# *The homeless population and a psychosocial* care network: walking on the tightrope of care

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Abstract: The interface connecting street and mental health increases vulnerabilities, hardening the guarantee of the right to health. The objective was to analyze how the health care of the Homeless Population is provided within the scope of the Psychosocial Care Network in Natal/RN. It is qualitative descriptive-exploratory field research. A focus group with 10 professionals from this network was created, and a semi-structured interview with 13 homeless people. The results were submitted to thematic content analysis, systematized into two categories: 1) The bare life of the Homeless Population; 2) The hindrances of the care network and the life flows of the Homeless Population. There is an invisibility of this population or an association with stigmas and labels. A street that segregates and a bare life are outlined. In this condition, these people face numerous impediments in accessing the health network in this scenario. There are numerous challenges faced by this network against the dissonances of a policy that, at the same time, cares for, segregates, isolates, protects, and surrounds. Obstacles going against the Brazilian Psychiatric Reform and potentialities that favor its realization were identified, while it finds a way "on the tightrope".

➤ **Keywords:** Homeless Population. Mental health. Access to Health Services.

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## Introduction

The definition of Homeless Population (HP) is complex and its denomination is polysemic. In the international scenario, expressions such as "vagrant" and "unsheltered" are used to designate the phenomenon, representing specificities of the historical, cultural, political, legal, and economic contexts common to these countries (United States, Canada, United Kingdom, and New Zealand). In Brazil, the "homeless population" emphasizes the procedural character of life on the streets and the situation of these people regarding the street, not the "mere absence of a home" (PAIVA; RAMOS; GUIMARÃES, 2018).

There is a lack of official public data on this population, which ends up reinforcing their invisibility. The national census that provides a profile of this group still dates from 2007 and 2008, with 31,922 homeless people having been identified (BRASIL, 2009).

According to the figures from a registry system, the Cadastro Único, for social programs of the Brazilian federal government for 2019 (it should be noted that this is extremely underreported since most homeless people do not access government programs), there has been an increase, in the last seven years, of over 16 times in the number of homeless people in the country, from 7,368 families in 2012 to 119,636 in 2019 (BRASIL, 2019). A survey by an institute of economic research, the Instituto de Pesquisa Econômica Aplicada (IPEA), pointed to the existence of 222,000 homeless people in Brazil (IPEA, 2020).

In the city of Natal-RN, which took part in this survey, there are an estimated 2,200 homeless people. A survey developed in 2013 and 2015 brings a profile of the HP in this city: they are mostly males (61%), with a mean age between 26 and 45 years, single (72.3), incomplete elementary school (50.9%), black (43.4%), and born in Natal (41.5%). Among the reasons for living on the streets, different situations stand out, such as domestic violence, family breakdown, unemployment, migration, and diseases in general (HIV, mental illness, etc.). These reasons do not appear separately, indicating a complex and particular framework regarding the life history of these people (AMORIM; NOBRE; COUTINHO, 2019).

It is necessary to clarify that discussing the interface between mental health and the homeless population does not imply a simplistic association; it is, above

all, a matter of recognizing the density of vulnerabilities that transversalize these situations and identifying policies and strategies in the face of the problem of social exclusion.

Historically, health policies, as well as other public policies, have been little concerned with the HP, a problem that is not specific to Brazil. In other countries with universal health systems, such as the United Kingdom and Canada, the difficulties of this population in accessing these services and the existence of structural and behavioral barriers that compromise their entitlement to the right to health stand out (AGUIAR; IRIART, 2012).

The construction of a proposal of care for this public at the national level was the result of the accumulation of years of debate and successful experiences - such as a health strategy for homeless families, the Estratégia Saúde da Família Sem Domicílio and the social program A Gente na Rua, in São Paulo, in addition to religious initiatives (as the Pastoral do Povo na Rua, 1970/1980) - besides the valuable role of the organized movements of homeless people (PAIVA *et al.*, 2016).

The alleged "crack epidemic", in 2009, called attention to this population, albeit from a hygienist perspective that focused on a strategy of social control and criminalization of poverty. A simulacrum of this "epidemic" was created, with no scientific evidence. Lancetti (2015) criticizes its logic, calling it the "perverse triad of multicausality", which seeks to combat the agent (in this case, crack), hosts (the homeless users), and the environment (the territory occupied by the hosts), making invisible what is behind this circuit of production-commercialization-judicialization-repression-therapeutic-media exposure.

In this context, fighting crack became a priority on the Psychiatric Reform agenda, with the expansion of mental health services, primary care, and the expansion of the care network. One of the strategies of the national plan for this situation, the Plano Nacional de Enfrentamento ao Crack, was the creation of itinerant clinics roaming the streets, inspired by a successful local experience in Salvador-BA (1999). These clinics were assigned to the National Mental Health Coordination, and, afterward, transferred to the National Attention Coordination, and named Street Clinics. This change was due to the demands of the HP, which requested to be seen in its entirety, in addition to problems related to psychological disorders, alcohol, and other drugs (HINO; SANTOS; ROSA, 2018; LIMA; SEIDL, 2015).

Public policies involving the interface between the street and mental health are sometimes contradictory; so, at the same time that some welcome this population, others segregate/exclude them (MARTINEZ, 2016).

Although the Brazilian Psychiatric Reform (BPR) represents a major milestone in the reorientation of mental health care (Psychiatric Reform Law n. 10,216/2001), much remains to be done to ensure non-imprisonment care, and it is necessary to break with the contradictions within the state apparatus itself (HINO; ROSA, 2018; RAMOS; PAIVA; GUIMARÃES, 2019).

The disorganization in this scenario is highlighted, with so many policies and programs often with divergent rationales about the phenomenon. The Psychosocial Care Network itself combines non-governmental (Therapeutic Communities) and governmental (Homeless Care Units) services, which, on top of that, have a contrasting care model (RANZONI; COSTA, 2015). In this direction, there is the current phase of psychiatric "counter-reform", a term that alludes to the agenda of setbacks of the mental health policy started in 2015. Its dismantling intensified with the reformulation of the National Mental Health Policy (Ordinance n. 3,588 /2017), placing again the centrality in psychiatric hospitals (Asylums), in the expansion of funding, and legitimation of Therapeutic Communities (NUNES *et al.*, 2019).

Given this scenario, which makes it difficult to implement the Psychosocial Care Network (PCN) in the territory, we question how to care for the homeless population in this network. To reflect on a service that might happen, depending on a whole conjunction of workers and resources, we make use of the tightrope metaphor. The term was originally used by Dalmolin (2006) when studying the cartographies of two subjects with psychological distress; Aldir Blanc and João Bosco, in the song "O bêbado e a equilibrista" (The drunk and the tightrope walker, in English), also mention an embodied figure of hope, that stays the course on the tightrope.

We agree with Martinez (2016), in stating that the construction project of this network is not a simple undertaking; there are several services, each with its institutional projects, different teams, professionals from the most varied backgrounds, conceptual divergences, dissonances, and few consensuses. It's a constant walk on the tightrope.

This article aims to analyze how the health care for the HP is provided within the PCNs in Natal-RN. This study contributes by identifying forms of a renewed existence of this population which, in a manner much similar to the embodied hope

balancing on the tightrope that represents the gaps in mental health care, blooms through all the chaos through individual and collective resistance.

## Method

This is field research with a qualitative approach and a descriptive-exploratory nature. Considering the structure of the PCNs in the city of Natal-RN, services representing the five local Sanitary Districts were selected, as well as the following components of the PCNs: Primary Care, focused on individuals and families – in the form of a Núcleo de Apoio à Saúde da Família (NASF); two teams of street clinics – the Consultório na Rua (CnaR); a community center; a unit administering general care for the population, the Estratégia de Saúde da Família (ESF); Specialized Psychosocial Care Center – a Centro de Atenção Psicossocial para Álcool e Drogas (CAPS AD) type II and III, a CAPS type III; Urgent and emergency care – a 24-hour Unidade de Pronto Atendimento (UPA); and Hospital Care – a Psychosocial Care Unit located in a General Hospital.

Ten professionals from the PCNs and 13 homeless people who use these services have participated in this study, they were selected according to inclusion and exclusion criteria. Professionals were only included if they were working in the PCNs for at least one year, had experience in a substitutive mental health service, were over 18 years old, were available and interested in participating in the research, in the focus group session. Homeless participants were included if they were 18 years old, lived on the streets (in shelters or not), and agreed to participate in the semi-structured interview. Professionals who were on vacation, study, or medical leave at the time of the field research and HP without a history of utilization of the PCN service were excluded.

For the construction of the data, 22 visits were made to the health installations at the site of the investigation, from August 2018 to January 2019, using a focus group technique with professionals and semi-structured interviews with the homeless participants.

The interviews and the focus group were conducted based on a script prepared by the main researcher. The focus group session had ten participants and lasted 2h17min. The 13 interviews totaled 4h33min of recording. Their audio was recorded on a cell phone and MP4 player belonging to the main researcher, who also transcribed them. It should be noted that the sample size was conditioned to the theoretical saturation criterion (FONTANELLA *et al.*, 2011).

Data analysis was guided by the operative proposal by Minayo (2014), resulting in the formulation of two analytical categories: 1) The bare life of the Homeless Population; 2) The hindrances of the care network and the life flows of the Homeless Population.

This article is one of the outcomes of the thesis developed by the first author for the Postgraduate Program in Public Health at the Federal University of Rio Grande do Norte. The research project was submitted to the Research Ethics Committee (REC) of the Onofre Lopes University Hospital of the Federal University of Rio Grande do Norte (HUOL-UFRN) and approved under Opinion No. 807,659. It meets the recommendations of Resolution 466/12 of the National Health Council and complementary ones. Aiming at the confidentiality and anonymity of the study participants, we have adopted the letter "U" for the HP who use the PCN services and "P" for the professionals.

## Results and discussion

### The bare life of the Homeless Population

The historical and cultural production of exclusion uses the homeless population as the new face of deviants in our society. Considered dangerous because of the consumption of alcohol and other drugs, those who deviate from the establishment end up being displaced to the borderline of humanity. All this symbolic load is part of the process of criminalization and extermination of these people (ALDEIA, 2018; LONDERO; CECCIM; BILIBIO, 2014).

In this context, bare and killable life is outlined. For Agamben (2010), bare life is defined as worthless, in which individuals are considered "incurably lost". This life is stripped of all rights, thus, it is in a constant relationship with the power of those who are sovereign, and it is for them to decide on the threshold of what is a worthy or unworthy life.

With this understanding, the purpose of associating a "bare life" with that of the HP is to highlight the similarities in the processes of exclusion and elimination. The appearance of those in the HP is close to that of bare life, although not so extreme. The street becomes a place of exposure, danger, humiliation, harassment, and naturalized violence. Human rights seem to fade and these lives are placed far from humanity itself, closer to a state of animality. Disconnected from a legal status,

they see themselves as desolate, victims of everyday violence, often made invisible (DE LUCCA, 2016).

The symbolic production of a bare life ends up legitimizing violence. From this perspective, elements that reinforce the stigmatization of the HP were identified in the PCN services in Natal-RN, as highlighted in the excerpts:

> When I arrived at the CAPS unit I was kinda rejected [...] maybe 'cause of the **dirt**, **the mental illness** [...] I felt the contempt [...] people are not prepared to accept mental illness [...] **they think you're being devious** (U).

> Because they go by the looks... and you're there, looking like a hobo, then you're a nobody there (U).

For Medeiros (2015), dirt is eminently social and is associated with pollution, impurity, disorder, legitimizing hierarchies, and leading to exclusion.

The psychiatric discourse still reinforces this conception, associating mental illnesses with a deviation from morality and social danger, as highlighted in "they think you're being devious" (U). Deviants receive a mark, an infamous sign that makes them the target of prejudice and contempt, disqualifying them as human beings (BASÁGLIA, 1985). Becker (2008) already warned that deviance is a socially elaborated phenomenon and is individually assimilated through social role-playing games.

The HP in Natal-RN seems to be marked by labels such as those of addiction and drug use "because one of them [professionals at the PCN] will speak to another one 'he is an addict' [...] 'for us here, you are still a junkie" (U).

Terms such as "addict/junkie" or "chemical-dependent" are fruits of a complex production anchored in prohibitionist, inappropriate, counterproductive, and harmful laws, which serve more to hamper rights than to protect the citizen (MEDEIROS, 2015). Using these terms also refers to a prohibitionist context that goes against internationally validated Harm Reduction strategies. This approach has proven insufficient to address health inequities and promote access to health care for the homeless population (PAIVA; RAMOS; GUIMARÃES, 2018).

It is necessary to denaturalize the simplistic association of cause and effect in which every discussion about "drugs" turns all eyes to the streets. These issues imply much more strategies of subsistence or alienation of the homeless situation itself than defining this population contingent (PAIVA; RAMOS; GUIMARÃES, 2018).

In the context of "the war on crack" in the late 2000s, the HP emerged as the junkies, the zombies, and health policies and projects aimed at this public brought the mark of ambivalence (MARTINEZ, 2016).

This dichotomy was also identified in the reality of the PCNs in Natal-RN, when the actions eveloped with the HP range from mere guardianship to police cases, as observed below:

> He (HP) would stare at people like that! As if he didn't believe he was being welcomed, that he was no longer invisible, that people (professionals) would say to him, 'Shall we wash your hands? Shall we trim your nails? You will have to wash your hands when you eat, pay attention, right? Let's clean this up' (P).
>
> I was best welcomed at the UPA [...] Because they took care of me, I was pampered, like a child (U).
>
> They have already called the police there, because of me [Primary Care Unit - UBS] [...] the officers have already beat me up there (U).

The first two statements reinforce an excess of assistance that protects and infantilizes the HP, going against the process of promoting their autonomy. At the other extreme, there is their repression and criminalization.

From the last report above made by a User, perilousness and the idea of "dangerous classes" are highlighted as part of the process of a slow and gradual elimination of excluded groups. Coimbra (2001) already warned of this association between poverty and dangerous classes, with historical roots in the process of urbanization and the social hygiene movement in the country, with the belief that the subordinate classes were responsible for diseases, insecurity, threats, and violence. It is urgent to pay attention to this conceptual misrepresentation between poverty, mental illnesses, and "dangerous classes", that end up reinforcing the process of exclusion and extermination of the HP nowadays.

Bare life is evident and the HP is associated with perverse visibility that reinforces stigmas and prejudices. In the eyes of outsiders, that are "part of the establishment", the street can be interpreted as a space for vagrancy, for the unemployed:

> People arrived and were put ahead of me in the line. Then I would talk to her (professional at the front desk) and she would say something like – 'are you homeless? If so, you can wait' -- it's not because I'm homeless (User) that I have nothing to do, right?

There are beacons of pure violence operating within the institutions; there is another kind, more subtle, in which means of adaptation to a specific model of

citizen are erected. For those who are on the borderline of humanity, violence and exclusion are justified as being necessary, the first being a consequence of the educational purpose, and the second of guilt or illness (BASAGLIA, 1985). Thus, the lives of the homeless present themselves as the ones that can be violated, therefore, it draws attention not to an efficient justice system, but the very statute of killability described by De Lucca (2016).

It is not death on the street that bothers city dwellers, but life and its uncomfortable living, its slow death (DE LUCCA, 2016). The presence of the HP in some services seems to cause discomfort:

> This man [HP], I [professional at a family care unit] don't like him, because, every time he comes here, he is very dirty and his bandages are filthy [...] Then we asked (another FHS professional) if he doesn't have water to take a bath, and he [User] said: when I am allowed to, I take a bath in the Alecrim cemetery (P).

The difficult balance on the tightrope is evident in the speech above, in the challenge of caring without the imperative of social hygiene. It should be noted that these workers operate in a controversial territory: on the one hand, they must care and, on the other, they repress, often due to a poor educational background or for being ill-prepared by their universities to act in services aimed at welcoming lives trying to escape from the misery of society (LANCETTI, 2016).

## The hindrances of the care network and the life flow of the Homeless Population

The consolidation of Psychiatric Reform, in several countries of the world, occurred with an emphasis on the construction of a care network. Since the 1970s and 1980s, the decentralization of services has been advocated and the universalization project points to health networks (MARTINEZ, 2016). Nevertheless, there is evidence from several countries that psychosocial care networks (RAS) improve the health and economic results of health care systems; hence, a universal movement in search of their construction begins (MENDES, 2011). In this direction, Decree 3,088/2011 must be mentioned, which regulates the thematic (and priority) network of mental health care, the Rede de Atenção (RAPS) (BRASIL, 2011).

Currently (period of data construction), the city of Natal has a total of five CAPS in its network: CAPS i II Oeste; the CAPS II West; CAPS II AD North; CAPS III East, and CAPS AD 24h East (DIÁRIO DE CAMPO, 2019). Regarding the

Primary Care component, the municipality has a coexistence center, three teams for the Street Clinic, and two teams from NASFs 1, in addition to 56 UBS units, 70% of which are models of ESF (DATASUS, 2018).

In Urgent and Emergency Care, there are the Emergency Care Units (four UPAS), Mobile Emergency Care Service (SAMU), in addition to the Emergency Room (PS) of Hospital João Machado (HJM); Residential care on a transitional basis (under construction) and a Health Shelter Unit (DATASUS, 2018). And, in the Hospital Care component, there are specialized wards in general hospitals (HUOL) and beds available in a general hospital. Regarding the deinstitutionalization strategies, there are three Therapeutic Residential Services, and no initiative was identified regarding the Psychosocial Rehabilitation component (DATASUS, 2018; RAMOS, 2018).

The city of Natal is divided into five Health Districts, North 1 and 2, South, East, and West, with a greater concentration on social assistance and health services, more specifically for the HP, in the East. It is noteworthy that, in this district, there is a large number of HP, given the proximity to the shopping center and other institutions that facilitate the tactics of surviving on the streets.

It is important to highlight that in the North Zone of Natal a care void was identified regarding this installation and other PCN services, as highlighted by the research subjects:

> The design [...] is plain, and beautiful, just as the SUS principles are, they are plain and beautiful [...], not only equity, but other SUS principles are going astray. For the PCNs, you know, in the North, we only have one CAPS AD for a population of 200,000 inhabitants, so, in fact, it is a fragile network (P).

> Because we are actually not a network at all, it is merely on paper. In practice, it does not exist! [...] And to make this link, we are needed, because, actually, we are the network! (P).

The statements of the professionals above make us question: What kind of network is being designed? Why are SUS principles so close to a utopia?

The first two statements raise awareness of health inequities arising from a model of decentralization and unequal regionalization that is based on a geographically delimited territory, making access and accessibility to health services difficult for the most impoverished social strata.

As for the accessibility and universality of SUS actions and services towards homeless people, it can be inferred that these principles are going astray, as mentioned in the statements.

It is known that mental health services have difficulties in establishing strategies to host the HP. This occurs because of problems in the staff and public policies. These issues are related to the organization of actions on the street and their inflexibility when faced with the behavioral complexity of this population, in addition to the absence of more substitutive spaces to accommodate such demand (BORYSOW; FURTADO, 2013).

Among the barriers related to the access of the HP to the PCNs in Natal-RN, stigmas and labels that disqualify them as legally entitled to it (as discussed above) are highlighted; besides the geographic notion of territory, that limits the service to an ascribed area:

> The network sees what it can see [...] And when we start this articulation between a network of care (psychosocial) with the primary care, we are faced with something very disturbing that are those "out of range" (P).
>
> In the care program for families (ESF) there are a lot of territorialization issues. Should there be? Unfortunately, because the SUS is federal, there has to be this territorialization, then we come back to discussing the data, the transfers (P).

The expression "out of range" is part of the established logic that uses these terms in an attempt to make some people invisible and sustain a wrong impression that access to such services is guaranteed, constituting a major challenge for the reorganization of the care network. Similar results were identified in a study on the subject, and this population was classified as "leftover", "astray" and "remnants" (LIRA *et al.*,2019).

In the last excerpt above, there is a reinforcement of the theoretical basis of the RAS guided by an arborescent model that does not follow the dynamics of a living territory (BORGES, 2015).

It is possible to give rhizomatic use in relation to the concept of territory, as described by Deleuze and Guattari (1995). From this perspective, health actors consist of clinical devices for the production of subjectivities capable of provoking a difference in the homogenizing panorama, instituted by the capitalist subjectivation mode (GUATTARI; ROLNIK, 1996). However, the crystallized and bureaucratic structures in the formal mental health network in Natal-RN end up putting the HP away. Although Ordinance 940/2011 (BRAZIL, 2011) exempts the HP and gypsies from presenting documents for receiving assistance from the SUS, their absence is still an impediment to access:

> I had difficulties accessing all [PCN services] because I had no documents (U).
>
> My SUS card is a problem because I've been waiting for more than a month [...] I missed the day to do my exam [because] they didn't let me into the room to do the cytology exam, I could only enter if I had the proper documentation (U).

Difficulties in accessing health services related to their bureaucratic issues, the requirement for specific documentation, the reduced number of professionals, structure, and supplies, the absence of fixed residence, the social despise for the HP; in addition to the obstacles to equity in accessing these services, the access restricted to spontaneous demand, and limits on intersectoral action, some aspects have already been debated in publications in the area (LIRA *et al.*, 2019; CARNEIRO-JR; JESUS; CREVELIM, 2010).

The tightrope is pulled beyond the theoretical-organizational construct of the health work process. The HP, in its inventive movements, draws lines that are sometimes invisible and undertakes its trajectories that are not restricted to health services, as a privileged place of search.

> It's like what many brothers (religious entities) do for those who live on the street, two or three cars full of food arrive at night, and there is no government help [...] last week was like this, they've brought the car, bathed us, gave everyone clothes (U).
>
> I was with some people who passed by on Friday [...] in Nordestão (near the supermarket), it is a doctor who takes care of homeless people [...] I was given some medicine for high blood pressure [...] there's a broth for us, a bathroom and everything (U).

These excerpts indicate that users seek alternative points of social support in entities and people linked to non-governmental organizations, communities, and religious collectives. A finding that, on the one hand, highlights the resistance tactics by which the HP develops a survival network on the streets; on the other, it denounces the specific actions of a charitable nature (without belittling them), which gain space in the absence of public policies, obscuring the right to health. Superficial relationships are established with no bond and no guarantee of continuity of care.

There are, therefore, numerous challenges for the RAPS to ensure comprehensive health care for the HP, especially when psychological distress and problems related to the use of alcohol and other drugs are associated with them, increasing vulnerabilities, requiring of the network new flows and possibilities of meeting different needs.

The challenges for the HP care are amplified by the disarticulation and lack of structuring of the RAPS itself, which instead of being integrated, has disconnected

lines and isolated points formed by services that are barely known and poorly defined flows, as denounced by professionals:

> The points, units that provide services, were not created as they should have been, and neither was the connection among them (P).
>
> What we have is incoherent (P).
>
> There is no clarity of flows (P).

The network flows are not well defined. Of the ten services visited, only two have document flows in the elaboration phase. Overall, such flows are unclear. Martinez (2016) already warned that there is not just a network, but networks, which are weaved to each other all the time, involving people, cases, papers, protocols, materials, equipment, etc. Hence, the importance of planning actions, case studies, articulations, and partnerships because they also move and open flows.

The flows of the formal network that depart from the ESF and the CnaR towards the CAPS seem stagnant in the face of their overcrowding. This reality was also found in studies by Martinhago and Oliveira (2015), who called this tendency "CAPSization", using the term "enCAPSulate", to express the transinstitutionalization of users in CAPS.

The role of the CAPS is recognized as the main instrument for implementing the national mental health policy, which is not materialized only with implementing a service - the CAPS itself -, but by the weaving of a web of care that is not carried out only in one place, but with a wide range of alliances, including different social segments, services, and actors (REIS, 2010).

The absence of well-defined flows, more spaces, and the structuring of substitutive services or an intersectoral support network to accommodate this demand end up reinforcing the already known change into a psychiatrization circuit.

In a meeting at CAPS III, a case of a user who sought the aforementioned service during the night shift was discussed. In the event, the emergency team, as they did not have a psychiatrist in this shift, immediately referred the user to a local psychiatric hospital – Hospital Dr. João Machado. Ambivalent professional attitudes were observed in this situation since part of the professionals defended a standard flowchart that referred users on night shifts and weekends (when the service does not have a psychiatrist available) to the aforementioned hospital, while the others complained about using an asylum and bet on a less drug-induced and psychiatric approach (DIÁRIO DE CAMPO, 2019).

It should be noted that the minimal multidisciplinary team in CAPS III (open for 24 hours) is made up of two psychiatrists, one nurse, five university-graduate professionals – psychologist, social worker, occupational therapist, pedagogue –, eight health undergraduate-level professionals (nursing technician or assistant, administrative technician, educational technician, and an artisan (BRASIL, 2004). Therefore, substitutes for this place are scarce, mainly because it is properly equipped with human resources and materials to welcome subjects with psychic disorders. On the other hand, it is necessary to pay attention to the results that come from asylums, manifested by the need for control and social adjustment, giving little attention to human suffering, traditionally placing it within the crisis-emergency-internment circuit (DALMOLIN, 2006).

The difficult balance on the tightrope for the care of the HP in PCNs is evidenced. There are numerous partnerships to be made, gaps that can be filled, and paths that must be cleared for the network to be made. Within this proposal to connect points, articulate services, open flows, and establish bridges between the street and the services, the work of the teams in the Street Clinics stands out.

When assessing PCNs in Natal-RN, the work of the CnaR teams appeared as a resistance force, called by Lancetti (2015, p. 77) the "new kind of care [...] not less intense, but undoubtedly fast-moving, transiting through the harsh, legalistic, and brutal part of society that another part does not want to see". About the work of CnaRs, the research subjects say:

> We (CAPS AD) have a good articulation with the girls from the Street Clinic (P).
>
> These girls from the Street Clinic work well, they are nice, they make SUS cards [...] this service is going well, there is no prejudice [...] they like to talk to me, they laugh, we tell jokes [...] they measure my blood pressure, I am well taken care of (U).

Corroborating this, studies highlight the construction of bonds, qualified listening, dialogic relationship, intersectionality, interdisciplinary work, and shared care as essential elements in the work of the CnaRs (HINO; SANTOS; ROSA, 2018).

The power of the work by the CnaRs is recognized, but there are difficulties to be overcome as reported by professionals:

> Prejudice of other services towards professionals working in CnaRs; lack of health inputs; a great effort by professionals to respond to the demands of the users; absence of a room for the CnaR team; difficulties in intersectoral work and the access to other PCN services by the HP; in addition to the fragility of the employment contract due to the absence of hirings and career plans for the area (P).

Similar to these findings, Kami (2016) highlighted that among the elements that hinder the work of the CnaRs, there is the suffering these professions undertake because of the lack of respect for the human rights of users; team effort, and the struggle to meet user needs; difficulties in the access of services in health units; lack of acceptance in civil society for the HP; lack of inputs and materials; and precariousness of support from some partner institutions.

Among the difficulties in the work of the CnaRs in Natal-RN, there is the lack of knowledge regarding the true role of this service by the other members of the health network, as revealed in the following statement:

> The CnaR team is called to transport the HP in emergencies when the transport should be done by the SAMU; they are also called to solve social assistance issues and even as a "passport", when the HP can only be accommodated in the other PCN services when accompanied by this team (P).

It is important to emphasize that a Street Clinic has the function of organizing the Network, inserting the care of the HP in the most varied spaces of the SUS, and other public policies. Facing it as a specialized service for the HP would only reproduce the exclusion that these people already suffer in the city (PAIVA; RAMOS; GUIMARÃES, 2018; LOPES, 2014).

There are, therefore, numerous challenges faced by substitutive services for the health care of the HP. Despite the various barriers that go against the Reform, the embodied hope, now walking the tightrope, is challenged to stay the course.

## Final considerations

The study allowed us to know how the PCN services in Natal-RN have been articulated from the perspective of comprehensive care for the Homeless Population. More than identifying the obstacles and limitations of this network, it was also sought to recognize the instituting forces capable of enhancing a new architecture of public policies that favor the inclusion of diversity and the opening to new subjectivities.

We sought to point out how the PCNs see the Homeless Population. In "the bare life" of the HP, this public has been made invisible and associated with stigmas and labels. In this context, the space of a street of segregation, of killable life, is outlined. Numerous barriers make it difficult to promote care, and despite these, potentialities were identified in the forces that resist the "tightrope", relentlessly. There is more emphasis on tuning than on noises for staying the course on the "tightrope" and, on

the development of care practices that resist, as the embodied hope would, amid the dissonances and ambivalences of the network itself.

The resistance must also start from a vigilant awareness of the political moment we are going through, focusing on defending democracy, the fight against the weakening of the SUS, and the defense of the principles of the BPR. In addition, the living condition of the homeless population places a challenging situation of inequities in the scenario of public mental health policies, and advancing the construction of a model of care aimed at this population segment will require considering the different ways of living and circulating in the city, by adopting strategies that favor the inclusion of diversity, openness to new subjectivities, a counter-conduct capable of resisting the investitures and abductions of power.

It is also intended to bring the sound of the voices that follow the flow of this network and, in the counter-flux, let other voices emerge, eager for transformation. Thus, we hope that the results of this study can contribute to the constant (re) formulation of public policies that dialogue with the real needs of the homeless population. May the street hear a song from the city, may this song be a peaceful one.[1]

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## Note

[1] I. K. S. de Paiva: project design, data analysis and interpretation, writing and guaranteeing the integrity of any part of the work, relevant critical review, and approval of the final version. J. Guimarães: relevant critical review and approval of the final version.

# *Resumo*


## *População em situação de rua e Rede de Atenção Psicossocial: na corda bamba do cuidado*

A interface rua e saúde mental adensa vulnerabilidades, o que dificulta a garantia do direito à saúde. Obetivou-se analisar como se dá a atenção à saúde da População em Situação de Rua no âmbito da Rede de Atenção Psicossocial em Natal-RN. Pesquisa de campo, qualitativa descritivo-exploratória. Realizou-se grupo focal com 10 profissionais dessa rede e entrevista semiestruturada com 13 pessoas em situação de rua. Os resultados foram submetidos à análise de conteúdo temática, sistematizados em duas categorias: 1) A vida nua da População em Situação de Rua; 2) Os nós da rede e os fluxos de vida da População em Situação de Rua. Tem-se uma invisibilização da população em situação de rua ou uma associação a estigmas e rótulos. Delineia-se o espaço da rua de exceção, vida nua. Nessa condição, essas pessoas enfrentam inúmeras barreiras no acesso à rede no cenário estudado. Destacam-se inúmeros desafios da rede frente às dissonâncias de uma política que ao mesmo tempo que cuida, segrega, isola, tutela, cerca. Identificaram-se entraves que caminham na contramão da Reforma Psiquiátrica brasileira e potencialidades que favorecem sua efetivação resistindo na "corda bamba".


➤ **Palavras-chave:** População de rua. Saúde mental. Acesso aos serviços de saúde.