taken, considering that these approaches complement each other, though this article favors the qualitative.

The quantitative stage had the objective of characterizing care at the Psycho-social Attention Centers (*Centros de Atenção Psicossocial - CAPS*), by a questionnaire composed of: identification and location of services, number of patients attended, diagnosis of cases, action taken, constitution of team and qualifications of team members. This instrument was applied by electronic mail to the 19 CAPS that make up the municipal network, from May to October 2011. Despite numerous attempts to obtain participation, only eight responded to the instrument, and in incomplete form. In order to complement the data, the management made available numbers of patients attended in the 19 CAPS. The information from this stage was processed in a microcomputer, codified in Excel software, forming a specific database and analyzed in absolute and relative terms.

The qualitative approach explored perceptions of professionals on the characterization of services and on attention given to victims of violence in the municipality through two semi-structured interview routes, one directed to medical professionals and another to managers. Both routes consider the implementation of mental health policies in the municipality and prevention of violence, the structure and organization of services and the network, care for the victims and concepts and perceptions on violence and its prevention. Medical professionals were requested to provide a brief case report identifying strategies with positive or negative results. There were 21 interviews from April to October 2011, two with managers, (one A representative of the *Núcleo de Promoção da Solidariedade e Prevenção da Violência*), and five professional categories (doctors, psychologists, nurses, social assistants, and occupational therapists) who worked at four Psycho-Social Care Centers (*Centros de Atenção Psicossocial - CAPS*) (two CAPS II, a CAPSad and CAPSi), a Psychiatric Emergency Unit, an Ambulatory unit and a team from therapeutic residence services.

These services are located in the programmatic area 3.2, which includes the regions of Inhaúma, Grande Méier and Jacarezinho, where there are 569.970 residents (IBGE, 2011), selected for having the best structures and the widest variety of services. It was up to the services to appoint a professional interested in participating in the survey.

Interviews lasted 40 minutes on average and were recorded with authorization of the informants. They were transcribed and codified so as to avoid their identification. Analysis of this material took the following steps: 1) carefully reading the file to capture its particularities; 2) highlighting themes in the interviews on the questions: what is the structure and organization of the mental health network, what are the conceptions on violence shared by its professionals, how are victims of violence attended to; 3) observation and analysis of implicit and explicit ideas. The interpretation sought to understand the regularities and discordances among respondents.

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What is this network?

According to data from the Mental Health Coordination (*Coordenação de Saúde Mental*) for 2010 (Rio de Janeiro, 2011a), the mental health care network in the municipality of Rio de Janeiro was made up of: 15 Family clinics; 2 Street clinics; 223 specialized services comprising polyclinics, municipal health clinics and specialized clinics; 21 CAPS; 5 psychiatric emergency units; 10 psychiatric hospitals; and 35 therapeutic residence services, spread over 10 programmatic areas of the city. These programmatic areas (AP) constitute the administrative divisions through which the health sector organizes its medical care. In the qualitative stage, this survey included only the services in AP 3.2, which is considered the best structured and having the widest variety of mental health services.

Although there are legal frameworks regulating mental health services, defining their objectives and users, it was decided to qualify these through a triangulation of information gathered in the quantitative and qualitative stages of the survey. This choice enables apprehension of activities beyond the prescribed (Dejours, 1994) bringing out a complex set of practices that are the focus of this article. Thus, the ambulatory unit covered in this survey, was described as a community service that offers psychological, psychiatric and social care to all age groups. According to respondents, the ambulatories have input from the areas of physical education, dance, singing and formation of therapeutic groups. This service has a team of four professionals: two psychologists, a social assistant, and a psychiatrist, as well as six psychiatrists who are nearing retirement and do not receive new cases. It was not possible to survey demand for care as this was not systematized. The service receives demand spontaneously and directs people to the network, especially to psychiatric emergency units associated with it. This demand is analyzed in a multi-professional team from reception groups that have the objective of 'sorting out' complaints and identifying those for psychology or psychiatry and those who can be attended by other facilities in the network. Those sent to ambulatory care have less serious symptoms but require evaluation and follow up. This service is not recommended for *cases of drug addiction, alcoholism or serious psychosis* and these are sent to the appropriate CAPS.

At the time of the survey, in the area covered, there were five therapeutic residences and two 'assisted housings' with 22 residents. Their objective, according to the respondents, is to provide places for living and shelter in a humane environment, approximating as far as possible a home, which is an important support service in the process of deinstitutionalization and social reinsertion. Most inhabitants have spent long periods or several short periods in psychiatric hospitalization and are highly socially vulnerable. The care available in these houses is offered by health professionals (carers and therapeutic carers) intensively (24 hours) or semi-intensively (shifts of 4 to 8 hours, or just daily visits) according to needs. In relation to the complexity of

services, the 'assisted housing' is recommended for those with a higher degree of autonomy.

At the CAPS, the most cited objectives were: receiving new cases; orientation as to possibilities for treatment and options; care working towards the construction of resources and possibilities in life; social support for patients and their families; intervention in society that aims, above all, at overcoming prejudice towards those who use the service; and the prevention of violence. Only CAPSad, due to its specific function, had two different objectives: attention to drug users so as to alleviate suffering, reduce the level of substance use or even achieve abstinence; inclusion of the problem of drugs as object of intervention in the area of health. All the services have multi-professional teams and offer actions provided in their statutes. According to data from the Municipal mental health coordination, at the end of 2010, there were 4.702 drug users under observation by services like CAPS in the municipality, which makes an average of 247 users per service branch (Rio de Janeiro, 2011b). It was not possible to characterize this clientele as most of the services do not yet have computerized records. Considering only the information from the eight services responding to the questionnaire, for January 2011 there was a ratio of 28 patients for each university-level non-doctor professional, which is almost double the recommendation of Directive 336/2002 (Brasil, 2002). This very high ratio does not include new cases that arrive at the services, and this indicates a work overload.

As well as priority care to people with serious and moderate mental disorders (neuroses and serious psychoses), the specifications regarding care for children and adolescents are provided exclusively by CAPSi and the management of sheltering users of alcohol or other drugs at the CAPSad. There was a consensus among the respondents that continuity of the treatment services should go beyond psycho-pathological diagnoses. Among criteria for maintaining treatment at the CAPS are: a high level of commitment by the patient, the risk and vulnerability of the syndrome, the high demand for intensive care, fragile family conditions and the absence of a social support network.

The psychiatric emergency unit in this survey

is outside the psychiatric hospitals, and is responsible for assessing the need for hospitalization in programmatic areas 3.1, 3.2, and 3.3, but also receives patients from other areas of the city. Only three professionals were part of the daily team: a doctor, a nurse and an occupational therapist. Two academic scholars participated in the team, though with a lower daily schedule. This unit has six beds for short durations that are occupied by patients of all age groups. According to respondents, the objective of the emergency unit is to provide shelter and support in a crisis, as well as diagnostic evaluation for construction of a therapeutic project. One of the respondents also added that the psychiatric emergency unit is still much sought for due to problems such as: lack of doctors at ambulatories; social support for drug users who seek the service while still drugged in order to 'hold on until the crash is over'; and people who look for the service because they have not eaten, slept and want a bath.

All respondents claimed to know the several services that make up the mental health care network and perceived an improvement in integration of these services.

Articulation of mental health services with other health care sectors was evaluated by the respondents as worse, as they said that psychiatric patients, drug users or the elderly, found restrictions for attention when not accompanied by a professional for reference. The following discourse reflects this scenario: *it is difficult to get attention. Especially due to the difficulty of health workers to approach psychotic patients. They think they speak another language. If we (mental health workers) are not together (psychological) attention is not given.* These findings match previous studies (Valadares and Souza, 2010) that showed restrictions for those with mental disorders in receiving attention from the health services in general.

Intersectoriality was related through a set of situations that exemplify impasses and progress in relation to other health services, shelters, guardianship councils, police stations, public prosecutors and schools, in the case of services that attend to children.

This articulation was rated in all services as fragile and not institutionalized, as the quotes show: *it is as though there was never any contact and we go*

and look for them for the first time (psychiatrists); I have been in mental health for 20 years. And so if you call I know everyone, but it's asking a favor. I think that is terrible (occupational therapy). This kind of informal articulation shows that the network in the municipality is sustained only by personal ties and not a structured, formalized, integrated organization. This reflects findings of another study (Minayo and Deslandes, 2007).

Guardianship Councils were depicted in a disparate ways: for some health workers articulation with them was successful and carefully worked out while for others this contact was always on an emergency basis in each case with interferences that made follow up difficult. The passage that follows expresses this situation well: *when we perceive that even with our approach we are not succeeding, that violence is at a serious level, with a serious case of negligence, then we go to the guardianship councils or call them and ask for help. Always with a lot of trepidation, not so much here at CAPSi but at other institutions, I have seen disastrous interventions, we are terrified of the family losing guardianship, because that does happen (psychologist).*

Relations between mental health services and schools show tensions, as in the last few years they have demanded medication of students, which reproduces the findings of other studies (Abreu, 2006). Again, the following passage exemplifies the matter: *She (the teacher) thinks that medication will keep the children calm so she can teach fifty at a time, then that's difficult (psychologist).*

What care is this?

It was sought to understand in what ways the mental health network in the municipality of Rio de Janeiro is being structured and articulated to face the problem of violence. Thus the conceptions and perceptions of health workers on the following topics were analyzed: violence; attention given to people in situations of violence; what they think of actions of prevention of violence in their practices.

What is this violence?

With this question it was sought to understand what health workers perceive as violence, considering

that these notions can influence in what is seen and what is natural in their practices.

When the research field stage began, there was little discussion on the theme of violence in the ambit of mental health care in the municipality, which according to respondents was discussed only in the case of suicides - which clearly demonstrates this approximation. Some of the respondents affirmed the strangeness of the theme of research, as they did not recognize it as an object of day-to-day work - a scenario that underwent changes during the interviews, as shown by the statements: *I said I didn't recall any cases of violence, but as we talk, we begin to remember (social assistant); because I had never thought of this theme, [...]. But after you talked about the study I began to ask myself whether we actually run into this (psychiatrist).* The constant reticence in the answers towards the theme is associated to the fact that it does not appear as a major complaint, but rather as a question that emerges after a process of connection and therapeutic intervention. In this care process, therefore, health workers did not identify specific action of the mental health area in these cases but rather continuous follow up that is part of clinical practice. This difficulty in indentifying cases of violence and producing interventions in the health area on the part of many health workers was illustrated by Cavalcanti and Souza (2010). According to these authors, health workers can distinguish situations of mistreatment and identify in them possibilities of intervention in the health ambit, however, they show difficulty in relating these cases to violence, which shows a distorted understanding of this theme, often relating it to police work.

Generally speaking, all respondents show an awareness of the terminology by which the health area approaches violence, where the landmark is the *Política Nacional de Redução da Morbimortalidade por Acidentes de Violências* (PNRMAV - National Policy for Reducing Deaths by Accidents and Violence) (Brasil, 2001). In this policy, violence was identified, generally, as a complex social phenomenon that impacts its direct and indirect victims, resulting in injuries, death and reduction in the quality of life.

In everyday health services and management, violence was identified as an expression of macro-social problems: structural violence related to inequalities in social, cultural, gender, age and

ethnic areas that produce vulnerabilities, including poverty. In this vein, urban violence associated with armed conflict, interpersonal and criminal violence, situations of abandon and neglect often perpetrated by the public administration (such as lack of qualified personnel and lack of organization or structure in the services), and finally, violence against children were expressly related. The passages that follow demonstrate these perceptions: [...] *the question of violence, especially for those in lower-income communities, is often violence by the police, where community agents are sometimes the witness and sometimes the victim* (manager); *(There is a great lack of psychologists, psychiatrists, and deep worry about not being able to handle the demand* (manager).

Although the theme of violence has been under consideration by the Municipal Health Secretariat since 1995, according to managers, this is still a theme which is difficult to appreciate by health professionals. These impressions are reflected in other studies (Santos, 2005; Ferreira and Schramm, 2000; Souza et al., 2009) who point out that many health workers feel poorly qualified to deal with this public, which in turn reflects gaps in training. Thus, few recognize their role in treatment, exposing questions such as their own fears and insecurities. However, this impression made by managers differs from most reports from health professionals who work in the services, as, for them, violence is part of the context of people attended and is expressly one of the objects in the field of mental health care.

For most respondents that work in the services covered, the theme of violence is immersed in the set of mental health field practices, even if apparently it is treated as a recent problem, as cited in the following passage: *(Violence) is a new subject for us, although we have dealt with it for centuries* (psychologist). Intra-family violence, in the form of physical, sexual or psychological aggression, related to humiliation, threats or negligence and mistreatment were the most cited. Furthermore, community violence expressed as threats and lawsuits that lead to negation of rights and exclusion were also frequently described. Workers from CAPSad, emphasize criminal violence associated with harmful use of drugs as a problem that is gradually being

incorporated by the health sector, exposing the difficult interaction between health, public security, justice and social assistance. Intra-family and urban violence that appears at the health services, at all levels of assistance, has been amply described in the literature (Assis et al., 2009; Reichenheim, 2009; Ribeiro et al., 2009; Martin et al., 2007) as to its impact on producing fear, despair and alienation, often related to rise of psycho-pathological syndromes.

The conceptions presented by respondents seem to have been constructed from their work practices and not from formal training. In regards to this, there were differences between the information collected in the questionnaires, in which 12.5% of the services surveyed informed that there was training for care to victims of violence, as provided in PNRMAV, and reports from respondents claiming the absence of such training. These workers also could not identify any initiative, which according to information from managers was being promoted by the *Núcleo de Promoção da Solidariedade e Prevenção da Violência* (Nucleus for Promotion of Solidarity and Prevention of Violence).

Although there were no reports of training directed towards the theme, experiences were cited where in supervision and participation in events and seminars, among other questions, violence was approached as a theme that traversed clinical practice.

Where you are going, where you are coming from and the middle of the way...

Respondents from all services approached in the qualitative stage affirmed that there was no reference to care for victims of violence. These affirmations reveal the understanding that this care requires specialized service from trained professionals and integrated into other sectors such as justice and social protection. Similar aspects were found in the literature (Lima et al., 2009; Leal and Lopes, 2005) demonstrating the difficulty encountered by health workers when attending to victims of violence, such as: disarticulation with the specialized assistance network; fear and insecurity; lack of qualification and infrastructure.

Thus, when asked whether there was some protocol, formal or not, to deal with cases of violence, the answer was always negative. However, in most of the services some procedures appear to have consolidated even though there was no formalization either for health workers or for managers. It should be pointed out that after the field stage of this study, the Mental Health Coordination published online “*Protocolo para a Atenção à Demanda Espontânea de Pessoas em Sofrimento Mental nos Serviços de Atenção Primária à Saúde*” (Protocol for Care of Spontaneous Demand of People with Mental Suffering in the Primary Health Service) (Rio de Janeiro, 2011a) where the flows of reference and counter-reference are defined and the theme of violence is integrated.

From the discourses of health workers, it was possible to identify a tacit form of attention to cases where violence is identified. All affirm that they are alert to signs such as bruises, scratches, lack of cleanliness and personal care or depressive symptoms, and that they investigate suspect cases more delicately, viewing these actions as inherent to the context of the clinics. The following fragments exemplify these perceptions: [...] *because I think we end up incorporating this (violence) to a greater context which is the context of the clinic itself. And so it is part of the story, it is not something isolated or occasional* (psychiatrist); *we have to understand violence as part of the context within the resources we have to work with* (psychologist). These reports appear to converge so that some authors (Schenker and Cavalcante, 2009) propose that victims of intra-family violence should be understood within the social context that produces it and intervention by health professionals is possible.

The only exception was recorded in psychiatric emergency units where the high turnover of beds and the absence of records of cases makes it impossible to build a vision of violence or even investigate other signs or symptoms. One of the respondents in this service stated that when there are evident cases of battery or sexual violence the police officer on duty is asked to fill in a police report, which shows that understanding is restricted to seeing it as a police matter.

In all units studied, greater care can be seen in defining interventions in cases of violence. This

action proposes not breaking ties between patients and family members, considering that maintenance of therapeutic associations enables changes in standards of behavior, which is amply described in the literature (Carter and Macgoldrick, 1995; Deslandes et al., 2004; Ferrari and Vecina, 2002). This care was even more emphasized in services that care for children and adolescents, as shown in the following report: [...] *medical attention* (is the possibility of) *of parents talking about it* (physical violence), *things to which otherwise we would not have access, and we access because they are talking, and in talking they are asking for help* (psychologist).

A multi-disciplinary approach was reported in all services that have team meetings, local supervision and articulation with partners in the network, such as the Family Health Strategy, ambulatories, and therapy residence services, Guardianship Councils, schools, police stations, emergency units, hospitals and shelters.

Records of information on suspects or confirmation of violence on medical records, considered by all to be extremely relevant, and filed whenever possible. Once again, at the emergency and at the ambulatory units records were not made on a single sheet because at these units the medical records are kept in the polyclinic general file and there are no support workers to retrieve these files at each case of medical attention.

Notification of violence, which should be at the Municipal Health Secretariat, takes place at all health units only in cases of children and adolescents, and is sent to the guardianship councils. None of the respondents reported having sent the notification to the Health Secretariat and when asked about notification of adult victims, the term “notification” was often confused with “accusation” and it was sent to the public prosecutor’s office or police stations, which expresses mistaken concepts that still associate questions of violence with the areas of justice and public security. One of the results of the quantitative stage shows problems in forwarding notifications: 50% of the services surveyed answered mistakenly that the Social Development Secretariat is the main office in regards to notifying violence. This appears to show a lack of training on the part of these health workers.

With the exception of psychiatric emergency units, all the services stated that they make contact with families, members of the community and institutions that appear on reports on patients as authors of violence, thus promoting interventions that aim to prevent recurrence.

In all services it was possible to perceive that the health professionals consider it a good development when the patient and the family manage to construct family and community ties. In all the services, workers considered actions that assure good care: involvement of the entire team and articulation with other actors in the network. They also believe that positive developments in the case depend on factors such as: availability of a space for listening to everyday concerns; avoidance of institutionalization; special care to those with special challenges; caution with false accusations; intensive attention and care of families where there is violence. The reports that follow exemplify some of these views: Sometimes we have reports of violence that are not quite that way, not quite so intense, did not happen quite that way. And so you need to take some care in how you accept this kind of discourse (psychiatrist); And then, curiously, when she saw I was not going for the story, that she was an addict, she perceived the difficulty she had with her mother, she came every week for care, she reflected on her life, mourning her father, she was even kicked out of school, but then she took care of her life (psychologist).

On the other hand, the precarious integration and articulation between the components of the teams and with the other actors in the network, causing misunderstandings and tension in relations, as well as the complexity of cases, appears in the discourses of respondents as the main unsuccessful points. Among the factors that contribute to unsuccessful care were also cited: the absence of effective responses on the part of institutions involved in the case; the precarious structure of the team; not keeping to the treatment due to resistance from family members; lack of communication between services; difficulties in managing complex cases; lack of mobility and sensibility towards other health problems.

However, the predominant evaluation among respondents is that care is being well provided to victims of violence, as, insofar as mental health

services can intervene, they have observed good results. Despite deficiencies in qualifying personnel, the teams that make up these services have done this work for many years and work in a consolidated and integrated fashion, which enables good development of actions, as shown in the following statements: we do manage to do a lot of things, we transform relations, with patience, with investment we manage to make it so this kind of violence does not occur again (psychiatrist); we have managed to make these families rethink themselves, [...] but I think that, as far as we can change this everyday life, we are balancing dishes... (social assistant).

Is prevention possible?

Assis and Avanci (2009) discuss how the concept of violence can be incorporated into the health area. For these authors, violence is not necessarily a complex social phenomenon that extrapolates the health area, and in the same way that one can learn to live with it one can also unlearn. In the field of interventions in health, it is possible to identify what factors contribute to violence and intervene to interrupt the violent cycle. In this way, ways were sought to identify how the mental health network can contribute to prevention of violence, seeking to understand what concepts of prevention are shared among respondents, what actions they recognize as prevention, and what the role of their service is in this context, as in the ambit of health, prevention should be considered at all levels (primary, secondary and tertiary).

The understanding that violence is a phenomenon that can be prevented was not shared by all respondents in the study. In this it was possible to see that the concepts of what violence is has a great influence on the possibility of intervention considered by health-care workers.

Some of the respondents do not see this action as possible in the mental health area. Their opinions are centered on the understanding that violence is a social problem that leads to injuries and deaths, and in their approach from a macro-social context, inequality, poverty, globalization and organized crime are considered fields that go beyond the bounds of mental health. Within these

greater social problems, violence is not understood as something that can be prevented, as shown in the following discourses: [...] *prevention of violence is not something within mental health, although there the question of suicide, which I think could be, but it often is not* (manager); *I don't know what we can think about preventing violence pure and simple. I really don't know* (psychiatrist); [...] *but you are not talking about CAPS, but another service* (social assistant); [...] *because how can we as a service avoid that these people suffer violence?* (nurse).

On the other hand, some of them consider that actions developed in everyday services have the function of preventing violence. Some who notice physical and sexual injuries of violence suggest that early identification of victims is prevention in the area of mental health care: If you think that early identification is prevention, then we are already doing it (manager).

There is, further, a portion of respondents, more numerous and present in all services surveyed, that perceive the question of prevention of violence as a process of intervention in culture, through continuous initiatives that have greater or lesser impacts, as seen in the passage below: *I think that this work outside our area, work in culture, it can make a difference, and in this question of violence too, on the stigma of craziness, the place for crazy people in society, changing this place a bit, changing this regard from society towards psychotics* (psychologist).

From these reports it can be seen that of the different conceptions on prevention of violence, the mental health network has been incorporating the discourse of intervention in culture, which is the main flag of the struggle for Psychiatric Reform.

To finalize

The literature shows that the process of inclusion of the theme of violence in the ambit of public health is occurring slowly and gradually (Minayo and Souza 1998). However, this study demonstrates that in regards to care provided by the mental health services in the municipality of Rio de Janeiro, this insertion is concrete and has been occurring from a long period. It should be noted that the programmatic area

of the city covered in the qualitative stage of the research could have influenced in the construction of this result, as it was chosen precisely because it is the region where mental health services are best structured and has the widest variety of services, which should be taken into consideration.

Historically, the mental health area has been serving in its units, clinics, beds, therapeutic residences, groups and workshops, people who are in violence situations from themselves, from families, the community, the culture or society, and has been constructing forms of intervention that are consistent and critical.

However, inclusion of the theme of violence in this field has been taking place in a much more organic form, that is, integrated and built up day by day by working processes with workers and their patients, rather than from a structured process in the network as is envisioned by PNRMAV. In this way, there are gaps from the absence of training for these health workers to lack of institutionalization in flows in the network, lack of notification and lack of knowledge on the part of these workers of the importance of this resource for planning their actions.

Although the mental health network is complex and the organization precarious, with fragile attachments and a high turnover of workers, it can be said that there is a network anchored especially on health workers and on users of the service, through the personal informal ties that they establish amongst themselves. This finding is worrying as there is currently in the municipality a process of reducing the number of selected employees, which are those that support these ties and are the knots in the network. In their absence, the network could become more fragile and less effective.

The main finding of this study is in identification of the set of strategies built by the mental health network for caring for victims of violence. All professionals affirm that they are alert for signs of violence such as injuries, traumas, scratches, changes in routines, excess losses or gains in weight in a short period, sleeping problems, amongst others. These signs are recorded and investigated by the majority of respondents and when violence situations are confirmed, multi-professional care, inclusion of ac-

tors involved in the situation, and discussions as a team are the main measures taken. Construction of a support network with several actors, including those outside the health area, is placed as a strategy for intervention for interrupting the cycle of violence.

The main gap in this attention is in precarious recording of information in some services and the limitations in notification of violence. When these actions are taken they do not generate systematic analyses. Inclusion of these actions could aid in planning and intervention, as well as empowering health workers in their requests from management.

Finally, it is fundamental to train health workers in the network, as formalized knowledge enables construction of new strategies for intervention including for management itself.

Authors' collaboration

The authors contributed equally at all stages of producing the article.

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