

## Consultation office of/in the street: challenge for a healthcare in verse

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This paper discusses healthcare practices relating to consultation offices in the street, which are a service delineated within the Brazilian National Health System that is directed towards caring for people living on the streets. The intention was to pose questions regarding healthcare and reception strategies, along with the guidelines or values of this work. These are often discordant with each other, like the programmed actions of tracking and moral authority over people living on the streets and the disruptive actions of the urban model for healthy and safe cities, in relation to strong inclusion of people who, for various reasons, live in such situation. Field diaries written by workers at one these consultation offices, located in Porto Alegre, Brazil, comprise an analysis resource. In these workers' day-to-day routine, they pass through the streets and health and intersectoral networks with all their difficulties and strengths.

*Keywords:* Consultation office in the street. Psychosocial care network. Primary care network. Street dwellers.

### Announcing the problematic field

The present text approaches a service that is relatively new in the scenario of the *Sistema Único de Saúde* (SUS – Brazil's National Health System), the *Consultório de/na Rua* (CR – Office of/on the Street). It emerges in light of an intricate panorama in terms of health care for people living on the streets with problematic use of crack, alcohol and other drugs. Deinstitutionalization, which became effective in the 1990s in Brazil and focused on the population segregated in asylums, has had little effect on segments that did not experience asylum admission or on people who have mental health problems without access to regular mental health services. Thus, these

people have become the focus of State apparatuses like the judiciary and the police. Even in view of deinstitutionalization, there has not been, in a relevant way, a social and health policy that addresses psychic suffering or disorder and that welcomes the population living on the streets, which has been growing in an expressive way in Brazil's large cities over recent decades. This population is stigmatized, and it is not difficult to realize that, in the social imaginary, people living on the streets have started to be seen as the "new society deviants", dangerous individuals, due to their consumption of crack, alcohol and other drugs and because they wander the streets, begging or stealing to support their drug addiction. They have ceased to be "desiring subjects and have become mere objects, inert and irresponsible for their own acts" (p.9)<sup>1</sup>.

Varanda and Adorno<sup>2</sup> quote a series of designations that are present in the social imaginary, specific to people living on the streets: bums, beggars, tramps, individuals in a degradation stage, adrift. What joins them is the notion of people living on the streets with no defined earnings, and this has translated them as "urban disposables": individuals/groups "victimized by structural problems", whose situation is aggravated "by their continuous permanence in unsanitary conditions, subject to violence or under the continuous action of alcohol and drugs", seen, in urbanized societies, as "an inopportune and threatening presence" (p. 66)<sup>2</sup>.

Merhy<sup>1</sup>, concerning the collectives formed by drug users, comments that such street and square dwellers can be considered, in any city, as the new abnormal individuals in light of the Foucaultian thought in current days, "when there is great effort, on the part of conservative sectors, to conduct to the construction of a social imaginary that makes drug users become visible as zombies, not as humans". Street dwellers or drug addicts would "become an excellent reason for the construction of an atavistic fear of what is not controlled", taking with them any kind of movement that is related to a bet on a free life, "victims of the capture-addiction that illicit chemical substances cause" (p. 9)<sup>1</sup>.

According to Romani<sup>3</sup>, in the field of drugs, it is possible to act or develop interventions according to two great models: one with a prescriptive approach and the other with a participatory approach. The first is characterized by the "knowledge of institutions"; a legitimate, but partial, statute, as it requires specific production and management conditions (scientific, legal and administrative structure or strategy, for example). The second promotes the creation of different interlocution channels between institutions and the opinions and knowledge of the assisted population. The first is the one in which "the professional, legitimated by knowledge, which grants him a certain social power, indicates what is to be done; even though the population knows, from its own experience, that what used to be evil yesterday, today may be healthy and convenient, and vice-versa." (p. 303)<sup>3</sup>.

The journal of the Medical Union of the State of Rio Grande do Sul ratifies the first model, a type of health policy that places the Office on the Street in a "palliative" level<sup>4</sup>, as "it is not of much use; what is important are the psychiatric beds for hospitalization", the only recognized form of treatment. In addition, it is possible to notice a strong media campaign, such as that of *Crack*

*nem Pensar* (Crack – No Way) (launched in 2006 by the main communication company of Rio Grande do Sul), with a discourse practice of drug eradication.

Romaní (p. 303)<sup>3</sup> shows that there is a series of factors to which the specialists are submitted – based on the institutions' logic – that not necessarily correspond to real intervention needs, nor to the needs of people's daily lives. In the end, according to the first model, "the population must accept what the specialist says". The participatory model, on the contrary, proposes to "incorporate the population's set of needs and to identify, together with the community, the problems and the approach criteria".

In light of this scenario, it is possible to observe, on the one hand, proposals for compulsory hospitalization and dismantlement of drug consumption places through police offensives, without minimal planning to include this population in programs that focus on their social needs. What we see is a movement of expulsion and greater exposure. On the other hand, the Ministry of Health, together with representatives of health workers, social work and street population movements, offers care practices based on the affirmation and creation of health care services and intersectoral services to meet the demand coming from the streets. In this second channel, we find the affirmation of health and intersectoral networks, such as the National Primary Care Policy and the establishment of the Psychosocial Care Network (Directive GM/MS no. 3088/2011) for people with mental suffering or disorder and with needs deriving from the use of crack, alcohol and other drugs in the scope of the SUS.

The interaction strategies inside one or the other model mentioned above (the prescriptive and the participatory) are distinct, as Romaní<sup>3</sup> states regarding the field of drugs: on one side, "the level of the slogans of advertising campaigns and the advices given by experts"; on the other side, "group discussion, which gradually allows the distinct definition of problems, according to distinct contexts". To the author, the prescriptive model subsidizes "global campaigns of the type "say no to drugs" in the major means of mass communication", while the participatory model "outlines objectives based on more concrete problems, detected in specific sectors of the population" (p. 303)<sup>3</sup>.

Such models are clearly expressed in the different practices that are in force in the current Brazilian conjuncture. To Romaní<sup>3</sup>, the participatory model refers to "the collection of efforts that a community sets in motion to reduce, in a reasonable way, the probability that problems related to drug consumption emerge within that community". The author emphasizes: "we are not presenting here a dichotomous perspective of the type good-bad, white-black, drugs and non-drugs fostered by prohibitionism"; the aim is to "provide a more realistic and professional focus, centered on the possibility of solving some problems or facing the most harmful effects of certain drug consumptions" (p. 304)<sup>3</sup>. Therefore, the diversification of criteria becomes relevant, such as damage reduction policies, which devise care corresponding to the desire of the person who is suffering and requests/requires care. To the author, the central aspect is to project an intervention that coincides with different consumptions and different consumer groups, developing capacity for

assuming a certain level of self-control and, at the same time, some normativeness of the belonging groups over the individual and his/her relation to the consumptions (of drugs and other things).

So that an approach to reduce damages and to prevent consumption and addiction caused by the use of crack, alcohol and other drugs effectively works, "it is necessary that the point-of-departure is the culture and knowledge of the local worlds of meanings" (p. 304)<sup>3</sup>. There would be more chances of care provision, either because it would be able to fulfill the objectives of what one desires to achieve, avoiding "utopianisms made in the Cabinet, not by wise men, but by drug control bureaucrats", or because it would be in accordance with a practice that respects and is concerned with people's lives (p. 304)<sup>3</sup>.

Today, based on the two large models presented here, there is an increasing demand for understanding how to meet the social health needs of populations living on the streets, and divergent actions have been verified within society based on the position of citizens, the State, the media, health care services and collective organizations, such as the National Movement of Street Population, which has become an organized movement. In the attempt to produce a comprehensive care practice that is able to adapt to the reality of each user and his/her social context, the Ministry of Health has configured the Psychosocial Care Network, which must link specialized services of health care and of social work: Social Work Reference Centers, Primary Care Units and Family Health Strategy, Primary Care Support Nucleus, CR, *Centros de Atenção Psicossocial* (Caps - Psychosocial Care Centers) (for users of alcohol and other drugs: Caps-ad; for assistance to childhood and adolescence: Caps-i), Welcoming Units and Therapeutic Residential Services, as well as the Therapeutic Communities, all of them with the potential for being collaboratively supported by the Caps-ad, with a professional team that is more diversified and specialized, and with uninterrupted operation (Caps-ad III).

Within the field described above, the CR stands out as a device created to provide care for populations living on the streets. The CR is part of the health and intersectoral networks, in which it is included with the aim of producing a singular therapy to each person/street population. However, in view of the fragility of these networks, which are always moving and under construction, the CR, besides being a care service to people living on the streets, has become an important problematization instrument of the care modes that pervade health care. With its practice in transit, it runs through the health and intersectoral network, mingling with it – often under tension -, searching for articulation in order to assist those who, until that moment, had been invisible within/to the scenarios of the SUS.

In a certain sense, the initiative of effectively configuring a multiprofessional team in transit across the city – nomadic among the sociocultural scenarios of each territory (geographic, cultural, existential, professional, disciplinary) -, puts the health system in check when it brings to light a diverse type of population that problematizes the structured modes of producing health and the network characteristics used in the organization of the services and their priorities. The CR, by

interacting with the street population in different scenarios, brings to the present, in the daily routine, an uncommon set of health needs to the care network.

The stories of life on the streets are strange, and its health needs are equally strange. The CR, by welcoming, in an alterity exercise, people living on the streets, and by taking such cases to the care network, produces estrangements in the network itself on a daily basis. With the estrangement, there is the emergence of observed and felt situations to which there are no ready answers and through which we are significantly dragged out of our comfort zone of diagnoses and recommendations for performing self-care at home. The network is tensioned by an invisible demand of a population that had not existed up to this moment. The CR reveals a new face, a new point of network connection; it poses challenges and questions the construction, in which we participate, of a SUS that concerns all.

### **The creation of the Office of/on the Street**

The first Office of the Street was created in 1999 in the city of Salvador, State of Bahia (Northeastern Brazil). It was a pilot project targeted at children and adolescents living on the streets who were under the influence of problematic drug use. The experience was of the Center for Drug Abuse Studies and Therapy. In May 2004, a CR was implemented in the first Psychosocial Care Center for assistance regarding alcohol and other drugs (Caps-ad) of Salvador, structuring the care model of this unit. In 2006, the Ministry of Health proposes that the CR becomes one of the strategies of the Emergency Plan for the Expansion of Access to Treatment in Alcohol and Other Drugs. In 2010, it was included in the National Integrated Plan to Combat Crack, with the aim of expanding the access to care services and qualifying the assistance offered to people who use crack, alcohol and other drugs by means of health actions on the streets. To the Ministry of Health, “the backup of the CR” favored “the flow of referrals and the inclusion in the network” of drug users who were most committed to this use and “in a situation of highest social vulnerability” (p. 8)<sup>5</sup>.

Another Brazilian experience that happened at the beginning of the CR was the Homeless Family Health Programs, which later became Family Health Team for Street Populations. It is possible to mention, from 2004 onwards, the Homeless Family Health Program of the city of Porto Alegre (Southern Brazil), followed by the Family Health Team for Street Populations of the cities of Belo Horizonte, São Paulo and Rio de Janeiro (Southeastern Brazil). The Homeless Family Health Program of Porto Alegre provided itinerant assistance for the population living on the streets, as part of the Primary Care network and of the Integral Care Program to the Adult Street Population, of the area of social work. Its objective was to approach street dwellers, to identify the causes of their situation, and to call the sectors that could help in the search for family bonds and for occupation, as well as providing assistance related to health promotion, with treatment and clinical examinations. Today, the Family Health Strategies for Street Populations operate as an “Office on

the Street”.

Today, the Office of or on the Street represents the convergence, under different modalities, of the experience in Damage Reduction and in the Homeless Family Health Program. The passage of the CR, which was linked to the National Mental Health Policy until 2012, to the National Primary Care Policy, does not represent only a change in nomenclature (Office “of” to Office “on” the Street), but a change in the strategic guidelines of this device. Moreover, it meets the priority of the Brazilian Government: prevention of consumption and addiction to crack, alcohol and other drugs. It is important to remember that the National Movement of Street Population was contrary to the extinction of the Homeless Family Health Program, as it understands that it is not only care in relation to consumption and addiction to crack, alcohol and other drugs that the street population needs.

In 2011, as a consequence of the Presidential Decree no. 7.053/2009, which instituted the National Policy for the Street Population and its Intersectoral Monitoring Committee, the Ministry of Health adopted the CR as a strategic service of Primary Care, combining the devices of Mental Health and of Family Health instead of extinguishing one to the detriment of the other. In 2012, with the interposition of the concept of Psychosocial Care Network for people with mental suffering or disorder and with needs deriving from the use of crack, alcohol and other drugs, the primary care network participates through its Primary Care Units and the CR.

The public health network currently has more than one hundred CR implemented in the entire Brazilian territory, with a clinical care practice that permeates the network, promoting care to and including the street population. Due to the broad action that takes place on the streets, the CR is a transversal service, as it produces mental health care and also primary care practices. It is possible to verify the production of primary care with the “use of practices of disease prevention and health promotion”, as well as the “improvement in the access to the health services and the attempt to protect the quality of life” (p. 5)<sup>5</sup>.

In relation to Porto Alegre, there is a severe situation in terms of health care for people who live on/transit across the streets and use crack, alcohol and other drugs, as well as other problems that affect such population concerning health and social inclusion. In 2009, the direction of *Grupo Hospitalar Conceição* (GHC), responding to the capital city’s need, invites the workers of the “Mental Health Line of Care” to develop and implement a project for a Care Center in Alcohol and Other Drugs. This project included the composition of five services: Caps-ad III, Caps-i, CR, the Treatment Unit in Alcohol and other Drugs for Adolescents and a Center for Studies and Research in Alcohol and other Drugs. Based on this project, in 2010 the CR “*Pintando Saúde*” or CR-GHC was implemented.

The problems discussed in the present paper are based mainly on the care production experiences that happened in the CR-GHC. The work of the CR-GHC started in August 2010. It ran through the North region of the city, aiming to analyze territories where street people lived. This work was initially carried out with the health and social work network with the purpose of

mapping possible places that would be strategic for the presence of the CR-GHC. Based on the demand of the region's health and social work network, the spaces in which the CR-GHC would start its health care work emerged. After the mapping was duly performed for the region, in November 2010 the health care interventions with the street population effectively began.

In the first interventions it became clear that such population did not need care regarding only the approach to problematic use of crack, alcohol and other drugs; it needed health care in a broad sense, due to the problems deriving from the street situation.

### **The production of care**

The CR-GHC offers to its users an open service based on spontaneous demand. It aims to meet the needs of people who live on the streets. The actions are constructed according to the person's particularities and vulnerabilities. This implies the challenge of producing care that is able to absorb, in its interventions, unexpected or non-programmed assistance. In a certain sense, this challenge affects any and every health care service; however, on the street, these requirements seem to impose themselves in an intense, persistent and unusual way.

The lack of walls. The absence of a table. The encounter at moving places. The sunlight, the wind, the cold, the heat. The filth, the strong smell. The conversation about health with people sitting in a circle, using drugs. Fear of the police and of the rain. Strange sensations, inopportune joys. Intervention in desire, production of desire. The encounter with life histories in distressing contexts as they unfold. Events that demand an alterity exercise strongly marked by the "transvaluation of values"<sup>6</sup>. The welcoming or the care projects in the CR-GHC occur under such circumstances.

There are few preconditions to coordinate health care. The path is always to be constructed with the welcomed user (in the real encounter and in his/her time); therefore, the so-called identitary places of each profession are reconfigured in action, or rather, the professional is entangled in events that enable a deconstruction of the disciplinary way that had delimited him/her as a therapist up to that moment. This working process summons the emergence of a caregiver that is almost an "anomaly, who is distant from the fragmented approaches" (p. 25)<sup>7</sup>. According to the Ministry of Health, "the street context is dynamic and the team must adapt its work in view of the unexpected" (p. 16)<sup>5</sup>.

Producing a health care service that transcends the expected, the programmed, the prescribed, within a team, had become a great challenge, mainly because the CR does not work in isolation; it needs the health and intersectoral network to cover the integral, universal and egalitarian care recommended by the SUS. This dynamic way of providing care in the CR can reverberate on the services that it contacts, tensioning a chain of care that, many times, not even imagines a horizon that is more distant than its own daily actions. Looking beyond, bearing unpredictability and investing in care actions while encompassing particularities and engendering

desire in the other are practices that are difficult to be performed in the daily routine of a health care service that is extremely regulated, characterized by an assistance that is guided by professional knowledge, with a minimal opportunity of intersection with users, who arrive with their diffuse or confused sufferings.

How can we invest in a type of health care logic that can absorb unpredictability? How can we encourage workers and services so that their involvement in the care practice is open to unpredictability, connected with desire and attentive to particularities? These are questions-challenges that pervade the development of these workers and the welcoming of this population; questions that are being increasingly announced to the health network.

In order to qualify the discussion, a "case-thought" is offered here. It occurred in the care process of the CR-GHC and involved a homeless user. The tool of the "case-thought" composes a "conceptual web" (p. 55)<sup>8</sup>, and it bets on a writing strategy that is more incarnated than just faithfully reporting a certain scene. Therefore, cases-thoughts are versions that emerge from the intensive plane of the memory of the CR-GHC team, when they express discomfort or some estrangement that does not cease to affect them. The case-thought brings an event to light in what it has of "current and virtual" (p. 51)<sup>9</sup>; something that does not fall into the absolute, the exact or into what has already been given, but something that enables a coming-to-be. The same situation is mentioned in one thousand different ways.

The marks and sensations, the signs that are experienced and estranged in the event are configured in the case-thought as the affirmation of the memory of chosen-invented elements that intend to trigger a problematization. We believe that the encounters with the user welcomed by the CR-GHC can help to problematize the ethical condition and the limits that the health care network finds when it contacts street dwellers. The utilization of the case-thought aims to reveal the intensity of the problematized theme: the constitutive tensions that the health care network is about to experience in the challenge of providing care for street populations.

The ethics and the limit presented here are related to offering a health care service in which, based on the interventions, there is an affective investment on the part of the professionals, who, many times, have difficulties in dealing with this relational load, extrapolating or not the notion of professional and humanized care, sheltering or not affections invested in the situation. As it is a service devoid of a house to centralize its actions – an itinerant service whose temporality is singular in relation to the logic instituted in care provision-, there is suffering caused by the anguish that is inherent in such deterritorialized practice.

It is obvious that affective investment and anguish emerge in any professional relationship in the area of health; however, working with such populations and with what they demand invokes an "affective" investment that seems to be peculiar to this service, as such weave of care occurs in unexpected places, in times that sometimes are accelerated and sometimes, slow, with people who were not seen by the services. Why did the services not see them? This is the affection (*affectio*) as learning and feeling by a "mental state", which is not the same as the affection (*affectus*) related



to a possible feeling of tenderness.

### **Which focus to support care?**

Sepé does not know how long he has been living on the street. He has inhabited the ruins of an old Primary Care Unit for three years. His daily life involves collecting cans and other kinds of garbage to resell and support himself. His life is hard, under the sun and the rain when he is working, and enduring the darkness of the night (due to lack of light) in the place where he lives, where he only notices the shadows of those who pass by at dawn, looking for an abandoned place to consume drugs.

Sepé does not smoke and only drinks *cachaça* (sugar cane liquor). When he is collecting recyclable material, if he does not drink some of this energy drink, sometimes he starts trembling. However, compared to what is perceived in other assistances, it seems that his everyday dose of alcohol is not something that harms him in a worrisome way. It is not a “problematic” use, even though excessive. At least, it is not the current focus.

Focus... This is one of the problems that are faced in the assistance provided for street people. How to focus on health care in a subject who presents several needs? Care concerning alcohol and other drugs, primary care regarding wounds and other injuries, depression, aggressiveness and nervous breakdowns, and also social assistance, such as the making of personal documents, sheltering/housing and income.

The current “focus” in relation to Sepé is the results of his HIV and tuberculosis tests, which were positive. Among other care actions, the team has been trying to recover part of his civil rights by requesting the making of his birth certificate; in addition, they have been trying to contact his family, in the interior of the State. The primary care team, housed next to where he lives, has been working intensely and under tension; up to then, it had closed its eyes to his welcoming, as well as to the rest of the street population that is around him, on the margins of the city and of society. A society that “lets die”, nowadays, in a way that is very similar to the “cause the death” of the time of sovereign power, as Foucault would put it<sup>10</sup>. Nevertheless, such practice, which has been enhanced today, is undertaken in a discrete and subtle way, eliminating those who are not regulated, who are submitted to the various cases of negligence that pervade the health care practices (p. 202)<sup>10</sup>. In defense of society, we still continue to kill those who do not join it!

Returning to the “focus”, it is possible to argue that the health care team is tense in relation to the caregiver’s “affective” investment in the welcomed person and, many times, the professionals experience anguish and suffering. In the several interventions performed by the CR-GHC, at certain moments, the limits regarding providing care for what and why are surpassed, and the caregiver ends up showing feelings of anger, frustration and anxiety in the attempt to solve problems. The caregiver suffers in view of the condition of total despair of the user who lives on the street, feels the need to solve this problem as soon as possible and ends up disrespecting the

time of the person he/she “welcomes”. The caregivers, permeated by the logic of prescriptive health care, have actions that are characterized by objectivity and problem-solving. Which resolution would this be? The resolution of what the user requires or of what the caregivers, marked by health knowledge, imagine that is correct? This is even more so because we are talking about people who have broken almost totally with the social contracts and live in a distant way from any logic that the caregivers share in their world. How can we have access to this other space-time that is so distant from the urban characteristic of a “safe and healthy city”? Is it possible to be contaminated by a different logic of the senses: that of the daily life of street dwellers?

It is difficult to answer this question... Only in the welcoming experienced during the “approaches” is it possible to notice the subtleties, the impossibilities to “connect” with users and the possible openings that gradually compose learning or enunciate what still remains to be developed as the caregiver delivers his/her body to this type of encounter. It is in this opening of the body to the other that the CR worker practices new forms of care that had not been visible until that moment and with which he/she starts to process encounters in an inventive way. It is by accompanying the person affectively that it becomes possible to “reframe the subject’s existence, creating original modes of subjectivation” (p. 55)<sup>11</sup>, an inflection point between the caregiver’s and the street dweller’s affections. This contact is performed through body perception, which makes a reverberation, in each other, of quanta of life power, of the emergence of a good encounter, and of an affective exchange that puts the bodies in a movement of composition.

In one of the approaches to Sepé, this tension of desire was revealed with the proposal of an intervention scheduled by the CR-GHC team. The focus of the intervention was to perform a tuberculosis test that could be carried out on the street, close to Sepé’s *locus* – an intervention that was taking too long to occur. However, things did not happen in the expected way, according to the report of one of the caregivers:

We went to his home and he welcomed us warmly. My colleague introduced me as the nursing technician who was going to collect his sputum to perform the tuberculosis test. We explained the procedure to him, but he became apprehensive. We asked him to drink water, but he kept making excuses and seemed to be afraid.

Sepé asked for condoms. He had company and asked her to come to the door. As I knew her, I gave her a hug and we talked for a while. After some time, we returned to the idea of collecting Sepé’s sputum, but he wasn’t convinced yet. We talked about the changes in the X-ray result that needed confirmation through the test, and asked him if he had recently lost weight or if he had night sweats. He answered that he sweated a lot at night. We informed him that these could be symptoms of tuberculosis. He said he didn’t cough and he didn’t have sputum. He

had had lunch a while ago and he was afraid of vomiting if he did the test.

Time went by and we would have to leave soon, so the pressure to perform the test increased. Sepé started to do it, but became agitated and started trembling and sweating. I realized that he was not going to make it because he was very anxious. I tried to calm him, asked him if he wanted to sit down, touched his arm and he said he was okay. I stated that we were not going to do the test at that moment.

I had a guilty conscience for having insisted so much for him to do something that, to me, was simply inspiring, expiring and spitting into the pot, but that, to him, sounded as something terrifying. I was more concerned about confirming the suspicion of the disease than about understanding his pronounced fear in relation to the sputum collection.

We talked for some minutes and I said that, sometimes, we must say no to the other person when we don't want to do something. He then told us that neither his father, who was already dead, his family, nor anybody worried about him like my colleague did, as he visited him every week and accompanied him in the services and through the network. We talked some more and he relaxed, feeling better. After this failure, at least as far as the collection was concerned, we instructed him that, if he was able to collect the sputum into the provided pot, he could contact our service or the Primary Care Unit next to his home. We said goodbye and left. (Field diary, March 2012).

This intervention makes us think about the intense form in which people say no to what is proposed in terms of care, sometimes expressing themselves aggressively, others, feeling sick. To what extent is this form related to our attitude of proposing, or perhaps, delicately imposing care? Do they act like this because they think that we do not understand what they really want? If they said what they desire, would the caregivers understand? It seems necessary to develop some welcoming sensitivity in order to connect with the user's subjectivity, even without words. It is important to be attentive to the way in which an offer of care is proposed, so that it is compatible with the user, rather than listening to the patient with the purpose of convincing him/her regarding tests, medications and procedures that we think are important for 'their' wellbeing.

Another issue that emerged from this intervention is that Sepé argued that he did not care about the disease and its consequences because we are all going to die. However, Sepé was able to try to do something that he did not want to do because of his fear of opposing someone who was concerned about him (all of us are going to die, but he does not want to yet...). Are the CR's objective of offering an inclusive health care service compatible with the user's wants ("his" not

dying?) If he just wants to be important to someone (“his” being alive), will he have to participate in actions despite not wanting to? Is this the only way of attracting some attention? Until when? And if the user does not meet the expectations of the health care team, will he be left aside because he does not comply with what was agreed about care provision (therefore, he can/should die)?

### **Conclusions and confluences of the streets: the sensitivity of the instant!**

The encounters that take place on the street are sensitive and refer to questionings that permeate the distressful imaginary of all who share this care proposal. It is important to highlight, in the presented case-thought, the moment of the approach to the user in which the caregiver takes a moment to reflect on what she was proposing. It makes us think that all professionals should have more moments to pause during the interventions. This pause shelters the other; during pauses, we become closer to the users – to their intimacy and their meanings. In these instants of slowdown, in which sensitivity emerges from under what was instituted, it seems that the caregivers position themselves alongside those they are providing assistance for, in a “composition” of care.

This would be the perspective of the alterity-centered care, which develops in a “mixed zone, capable of escaping the disciplinary limit of the professions and of exposing itself to alterity with users”, allowing original productions (p. 261)<sup>12</sup>. Such instants of courage authorize us to enter into a chaotic logic instead of the place inhabited by disciplinary norms and by the extremely hard “professional” education. Perhaps, in the hurry of the interventions, in the urgency required by the prescribed logic of the care that crosses the health care action, there is something that becomes lost: the sense of accompanying and sharing issues with the person who needs care and shelter.

The moments of pause are the very instants when we stop the time rooted in the prescribed logic and give rise to the production of another type of listening. This is difficult; limitation is the feeling that most affects the professionals, as it is not possible to obtain immediate answers and it is necessary to wait in order to make an arrangement with the time of the other individual, which limits the programmed health care intervention.

We support the composition of care, rather than the usual logic that always tries to organize the patients' time based on professional knowledge. It is not surprising that many users resist the offered welcoming – they become impatient – and, in a certain way, within the logic in which they live, they have a health act when they resist what “invades” them, even if it was with the best intention. Unfortunately – and as astonishing as it may seem -, this resistance and active reaction on the part of the users is seen as unprovoked aggression that must be combated and contained without understanding the life context that is installed there. On the street, both the CR and the health care network need the exposure, the outside, the other side, the surprise, the estrangement, the reverse or the ‘inverse’, or the ‘verse’ – the “poetic” composition of care.

### Collaborators

The author Mário Francis Petry Londero conducted the research with workers of the Office on the Street, collecting and analyzing the field diaries that were written to the production of the paper. Luiz Fernando Silva Bilibio supervised the interventions and writings of the research authored by Mário Francis Petry Londero, who was a resident at the time, and also collaborated with the writing. Ricardo Burg Ceccim evaluated the text that resulted from the research in order to approve Mário Francis Petry Londero, who was a resident at the time, in his TCR (Residency Conclusion Work). In addition, he collaborated with the finalization of the paper, making suggestions and enriching the text.

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