# Centro Pop and Intersectorality:
## the problem of the articulation with the mental health network

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**Abstract** *Mental health care for the homeless population (HP) is an important topic but supported by several studies as underexplored. Given the complexity of this demand, there are several services in the SUS and SUAS that require an intersectoral work articulated in a network; however, studies point out several flaws in their performance. In this secondary statistical study, we propose a discussion of this articulation based on the results of the SUAS 2019 CENSUS. Participants: 228 Centro Pops, from 25 Brazilian states. Variables from the block of questions related to the articulation of the Centro Pop with CAPS and hospitals were chosen for analysis and the Multiple Correspondence Analysis (MCA) was used to establish associations between variables and their categories. The results show a moderately satisfactory articulation with the CAPS and unsatisfactory in relation to the hospitals. It is concluded that the articulation of the Centro Pop with the CAPS is relevant mainly in large municipalities, and incipient with hospitals, regardless of the population size. The flow protocol is highlighted as an important tool for effective intersectoriality in health care for the HP and the right to the city, and longitudinal studies on the subject are suggested, to aid in decision-making instances.*

**Key words** *Homeless, Intersectorality, Mental health, Psychosocial care, Networks*

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## Introduction

The characterization of the homeless population (HP) is characterized, among other factors, by great social vulnerability and health problems, especially the abusive use of psychoactive drugs and intense psychological distress[1-3]. The Psychiatric Reform in the Brazilian context, resulted in a great change in the lives of people with intense psychological distress, especially those who were institutionalized for a long time, changing the previously established paradigm from asylum logic to the logic of care in freedom, with the enactment of Law N. 10.216/01 being the most important example of this reorientation[4].

This epistemological change is responsible for promoting the basis on which public policy on mental health is established in Brazil and, at the same time, it reflects on other public policies that safeguard approximations with the Psychosocial Care Network (RAPS, *Rede de Atenção Psicossocial*) - Ordinance GM/MS No. 3.088 of December 23, 2011 – and need mutual feedback and intersectoral work. This is the case, for instance, with the HP's health care[3]. Thus, there is an important challenge in the care of this population, for the Brazilian mental health public policy, especially for RAPS and, especially, for the Psychosocial Care Centers (CAPS, *Centros de Atenção Psicossocial*), considering the principles of universality, equity and integrality of the Brazilian Unified System of Health (SUS, *Sistema Único de Saúde*), which provides access to health care for all Brazilians without distinction[5].

In the social field, the fight for the HP's rights has gained the force of law, when the Organic Law of Social Assistance (LOAS, *Lei Orgânica da Assistência Social*) is modified in Brazil and starts to include under its aegis the people who are homeless in 2005. In this context, in the scenario of the creation of the National Policy for Homeless People[6], the *Centros Pop* were created, which are services that act as a gateway for the HP in the medium-complexity care network of the Unified Social Assistance System (SUAS, *Sistema Único de Assistência Social*) and possible facilitators of intersectoral actions for the field[7,8].

The *Centro Pop* is a Specialized Reference Center for the HP, which attends to families and individuals, offering everything from listening and initial embracement, to attention to immediate basic needs such as: showering, food, space for washing clothes and referrals for the obtaining of identification documents. The main dimensions of work at the *Centro Pop* are: Embracement,

Specialized Monitoring and Network articulation, that is, intersectoral work[7]. It is important to mention that the intersectoral demand for care for this population has been discussed for some decades, as suggested by a research published in 1998[9]:

*Even recognizing that the effective establishment of an articulated policy between the government and civil society has been the subject of several discourses, as the most effective way of intervention in this social situation, the construction of a service network, consisting of public and private institutions, consolidating effective partnerships with the State, as the most adequate assistance response to this population group, remains a great challenge for the different social agents* (p. 61).

In the case of health care for the HP, the national literature continues to highlight the need to develop and strengthen an intersectoral network to provide better care[10]; however, the concept of intersectorality appears as a problem regarding its own terminology, due to its polysemy[11,12]; thus, seeking to minimize this impasse for the specific purpose of this discussion, we will use the concept of intersectorality as presented by Junqueira: "It is a new logic for city management, seeking to overcome the fragmentation of policies, when considering the citizen as a whole. This involves the human/nature and human/human relations that determine the social construction of the city" (p. 42). In short, it is to "guarantee equal access to the inequitable".

With the tendency towards the concentration of the HP in large urban centers[7,14], care for this population has become even more complex, considering the mobilization difficulties in metropolises and large cities and the displacements inherent to the HP[8]. Moreover, people who are homeless usually seek health services when their physical condition reaches critical levels, resulting in a demand for emergency care[8,14,15]. In relation to these issues, we ask ourselves how the HP care services are articulated to meet the health needs of this population, with an emphasis on mental health and emergency care, considering access to health care for this population segment, as a premise of the right to the city[16].

Although the socially relevant topic of the HP's health care in the context of RAPS, few studies are found, with qualitative, exploratory and small-range studies standing out, since the focus is on a few teams and services[3]. Considering the above, we justify the relevance of this study with the proposal to carry out a quanti-

tative analysis of the intersectoral articulation between the *Centro Pop* and mental health care services (including a general hospital), using data from the SUAS 2019 Census, in an attempt to make it visible some gaps that still exist regarding the intersectorality between mental health care and its intersection with SUAS.

## Method

### Participants

228 services that care for the homeless population from the Unified Social Assistance System in Brazil (*Centros Pop*). The study included the participation of services from 25 units of the federation.

### Design

Experimental, cross-sectional, retrospective.

### Instruments

This study is a secondary analysis that uses the SUAS 2019 Census database[17], available in Excel format on the website of the Ministry of Citizenship, formerly "Ministry of Social Development", specific to *Centro Pop*, obtained from the application of the SUAS CENSUS[18] questionnaire, which is a census survey, carried out in all states and federal districts of the country, excluding only the states of Roraima and Tocantins which did not have a *Centro Pop* in 2019. The SUAS CENSUS is carried out annually with the *Centro Pop* since 2011.

The following was used as an administrative questionnaire to assess services, consisting of seven blocks of questions: 1) Identification; 2) Physical Structure; 3) Specialized care for homeless people; 4) Specialized care in social approach; 5) User benefits, single registration and participation; 6) Articulation; 7) Human Resources[19] (Ministry of Citizenship, National Secretariat for Social Assistance, 2019). No errors were pointed out when the general questionnaire was conducted, thus validating the instrument.

Subsequently, the Multiple Correspondence Analysis (MCA) was used to reduce the information and establish associations between variables and their categories. The MCA is an interdependence technique that allows establishing associations between the qualitative variables included in the study, as well as associations that may arise between categories of the same variable or different variables[19]. As an analysis of the main components, it is also an information reduction technique[20].

### Procedure

The SUAS CENSUS[17] was carried out by the General Coordination of Planning and Social Assistance Surveillance of the SUAS Management Department. A search was carried out through the database, which is available on the Ministry of Citizenship website, as public information. After obtaining all the files related to *Centros Pop*, we selected the variables related to CAPS services and urgency and emergency services (hospitals) from block 6 "Articulation", also taking into account the population size of the municipalities (Large, Medium and Metropolis) and we obtained a total of 24 variables.

First, a descriptive analysis of all 24 variables selected in the applied questionnaire was performed, but it was decided to eliminate all those in which one of the response categories was answered by a percentage ≥90%. These questions showed little variability and did not contribute to the analysis. Consequently, only 15 variables were included in the subsequent analysis. As the variables are dichotomous, only frequencies and percentages are reported.

The Multiple Correspondence Analysis (MCA) is a multivariate interdependence technique, sometimes understood as a generalization of a graphical representation known as a dispersion diagram[19]. It allows describing the association between categorical variables, such as multiple-choice or dichotomous nominal questions, such as those answered with a "No", called a perceptual map.

Statistical significance tests are not used in the MCA; the method involves the construction of a contingency table consisting of "i" rows and "j" columns, which originate an I x J table. Based on the table, which contains the joint frequencies of the variables and their categories, it is represented on the perceptual map, with the distances between the variables and the modalities of the variables considered in the analysis, assuming that a shorter distance implies an association between categories and a longer distance, the opposite[21].

The two-dimensional space or factorial space is constructed by axes or projection planes, taken two-by-two, from a set of factors that were obtained in the preliminary solution of the analysis.

The choice of axes, on which the variables and/or their categories are projected, is based on objective and subjective criteria. These axes are components extracted from the available information and reduce dimensionality as in the main component analysis, allowing explaining the inertia present in the data represented in the two-dimensional space formed by these axes[19]. Typically, the axes that explain the greatest percentage of variation are selected.

Once the factorial axes or dimensions have been chosen and the observations and variables and their modalities or categories have been projected onto them, it will be necessary to study how much each modality contributes to the axis variability and how well represented the observations and/ or modalities are by the said axes[21]. The quality of representation is usually evaluated based on the calculation of the squared cosines between category and axis and, therefore, the higher the value, the better the representation[22].

If the representation is acceptable, the interpretation of the results is carried out through a graphical approach, observing the constructed perceptual map, with no harm in complementing this interpretation with the quantitative results that accompany the analysis. The present study uses the MCA based on the work of Benzecri[19] and its corresponding analytical procedures, implemented in the FactoMineR analysis package[22].

Operationally, the first step consists of a) selecting the variables that can be associated and, consequently, can contribute more strongly to generate the axes which will be used to build the factorial space where the variables and their modalities will be positioned. The second step consists of b) applying the technique, considering the selection of the most adequate axes on which to project the categories, aiming to obtain their position on the perceptual map. Usually, this criterion is nothing more than keeping the axes that explain the largest proportion of variance in the data. These are normally the first two extracted axes[21].

## Results

### Descriptive Analysis

First, the variables included in the analysis, their frequency and percentage are provided.

Table 1 provides the frequency of choice of answer for each of the questions in the questionnaire. The column labeled "Key" is the summary expression of the variable in the map analysis (including the complete question interferes with the quality of the graphical representation). It can be observed that only those questions with greater variance were maintained, eliminating those in which a category accumulates 90% or more of the preferences, as these variables contribute little to the discrimination between the entities. Observe that questions about the hospital are indicated by the letter H at the end.

### Multiple Correspondence Analysis

With the variables previously organized, a MCA was performed. The first two dimensions were preserved, explaining 50.3% of the total variance. Not all preserved variables contributed to the construction of dimensions also, so a first analysis consisted of studying the contribution aliquot of these variables, as well as their representation quality. The results are shown in Table 2.

The Table 2 provides the results of the contribution of each variable categories to the dimensions. It should be noted that less frequent categories contribute more because they contribute more to the inertia (variation) of the axes, in terms of percentage. This explains a greater contribution from the "No" categories, which are less frequent answers.

In turn, the squared cosines express the quality of the representation of the variables in the dimensions extracted to generate the solution. This representation quality is evaluated from 0 to 1 and values close to one are expected.

In the Table 2, it is possible to observe that the best quality of representation of the variables is given with dimension 1, with the exception of the variables Regular Meetings and Activities as a whole, whose projection is better in dimension 2. The quality of representation must be considered when interpreting the results, since low-quality representations can lead to misleading solutions.

Having assessed the contribution of variables and their representational quality, we started to study perceptual maps, which provide a graphical approximation of the associations between variables and their categories.

The Graph 1 has the first two axes or dimensions in which the study variables are observed. The proximity of the variables to the axes indicates their greater or lesser correlation (the coefficient value is shown on the axes). It can be observed that dimension 1 has higher correlations

**Table 1.** Descriptions of the questions included in the analysis.

| Questions | Key | No | | Yes | |
|---|---|---|---|---|---|
| | | Frequency | Percentage | Frequency | Percentage |
| Accompanies the derivations | Acomp_deriv | 45 | 19.7% | 183 | 80.3% |
| Regular meetings | Reg. meetings | 118 | 51.8% | 110 | 48.2% |
| Conduct case studies together | Case studies | 83 | 36.4% | 145 | 63.6% |
| Joint activities | Joint_Act. | 108 | 47.4% | 120 | 52.6% |
| Has flow | Has flow | 120 | 52.6% | 108 | 47.4% |
| Has location data (hospital) | Loc. data | 53 | 23.2% | 175 | 76.8% |
| Receives users (hospital) | Receives users.H | 81 | 35.5% | 147 | 64.5% |
| Derivates users (hospital) | Derivates users.H | 77 | 33.8% | 151 | 66.2% |
| Accompanies the derivations (hospital) | Acomp_deriv.H | 113 | 49.6% | 115 | 50.4% |
| Regular meetings (hospital) | Reg. meetings.H | 198 | 86.8% | 30 | 13.2% |
| Exchange information (hospital) | Exchange_infoH | 72 | 31.6% | 156 | 68.4% |
| Joint case studies (hospital) | Joint_case_studies.H | 167 | 73.2% | 61 | 26.8% |
| Joint activities (hospital) | Joint_Act.H | 186 | 81.6% | 42 | 18.4% |
| Has flow (hospital) | Has flow.H | 170 | 74.6% | 58 | 25.4% |

Source: Authors.

**Table 2.** Contribution to the construction of the axes and quality of representation.

| Question | Category | Contribution | | Squared cosines | |
|---|---|---|---|---|---|
| | | Dimension 1 | Dimension 2 | Dimension 1 | Dimension 2 |
| Accompanies the derivations | No | 4.92 | 0.31 | 0.31 | 0.01 |
| | Yes | 1.21 | 0.08 | 0.31 | 0.01 |
| Regular meetings | No | 2.39 | 6.24 | 0.25 | 0.27 |
| | Yes | 2.56 | 6.69 | 0.25 | 0.27 |
| Conducts case studies together | No | 3.87 | 5.66 | 0.30 | 0.18 |
| | Yes | 2.21 | 3.24 | 0.30 | 0.18 |
| Joint Activities | No | 2.58 | 7.62 | 0.24 | 0.30 |
| | Yes | 2.32 | 6.86 | 0.24 | 0.30 |
| Has flow | No | 2.23 | 5.60 | 0.24 | 0.24 |
| | Yes | 2.48 | 6.23 | 0.24 | 0.24 |
| Has location data | No | 6.37 | 7.73 | 0.41 | 0.21 |
| | Yes | 1.93 | 2.34 | 0.41 | 0.21 |
| Receive users (hosp) | No | 5.76 | 5.70 | 0.45 | 0.18 |
| | Yes | 3.17 | 3.14 | 0.45 | 0.18 |
| Derivates users (hosp) | No | 6.56 | 7.13 | 0.49 | 0.22 |
| | Yes | 3.34 | 3.64 | 0.49 | 0.22 |
| Accompanies the derivations (hosp) | No | 4.93 | 3.60 | 0.49 | 0.15 |
| | Yes | 4.84 | 3.54 | 0.49 | 0.15 |
| Regular meetings (hosp) | No | 0.84 | 0.40 | 0.32 | 0.06 |
| | Yes | 5.51 | 2.67 | 0.32 | 0.06 |
| Exchange information (hosp) | No | 6.90 | 5.33 | 0.50 | 0.16 |
| | Yes | 3.18 | 2.46 | 0.50 | 0.16 |
| Joint case studies (hosp) | No | 2.12 | 0.17 | 0.40 | 0.01 |
| | Yes | 5.79 | 0.46 | 0.40 | 0.01 |
| Joint activities (hosp) | No | 1.13 | 0.30 | 0.31 | 0.03 |
| | Yes | 5.02 | 1.32 | 0.31 | 0.03 |
| Has flow (hosp) | No | 1.48 | 0.38 | 0.29 | 0.03 |
| | Yes | 4.35 | 1.12 | 0.29 | 0.03 |

Source: Authors.

with "Accompanies the derivations", "Has flow" (H), "Joint case studies" (H) and "Joint activities" (H). The variables "Joint activities", "Has flow" and "Regular meetings" have a greater relationship with axis 2, which is consistent with their representation quality, greater with dimension 2. Note that this result also indicates that the variables that are related to the same axis, are also correlated with each other. Consequently, there is an association between the groups of variables we mentioned.

The Graph 2 shows the categories of variables on the graphic map. A graduated color scale has been added to indicate the quality of representation of the categories (cos2).

One of the evident aspects of the map is that there are sets of categories grouped by quadrant and that, as the categories are dichotomous, with 'Yes' and 'No' answers, the axes oppose some answers to others. So, for instance, in the lower left quadrant the category Exchange_infoH _Yes is observed and in the upper right quadrant, Exchange_infoH is not found, and the same happens with Accomp_deriv.H_Yes and Accomp_deriv.H_No. The axes have the ability to discriminate between positive and negative responses. Something similar happens between the lower right and upper left quadrants.

However, the most important aspect is that the distance between the categories represents a measure of the similarity or dissimilarity between them. Thus, for instance, in the upper left quadrant we observe that an affirmative answer to "Has flow", "Regular Meetings" and "Regular Activities" as a whole, indicates an association between them, or that an affirmative answer in one of them implies in an affirmative answer in the others. However, on the opposite side of the axis (lower right quadrant) the opposite occurs: whoever answers "No" to "Has flow", does not hold regular meetings or activities together.

The same organization can be seen when looking at the lower left quadrant, towards the upper right corner: *Centros POP* that respond Yes to: Derivates users (hosp), also respond 'Yes' to Receive users (hosp), Exchange information (hosp), Follows derivations (hosp) and Has location data. In the opposite quadrant, the upper right, the opposite occurs, and the proximity of these categories indicates their association.

Finally, to the Graph 2, we will add the type of population size to which the *Centros POP* belong and we will try to determine their association with the categories analyzed above (Graph 3).

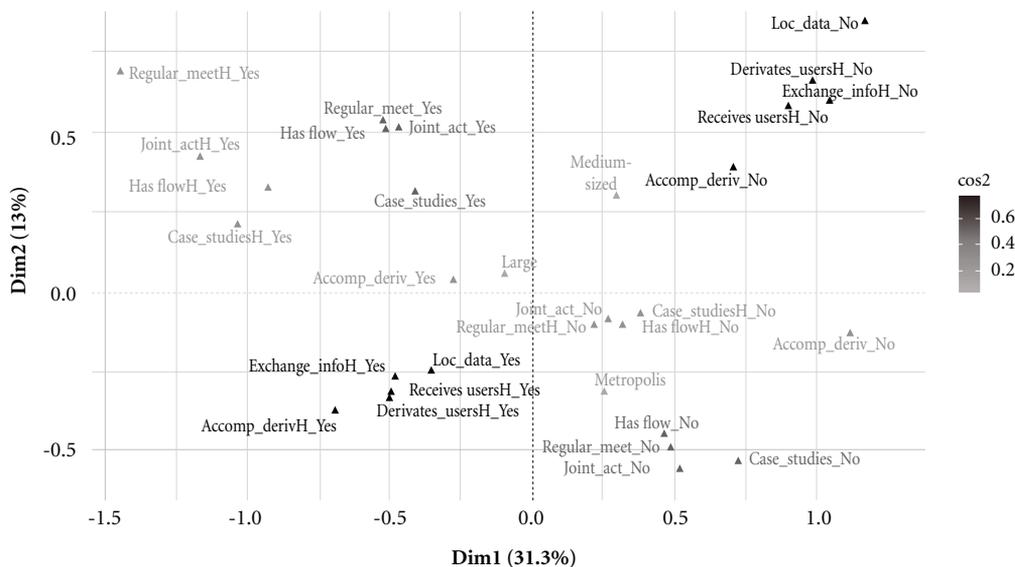Although unfortunately the quality of the representation of the populations is low, and
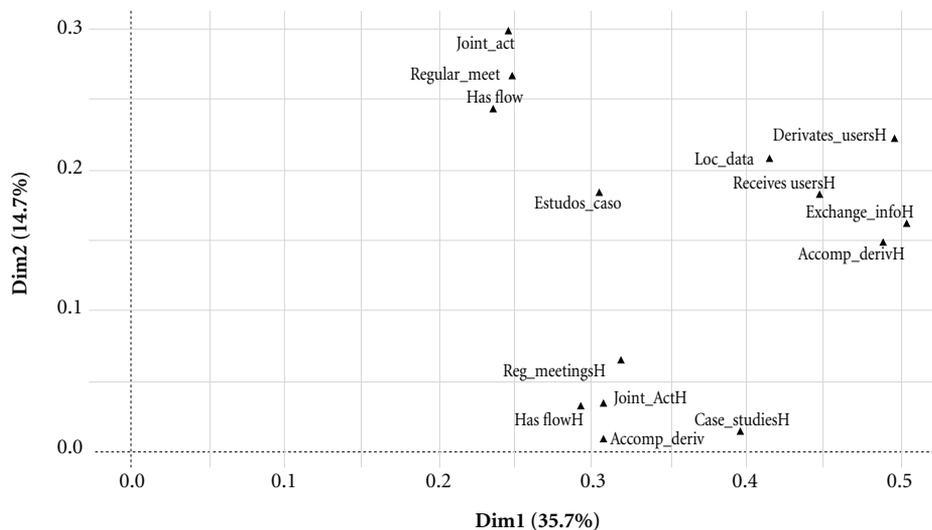


**Graph 1.** Correlation of variables with dimensions.
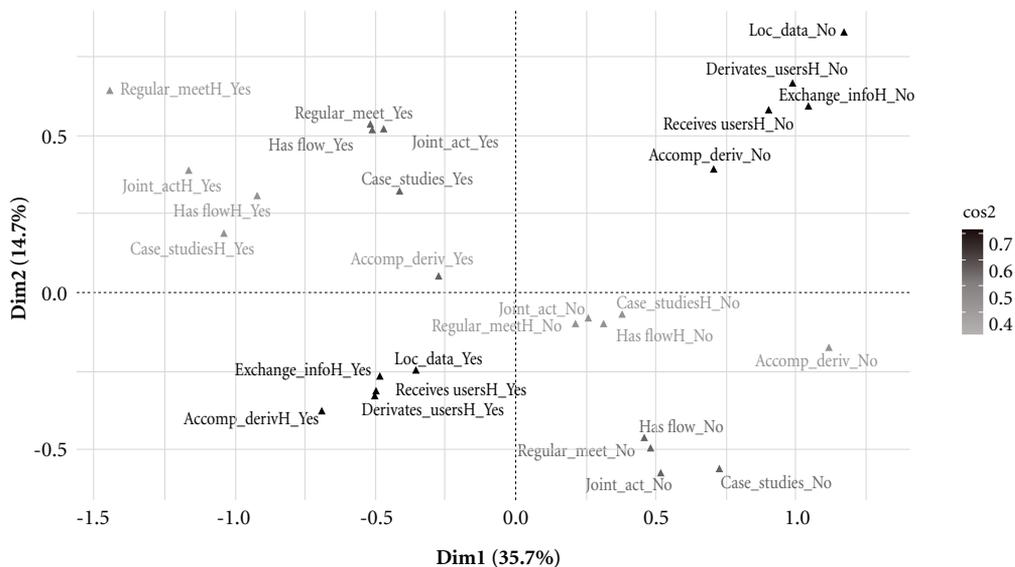
Source: Authors.

**Graph 2.** Categories of variables in MCA dimensional space.

Source: Authors.



**Graph 3.** Population categories and sizes in MCA dimensional space.

Source: Authors.

therefore the interpretation of this map should be taken with caution, what is shown is an association between answering negatively and together to the questions: "Has flow", "Regular meetings", "Joint activities" and "Conduct joint case studies" and the Metropolis population type.

Something similar occurs with the Medium-sized population type, which is associated with a negative answer to questions such as "Derivates users (hosp)", "Follows derivations (hosp)", "Receive users (hosp)", "Exchange information (hosp)" and "Has location data".

Only the large population type is more associated with a positive response, as shown in the map, because it is in located in the same upper-left quadrant as the positive responses.

It is important to note that the association of categories with types of populations must be interpreted as a whole; for instance, in the medium-sized population type, it is observed that a negative answer is given to the full set of closely related variables, not just to a few.

Consequently, in Metropolises there are many actions that are not carried out and the same occurs with the *Centros POP* in medium-sized areas; many of the actions that the *Centros POP* must comply with are carried out only in large-sized areas. However, it should be noted that in areas defined as Large, the greatest non-compliance is related to the connection with the hospital. Something similar happens with the Metropolis, but to a lesser degree.

## Discussion

### Weaknesses and strengths in intersectoral actions between the Centro Pop and RAPS

According to the results, the *Centros Pop* appear with a significant positive response in relation to the articulation with mental health services in most of the variables, emphasizing that in most municipalities, there are referral mental health services in the territory where they are located, which may reflect the development of RAPS in recent years.

However, despite the great coverage of the CAPS and the significant articulation of *Centros Pop* with them, the fact that there is an important weakness in the articulation with other services such as urgency and emergency (hospitals) confirms that:

*Despite the positive investments and articulations with the RAPS guidelines, obstacles are found*

*in this process. Some teams report difficulties in articulating the network's work to respond to emergencies and carry out complex actions, suggesting an insufficient integration of the points of the care network and lack of co-responsibility[3].*

This fact demonstrates that other public policies have difficulty prioritizing care for the homeless population, which is also evident in other health practices: "The workers' criticism of the care provided by the SUS health teams is based on the lack of training of professionals to deal with homeless people, the stigma in the provision of care and discrimination shown by health professionals"[23].

In the context of the gap between public policies responsible for the care of the HP, the national literature also indicates some issues that influence the effectiveness or inefficiency of intersectorality, such as the existence of gaps[9] in intersectoral communication and disagreements between the roles of social assistance and health care[3,1022-24]. The role of intersectoral articulation for the HP, for instance, is met most of the time by the social work teams[10].

However, according to Sicari and Zanella[25]: "the feeling of belief and trust in the services provided by the *Centro POP* was identified among the homeless, but it emphasizes that this service must develop more actions that meet these people's unique needs, guaranteeing them basic rights and access to the intersectoral network". We can infer from this study that, in fact, the *Centro Pop* has a relevant role in the articulation with RAPS, due to the high positive responses mainly in relation to CAPS, but the negative responses related to the variable "Has flow" provide clues about a possible problem previously reported by professionals in the area, such as restrictions to services and absence of flows[10].

### Flows as network organizers?

The study suggests that in some cases, the negative answer to "Has flow"(H), (mainly in the case of articulation with hospitals), is associated with negative answers to other variables, such as "Has regular meetings" or "Regular joint activities". The absence of flows may be related to difficulties in the intersectoral articulation and health inequities, which also reveals a model of society that rejects the *crazy individuals, the wanderers or the street bums*. It is noteworthy that not always having established protocols, or flows, guarantees better quality of care, but the absence of the flow protocol in public policies for the HP is not very

often problematized, which can be interpreted as a naturalization of the denial of the right to the city for this population segment. Why would this demand not require established attention and care flows or protocols?

In the health sciences descriptors of the virtual health library, one find the expression "workflow", which describes what we are considering here as "flow protocol": "description of the pattern of recurring functions or procedures that are often found in organizational processes such as notification, decision and action. Synonyms: Flowchart; Process modeling; work flow, or Workflow".

According to this description, we believe that the institution of flows between services has an important role, as a guarantee of access and demonstration of co-responsibility, since there are signs of a lack of flows in the care for the HP[10,25,26]. On the other hand, it may be necessary to problematize the Brazilian tendency to articulate actions through people and not established flow protocols[10,26].

In this case, it is necessary to pay attention to the possible health inequities that may emerge from the lack of flow protocols instituted at different levels of health care; thus, when discussing the articulation with the mental health network, which strives for care in freedom , the data analysis indicates the materiality of the practice in the daily actions. For instance: how to deal with a user who has just arrived in town, a wanderer, who has a psychotic break at the *Centro Pop*? Who is engaged? And who responds satisfactorily to psychosocial care and embracement? The CAPS? The General Hospital? Which flow is established? This study points to the materiality of actions in the daily practice.

### Centro Pop and cities, by population profile

Considering the greater concentration of HPs in large cities and urban centers[7,14,15], we indicate the need to think of access to health as a right to the city as well, as analyzing the data in this study, it was demonstrated that the articulation between *Centros Pop* in relation to CAPS and Hospitals is still fragile, especially in metropolises[14]. A large part of large and medium-sized cities and cities also do not have a flow protocol for inpatient services related to the HP, which was already been indicated as a possible problem in the previous session.

On the other hand, the study showed that among the population sizes Metropolis, Large and Medium-sized cities, large municipalities had more positive responses, especially regarding the variable flow protocol in its articulation with the CAPS, with the articulation with hospitals being shown as much more fragile. These data can contribute to decision-making instances by agents in the public sphere regarding greater investments in metropolises and medium-sized municipalities, with the need for in-depth studies on the causes of fragility in the articulation with the mental health network of these municipalities. Such strengthening is relevant, as it is precisely in the metropolises where one finds the highest concentration of HPs and, paradoxically, it is where the network is at its fragile.

Recovering the concept of intersectorality as a key part of this debate, it is important to know and recognize the difficulties involved in guaranteeing the right to health for the most vulnerable populations, precisely where and when they need it most, in the case of HPs, in urban spaces, understanding that "the right to health intersects with the right to the city as, by guaranteeing healthy urban spaces for the population, inequities will also be reduced and the enjoyment of the positive effects of urbanization will be expanded to the disregarded and disadvantaged groups"[16] ( p. 3822).

### Conclusions

Despite the clear intersectoral advances created inside the context of public policies for the homeless population, this study indicates an intersectoral network that is still fragile, as suggested by other studies, with a moderate advantage in the articulation of *Centros Pop* with the CAPS to the detriment of articulation with urgency and emergency services, mainly in large cities, lacking an improvement in coordination in metropolises and medium-sized cities.

We point to the variable "Has flow" as an important analyzer of the intersectorality function carried out by the *Centros Pop*, stressing the importance of new quantitative studies as complements to qualitative ones on the subject, aiming to add new data. The choice to carry out a quantitative study strives to fill the gap regarding this type of study, indicated by the literature on the subject and to give materiality and visibility to the problems that involve the articulations in mental health care for the HP in the daily practices. The difficulties in providing health care to the HP have been reported in different studies and remain la-

tent today, which makes it relevant and exceptional to think about carrying out longitudinal studies on the issue of intersectorality in health/mental health, including the variable "Flow".

Therefore, the contributions of this study are also its limitations, that is, they reveal the importance of flow protocols in the care of HP, but they do not reveal the causes associated with the difficulties in this articulation. It is necessary to continue researching on the subject and invest in the training of professionals who are sensitive to the complex demand that is to deal with sociopolitical suffering in perhaps what presents itself as its maximum expression (homelessness), psychic suffering and care in freedom, as the ultimate premise of the right to the city.

## Collaborations

TB Pedrosa was responsible for the study design, introduction, logical arguments and justification, discussion and conclusions. P Cáceres-Serrano was responsible for the definition and applicability of the research method and contributed to the data analysis. Both authors are responsible for the writing and final review of the manuscript.

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