v. 3, n. 33, 2023

Scientific Journal of Applied Social and Clinical Science

TRENDS IN THE INTERVENTION OF SOCIAL WORKERS IN MENTAL HEALTH CRISIS CARE

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Abstract: This essay, a by-product of research carried out in the Brazilian northeastern context, aims to rethink the trends in social worker intervention in mental health crisis care. Part of the experiences of the authors and the category's collection. It is divided into two topics. The first topic historically, politically and conceptually contextualizes the legacy of the mental health crisis in the context of Brazilian psychiatric reform. The second seeks to understand the appropriations of the crisis from the Brazilian Social Service, exploring the trends in the direction of professional practice.
Keywords: Social service. Mental health crisis. Psychiatric reform.

INTRODUCTION

Although Brazilian health policy is one of the largest fields employing social workers and Social Work is considered one of the health professions by Resolution 287/1998 of the National Health Council,During the undergraduate training period, the literature points to incipient mediations for interventionsin the multiple expressions of the social issue, such as those that affect mental health. After all, as Iamamoto (2008) has already pointed out, understanding the social issue also means understanding how individuals experience it.

In this context, the Social Service professional, in order to respond to the particularities of this policy, must have complementary training, ideally on a continuous and permanent basis, which enhances professional updating that enables both to criticize the rationality placed in the current stage of capital (which, in the case of mental health, has opted for a line of using neoliberalism as a manager of suffering), in terms of improving its knowledge in a certain societal and professional direction.

The Unified Health System (SUS), when defining healthbased on the social determinants of the health-disease process, it also brings other elements, on the one hand, reinforcing the importance of the profession, as it calls for the perspective of integrality, totality, as condensed by the Marxian perspective, inherent to the Ethical-Political Project of Brazilian Social Service. But they are also tensioning, as the social becomes incorporated as a presupposition ofinterventions from all professions and workers in/from the health field, characterized by polysemy, comprehensiveness and conceptual "imprecision" (Costa, 2000).

Social workers have been part of Brazilian health policy, including mental health, since the 1940s, as identified by Eduardo Vasconcelos (2000), forming multidisciplinary teams, based on their work in Child Guidance Centers.

In mental health, especially in crisis care, until the 2010s, the presence of social workers in discussions involving: psychopathology, crisis management was not observed; psychotropic medications/ psychopharmacology; approaches to suicide, and similar ones, beingconsidered by many as themes and fields of biomedical professions and/or Psychology. Such an absence sounds strange for a profession whose Ethical-Political Project is based on access and guarantee of rights, based on principles such as: freedom as a central ethical value, the uncompromising defense of human rights and the commitment to the quality of services provided. to the population (CFESS, 2011), which tend to be put in check and even suspended in many traditional mental health crisis interventions.

With these premises and how the professional integrates multidisciplinary teams, in different areas of mental health policy, it is very common to comment on the lack of knowledge by other professions of what Social Service is and does, making it necessary

to intensify the debate about the profession's accumulations in relation to its intervention in mental health crisis care. Even due to the growing interfaces, interprofessional action, increasing blurring of borders and common skills, between professions. For example, working with families, networking, welcoming actions and the demands of interdisciplinary and intersectoral work.

This essay is a by-product of research on the participation of social workers in mental health crisis care, approved by the Research Ethics Committee of ``Universidade Federal do Piauí``, under CAAE: 66701822.8.0000.5214. It aims to bring elements to rethink and problematize the insertion and intervention of the assistantsocial context in the context of a mental health crisis, as well as contributing to the debate on the profession in the context of threats to Brazilian psychiatric reform and the advancement of neoconservatism. It is part of the collection produced by the category, in the public domain, on action based on urgencies and emergencies in mental health. To this end, we recovered, through a brief historical contextualization, political and conceptual discussions and the legacy of the mental health crisis in the context of Brazilian psychiatric reform. Next, we seek to understand the discussions about the crisis based on the production of Social Services and the authors' experiences in the Brazilian Northeast.

THE MENTAL HEALTH CRISIS AND ITS APPROPRIATION BY PSYCHIATRIC REFORM

Since the biomedical appropriation of madness by the knowledge-powers of psychiatry, from modern, capitalist society, madness has been reduced to a disease, from an anatomopathological perspective, that is, as if it were a strictly organic disease, more recently related to brain neurochemistry, but materialized in signs and symptoms limited to the psychiatric clinic, the firstmedical specialty, as recognized by Castel (1978).

In research carried out by Artur Perrusi (1995, p. 226) on the representations of mental illness, the author already pointed out that the hegemony of the biomedical model of illness brought obstacles, as what has been understood as a "psychiatric symptom" encompasses deviant behaviors, which, in turn, means that the hegemonic understanding and discourse present in mental health is used as a technology for standardizing, controlling and dominating bodies and naturalizing barbarity, making it difficult to perceive the political and social meaning of a intervention that has this understanding as its background. Under this approach, the author also shows that the psychiatrist's representation of mental illness (to which we would add all other areas of knowledge, which have often been replicants of this discourse) is reduced to the diagnosis that will direct everything else that comes to be used as a treatment idea, disregarding the complexity and plurality that involves the experience of different users and different mental disorders.

We emphasized that considering mental disorders as a strictly chemical and biological problem is functional for capitalism, and a threat of a regression to the conservatism so present in the history of Social Work, when it flirts with and reinforces conservative discourses and interventions/omissions again, by individualizing social problems. This biochemicalization (Fisher, 2020) of extreme suffering and mental disorders is directly proportional to the depoliticization of this discussion and mental health policy, in addition to fueling a very profitable market for pharmaceutical multinationals and their pharmacological products. At this point, it is worth emphasizing that this discussion does not seek to deny the existence of the physiological and/or neurochemical-cerebral

impact of mental disorders, but rather to question the current path that has been adopted to explain them, which, by placing everything in the account of "Multifactoriality" ends up saying nothing about the cause of these, and very little about the cure.

Under this paradigm, there was also an association of people with mental disorders with incapacity, especially in terms of discernment, lack of reason, including at work, being placed as an unproductive being for capital and, a priori, a threat to social life, due to the increasing association between madness and crime (Delgado, 1992). As a result, in the Western, capitalist world, internment in total institutions, which lock the subject into organizational logic (Goffman, 1992), became the rule, which resulted in thesegregation and stigma towards this segment.

The biomedical paradigm was strengthened in the 1950s, with the availability of neuroleptics on the global pharmaceutical market, a fact that also expanded the possibility of carein freedom"[1], by no longer institutional, but chemical containment. As a result, there was a greater focus on the attention of this segment with the medical category, which diagnoses, prescribes and defines therapy, based on hospitalization and medicalization.

A parenthesis is in order here to clarify this last term. Medicalization of life must not be understood as medicating (the act of medicating, which is just one facet of medicalization). The culture of medicalization tries to translate a set of social phenomena from the perspective of health (technical-scientific discourse, mostly biomedical). This implies transforming experiences considered unwanted (social, moral or political) into health objects (Freitas and Amarante, 2017), which will impact hygiene rules, moral standards, social behaviors and directions of what is understood as care in health policy, especially mental health. For example, if someone looks for a social worker and expresses that they are thinking about killing themselves and is referred to a psychiatrist as their first (and sometimes only) referral, we may be as medicalizing as a doctor. After all, contained between the lines of this approach is an understanding that the only thing that individual needs is a magic pill for their brain - which disregards the direction of the assumptions of the Brazilian Psychiatric reform and delegitimizes that that suffering has an intense relationship with the conditions of your social life.

Returning to the discussion of the biomedical context, in the post-World War II context, criticism of asylums, equated with concentration camps and hegemonic psychiatric power-knowledge, strengthened, from which various traditions of psychiatric reform emerged, which show the fissures hospital-centric logic.

Brazil, with the redemocratization process,under the influence of the paradigm of deinstitutionalization as deconstruction (Amarante, 1996) originating from the reformist process in Italian mental health, it adopts the psychosocial paradigm, understood as synonymous with the citizenship of people with mental disorders (Saraceno, 1999), materialized in Law nº 10.216/2001 which redirects the assistance model and recognizes the rights of this segment, a milestone of their citizenship.

In this context, attention to the mental health crisis begins to be deconstructed in different directions, with the aim of no longer being associated with medical and psy field exclusivism, although several paradigms in

1. Here we put freedom in quotation marks because we understand that this corresponds to the existence of alternatives, the possibility of choices, the existence of conditions for the experience and expansion of human capabilities (Paiva and Sales, 2005) – which does not fully exist in capitalism nor in what refers to the mental health user who ends up trapped in the medicalization of life as the first and often only form of response found in some services, even after the Psychiatric Reform.

vogue coexist. The Primary Care Notebook nº 34 (BRAZIL, 2013), focused on mental health, endorses this direction, firstly showing how health workers and society in general feel insecure and unprepared to provide care to this segment. We emphasize that the ability to manage people in crisis was necessary, above all, with the increase in cases of mental illness during and after the COVID 19 pandemic.

The aforementioned notebook brings an important caveat by deconstructing the idea of crisis associated exclusively with health services, associating it constitutively with the human condition. In this field, the main health technology used is the light type (Merhy, 2007), based on human relationships, which requires knowing how to communicate, relate and negotiate. In the psychosocial paradigm, medication and hospitalization must be the last resources used, after considering other offers, related to reception and support (Brazil, 2013). Therefore, handling crisis situations must be considered "essentially relational".

As a prerequisite for managing the person in these circumstances, the following is guided: accepting difference and what is different; knowing how to welcome; communicate, relate, negotiate, guided by the purpose of avoiding psychiatric hospitalization; ensure longitudinal care; place hospitalizationas a last resort and, if essential, be based on a Singular Therapeutic Project and take place in general hospitals or Psychosocial Care Centers. Thus, the professional is situated as a mediator between the user and their network of social relationships. In this tuning fork,

> There is no specific location solely responsible for responding to crisis situations. The approach to crisis situations must take place where the user is, that is, in their life or care circuit: the home, street, UBS, Caps, emergency room, etc., not being the exclusive responsibility of the medical professional or even from the Health professional. Expressing willingness to listen, procedurally negotiating the approach are fundamental postures for seeking a meeting with the user (BRAZIL, 2013, p. 102).

Therefore, as long as it is minimally equipped for this purpose, any institution and professional, other than just the doctor, can and must offer some level of support to a person in a situation of mental health crisis. But, of course, more substantial preparation is expected from a mental health professional/ worker.

As Zeferino (2015) discusses, the concept of crisis is polysemic, varying in each time, place, culture, between different professions and professionals, being a field of theoretical, political and ethical disputes. Dias, Ferigato and Fernandes (2020, p. 596) conceptualize mental health crisis care as "a set of care practices developed within the scope of the community care model and developed with users in situations considered acute and serious".

Ferigato, Campos and Balarin (2007) point out that the conception of crisis is reconfigured in the particularity of the praxis of each service. Here we prioritize emergency andemergency, which in Brazil refer to:

> Health Promotion, Prevention and Surveillance; Basic Care; SAMU 192; Stabilization Room; SUS National Force; UPA 24h; Hospital Units and Home Care. Its complexity is due to the need for 24-hour care for different health conditions: acute or acute chronic; They are of a clinical, surgical, traumatological nature, among others. Therefore, for the Network to offer qualified assistance to users, its components must act in an integrated, articulated and synergistic manner. It is essential to implement professional qualification, information, the reception process and regulation of access to all components that constitute it (MINISTRY OF HEALTH, 2022, p 1).

Historically, the mental health emergency (commonly called psychiatric) is linked to the worsening of psychopathological symptoms

associated with the psychotic crisis, the moment of the outbreak and pharmacological and segregating treatments, assuming anegative connotation, which the authors try to question and broaden the view. Based on Dell'Aqua, the authors explore crisis situations based on five parameters, requiring the existence of at least three: "severe psychiatric symptoms; serious disruption at the family and/or social level; refusal of treatment; obstinate refusal of contact and alarm situations" (p. 34) and personal inability to face them.

However, as Dias shows; Ferigato and Fernandes (2020), in the dispute to maintain biomedical hegemony, the concept of crisis in mental health associated with anatomopathological medicine has taken root and persists, linked to risk (especially death, intense suffering and irreparable injuries). The authors point to the contradictions and particularities of mental health crisis care whose characteristics, the biomedical modelproved insufficient to cope, redirecting it to the psychosocial paradigm, from the perspective of inclusion, bonding, knowledge of the subject's history and context, appreciation of singularity and based on the concept of vulnerabilities.

Saraceno, Asioli and Tognoni (1994, p. 22), highlight the importance of shedding light on the "shadow variables" (individual resources; life context, including family; resources of care services and the social assistance network), that is, shed light on thesocial determinants of the health-disease process, considered by the biomedical paradigm as "irrelevant" as opposed to strong variables (diagnosis, acuteness or chronicity and history of the illness). The authors assess that,

> In reality, patients who have the same diagnosis develop different evolutions and results, just as patients who have the same pharmacological therapy develop different evolutions and results. Therefore, the diagnosis alone, as well as the fact that the patient takes some psychotropic drugs, does not lead to a prognosis. The diagnosis can help to establish the opportunity for pharmacological therapy, but not to establish more complex and articulated intervention strategies (IDEM; IBIDEM).

Basaglia himself, largely responsible for the Italian psychiatric reform on which the Brazilian one was inspired, stated that to establish a relationship with the individual, it is necessary to consider him independently of the label that defines him: Because when I classify someone as having a certain disorder, such as schizophrenia (with everything the term implies, knowing that it is a disease against which hegemonic psychiatry states that nothing can be done), I relate to it in a particular way. And, in the case of other professions outside of biomedicine, if there is agreement with the idea of biochemicalization of the disease, there is an implicit agreement that there is no way my profession can intervene. It is for this reason that it is necessary to focus on this patient in a way that puts their illness in parentheses (Basaglia, 1985), since it does not say everything about the individual being treated.

Conservative hegemonic psychiatry continues to be dominated by a biologicalism that does not encourage (and, sometimes, does not accept) dialogue with other fields of knowledge. Fascinated (and sponsored) by the discussion of brain chemistry, and all the magic pills for brain regulation, they are unaware and/or deny that the individual's crisis is related to and impacted by their life context and the expressions of the social issue (Barboza, 2023).

Anti-asylum psychiatric reform as a complex and dynamic social process has added new elements, tools to broaden the discussion, change practices and expand the

citizenship of people in extreme suffering and/or with mental disorders[2], including experiences from other countries, such as: the crisis card; mutual aid and voice hearing groups; the speech community; autonomous medication management; the open dialogue method and recovered the importance of intersectional dimensions. Configuring Yourself as Toolsto contribute to the deinstitutionalization process, including to demedicalize, depathologize and strengthen the protagonism, participation and social control of users and families in mental health.

Under the aegis of the expanded clinic, which involves the clinic with the social, how is the social worker situated as a component of the multidisciplinary team in the care of the Brazilian mental health crisis? What appropriations do they implement? And, perhaps the most crucial question, speaking ofcapitalist society, based on exploitation, oppression, inequality, individualism and many other phenomena that produce suffering and illness, where do these elements connect in the analysis and intervention of Social Work?

THE SOCIAL WORKER IN CARE FOR THE MENTAL HEALTH CRISIS

At the III Health ConferenceMental, in 2001, the Federal Council of Social Service, as it traditionally does, invited the social workers present for a dialogue/meeting. The power of the report from a colleague working in the interior of Ceará/Northeast is important. She explains that a user arrives at Caps, in crisis. Speaking loudly, gesturing, altered in general behavior. The doctor immediately takes out a block to send for admission to a psychiatric hospital in Fortaleza. Which would mean sedating, restraining and triggering the typical "ambulance therapy". The social worker objects to the psychiatrist's conduct and resists, informing him that she can report him for failing to provide assistance. The social worker successfully takes on the task of calming the user, using what is called "verbal restraint" instead of physical or chemical restraint, and leaves her in a position to dialogue. So, she asks the doctor to consult her and keep her in his territory.

This report shows the effectiveness and relevance of the work of the social worker, sometimes seen as subordinate in teamwork. Unfortunately, many agents of the profession still persist as subordinates for several reasons: macrostructural issues, especially due to the increasing hiring through outsourcing, defunding, imposed budget freeze (by Constitutional Amendment 95/2016, which provides for the ceiling on public spending) and scrapping of the SUS ; but also, due to factors internal to the category, above all, the secondaryization of the discussion of mental health, in some contexts under the mantle of the "risk of psychologization", which is a real possibility, but which, paradoxically, has tended to intimidate discussions. Furthermore, by adopting clinical perspectives in the foundations of professional practice, whether through clinical Social Work, family therapies or systemic therapies.

The result is that mental health, a socio-occupational space present since the origins of the profession incountry, still has little production in mental health, especially in emergencies. However, the literature in the field provides important elements on the directions of professional intervention.

Our research carried out a survey on Google Scholar, Virtual Health Library-VHL and Brazilian Digital Library of Theses and Dissertations - BDTD, based on the descriptors

2. We established this differentiation of suffering versus mental disorder, going against the hegemonic and conservative discussion of mental health, which tends to put everything in the same package, disregarding the political and natural character of suffering.

ServiceSocial; social worker and psychiatric emergency. For the analysis, what was found based on the topic of suicide, in the dialogue with Social Services, was also included. 8 works were located in Portuguese, carried out in Brazil, considering only those with full availability of the work, 1 being a dissertation; 3 monographs/course conclusion works and 4 articles. The oldest work dates back to 2014. Between 2014 and 2022, there is generally one work per year. The majority have an empirical basis, emergency services located in the state of Rio de Janeiro (Southeast). However, other cities also served as an empirical base, such as Fortaleza (Northeast) and Santa Cruz do Sul (South).

As can be seen even from the titles, a very generic approach to Social Work in psychiatric emergencies commonly prevails, with broad reflections being processed, focused on the importance/contributions of Social Work in this device. When there is a more specific focus, tools or concepts are highlighted, such as the word, reception, welcoming, interdisciplinarity. Or, specific contexts, such as approaching people with suicidal ideation or attempts and Social Service work processes in Emergency Rooms. Or a certain audience, like teenagers.

When exploring each work, three trends are observed, for and about the social worker's professional practice. The first, points to the use of specific tools and concepts, which permeate and call upon the praxis of all professional categories that work in the SUS, treated in a generic way, for example, based on the reception that is part of the National Humanization Policy (Moreira, 2016). Integrated reception is explained, but without discussion about the competencies and responsibilities of Social Service, with a tendency to dilute the place occupied by the professional, in general, with the emptying of the specific contributions of the profession. Even due to the versatility of the activities carried out, more focused on institutional interests and objectives, without a specific work plan for the area, despite the increasing expansion of the number of social workers, as shown by Pimentel (2014).

The article entitled "Psychiatric Emergency Service in the Federal District: interdisciplinarity, pioneering and innovation", authored by Machado; Veras; Frausino and Silva (2021), although they present a pioneering experience on psychiatric emergency in the Mental Health Center of the Mobile Emergency Care Service – SAMU, which has a multidisciplinary team, including a social worker, although focused on interdisciplinarity, it emphasizes the actions of nursing staff, focusing the analysis on the perspective of humanization. Although many works seek to focus on interdisciplinarity, there is a tendency to prioritize actions in one category and dilute the responsibilities and competencies of the others and also collaborative work, carried out in common.

The second trend tends to reaffirm the subalternity of Social Work in teamwork. Illustratively, the dissertation "Valorizing the word in psychiatric emergency: the reception of differences" (OLIVEIRA, 2002), written by a psychologist, brings one of the pioneering experiences guided by psychiatric reform, the Integrated Reception of the Phillippe Pinel Institute, seeking to analyze multidisciplinary team care, focusing on attention to migrants, especially poor northeasterners, who migrated from the countryside to the city.

The service is based on listening in integrated reception, which "determines greater detail of the subject's history, greater attention to relevant aspects of reality" (Oliveira, 2002, p. 7). The service is provided by at least two professionals from different professions, in theory, decentralized from the doctor, to enrich listening, through

Author/Place/	Title	Type of publication/ periodical	Year
Oliveira, PRMO/RJ. FIOCRUZ	Valuing the word in psychiatric emergency: the reception of differences	Master's thesis Public Health	2002
Eliana de Jesus Santos/ Campos de Goytacazes/RJ	Social Service in psychiatric emergency: an analysis from the Airport Emergency Room, in the municipality of Macaé-RJ	Completion of course work	2022
Ivo Jonathan de Andrade Moreira/Rio das Ostras - RJ	Social service in mental health reception: an analysis of the service in the psychiatric emergency at the Pronto Socorro Aeroporto de Macaé-RJ	Completion of course work	2016
Andreia Queiroz Pimentel. Social Service and Mental Health/Rio das Ostras- RJ	Social Service and mental health: a view of Social Service in the psychiatric emergency at Pronto Socorro Aeroporto, Macaé-RJ	Completion of course work	2014
Aline Cristina da Paixão Costa/RJ	Reflections on the work of social workers in psychiatric emergencies	Article in the Social Service in Debate Magazine - UEMG	2020
Machado, DM; Veras, IS; Frausino, LHFC; Silva, JL / Pravida/Fortaleza-CE	Psychiatric Emergency Service in the Federal District: interdisciplinarity, pioneering and innovation.	REBEN Article – Brazilian Nursing Magazine	2021
Nascimento, FER.; Rocha, MGF; Silva, A.P.L.	The scientific production of Social Work on the issue of suicide	Barbarói	2019
Stavizki Junior, C.; Viccari, EM/Santa Cruz do Sul	Social work in the care of psychiatric emergencies: work processes of social workers and residents in the care of adolescent patients with suicidal ideation and attempts	Barbarói	2018

Table 1. Survey of texts on social services and psychiatric emergencies in the public domain

interdisciplinary action.

The social worker participates in the initial screening, focusing on whether it is a return visit or the first time and, based on the reason for the consultation, mainly using individual care for a "selection to check whether the condition would be an emergency" (p. 75). A social assessment is carried out, starting at reception, which denotes power over who and in what situations will be allowed or denied access to the institution and its teams. Thus, the social worker participates in the initial reception of users, to screen, select the directions of the flow of users in the Pinel Emergency Department or in the social assistance network, without being mentioned in the actions with a group of patients and a group of professionals, apparently participating in "secondary" way in multidisciplinary teamwork, which has a stricto sensu clinical core, composed of "psi" professionals, under the imperative that listening is based on psychoanalytic knowledge.

The author shows some limits in the teamwork approach that, when assisting northeastern migrants, this fact tends to persist as invisible, without meriting registration in assistance documents, with fundamental sociodemographic data such as place of birth, education, religion, profession and income, indicators being ignored. which contribute to the characterization of the preponderant social classes in this service and, also, the impacts on illness/mental disorder, as a factor that makes the poor migrant working class even more vulnerable, without family support, uprooted in a metropolis, as analyzed by the author. It is worth highlighting that thisNortheastern migration also carries a weight of expulsion from the previously known world of work, driven by the search for better living conditions in a metropolis, which results in adverse contexts, such as tiny homes, sharing these spaces (including with unknown people).), not to mention the

xenophobia experienced.

Such signs seem to be a demand for the profession of Social Service, which has some axes to parameterize its action, above all, the investigative profile, aimed at carrying out socioeconomic studies on users, surveying their profile and social class condition and, articulation actions with the health team (CFESS, 2014). The social worker in a reception space can also check the way in which the user arrives at an emergency, often with violated rights, even due to the pilgrimage without resolution between different services, which can signal the fragility of the social assistance network and/or bonds.

In the texts by Costa (2020), Moreira (2016) and Pimentel (2014), the precarious working conditions of on-call teams and in particular social workers are explored, in some spaces, without a private room, with outsourced work contracts, without their own instruments, despite what the CFESS resolution 493/2006, which advocates the defense of minimum working conditions. Stavizki Junior and Viccari (2018) point to limits in intrasectoral work, between mental health policy services that, for example, do not discuss cases. This would require the connection between various actors and different knowledge in sharing interdisciplinary care in addition to intersectoral actions, which would enable comprehensive care for the person requiring care.

Nascimento, Rocha and Silva (2019), through a narrative bibliographic review, show that in addition to the low production of Social Services in addressing the issue of suicide, interventions occur in rare and punctual ways, focused on aspects related to the hospitalization and discharge process user's hospital (family support, transportation), referrals to the social assistance network, support for survivors (people who have lost someone to suicide) and aspects related to the basic principles of human dignity (such as clothing and food baskets), highlighting an action referenced to the "bureaucratic nature of professional practice" (p.115) in the face of suicide.

Talking about the act of killing oneself requires knowing the main risk factors, and, in the case of Social Work, especially those that are related to social determinants, in order to be able to act on them, such as: the fact that the user is disconnected from the world of work in this society that centralizes it (unemployed, retired), social isolation, migrants, history of violence, easy access to means of killing oneself, and others. These will often not be taken into consideration, in the biomedical care plan, which reinforces the imperative of a social perspective, in order to reduce the chances of new attempts.

Under the imperative of subordination, dilution and low reflection and systematization of Social Servicein mental health in general, Costa (2020, p. 189) endorses that "Social Service has been depriving the field of mental health of the wealth of its own knowledge, fertile of contributions so that Psychiatric Reform achieves its political ethical project: a egalitarian society, which accommodates differences". It also discusses that professionals have difficulty in "giving concreteness to the principles of psychiatric reform and the professional political ethical project" (p. 190) referenced in professional practice in an abstract way, without mediation from thereality of users' lives.

We highlight the privileged place of the Action Parameters of Social Workers in Health which, among other elements, points to the need for social workers to develop socio-educational actions in their daily professional lives linked to "reflective guidelines and socialization of information carried out through individual approaches, group or collective to the user, family and

population of a given program area" (CFESS, 2009, p. 33). Which, in the context of mental health, would involve favoring and expanding critical knowledge of the social reality of these subjects, enhancing sustainable strategies and resistance to this capture of biomedical discourse, acting to implement the principles defended in their Ethical-Political Project, such as the recognition of freedom as a central ethical value (which presupposes, as previously stated, the possibility of choice, which in turn, presupposes that the subject in question is informed about what these possibilities are), reaffirming the profession's commitment to seeking mechanisms and effective and ethical instruments for access and expansion of rights (Barroco and Terra, 2012).

The third, minority trend, points to the power of social workers in the teams they are part of, signaling more horizontal relationships and innovations implemented by Social Services. Stavizki Junior and Viccari (2018), based on the work processes of social workers and residents in the care of adolescents with suicidal ideation and attempts, report the construction of a protocol for the service, which includes reception/service, information gathering, planning, routing and monitoring. In this sense, they highlight that professional skills "contribute to the improvement of teams and qualification of workflows, providing comprehensive care to users" (p. 126).

Barboza (2023) highlights the importance of developing an articulated protocol forassistance to situations involving people in a mental health crisis, which includes the different points of RAPS – from basic care to emergency services – and different public policies (such as Education, Social Assistance and others). This protocol needs to be publicized and services need to organize themselves to receive this demand.

In emergency services it is alsoIt is highlighted that the Social Service works with users and their family members/companions, mostly women. Families are also part of the crisis and the approach. They are, in general, bewildered, with a feeling of impotence, unprepared to respond to acute contexts and receive difficult news, such as a diagnosis or the need for hospitalization in mental health, especially if it is their first experience with psychiatric emergency and with the mental disorder.

Based on the authors' experiences, teams are not always prepared to communicate with people with mental disorders, preferring, in general, to interact exclusively with the companion. However, as discussing crisis requires considering several elements that go beyond the clinic (such as the individuals' unique stories and the resources available in their family context), contact with this family cannot be limited to a bureaucratic investigation of facts. It is necessary to listen to them, accept the possible reaction to the situation experienced (remembering that affection and aggressiveness usually come to the surface, especially in the face of exhaustion caused by dealing with a person in crisis), helping them to help, since it is for them that the "patient" will return.

As one of the principles of Social Work is the uncompromising defense of human rights, it is urgent to know the different health technologies, including the types of restraint, other than just physical and medication, to propose to the team the guarantee of quality of care. Because, not infrequently, family members are traumatized and have their stigmas reinforced when they witness physical restraints, which in some spaces are carried out by janitors and security guards, without preparation and without humanization, and can lead individuals to death.

What is observed, in some academic works, is that when there is a definition of emergency and crisis, it is associated with the

hegemonic biomedical paradigm, acute cases, user in psychotic episode, suicide attempt. Commonly the processof work in mental health emergencies are organized based on the shift, which is circumscribed as a space concentrated on "immediate intervention" (Moreira, 2016), agile, quick, a place of passage – which if not well understood and managed slips to constantly "contain fires, whose original matches are never actually extinguished", since little or never action is taken to prevent the return and/or worsening of these cases that have proliferated.

Eduardo Vasconcelos (2016), when analyzing Social Service in mental health, highlights the common points between psychiatric reform and the anti-asylum struggle and the political ethical project of theSocial Service (PEP), highlighting the emphasis on the uncompromising defense of human rights. He also assesses that the profession, in the Political Ethics Project, assumed "the struggle to overcome class society and capitalism, in a process of politicization and activism unprecedented and without similarities in any other profession" (p.44).

Based on the analysis of the foundations, he informs that the anti-asylum movement relies mainly on two bases, from a Foucaultian and Basaglian perspective, although other theoretical bases are also present, with the "presence of Marxism being only punctual" (p.45). In turn, in Brazilian Social Service, the hegemonic foundation is the Marxian matrix. Therefore, the marker "social class" is not highlightedin psychiatric reform, despite the fact that poor users predominate in the SUS (Barata, 2008). Much less the discussion of intersectionality between class, gender, race, sexuality, and others[3]. This demands a broadening of the profession's perspective onsocial determinants of health.

> Marx already stated that the real existence of man takes place in the concrete world of concrete human relationships. Man would be his world in society, in production relations, in the conditions that determine his positioning in a given social class. He cannot be seen and treated in his troubles as if he were an abstract being, hidden somewhere outside the world where the changes and destructions that happen in it do not directly impact him (BARBOZA, 2023, p. 195).

In a work by Catiane Santos (2014, p.141), about the intervention of social workers on duty at the Hospital Areolino de Abreu, in Teresina-PI, she concludes that it is "guided by the precepts of psychiatric reform, which call for better care. humanized and articulated with the community service network, with a view to treatment that favors crisis control".

From this perspective, it is necessary to involve undergraduate and postgraduate programs, expanding the scope of the idea of health education to encompass the themes of crisis, death, suicide and humanization in the treatment of people in mental suffering, including the bereaved. (an audience that multiplied in number and demands after the pandemic).

FINAL CONSIDERATIONS

We conclude by pointing out that our intention is not to exhaust the subject, nor to provide magical answers to such a complex subject. But, rather, sharing questions and intellectual anxieties experienced in different occupational spaces with regard to dealing with individuals in mental health crises. It is worth highlighting that the social worker

3. "Intersectionality refers to a transdisciplinary theory that aims to understand the complexity of identities and social inequalities through an integrated approach. It refutes the enclosure and hierarchization of the major axes of social differentiation, which are the categories of sex/gender, class, race, ethnicity, age, disability and sexual orientation. The intersectional approach goes beyond the simple recognition of the multiplicity of systems of oppression and postulates their interaction in the production and reproduction of social inequalities" (Bilge, 2009, p. 70)

profession has a lot to enrich and invest in through research and the systematization of professional practice, and all paths involve the necessary ongoing education within the scope of their work.

There are challenges on the horizon that need to be overcome, such as low wages and precarious working conditions, which make investment in lato sensu training difficult, low investment and precariousness of the SUS – Unified Health System (which limit its policy of training human resources for health and the continuing education policy), limited ability to read reality and little use of the investigative dimension in the socio-occupational space.

Amidst the context of deepening expressions of the social issue, in which State action has been characterized more by social lack of protection and repression than by action through effective public policies which, if never broad and universal, have recently assumed a minimal capacity for intervention, minimizing its most extreme effects and with a predominance of the culture of favor/bossism and truncated citizenship. Follow the tone of responding tocrisis issues in mental health with the peculiar historical confrontation of the social issue (the police apparatus) and the disregard of the parameters for the action of social workers in Health Policy, which assert that the intervention "cannot be limited to the perspective of individualizing situations social" (CFESS, 2014, p. 7),

Thus, there is a long way to go towards building a robust Social Service in mental health emergencies, qualifying critical and propositional responses that grasp the multiple refractions of the social issue in light of the totality, doing justice to what the category sought to break.with the reconceptualization movement and denying positivist approaches that individualize processes that are collective and that psychologize illnesses that are also social, obscuring their collective dimension, as well as de-historicizing and depoliticizing their intervention.

Finally, several demands for Social Service were highlighted following the emergency, including: strengthening family ties, to avoid institutionalization and ensuring their presence with unaccompanied people with mental disorders (brought by SAMU or police); actions in favor of humanized assistance; coordination activities with the intra and intersectoral social assistance network; the socialization of information, via guidelines; and others that continue to be pregnant but not documented.

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