Health care for Homeless People by the Network of Psychosocial Attention of Sé

O cuidado a Pessoas em Situação de Rua pela Rede de Atenção Psicossocial da Sé

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ABSTRACT This qualitative study aimed to know the actions focusing on Homeless People that present mental disorders, developed by two services of the Network of Psychosocial Attention of Sé; identify obstacles and points of strength present in the daily work; and known the opinion of the users about the care received. Most of the actions offered by the services are in line with public policies guidelines, consider the characteristics of the population and seek to respond to their needs. The bond between professionals and users was understood as essential, but there is overload and risk of illness of the professionals.

KEYWORDS Homeless People. Health. Intersectoral collaboration. Mental health services.

RESUMO Este estudo qualitativo teve como objetivos conhecer as ações dirigidas às Pessoas em Situação de Rua que apresentam transtorno mental, desenvolvidas por dois serviços da Rede de Atenção Psicossocial da Sé; identificar obstáculos e pontos de força presentes no cotidiano de trabalho; e conhecer a opinião dos usuários sobre o cuidado recebido. A maioria das ações oferecidas pelos serviços encontra-se alinhada às diretrizes das políticas públicas, considera as características da população e busca responder às suas necessidades. O vínculo entre profissionais e usuários foi compreendido como essencial, mas há sobrecarga e risco de adoecimento dos profissionais.

PALAVRAS-CHAVE Pessoas em Situação de Rua. Saúde. Colaboração intersetorial. Serviços de saúde mental.

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Introduction

Care for Homeless People (HP) should consider the characteristics of this group and respond to their needs through intersectoral actions, preferably, coordinated by Primary Health Care (PHC) (WHO, 2005). Data from the literature show that this population presents precarious conditions of life and health (AGUIAR; IRIART, 2012; VALENCIA ET AL., 2011); is marginalized; has no access to human rights and/ or basic social rights (SARRADON-ECK; FARNARIER; HYMANS, 2014) and is exposed to risk factors and violence (AGUIAR; IRIART, 2012; BARATA ET AL., 2015; RIO NAVARRO ET AL., 2012), which makes it very vulnerable (BARATA ET AL., 2015; CHRYSTAL ET AL., 2015; HALLAIS; BARROS, 2015; SILVA ET AL., 2014).

This group is frequently discriminated against, which hinders their access to employment opportunities (ZERGER ET AL., 2014) and health services (CHRYSTAL ET AL., 2015; SARRADON-ECK; FARNARIER; HYMANS, 2014; SKOSIREVA ET AL., 2014). Access to services occurs, mainly, when there is mediation of specific programs or social assistance institutions and, in general, in the presence of significant grievances of the health conditions (BORYSOW; FURTADO, 2013; RIO NAVARRO ET AL., 2012; VARANDA; ADORNO, 2004).

The health services offer resistance to respond to the needs of this population and restrict their access, which often results in the abandonment of the accompaniments (AGUIAR; IRIART, 2012; BARATA ET AL., 2015; BORYSOW; FURTADO, 2013, 2014; HALLAIS; BARROS, 2015; SILVA ET AL., 2014). Some studies emphasize the limitations in public policies aimed at this group (BORYSOW; FURTADO, 2013, 2014; CHRYSTAL ET AL., 2015; SKOSIREVA ET AL., 2014).

The health field aims at the production of care and not only the promotion and protection of the health condition of each individual. Care should be taken by the citizen as a focus of action, along with his/her life projects and happiness, so that the interventions seek to resume psychosocial and cultural aspects of illness, instead of prioritizing technical-scientific resources (GARIGLIO, 2012).

Health policy proposes guidelines for the monitoring of HP that present mental disorders, but, the assistance practice is permeated by challenges related to the characteristics of this population, the availability of professionals and resources and barriers related to the functioning of services and care networks.

This work had as objectives: to know the actions directed to HP that present mental disorder, developed by the Psychosocial Care Network (Raps) of the Sé region in the municipality of São Paulo, especially, by the teams of the Street Office (SO) of the Basic Health Unit (BHU) Sé and the Center for Psychosocial Care (Caps) Adult II Sé; identify obstacles and points of strength found in daily work; and to know the opinion of the users about the care received.

Methods

This study, of ethnographic inspiration, is part of the field of qualitative research (DALMOLIN; LOPES; VASCONCELLOS, 2002). Data were collected from documentary research, semi-structured interviews and participant observations (FLICK, 2009A).

The documentary research consisted of searching and reading texts of the Mental Health Policy and the policies aimed at caring for the homeless people, as well as the institutional projects of the Caps Adult II Sé and the SO teams of BHU Sé, besides registries and statistics of each service and the network of attention.

The semi-structured interviews followed a previously prepared script and were carried out with managers of the 2 services; 4 professionals of the Caps Adult II Sé (1 nursing auxiliary, 1 pharmacy technician, 1 psychologist and 1 occupational therapist); 13 professionals from both SO teams (1 psychologist, 1 social worker, 1 physician, 2 nurses, 1 nursing auxiliary, 2 Social Agents (SA) and 5 Community Health Agents (CHA)

and 5 users accompanied by Adult Caps II Sé, and by team 5 or team 8 of the SO of BHU Sé. All interviews were recorded and transcribed.

The participant observations were guided by an observational script and registered in the field notebook, which included information, impressions, facts and other aspects that contributed to the understanding of the object studied.

Twenty-seven observation hours were performed: 10 hours related to the actions of the Caps; 12 hours related to the SO and 5 hours to shared actions. The structure of the observation was modulated from the characteristics of the actions and the teams that make up the services, in order to include typical situations of the practice with the HP that present mental disorder. All data were collected between february and april 2016.

The set of data obtained from the interviews and observations was textualized and the material was read and codified by two researchers, to obtain consensus on thematic categories. The codification took place in a hybrid way: from the data (GIBBS, 2009) and from concepts, being guided by the objectives of the research. The findings of the documentary research, interviews and observations were triangulated, to increase their quality and reliability (FLICK, 2009B).

The objectives and procedures of the research were presented to the participants, whose adherence occurred after reading and signing the Free, Prior and Informed Consent (FPIC). It was decided to preserve the identity of the participants, both in the data registry and in the subsequent analysis. For this purpose, all were decoded according to the place they work (SO or Caps) and numbered in the order of the interviews. Service managers were detailed (CRG and CAPSG).

The research project was approved by two Ethics Committes (CAPPesq and CEP/SMS-SP), according to opinions number 1.309.689, CAAE 46268215.4.0000.0068, and number 1.318.055, CAAE 46268215.4.3001.0086.

Context of the study

The center of the city of São Paulo occupies an area of 26.20 Km². It is composed of the following districts: Bela Vista, Bom Retiro, Cambuci, Consolação, Liberdade, República, Santa Cecilia and Sé. The population of the region, estimated by the 2000 Census, was 374.680 inhabitants; and by the 2010 Census, 431.106 inhabitants, which shows a significant increase in population density (SÃO PAULO, 2010).

In 2015, there were 15.905 HP in São Paulo, of which 8.570 were in reception centers and 7.335 stood overnight in the streets. Of this group, 3.864 (52.7%) were in the Sé region (SÃO PAULO, 2015).

The Raps of the Regional Health Coordination Center is composed of 1 School Health Center (CSE); 8 BHU; 11 SO teams; 4 Outpatient Medical Assistance (AMA) services; 2 Caps AD III; 1 Adult Caps II; 1 Caps Child II; 2 Emergency Rooms (ER), which are not references for mental health; 3 reception units.

The Caps Adult II Sé is a service in operation since july 2012 and that, until april 2016, had a team of 34 professionals from different backgrounds (manager; nurses; nursing auxiliaries; physicians; psychologists; occupational therapists; social workers; pharmacists; pharmacy technicians; physical educators; musician; plastic artist; technical-administrative auxiliaries, support staff – who contribute to the development of cleaning, maintenance and care actions, especially, with meals offered to users). According to service data, in september 2015, there were, approximately, 380 people in attendance.

The two SO teams (teams 5 and 8) of the BHU Sé were instituted in 2012, however, since 2008, they have already functioned as Special Family Health Program teams. Until april 2016, both were organized to cover the entire territory of the BHU Sé, and each one was composed of 1 physician, 2 nurses, 1 nursing auxiliary, 6 CHA and 2 SA. A social

assistant and a psychologist offered support to both teams. According to data from the service, in january 2016, each accompanied, approximately, 200 users.

Results

Actions developed by the services

THE PRACTICE OF CAPS ADULT II SÉ

For the interviewees, the work proposal of the Caps is aligned with the public policy of mental health and the assumptions of psychosocial rehabilitation. The objectives of the work are: the construction of networks; the development of autonomy and the organization of users; the expansion of experiences; sensitization in the fight for rights; the expansion of the care network; and the reduction of risks and vulnerabilities.

It is a consensus among professionals that care for HP should, initially, respond to immediate needs, such as food supply, bath and rest, so that it is possible to receive and listen to them. All refer that this conduct also contributes to the connection of the user to the service.

The professionals describe the accomplishment of actions in the territory as a strategy to access users that do not arrive or are not linked to the unit and to offer necessary care. The permanence of the user in the service is understood as a factor that contributes to the organization of daily life:

> The very fact that the person is going there every day and having that routine of taking the medicine, talking to some people, eating, bathing, is already a resource. (Caps1).

The situations of crises of the users demand intensification of actions, such as the activation of urgency and emergency services and presence of the team in the context in which the

user is. However, it was observed that the possibility of dealing with serious cases is limited by the lack of resources and the difficulties of attending them in the face of the demands of other users.

The concept of 'open door', defined as the availability of the service to the reception throughout its working period, without the need for scheduling (BRASIL, 2015), characterizes the functioning of Caps: *"The doorway is always the first recpetion. It is open door from 7 a.m. to 7 p.m., from monday to friday, it is a CAPS II"* (CAPSG).

Despite the consonance of the interviews about the guiding principles of the work, it is perceived that the actions and conceptions of care are not consensual among professionals. There are theoretical and technical divergences that can restrict the insertion of users in the service and produce actions that do not dialogue with the conceptions of all. Among the professionals, there are also different levels of engagement and involvement: some are not responsible for the development of the work, which can generate overload to the others:

> There is something more of the professionals than a more consolidated thing, a policy [about] what to do with the reception. [...] It has some general guidelines, but it depends on what the professional evaluated at that moment, and, depending on the professional, this user can be inserted or not in the service. (Caps1).

The accomplishment of the work overloads the professionals, since there is insufficient human, structural and material resources; insufficient food for users; of funds for transportation; of medicines and nursing supplies.

The team did not receive initial training or initial capacitation; only a process of discussions and presentations about the work. The team does not have clinical-institutional supervision.

THE PRACTICES OF THE SO TEAMS OF THE BHU SÉ

The interviewees describe the proposal of work in a complementary way and highlight, among the actions they carry out: sensitization of the HP regarding their rights; prevention and attention to risk groups; follow-ups to external consultations and services; provision of care, medications and basic care, such as food, bath and clothes; contact with family members and support social network. They evidence that the demand of the user will define the actions to be performed.

The HP can freely access BHU according to their demand. Access to the service is facilitated by the constant presence of a professional of the teams in the unit and direct referral to the reception rooms, without the need to open identification forms:

There is no need to schedule anything for the street patient. He comes and he does that. [...] being able to adapt the service in some way to the needs of those we take care of makes all the difference. (CR9).

The daily presence of the teams on the streets is a strategy to maintain the frequency of approaches to users and ensure continuity of care. Active search and constancy in the territory are resources for approximation and bond, which are slow in most cases, occur in the user's time and demand persistence:

One of the experiences I've had is that, since the first week here, I've been making weekly visits with a community agent, and I spent a year calling this [person]: *'Let's go', asking what he has: 'No, I do not want to', that was the answer', 'I have nothing'. Last week, even before I came to him, he came to me and asked for help [...] it was not the time of the service, it was his time.* (CR2).

The persistence of the team and its responsibility for care are highlighted by professionals, who describe approaches that address the needs of users:

We'll do whatever it takes to [the action] *make it happen, but it has to happen. Patient who takes continuous medication and can't handle taking it alone, it is the team that controls the medication, fractionates, separates, dispenses every day. If he does not come here, you go* [to wherever] *look for him and give him the medication.* (CR9).

Regarding the development of the work, it is a consensus among professionals that human resources are insufficient to meet the demands of the HP. There are only a few cases that improve during follow-up:

We do not have enough legs or arms. Many times, we will have a limit and stop there; we will not get more than that. (CR1).

Of 100, 150, 200 patients, there is 1 that we can manage to improve his situation. (CR10).

There are no physical and structural resources, such as space, living room, furniture, transportation; and material resources, such as supplies, medication, food and budget. The restriction of resources is understood as a limiting factor of work and produces suffering for professionals.

Teams do not receive supervision and mental health care and and had no training; currently, they receive very specific training. They say there are no directives and no clear guidelines for the work, and, therefore, learning takes place through the confrontation of practice.

ARTICULATIONS BETWEEN SERVICES

The articulation between services is understood as necessary for the care of HP, however, professionals describe difficulties of articulation and sharing with the network and affirm that the result of sharing will depend on the relationship established between the services (whether horizontal or hierarchical) and the conception of care, organization and permeability of each of them to receive HP.

Divergences about alignment of care can compromise actions and limit continuity:

> *When you work with services that have very different ways of functioning and flows, it's a bit complicated [...] the specialty places itself in a much higher place than Basic Attention. It is very difficult to argue with* [the expert]*, because he knows everything about that subject and ignores what the team that is in the territory every day can bring.* (CR9).

The articulations between services are facilitated from personal contacts and the previous relationship among professionals; therefore, the whitdraw of one of them can affect the continuity of the networking.

The difficulty of services in sharing responsibility for actions results in little openness to users, new referrals, overloading of responsible staff and limitation of care: *"Sometimes, you look for a support network, and that network sends you to another, and it is kind of a pushing and shoving game".* (CR1).

There are difficulties and lack of commitment of the management to support with teams referrals of situations that demand articulation and convene attention points.

Obstacles of daily work

CHALLENGES OF THE CARE

All professionals interviewed consider that the development of work with the homeless people is challenging due to the characteristics of this population, such as nomadism, immediacy in the demands presented, use of alcohol and other drugs, absence of support social network, difficulty of organization and perception of discrimination.

Nomadism is understood as the permanent situation of itinerant movement of the person in a street situation by different regions, which hinders the continuity of care.

Immediacy is understood as the urgency

to obtain what is desired and is related to access to services because this group knows the resources of the network of attention, but only seek them or accept help when perceiving urgent need or when faced with evident worsening of their health condition. In this regard, it is important to respond to the request of the HP for care at the time they seek the service or accepts help:

> *The user is short-sighted, it is at that moment that he decided to want to help himself. And* [when] *we* [come to the services, find professionals who do not answer and say]: *'it's not here, you have to go there', and even the patient perceives and already gives up too.* (CR11).

Professionals state that it is hard to respect and understand the time of the user to accept care and, sometimes, experience the feeling of failure, suffering and non-recognition of their work, which carries the risk of some actions being imposed:

> *The team has already done everything for him: hospitalizations, care with the clinical health, multidisciplinary intervention, intersectorial, quite actuation of Caps. But they forgot to ask* [him] *what he wanted... that's terrible.* (CR2).

Alcohol consumption is presented as a major problem that, in addition to resulting in health problems, poses as an obstacle to access to users. The presence of mental disorder is also a factor that hinders care, but its incidence is considered to be lower than alcohol dependence.

The difficulty of HP with respect to organization, especially, temporal orientation, is described as a factor to be considered in the development of care:

> [The person] *does not have a clock, does not even know what day of the week is [...] Temporality is greatly impaired for those who live on the street; it is important to remember when* you *have an appointment booked.* (CR9).

The annoyance of the people and the professionals before the presentation and the hygienic conditions of the HP is perceived by these users. The experience of situations of discrimination in services can produce abandonment of monitoring and restrict the search for help:

Many times, they have difficulty coming [to services], *sometimes, because they have not been well received at some point. And they think that in all services they go to, the attention will be the same.* (CR1).

RISK OF OVERLOADING AND ILLNESS OF THE PROFESSIONALS

The constant exposure to the context and the fragilities of the users, added to the emotional involvement inherent to the development of the work, generates overload, produces a feeling of exhaustion and risk of illness, which justifies the need to take care of the teams:

When you leave here, you feel exhausted, or of not having dealt that, or of having, but it has messed you up a lot. (CR1).

There was an agent who worked for 90 days, she was traumatized and left because she could not sleep at night, so we also need care in every way. (CR3).

The contact with difficulties related to the development of the work can hinder the involvement of the professional and, consequently, the offer of care. Not getting involved is a way of protecting yourself from difficult situations, but that can produce actions that are unrelated to the user needs and the care guidelines.

Strenght points of everyday work

ESTABLISHMENT OF BOND AS A CARE BASIS

The difficulties present in the construction of bonds with this population are explained and attributed to the nomadism, to the interaction impaired by the consumption of alcohol and other drugs and to the distrust that comes from the situations of suffering and deprivation experienced by the HP. Bonding is understood as the process of approximation of the user to register him/her and initiate follow-up and, also, as the process of building the care relationship, which involves establishing a relationship of trust, closeness and accountability:

I had a patient, that is not a positive story, a d. M. She was one of the first ones I registered and we made a very strong bond. And when she had a stroke and died, I got really bad, I really felt it. And we did the burial, we provided it, it was something that looked like someone from my family. (CR13).

The professionals explain that there must be affective involvement in the construction of the bonding process and that, therefore, it is not possible not to be affected by each case and its trajectories:

You have to worry if [the person] *is going to go back to the street, if is going to sleep in the open. As much as you say, 'oh, I do not think about it', but you do, yes. I think this overload a lot the professionals, both mental health professionals like us, from the SO. There is emotion... If the words they use most are bond, empathy, how am I going to say 'ah, it's his problem'? From the moment you know the story of the person and do not make judgments, it is difficult to detach.* (CR13).

The affective bonds tend to mobilize the professionals to dedicate themselves more to the care due to the approximation, the understanding and the recognition of the fragilities and necessities of the users. Such dedication can result in the performance of actions taken outside working hours or supported by own resources:

We talk, even outside work. Sometimes, I see him on the street, stop and talk. I know it's not right,

out of my working hours. Maybe just talking will make him feel important. (CR7).

There was a patient, I. [...] He passed away, and I had to recognize his body. I took out of my pocket the money to go to the Medico-legal Institute 3 days in a row for him not to be buried as an indigent. (CR10).

CITIZENSHIP AS A CARE NORTEATOR

The promotion of citizenship and access to rights are strengths in the accomplishment of the work, and their presence as a guide of actions qualify the care offered:

Users are treated as citizens [...] they are seen as people of right, who have will, desire, life, they are not an ICD 10. That is a very strong point of this team [...] we go after the right of these people, of a benefit [...] we change their condition of life, making them have some of their rights guaranteed. (CAPSG).

The involvement of the user in the care process is a point of strength and source of power and quality for the development of actions:

When we can access the user, involve him and respect him, in his entirety, we have [much] *potential. We can get the patient out of point A and take him to point B. This is where we see the quality of our work and the enormous difference we can make in daily practice, in the service we provide.* (CR2).

For professionals of the Caps Adult II Sé, this service differs from other Caps by attending a large number of HP. The work developed requires a lot from the team and exposes them to violent and unhealthy situations, but they need to be encountered so that care is offered to guarantee the right of follow-up of these people.

The work of the HP teams is characterized

as a strength point and facilitator for the care offered by other services, for expanding access and for already having a bond with the user and contact with their context of life:

This person, if he came here alone, would not have the reception he used to have. Even coming with a health professional, you have difficult accessibility. The RC is a facilitator so that the person can access other services. (CR1).

The CHAs and SAs, when monitoring users, provide security and defend their right to service and access to services:

That's a fight, because I will not let the patient return without being treated. If the one who is in supervision does not want to attend, I look for who is superior to him, and someone has to attend. (CR12).

Opinion of the users on care received

It is a consensus among the interviewed users that the services, professionals and care offered are good. One of them emphasizes that care is endowed with attention and commitment, unlike other services by which he has already passed, which only renew recipe and do not serve well.

Users describe that the search for rights, such as assistance to get a job, benefits and housing, and the expansion of everyday possibilities, such as an insertion into new activities, are actions offered by the services:

Today I'm in a little stall, which Caps and SO helped me to find. They helped me to do Loas [Organic Law of Social Assistance]*, and, with the* [money] *that I get from the bank, I pay rent, buy* [things] *to home.* (U5).

The importance of having someone to talk, who offers affection and attention, is recognized by the users, who emphasize that the services increase the social network

of support from the construction of new relations.

All users emphasize the importance of the bond between professionals and users for the effectiveness of care. The rupture of relationships from the withdraw of professionals produces suffering and carries the risk of discontinuity of the accompaniment.

Discussion

Development of actions

The work developed by the service teams is aligned with public health and mental health policies. The actions are guided by ethical principles and psychosocial rehabilitation presuppositions, configured by the construction and/or rescue of citizenship and by the validation of the population served as subject of rights. The users recognize that the actions developed by the services bring daily benefits in the social scope, in the validation of their rights and in the construction of new possibilities of life.

The Caps Adult II Sé, for being guided by the 'open door'principle, ensures the right to welcome all users who seek care. The prioritization of HP attendance at UBS Sé and the non-bureaucratization of access procedures are evident in the absence of prior scheduling and opening of identification forms. There is, thus, 'positive discrimination' of this population, since facilitation of the access respects the principle of equity and recognizes the greater vulnerability of this group. Studies have emphasized the importance of approaches in the life context of people and actions that seek to facilitate their access to services (LISBOA, 2013; LONDERO; CECCIM; BILIBIO, 2014; SARRADON-ECK; FARNARIER; HYMANS, 2014; SILVA *ET AL.*, 2014). Despite this, there are professionals who ignore, who are not prepared or do not conform to the guidelines of the Policy, and, therefore, develop practices guided by personal and subjective criteria.

The effort of most teams to develop a quality work in the midst of obstacles is noted such as: absence of care with the teams, in the mental health and training scope; need for improvement of actions and intersectoral articulations; insufficient human, structural and material resources; lack of monitoring and management support in the development of work. The results explain that actions are developed according to the guidelines, but it is necessary to overcome difficulties for this to occur.

Professionals, in particular those of the SO, highlight the difficulty of some services in considering the specificities of working with HP and in not adapting their functioning to respond to the needs of this group. There are services that do not ensure their right to care or that serve in a discriminatory way this population, which contradicts guiding principles of care proposed by the policies.

The difficulty of articulation between the points of the network and the lack of co-responsibility are described as challenges of care for HP. Their reception in the services can be harmed by the discrimination and the distance of the professionals, as well as by the bureaucratization of the care. The discrepancy between conceptions of care that guide services also undermines the construction of shared work (BORYSOW; FURTADO, 2013, 2014; HALLAIS; BARROS, 2015; LISBON, 2013).

The articulation between services is facilitated between personal contacts based on the previous relationship between professionals. This way, networking is fragile, since the absence of an articulating professional can compromise care (BORYSOW; FURTADO, 2014).

The results of the study make it possible to affirm that the norms proposed by health and mental health policies are not enough to guarantee the alignment of work and care processes. This may be due to the absence of models that clearly and objectively orient the development of practices, especially,

with regard to the role of the team and its different components. This gap is one of the aspects that determine the differences in the style and modeling of the work developed by the services and the teams in the same network.

For Hallais and Barros (2015), the current public policies do not guarantee the integral care to HP, and the offer of actions by the health services is limited due to the conditions of precariousness, deprivation and invisibility of this population. Lisbon (2013) emphasizes the need to build a care line for HP that is based on its characteristics and considers the determinants of the health-disease process, clinical problems and difficulties faced in the relation with the care network.

Obstacles and strength points of work

Aspects that characterize the opinion of the professionals about HP and that influence the development of actions agree with findings of the national and international literature and reaffirm the complexity involved in understanding and offering care to this group. The work with the population in the street situation is intuitive and experimental, therefore, it demands intense approximation of the users accompanied, as well as creativity and imagination on the part of the professionals. However, it is not recognized as care. It is devalued and misunderstood (SARRADON-ECK; FARNARIER; HYMANS, 2014).

The construction of bonds between professionals and users is the axis of the care process. The importance and centrality of building bonds as a central strategy for health work is a consensus in the literature, also debated in the field of attention to people in situations of extreme social vulnerability (HALLAIS; BARROS, 2015; LISBOA, 2013; LONDERO; CECCIM; BILIBIO, 2014; SARRADON-ECK; FARNARIER; HYMANS, 2014; SILVA *ET AL.*, 2014). The investment in the construction, maintenance and expansion of the bonds is possibly the main characteristic of

the work and is articulated to the SUS guidelines for the operation of the Health Care Network (RAS) and Raps (BRASIL, 2010, 2011).

The interviews with users also confirm this importance, since they evidence that, for them, the perception about how they are welcomed, listened and oriented, added to the affective character of these moments of communication, are the best quality indicator of a service or a team. For them, care is effective when they recognize the existence of a bond with the professionals who offer the actions, so that listening and affection take place during the follow-up process.

Empathy supports the construction of relationships in which professionals and users affect each other: professionals sympathize from the contact with the fragilities of the users, which influences the performance of actions; and users find affection and acceptance in the actions offered by the professionals. For Sarradon-Eck, Farnarier and Hymans, (2014), it is essential and vital that HP feel that someone cares about them.

The presence of this form of bonding contributes to the construction of humanized relations, which favors the recognition of the needs of the population and the production of actions that seek to answer them. Professionals, specialy, the CHA, defend the rights of HP to access services and receive quality care. The role of the CHA as a potential for work is also described in the study of Lisbon (2013).

The overload of professionals in face of the fragilities of users and the precariousness of services can also explain the heterogeneity of the practices and their more or less strong relation with the guidelines of the health policy. In order to avoid further distress, the non-implication with the development of the work may be a response of some professionals, which highlights the need to take care of the teams and offer permanent and non-occasional support and supervision processes (LONDERO; CECCIM; BILIBIO, 2014).

The results also highlight the importance

of educational and training spaces that increase the possibilities of responses of the teams to the needs of the HP (BORYSOW; FURTADO, 2013; LONDERO; CECCIM; BILIBIO, 2014).

Based on the above, it is important to emphasize that there are multiple factors that define the direction of actions directed at the street population. There is, therefore, a need for all those involved, especially, the management, to be involved in the set of elements that determine the production of social actions and care and in the organization and management of services and teams.

Conclusions

The care offered by the health services to the population of HP who present mental disorder is in line with the proposed guidelines. In its majority, the work of the teams is characterized by the involvement of professionals who seek to respond to the needs of this group.

The relationships established between professionals and users are humanized and contribute to the construction of actions based on affection, in which the user is validated as a subject of rights.

In this context, the health sector plays an important role in the construction of citizenship, and the teams are close to the new mental health care paradigm, in which subjects are not reduced to objects or diagnoses.

Citizenship guides the process of care and imbues professionals with the responsibility of mediating the relationship of users with other services, to ensure their access and seek care tailored to their needs.

Intersectoral work is understood as essential in the care of this population, but its implementation is not always possible due to the difficulties of the services in considering characteristics and needs of this group in their planning and organization.

Public health and mental health policies propose complex and demanding goals. Despite the efforts of the team to comply with them, there are real aspects that limit the accomplishment of good practices and evidence the need for articulation between public policies and the implication of different sectors, besides health and social assistance, in the construction of care directed to this population.

The possibility of deepening the theme and the limitations of the existing publications so far indicate the need for further studies on the work with HP.

Collaborators

Livia B. van Wijk wrote the article and worked on the analysis and interpretation of the data. Elisabete Ferreira Mângia collaborated in the conception, writing and revision of the article. ∎

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