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Beyond addiction: neglect of the mental health of people experiencing homelessness in clinical and social care

Muito além do vício: negligência da saúde mental de pessoas em situação de rua no cuidado clínico e social

Mucho más allá de la adicción: negligencia de la salud mental de las personas en situación de calle en la atención clínica y social

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Abstract:
This review article analyzes the neglect of mental health among people experiencing homelessness when clinical and social care is predominantly centered on alcohol and other drug use. It draws on the author's professional experience as a nursing technician in a Street Outreach Clinic as a source of reflection, with no identifying user information or primary data collection. This qualitative, exploratory and descriptive study combines bibliographic and documentary review with practice-based reflection informed by ethnographic sensitivity, without claiming to be formal field ethnography. Secondary evidence includes the Ipea estimate of 281,472 people experiencing homelessness in Brazil in 2022 (Natalino, 2023) and published qualitative studies on stigma and mental-health access. Personal reflections are clearly distinguished from empirical research results and do not support prevalence estimates. The discussion addresses harm reduction, the Psychosocial Care Network, continuity of care, patient-centered planning and intersectoral collaboration. Comprehensive care requires recognizing individual histories beyond substance use and reducing institutional barriers.

Keywords:
Homelessness; Mental Health; Street Outreach Clinic; Harm Reduction; Psychosocial Care.

Resumo:
Este artigo de revisão analisa a negligência da saúde mental de pessoas em situação de rua quando o cuidado clínico e social é organizado de maneira excessivamente centrada no uso de álcool e outras drogas. Parte-se da experiência profissional do autor como técnico de enfermagem no Consultório na Rua, mobilizada como lugar de problematização, sem identificação de usuários nem coleta primária planejada para pesquisa. O estudo é qualitativo, exploratório e descritivo, de revisão bibliográfica e documental, com reflexão sobre a prática de inspiração etnográfica, sem se apresentar como etnografia de campo formal. A literatura e as normas analisadas tratam de estigma, redução de danos, Reforma Psiquiátrica, RAPS e Atenção Primária. Como dado secundário, destaca-se a estimativa do Ipea de 281.472 pessoas em situação de rua no Brasil em 2022 (Natalino, 2023). Estudos empíricos publicados documentam experiências de discriminação e barreiras ao cuidado (Brito; Silva, 2022; Silva et al., 2026). A reflexão profissional, identificada separadamente, não é empregada para estimar frequências, produzir diagnósticos ou atribuir causalidade. Defende-se acolhimento ampliado em saúde mental, Projeto Terapêutico Singular, redução de danos, registros adequados e articulação intersetorial. Conclui-se que o cuidado integral requer compreender trajetórias singulares, enfrentar estigmas e garantir continuidade no território.

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Palavras-chave:
População em Situação de Rua; Saúde Mental; Consultório na Rua; Redução de Danos; Atenção Psicossocial.

Resumen:
Este artículo de revisión analiza la negligencia de la salud mental de las personas en situación de calle cuando la atención clínica y social se organiza de manera excesivamente centrada en el consumo de alcohol y otras drogas. Parte de la experiencia profesional del autor como técnico de enfermería en el Consultorio en la Calle, utilizada como punto de problematización, sin identificación de usuarios ni recogida de datos primarios planificada para la investigación. El estudio es cualitativo, exploratorio y descriptivo, de revisión bibliográfica y documental, con reflexión sobre la práctica de inspiración etnográfica, sin presentarse como una etnografía de campo formal. La literatura y las normas analizadas abordan el estigma, la reducción de daños, la Reforma Psiquiátrica, la Red de Atención Psicosocial (RAPS) y la Atención Primaria. Como dato secundario, destaca la estimación del Ipea de 281.472 personas en situación de calle en Brasil en 2022 (Natalino, 2023). Estudios empíricos publicados documentan experiencias de discriminación y barreras para la atención (Brito; Silva, 2022; Silva et al., 2026). La reflexión profesional, identificada por separado, no se utiliza para estimar frecuencias, realizar diagnósticos ni atribuir causalidad. Se defiende una acogida ampliada en salud mental, el Proyecto Terapéutico Singular, la reducción de daños, los registros adecuados y la articulación intersectorial. Se concluye que la atención integral requiere comprender las trayectorias individuales, combatir los estigmas y garantizar la continuidad en el territorio.

Palabras clave:
Personas en situación de calle. Salud mental. Consultorio en la Calle. Reducción de daños. Atención psicosocial.

Introduction

The homeless population occupies a paradoxical place in Brazilian cities. It is intensely present in the public space and, at the same time, remains socially invisible in essential dimensions of its existence. The street exposes bodies, needs and conflicts, but does not necessarily produce recognition of stories, bonds, losses, desires and sufferings. In the health field, this contradiction appears when the service focuses on the most visible or socially stigmatized problem and leaves in the background other needs. Among people who use alcohol and other drugs, there is a risk of consumption becoming a kind of total explanation of the subject's life. (Natalino, 2023; Brasil, 2009a)

To delimit the vocabulary of the study, the word "addiction" is used in the title as an expression of common sense and social labeling, not as a psychological or psychiatric diagnosis. The Brazilian Dictionary of the Portuguese Language presents, among its meanings, both persistent habit and dependence on alcohol or other drugs, as well as moralizing meanings associated with reprehensible behaviors (Michaelis, [s.d.]). In this article, "advice" specifically

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designates the label that tends to reduce people with substance consumption to a unique identity. In the clinical description, it is preferred to "use of alcohol and other drugs", "problem use" or "disorders related to the use of substances", according to the criteria and the evaluation of qualified professionals. The use of substances alone does not allow the diagnosis of dependence.

According to Natalino (2023), the estimate of the Institute of Applied Economic Research (Ipea) for the year 2022 was 281,472 homeless people in Brazil. The number results from a statistical model fed by administrative and municipal information; therefore, it should not be confused with individual census count or taken as the current number of people in 2026. This quantitative dimension highlights the need for national policies, but does not inform, by itself, the prevalence of mental disorders or problematic use of substances.

This work is born from the author's professional experience as a nursing technician in the Street Outreach Clinic. In his reflection on the territorial daily life, the author identifies as a research question the possibility that manifestations of psychological distress receive secondary attention when the initial reading privileges the use of substances. This perception is a reflexive starting point, not result of attendance counting or evidence that such a situation occurs with a certain frequency. The study investigates this hypothesis in the light of scientific production, which records experiences of stigmatization and access barriers (Brito; Silva, 2022; Silva et al., 2026). The problem is not to deny the clinical relevance of alcohol and other drugs, but to avoid that depression, anxiety, psychotic symptoms, trauma and grief are interpreted exclusively as a function of consumption.

The normative organization of the Street Outreach Clinic supports an expanded conception. Historically, the GM/MS Ordinance no 122/2012 defined multiprofessional teams aimed at different health problems and needs, including the use of alcohol and other drugs and the articulation with UBS, CAPS and urgency. More recently, the Ordinance GM / MS no 11.692/2026 established the National Policy of Integral Attention to the Health of the Population Experiencing Homelessness (PNAIS-RUA), reinforcing integrality, harm reduction, coping with discrimination, psychosocial care and intersectoral articulation (Brasil, 2012a; Brasil, 2026a).

The question that guides the research is: how is the mental health of homeless people neglected in the context of clinical and social care when the focus is predominantly on the use of alcohol and other drugs? The hypothesis is that this neglect stems from the combination of stigma, network fragmentation, access barriers, care routines centered on immediate problems

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and insufficiency of systematic strategies to recognize mental suffering in contexts of extreme vulnerability.

The general objective is to discuss the ways in which the mental health of homeless people can be neglected in clinical and social care, articulating literature, public policies and reflection on professional practice. As specific objectives, it seeks to characterize observable mental health demands in this field; identify social, institutional and clinical factors associated with the invisibility of suffering; discuss the effect of stigma linked to the "addiction"; examine limits and potentialities of the network; and propose practical and intersectoral recommendations to qualify care.

The social relevance of the study is linked to the fact that the street situation concentrates different forms of vulnerability. Poor or non-existent housing, food insecurity, exposure to violence, difficulty in accessing hygiene, documentation and transportation, discrimination and disruption of bonds can produce or aggravate psychological distress. At the same time, severe mental symptoms can hinder the search for rights, the continuity of treatments and the reconstruction of support networks. It is not, therefore, a linear relationship between ‘disease' and ‘street', but processes that feed back. (Organização Mundial da Saúde, 2022; Brasil, 2014)

The clinical relevance appears when it is considered that a limited assessment can generate equally limited responses. If agitation, isolation, distrust, irritability or disorganization are automatically attributed to the use of substances, the possibility of investigating other hypotheses and understanding the context is lost. Similarly, requiring abstinence as an implicit condition for reception can remove users precisely when the bond is still under construction. Territorial care requires to tolerate complexity, to work with possible objectives and to recognize that adherence is not synonymous with obedience. (Brito; Silva, 2022; Marques et al., 2022)

At the academic level, the work intends to contribute to a reading that brings together Psychology, Collective Health and interprofessional practice. Mental health cannot be considered only as an internal attribute of the individual. Social conditions, power relations, experiences of violence and concrete opportunities for social participation interfere in the production of suffering and in the possibilities of recovery. Therefore, discussing the mental health of homeless people implies discussing rights, territory, access, citizenship and intersectoriality. (Organização Mundial da Saúde, 2022; Amarante, 2007)

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Methodological path

This is a qualitative, exploratory and descriptive study, organized as a bibliographic and documentary narrative review, with critical reflection on the author's professional experience. The narrative review selects and discusses works and documents pertinent to the research question; it is not declared systematic review, nor is it stated the exhaustion of all available bases or publications. The descriptive character consists of the characterization of concepts, guidelines and problems identified in the sources. The reflection on the work was provided by the performance in the Street Outreach Clinic, which made it possible to understand the ethnographic sensitivity by considering practices, relationships and territorial meanings, but does not configure a formal field ethnography, as there was no protocol of participant observation, recruitment or primary collection planned for this study (Minayo, 2014).

The bibliographic and documentary review articulates three classes of materials: (a) scientific and conceptual studies on stigma, inequalities, harm reduction and territorial practices; (b) empirical research published with procedures and participants explained by the researchers themselves; and (c) norms and reports of public agencies. Decree No. 7.053/2009, Law No. 10.216/2001, Ordinance GM/MS No. 2.436/2017, Ordinance GM/MS No. 11.692/2026, Technical Note No. 103 of Ipea and scientific publications on access to RAPS and care for homeless people are used. (Brasil, 2001; 2009; 2017; 2026a; Natalino, 2023; Brito; Silva, 2022; Marques et al., 2022; Silva et al., 2026).

The professional experience material serves exclusively as a source of questions and interpretative reflection, not as an empirical database, case study or systematic observation record. No names, individualized ages, dates of attendance, descriptions of specific locations, collected speeches, transcripts of medical records or combinations of information that allow recognizing people attended. Expressions as "in the author's professional experience" point out points of problematization, which are compared with literature and documents, without assigning to these perceptions the result of research with participants.

Table 1 — Nature of materials and scope of statements

Type of material	Example in this undergraduate thesis	What it supports
External empirical research	Brito e Silva (2022); Marques et al. (2022); Silva et al. (2026)	Results obtained by the cited authors, in the places and samples studied; without extrapolating prevalence.

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Type of material	Example in this undergraduate thesis	What it supports
Official secondary data	Natalino (2023); Brasil (2023a; 2023b)	Contextualized numbers per year, coverage and production method; do not represent local clinical data.
Norm, theory and literature	Brasil (2009a; 2026a); Goffman (1988); Crenshaw (2002)	They support definitions, principles and interpretations, but do not demonstrate, alone, the execution of policies.
Professional reflection	The author's experience as a nursing technician in the Street Outreach Clinic	Problematization of practices and hypotheses; it does not constitute primary collection, census, interview or diagnosis.

Source: elaboration of the author, based on the methodological classification of the materials used.

To make explicit the difference between the sources, it is distinguished: secondary empirical evidence, when data comes from interviews or systematic observations conducted and published by other researchers; documentary or administrative data, when government records or statistical estimates are cited; and professional reflection of the author, when general dilemmas experienced in the assistance performance are interpreted. The three types of material perform distinct functions and are not interchangeable.

The discussion was organized in thematic axes: (a) street situation and social determinants; (b) stigma associated with substance use; (c) invisibility of other mental health demands; (d) bond, territory and harm reduction; (e) network fragmentation; and (f) possibilities of intervention. The grouping dialogues with the perspective of thematic analysis and content presented by Bardin (2011). This is an interpretative organization of the review and reflection, not of categorization of interviews or clinical records collected for this research.

As a limitation, the article does not estimate local prevalence, does not compare samples, does not test causal relationships and does not present primary results produced with service users. Its conclusions are interpretations of literature, public documents and general issues of professional practice, without the intention of representing all services or all people in the street.

The professional experience contributed to formulate the problem and to the reflective discussion, but did not compose corpus of interviews, individual reports, medical records or systematic observations of the research. The empirical information discussed is attributed to the authors of the published studies; the population data are presented with their sources, dates and limitations.

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ANALYSIS AND DISCUSSION Street situation, exclusion and social determinants of health

The street situation cannot be explained by a single cause. Decree no. 7.053/2009, landmark of the National Policy for the Population Experiencing Homelessness, recognizes the heterogeneity of this group and associates the condition with extreme poverty, interrupted or weakened family ties and lack of regular conventional housing, also considering the use of public spaces and reception units. This definition is important because it moves the analysis of an individual moral reading to a social and political understanding. (Brasil, 2009a)

Street trajectories can involve unemployment, precarious work, family conflicts, domestic violence, loss of housing, migration, illness, mental suffering, problematic use of substances and absence of support networks. These factors do not necessarily appear in the same order. For some people, mental suffering precedes going to the street; for others, it is aggravated by the experience of living in it. The same applies to the use of alcohol and drugs. The relationship is dynamic and requires care to avoid simplistic explanations. (Brasil, 2014; Natalino, 2023)

The continuity of care depends on the availability of relevant clinical information, legible records and communication between care points. In the multidisciplinary review of Haggerty et al. (2003), the informational continuity integrates the elements that allow connecting services made over time. In the SUS, the National Primary Care Policy assigns to Primary Care functions of coordination, longitudinality and registration of actions (Brasil, 2017). This does not mean crystallizing labels: the record should describe symptoms, conducts and context with objectivity, avoiding moralizing formulations capable of harming the reception (Brito; Silva, 2022).

The street produces a specific form of exposure. Sleeping in public places, relying on reception equipment, dealing with weathering, protecting belongings and seeking food make everyday life crossed by immediate needs. Under these conditions, attending a consultation scheduled for weeks later, maintaining medicines, maintaining documents or following a rigid therapeutic routine can be extremely difficult. Therefore, the so-called ‘non-adherence' needs to be analyzed in the light of the concrete conditions of life. (Brasil, 2014; Marques et al., 2022)

The notion of social determinants of health helps to understand why care cannot be restricted to the symptom. Mental health is influenced by income, housing, education, work, social relations, security and access to services. When these dimensions are deeply weakened,

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exclusively individual interventions tend to reach only part of the problem. This does not mean that the clinic loses importance; it means that the clinic needs to dialogue with the territory and with other policies. (Organização Mundial da Saúde, 2022)

In the field of Collective Health, Mattos (2001) develops integrality as a refusal of fragmentation and openness to dialogue between needs and practices. The user does not arrive at the service divided into independent parts. Physical complaint, substance use, mental suffering and social need may be interconnected. The team needs to establish priorities without erasing dimensions. This ability to integrate is especially relevant in high vulnerability scenarios, in which problems accumulate and change quickly. (Brasil, 2009b; Brasil, 2026a)

It is also necessary to recognize that the homeless population is not a homogeneous group. Age, gender, race, disability, sexual orientation, time on the street, family ties and clinical conditions cross needs and risks. This heterogeneity is expressly recognized in Decree No. 7.053/2009 and in the 2026 PNAIS-RUA, which highlights social markers and intersectional inequalities (Brasil, 2009a; Brasil, 2026a). In conceptual terms, intersectionality, discussed by Crenshaw (2002), helps to examine how discriminations combine, without reducing subjects to fixed categories.

The experience of being constantly observed, expelled, suspected or treated as a threat affects subjectivity. Symbolic violence is added to physical and institutional violence. The repetition of refusals can produce distrust in relation to services and professionals. In this scenario, bonding is not a relational detail; it is care technology. The regular presence of a team, the fulfillment of combinations and the listening without humiliation can gradually reconstruct the possibility of asking for help. (Brito; Silva, 2022)

The concept of social disaffiliation, discussed by Castel (1998), allows thinking the street situation as a simultaneous weakening of insertions in work, in the family and in protection networks. It is not a matter of affirming that every person on the street is ‘no bonds', because many maintain affective and community relationships. The concept helps to understand, however, that the loss of social support increases exposure to risks and reduces alternatives in the face of crises. (Saraceno, 2001)

Poverty should not be treated as a moral failure. When services interpret social needs as lack of individual effort, they produce culpability. In mental health, this can occur when suffering is understood as a personal inability to change life. A perspective of rights requires recognizing objective limits and building negotiated goals, avoiding unreal promises and requirements incompatible with the user's daily life. (Goffman, 1988; Brito; Silva, 2022)

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Violence is a frequent component of extremely vulnerable trajectories and can occur before and during the street situation. The clinic needs to consider exposure to aggression, abuse, threats, mourning and experiences of incarceration or institutionalization without assuming that everyone has the same story. A practice informed by trauma avoids invasive interrogations and seeks to build security, predictability and choice. (Brasil, 2014; Organização Mundial da Saúde, 2022)

Racism and social inequality also need to be considered as determinants of health. A psychology committed to human rights cannot treat discrimination as a peripheral event when it participates in the daily experience of the subject. The recognition of these dimensions does not mean to reduce the person to social markers, but to understand what psychological distress is produced in concrete relationships. (Crenshaw, 2002; Brasil, 2026a)

Gender issues alter risks and survival strategies. Street women can face sexual violence, without monitoring and dependence on ambivalent protective relationships. LGBTQIA+ people can carry stories of family expulsion and discrimination. Men, in turn, can suffer from norms of masculinity that hinder emotional expression and seek help. The team must receive singularities and avoid standardized responses. (Crenshaw, 2002; Brasil, 2026a)

Psychiatric reform, care in freedom and psychosocial network

The Brazilian Psychiatric Reform represents an ethical and political change in the way of understanding mental health care. The model centered on psychiatric hospitals and long hospitalizations was progressively questioned by practices that denounced violations of rights, isolation and loss of autonomy. Law No. 10.216/2001 consolidated the rights of people with mental disorders and redirected the care model, valuing protection, respect and community resources. (Brasil, 2001; Amarante, 2007)

Care in freedom does not mean absence of care or simple closure of institutions. It requires a territorial network capable of sustaining crises, daily monitoring, housing, work, coexistence and social protection. When community services are insufficient or fragmented, deinstitutionalization can find obstacles. It is methodologically inadequate, however, to affirm that the closure of asylums by itself "produced" a homeless population. The trajectories are multicausal and need to be analyzed with evidence. (Brasil, 2001; Saraceno, 2001)

The Antimanicomial Struggle expands the debate beyond the physical location of the treatment. Hospital practices may reappear in open services when there is excessive protection, silencing, coercion or reduction of the person to diagnosis. For the homeless population, a

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symbolic equivalent occurs when the label of "chemical dependent" erases all the rest. Overcoming the asylum also means overcoming totalizing identities. (Amarante, 2007; Goffman, 1988)

The concept of territory used in this analysis is that of ‘territory used', developed by Milton Santos (1999). More than a geographical area or an administrative area, the territory used articulates material space, identities, social practices, labor relations, circulation and belonging. Applied to the health of the homeless population, this reference allows us to recognize that places of permanence, daily paths, community ties, conflicts and possibilities of access to services are part of the concrete conditions of care production. Thus, acting in the territory does not consist only in moving a team out of a unit: it means understanding the ways of life and the resources of each person without naturalizing exclusion.

The transition from the hospital as the center of the system to a community network changes the position of the user. Instead of being an object of control, it must be recognized as a participant in decisions about its treatment. Autonomy, however, is not abandonment. In situations of serious risk, teams need to act with clinical and legal responsibility, seeking the least restrictive alternative possible and preserving rights. (Brasil, 2001; Saraceno, 2001)

In the territory, the continuity of care depends on communication between services. A user can circulate through UBS, CAPS, emergency care, hospital, social assistance and institutional care. If each point works separately, anamnesis is repeated, information is lost and the chances of interruption are increased. The coordination of care is especially important for those who do not have a telephone, fixed address or family network available. (Haggerty et al., 2003; Brasil, 2017)

The Individual Therapeutic Plan is a consistent tool with this logic because it allows to build individualized and shared objectives. For a homeless person, goals can involve symptom management, reduction of risks associated with consumption, obtaining documents, treatment of clinical diseases, resumption of bonds and access to housing. The plan needs to be reviewed according to changes and user choices. (Brasil, 2009b; Brasil, 2026a)

The Psychosocial Care Network was designed to articulate points of attention for people with suffering or mental disorder and needs arising from the use of alcohol and other drugs. CAPS occupy a strategic position in community care, but cannot respond alone for all demands. Primary care, urgency, general hospitals, residential services and social policies need to share responsibilities. (Brasil, 2001; Amarante, 2007)

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For homeless people, the formal existence of the network does not guarantee real access. Times, criteria of reception, displacement, bureaucratic demands and prejudice can function as barriers. An effective network needs to be accessible in everyday life. The Street Outreach Clinic can act as a bridge, but it should not become the only service responsible for this population, because the Ministry of Health states that health care is the responsibility of the entire SUS (Brasil, 2026b).

The risk of "walking" appears when care is reduced to delivering references to other services. Forwarding is necessary, but there must be shared accountability, contact between teams and, when possible, monitoring the course. For users with a history of refusals and traumatic experiences, reaching an unknown service alone may be enough to interrupt the attempt. (Silva et al., 2026; Haggerty et al., 2003)

Street Outreach Clinic, link and harm reduction

The Street Outreach Clinic is a Primary Care strategy to expand the access of the homeless population. Its historical organization was outlined by the GM/MS Ordinance no 122/2012, with itinerant actions and shared with UBS, CAPS, emergency services and other components of the network. The PNAIS-RUA, established in 2026, reaffirms the responsibility of SUS for comprehensive care, mental health care, harm reduction and the confrontation of inequalities, without transferring the care of this population exclusively to the itinerant teams (Brasil, 2012a; Brasil, 2026a; Brasil, 2026b).

The most recent milestone deserves attention: the Ordinance GM / MS no 11.692, of June 23, 2026, instituted the National Policy for Integral Health Care of the homeless population in the SUS. Among its actions are the mental health care in the scope of RAPS, the organization of flows and matriculation, the harm reduction, the monitoring after discharge and the recognition of differences in race, gender, disability, age group and sexual orientation. It is a national normative orientation; its existence, in isolation, does not prove full implementation in the municipalities (Brasil, 2026a).

In practice, working on the street requires flexibility. The setting is mobile, the meeting can happen in sidewalks, squares, shelters or social equipment. Privacy and continuity need to be built within the possibilities of the territory. The team often needs to respond simultaneously to clinical demands, mental suffering and social needs. This complexity requires interprofessional communication and definition of priorities without losing sight of the person as a whole. (Marques et al., 2022; Brasil, 2014)

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From the point of view of Psychology, this discussion requires attention to the relationship between subjectivity and context. Suffering is not produced outside history. Even when there is a well-characterized mental disorder, the way in which symptoms are experienced, named and managed depends on the relationships available. For those who live on the street, the absence of a protected space can turn a manageable crisis into a risky situation. Psychological intervention needs to consider simultaneously internal experience, relationships and material conditions. (Organização Mundial da Saúde, 2022)

The Critical Social Psychology of Silvia Lane (1984) contributes to understand subjectivity as constituted in historical and social relations, and not as an attribute disconnected from living conditions. In this perspective, the suffering of homeless people should be considered in their relationship with work trajectories, losses, links, discriminations and concrete forms of social insertion. It is an interpretative key, not evidence that all subjects experience the same conditions or present the same symptoms.

In a complementary way, Martín-Baró (1997) argues that the professional performance of Psychology considers the concrete circumstances of the population and the effects of structures of oppression. Its commitment to awareness and popular majority helps to problematize practices that convert social injustices into supposed individual defects. In territorial care, this contribution reinforces the need for listening, user participation and recognition of institutional limits and responsibilities, without replacing individualized clinical evaluation.

The nursing technician participates in this process through care, clinical observation, medication administration according to prescription and protocols, dressings, health education, construction of bonds and communication of changes to the team. In a territorial context, signals perceived during apparently simple procedures can open space for listening and identifying suffering. The role is not to carry out psychological diagnosis, but to recognize signs of alertness and trigger adequate professionals and services. (Brasil, 2014; Brasil, 2026b)

Equity, in the Unified Health System, consists of recognizing different needs and living conditions to organize proportional responses to the barriers faced, aiming at reducing unfair and preventable inequalities (Brazil, [s.d.]). Equity is not confused with offering exactly the same procedure to all people. A person without a telephone and without a fixed address, for example, may need an active search and another way to receive test results; who finds obstacles to store medicines requires viable planning. These adaptations are not privileges: they concretize the universal right to health and are articulated with the PNAIS-RUA, which

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provides equitable access, reception without judgments and responses to the specific needs of the homeless population (Brasil, 2026a).

Comprehensive attention also includes frequently neglected clinical problems when the user is identified by drug use. Wounds, infections, chronic diseases, oral health, sexual and reproductive health and other needs need to be welcomed. The opposite is also true: concentrating only on the body and ignoring mental suffering produces another form of fragmentation. (Brasil, 2014; Brasil, 2026a)

Linkage is built by the repetition of meetings and by the coherence between discourse and practice. For people who have already suffered refusals, unfulfilled promises or institutional violence, trust in a team can take time. The careful insistence is different from coercion. Returning to the territory, remembering a combined and respecting a momentary refusal communicates that the user will not be abandoned because he does not immediately accept a proposal. (Marques et al., 2022; Silva et al., 2026)

Active search is an important tool, but must preserve autonomy. It allows to locate people who would hardly spontaneously reach the services, to follow situations of greater risk and to offer continuity. It should not be used as moral surveillance. The objective is to expand possibilities of care, not controlling everyday life. (Brasil, 2026a; Brasil, 2026b)

Listening can occur in small windows of opportunity. A complaint of pain, request for dressing or request for document may be the gateway to other demands. The professional needs to avoid the rush to turn all conversation into formal intervention. Sometimes, recognizing suffering and maintaining presence is the first step in a longer therapeutic process. (Marques et al., 2022)

Harm reduction starts from the recognition that people can continue using substances and still have the right to care. Instead of establishing abstinence as the only measure of success, we work to reduce risks and damage, expand autonomy and build possible objectives. This does not prevent abstinence from being a goal when desired by the user; it only avoids transforming it into a universal condition to be welcomed. (Marques et al., 2022; Brasil, 2026a)

In the Street Outreach Clinic, the harm reduction is consistent with the territorial reality. Guidance on hydration, food, combinations of substances, prevention of infections, sexuality, protection against violence and recognition of signs of urgency can reduce immediate risks. At the same time, the link created by these actions can favor access to treatment when the person desires broader changes. (Brasil, 2026a; Marques et al., 2022)

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Damage reduction also has a relational dimension: it reduces the damage produced by the service itself when it replaces judgment by listening. A moralizing approach can increase shame and distance. A right-based approach recognizes the ability to choose and work with negotiation. The current policy of the Ministry of Health explains the harm reduction as a transversal strategy in the actions of the Street Outreach Clinic teams (Brasil, 2026b). (Brito; Silva, 2022; Marques et al., 2022)

Mental health beyond the label of "addiction"

In the conceptual use adopted in this work, "addiction" refers to the stigma linked to the use of substances and to the moralizing interpretations that may occur from it (Michaelis, [s.d.]; Goffman, 1988). This does not mean equating any consumption to dependence. On the contrary, the choice of the title seeks to explain the distance between the social language of the label and the precision required by the clinical evaluation.

The core of this work is to criticize the transformation of substance consumption into a unique explanation of suffering. According to the conceptual delimitation presented in the Introduction, "addiction" here designates a social label that can carry moral assumptions (Michaelis, [s.d.]); it is not a technical synonym of substance use disorder. The expression "far beyond addiction" does not minimize intoxication, abstinence, dependence or neuropsychological effects related to drugs: it questions the reduction of the person to this marker. Clinically, two people who use the same substance can present stories, functions of use, risks, symptoms and different needs (Goffman, 1988; Organização Mundial da Saúde, 2022).

An expanded assessment should investigate temporality of symptoms, relationship with intoxication and abstinence, previous history of mental distress, sleep, eating, traumatic experiences, risk of suicide, perceptual changes, mood, cognition, clinical conditions and use of medications. In street situations, this information may not be obtained in a single meeting. Evaluation is a longitudinal process, built with interprofessional bonding and observation. (Brasil, 2014; Organização Mundial da Saúde, 2022)

Consumption can work as an attempt to alleviate suffering, produce belonging, keep awake, withstand cold, reduce traumatic memories or face loneliness. These functions do not make the use "healthy" but help to understand why simply ordering someone to stop can be insufficient. If the substance occupies a subjective survival function, care needs to build concrete alternatives for this function. (Marques et al., 2022)

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There is also the opposite risk: romanticize consumption or attribute everything to social conditions. Dependence, intoxication, abstinence and drug interactions can be serious. Comprehensive care simultaneously supports the two dimensions: it recognizes damage to use and investigates suffering that cannot be explained only by it. This position avoids both moralism and clinical neglect. (Organização Mundial da Saúde, 2022)

The stigma interferes with the professional perception. When a person is already known for drug use, new complaints can be devalued. This phenomenon can affect both physical and mental symptoms. The team needs to create mechanisms of hypothesis review, case discussion and supervision to reduce automatic decisions based on labels. (Brito; Silva, 2022)

As an external empirical evidence, Brito and Silva (2022) They analyzed interviews with 24 homeless people, participant observation and focus group with professionals in the city of Rio de Janeiro. The research described stigmatizing representations, discrimination and repercussions on relations with services. The finding supports the debate on stigma, but its qualitative sample does not allow to affirm the proportion of people affected throughout Brazil.

Stigma is more than negative opinion; it influences relationships, opportunities and access to rights. The label "addictioned" can condense ideas of irresponsibility, danger and disability. When incorporated into institutional practices, it produces less expectation of recovery and punitive responses. In mental health, this can prevent signs of suffering from being taken seriously. (Goffman, 1988; Brito; Silva, 2022)

Diagnosis should guide care, not replace the person. In populations with multiple vulnerabilities, it is especially important to perform differential diagnosis and recognize limits of evaluation. Psychotic symptoms, for example, may be related to primary disorders, substance use, neurological conditions, sleep deprivation or other causes. A precipitated conclusion can direct the user to an inadequate flow. (Organização Mundial da Saúde, 2022)

The daily language of the teams deserves attention. Naturalized depreciative terms can reinforce distancing. Permanent education should include reflection on stigma, racism, poverty, gender and substance use, in addition to technical content. Language changes do not solve exclusion alone, but help to transform institutional culture. (Brito; Silva, 2022; Brasil, 2012b)

Invisibility also occurs when the service only reacts to the crisis. If contact with mental health occurs only in extreme agitation, risk of suicide or disordered psychosis, the possibility of early intervention is lost. Brief screening and longitudinal monitoring can identify changes before the situation gets worse, provided that instruments are not used mechanically or out of validation and professional competence. (Organização Mundial da Saúde, 2022)

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Depression and hopelessness can manifest by retraction, irritability, loss of interest, sleep disorders and death speech. In street situations, some of these signs can be confused with tiredness, substance use or ‘dismotivation'. The assessment of suicide risk should be performed when there are indications, with referral and management compatible with severity. No screening replaces complete clinical evaluation. (Organização Mundial da Saúde, 2022)

Anxiety and hypervigilance can be understandable in environments of constant threat. A person who sleeps in an insecure place can remain alert by real need. This shows the importance of differentiating symptoms from adaptive responses to the context, without disregarding that prolonged exposure to stress can produce intense suffering. (Organização Mundial da Saúde, 2022)

Traumatic experiences can affect memory, trust, emotional regulation and ability to remain indoors. Services that interpret evasion or irritability only as a lack of commitment can repeat control experiences. A sensitive approach to trauma offers choices, explains procedures, avoids unnecessary exposure and seeks to build a sense of security. (Organização Mundial da Saúde, 2022)

Clinical and psychiatric comorbidities make the evaluation more complex. Pain, infections, metabolic changes, drug effects and sleep deprivation can modify mental status. Therefore, separating rigidly "physical health" and "mental health" is inadequate. Interprofessional work allows integrating information and reducing the risk that each area sees only its part. (Organização Mundial da Saúde, 2022)

Access barriers, continuity, social protection and crises

The fragmentation of the network appears when services have criteria, records and flows that do not communicate. For users with address, telephone and family support, this fragmentation is already problematic; for those living on the street, it can mean complete loss of follow-up. The referral needs to consider transportation, schedules, documents, location and real possibility of attendance. (Silva et al., 2026; Haggerty et al., 2003)

Bureaucracy can function as an invisible barrier. Administrative rules have organizational purposes, but need to be applied in a way compatible with universality and equity. The homeless population cannot be excluded because it does not correspond to the user. Equity requires adapting strategies to different needs. (Brasil, 2009b; Brasil, 2026a)

Another possible problem is the transfer of responsibility. The existence of Street Outreach Clinic teams does not exclude the duty of other services to welcome this population.

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The Ministry of Health clarifies that the health care of homeless people is the responsibility of SUS professionals and that the Street Outreach Clinic articulates and expands access, not constituting a parallel network (Brasil, 2026b). The guideline is reinforced in the PNAIS-RUA of 2026 (Brasil, 2026a).

Matrification meetings, discussion of cases and agreement of flows can reduce fragmentation. In complex situations, direct contacts between professionals are more effective than impersonal referrals. The construction of reference and counter-reference needs to include essential information, respect secrecy and define who will follow the next steps. (Haggerty et al., 2003; Brasil, 2017)

Social assistance is an indispensable partner, but health and care have different duties. Housing issues, documentation, benefits and reception influence mental health, while clinical demands cannot be delegated to care. The intersectoriality works when each policy assumes its responsibility and cooperates with the others. (Brasil, 2009b; Brasil, 2026a)

In health services, the difficult user expression can hide a difficulty of the institution itself in responding to complex needs. People who arrive without documents, with impaired hygiene, under the effect of substances, agitated or accompanied by animals can challenge routines designed for a stable user. The problem arises when the inadequacy between routine and reality is attributed exclusively to the individual. A perspective of equity asks what adaptations are possible without compromising safety and quality. The cumulative rejection experience can also modify the way the user presents himself and increase conflicts with services. (Brito; Silva, 2022)

Continuity means that care maintains coherence over time and between different points of the network. For homeless people, it does not depend only on the agenda. The team may need to find the user in the territory, combine reference locations and maintain institutional channels for exchange of information. The planning must predict that trajectories are mobile and that changes in location do not necessarily mean voluntary abandonment of treatment. Reference and counter-reference need to function as clinical communication and co-responsibility. (Haggerty et al., 2003; Brasil, 2017)

In a qualitative study published in 2026, Silva et al. interviewed 21 homeless people in a city in the interior of São Paulo to investigate access to RAPS. The participants reported obstacles, experiences of reception and discrimination, with the presence of the Street Outreach Clinic as a facilitator of access. The result offers empirical support for the discussion of

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continuity, without representing statistically different municipalities of that studied (Silva et al., 2026).

The bureaucracy must be critically examined. Some requirements exist to ensure security; others persist due to institutional habit. The periodic review of flows can identify preventable barriers. The guiding question should be whether a certain rule protects the care or just facilitates the routine of the service. When there is no technical or legal damage, adaptations can increase access and produce equity. (Brasil, 2017; Brasil, 2026a)

The discussion about mental health inevitably finds the issue of housing. Sleeping safely, having a place to store belongings and medicines and having some privacy changes the possibility of organizing treatment. Housing is not a psychological intervention, but it can function as a material condition that makes other interventions viable. Therefore, housing and assistance policies need to dialogue with health, without one area fully transferring its responsibility to another. (Organização Mundial da Saúde, 2022; Saraceno, 2001)

Social protection involves income, food, documentation and access to benefits when appropriate. These elements do not replace psychotherapy, medication or clinical follow-up, but directly influence the ability to continue. An integrated approach avoids the false dilemma between treating the mind and facing social conditions. Often, the two dimensions need to advance together so that the user has concrete conditions to exercise autonomy. (Brasil, 2009a; Brasil, 2014)

The discharge of a service also requires planning. After clinical or psychiatric hospitalization, returning to the street without accessible medication, understandable guidance and follow-up point increases the risk of discontinuity. The discharge preparation should consider where the person will be, how he will arrive at the reference service and what signs require further evaluation. The planning needs to start before the last day of hospitalization and involve the territorial network. (Haggerty et al., 2003; Brasil, 2026a)

Teams that work in the territory deal with crisis situations and need to protect users and workers. The defense of humanized care does not mean to deny risks. Safety protocols, communication among professionals, emergency assessment and adequate service activation are needed. The ethical point is to use the lowest restriction compatible with security and avoid turning all agitation into a police case or every refusal to incapacitate. (Brasil, 2001; Brasil, 2014)

Crisises related to intoxication, abstinence, psychosis, delirium, trauma or clinical conditions may present similar signs. The recognition of changes in consciousness, fever,

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seizures, cranial trauma and other signs of severity is essential for urgent medical referral. The mental health of the homeless population cannot be separated from the general clinical assessment, and the differential reasoning needs to remain open. (Organização Mundial da Saúde, 2022)

After the crisis, the team must resume the bond. Conflict episodes can produce shame and withdrawal. Reviewing what happened, explaining limits and reconstructing combined helps to prevent an acute event from resulting in permanent exclusion. The continuity after the crisis is an important indicator of a network that takes care of instead of simply removing the problem from the field of view. (Silva et al., 2026)

Interprofessional reflections and limits of interpretation

In the professional experience that gave rise to this article, the author began to problematize the tension between responding to damages related to the use of substances and maintaining attention to other manifestations of suffering. Its performance in the Street Outreach Clinic offers repeated contact with care situations and allows to formulate questions about mood changes, behavior and perceived bond throughout the meetings. These perceptions constitute situated reflection, without frequency systematization, without identifiable user report and without pretension to represent the entire population. Research carried out by other teams, with their own methods, provides external empirical evidence to discuss stigma and access (Brito; Silva, 2022; Silva et al., 2026).

Another published research, by Marques et al. (2022), resorted to participant observation in a Street Outreach Clinic in the interior of Pernambuco and individual interviews in depth. The authors analyzed territoriality, drug use, medicalization and harm reduction, offering an example of ethnographic research with planned data production. The comparison explains a decisive methodological difference: this article dialogues with the results of that research, but does not reproduce its collection procedures (Marques et al., 2022).

In the reflection on the practice, the author problematizes precipitated interpretations in the face of disorganized behavior, as assuming exclusively the effect of substances. This is a working hypothesis, and not a proven description of all the consultations. It is necessary to consider onset and evolution of symptoms, sleep deprivation, use or suspension of medications, trauma, clinical conditions and risk situations, with evaluation by the qualified team. The expanded reasoning is consistent with the criticism of stigmatization and the perspective of comprehensive care (Goffman, 1988; Brasil, 2026a).

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Another reflection derived from territorial work is that the refusal of a care proposal does not allow us to conclude, in isolation, that the person rejects any care. The possibility of someone not accepting a referral and, at another time, accepting listening, nursing care or harm reduction measures is presented here as a general example of a professional dilemma, without reference to an individual case. The studies of Marques et al. (2022) and Silva et al. (2026) offer independent empirical material to discuss singularity, barriers to access and importance of the bond.

It also stands out, as a professional reflection, the care necessary to not confuse suffering and behavior considered inadequate. Irritability, hostility or distrust have possible interpretations and require evaluation and safe limits, not automatic labeling. This problematization dialogues with the stigma analysis of Goffman (1988) and with the qualitative findings on discrimination described by Brito e Silva (2022). It does not constitute diagnostic evaluation of people accompanied by the author.

Interprofessional work is essential because no professional gathers skills alone to respond to all needs. Nursing, Psychology, Social Work, Medicine, Occupational Therapy, social agents and other areas can build complementary readings. The team meeting needs to be a space for clinical formulation and not just the distribution of tasks. (Brasil, 2017; Brasil, 2026a)

The training in Psychology expands the author's perception of phenomena that, in nursing, could initially appear as clinical or behavioral complaints. This double trajectory favors an integrated reading, but also requires respect for professional limits. Recognizing signs of suffering does not mean establishing a diagnosis outside the competence or without proper evaluation. The work should strengthen responsible referral and shared care. (Brasil, 2014)

The sentence that guides this article — seeing the person before addiction — can be translated into concrete decisions. It means asking for the name and the story, investigating other complaints, explaining procedures, respecting choices, assessing risks, not conditioning dignity to abstinence, registering needs beyond consumption and discussing the case with the network. Humanization is not only an affective attitude; it is an organization of care. (Brito; Silva, 2022; Marques et al., 2022)

Thus, when this work describes the need for listening, active search and expanded evaluation, it is formulating a clinical-organizational recommendation anchored in norms and research. When it mentions the tension experienced between attention to drug use and other demands, it presents professional reflection of the author. And by informing interviewed

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participants, percentages or estimated population, it explicitly identifies the publication that produced the data. This separation prevents attributing appearance of empirical survey to personal perceptions.

The analysis of the norms confirms that this perspective is not just a personal preference. The historical guidelines of the itinerant teams and, especially, the 2026 PNAIS-RUA provide comprehensive attention, harm reduction, actions shared with RAPS, confrontation of discrimination and intersectoral strategies. The normative basis differentiates what the services should offer from the empirical evaluation on the extent to which they can do it in practice (Brasil, 2012a; Brasil, 2026a).

Neglect of mental health can occur without explicit intention. Overload, emergencies, shortage of professionals and fragmentation favor rapid responses. Therefore, the solution cannot depend only on individual ‘awareness'. Organizational devices are needed: brief instruments for risk identification, case meetings, matrix support, agreed flows, continuing education and monitoring indicators. (Brito; Silva, 2022; Silva et al., 2026)

At the same time, instruments cannot bureaucratize the meeting. A standardized screening should support listening, not replacing it. Questions about risk, mood, psychosis, trauma and substance use need to be contextualized. The result should generate concrete action: monitoring, specialized evaluation, safety plan, clinical care or social articulation as needed. (Brasil, 2009b; Organização Mundial da Saúde, 2022)

Listening to health is not just allowing the person to speak. It involves demonstrating that the information received will have a consequence in the care plan. When a user reports fear, sadness or perceptual changes and the team immediately returns to the drug's theme without exploring suffering, the implicit message is that only consumption matters. Qualified listening requires clinical curiosity, respect and ability to formulate open questions. (Brasil, 2009b; Marques et al., 2022)

In the street, listening can be interrupted by traffic, rain, other people or need for displacement. This requires working with continuity in small meetings. The professional does not need to get a complete story at once. Registering essential points and resuming later may be more respectful and effective than insisting on a long interview in an environment without privacy. The longitudinality compensates part of the limitations of the setting. (Marques et al., 2022)

Confidentiality also needs to be handled carefully. Sensitive conversations should occur, when possible, in a more reserved place. The team should explain limits of secrecy in risky

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situations and avoid discussing identifiable cases in the face of people who do not participate in care. Ethics remains valid outside the walls of the office and needs to be translated into the conditions of the territory. (Brasil, 2016)

Psychology in the territory can work with brief interventions, reception, psychoeducation, crisis management, groups, support to the team and construction of therapeutic projects. The model needs to be flexible. Demanding weekly frequency in fixed hours as the only legitimate form of monitoring would exclude many users. The intensity and format must follow necessity, possibility and desire, preserving technical criteria. (Brasil, 2009b; Amarante, 2007)

The psychological evaluation, when indicated, must respect professional standards and minimum conditions of application. Standardized instruments cannot be used as diagnostic shortcuts in contexts for which they were not validated. In many cases, clinical interview, longitudinal observation and interprofessional discussion will provide more useful information for immediate care decisions, without replacing specialized assessments when necessary. (Organização Mundial da Saúde, 2022)

Nursing has privileged contact with everyday aspects of care. Curatives, measurements, medication administration and guidelines create opportunities to observe general status, communication and behavioral changes. In an integrated team, these observations must circulate and contribute to evaluation, without exceeding the limits of professional assignment. The quality of communication between categories can modify the outcome of complex situations. (Brasil, 2014)

Drug adherence in a street situation presents concrete challenges: storage, schedules, feeding, adverse effects and risk of loss or theft. Prescribing without considering these conditions can produce a technically correct and practically unfeasible plan. The team must communicate difficulties to the prescriber and build possible strategies, without modifying medication on their own and without blaming the user for material obstacles. (Brasil, 2014; Haggerty et al., 2003)

Autonomy does not mean that the professional will agree with all user choices. It means recognizing decision-making capacity, providing understandable information and negotiating possibilities within the ethical and legal limits. In situations of serious risk there may be exceptional measures, but they should not be transformed into a rule for people living on the street. Social vulnerability does not automatically mean disability. (Brasil, 2001)

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There are also limits for the team. No service can solve poverty, violence, housing and mental suffering. Recognizing limits does not mean giving up; it means articulating networks and avoiding promises that cannot be fulfilled. Trust is protected when professionals are transparent about what they can do, about existing obstacles and about the next possible steps. (Brasil, 2026a)

Proposal for qualification of care

Based on the analysis, it is proposed a local protocol of expanded mental health care for teams of Street Outreach Clinic, adaptable to the municipal reality and subject to validation by the management and the responsible professionals. The objective is not to create a new service, but to organize practices already compatible with the attributions of Primary Care and RAPS. (Brasil, 2009b; Brasil, 2026a)

The first axis is reception and extended screening. In initial contacts and in reevaluations, the team must observe mental suffering, risk of suicide, changes in consciousness, psychotic symptoms, mood, anxiety, sleep, trauma, substance use, clinical conditions and social protection. Urgent situations require immediate flow; other demands should compose a longitudinal plane. (Brasil, 2026a)

The second axis is the Individual Therapeutic Plan. Complex cases should be discussed interprofessionally, defining objectives, responsible and revision deadlines. The plan needs to record the user's own goals and not just institutional goals. Damage reduction, clinical treatment, mental health, documentation and social ties can coexist in the same project. (Brasil, 2009b; Brasil, 2026a)

The third axis is the weekly or periodic articulation with CAPS and other RAPS points. Brief meetings for priority cases can avoid missing referrals. When necessary and possible, it is proposed shared care and user monitoring in the first access to another service, especially after repeated interruptions. (Brasil, 2026a; Silva et al., 2026)

The fourth axis is permanent education. It is suggested a training cycle on mental health in the street, differential diagnosis, crisis management, suicide prevention, harm reduction, trauma, stigma, racism, gender, human rights and team safety. Training should use fictitious or properly anonymized cases and include discussion of institutional attitudes. (Brasil, 2012b; Brasil, 2026a)

The fifth axis is the registration and monitoring. Without exposing users, the team can follow process indicators, such as number of cases with shared plan, effectively completed

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referrals, returns after crisis and intersectoral meetings. Indicators should serve to improve care and not to punish users or workers. (Brasil, 2017; Haggerty et al., 2003)

The sixth axis is the social articulation. Documentation, benefits, food, reception and housing are not "extra" when they directly interfere in the continuity of treatment. The health team must activate the competent sectors without assuming attributions that belong to other policies. The proposal is co-responsibility, not substitution. (Brasil, 2009a; Brasil, 2026a)

As a practical flow, it is suggested: approach and identification of demand; immediate risk assessment; necessary clinical care; expanded listening to mental health; interprofessional discussion when there is complexity; definition of plan; articulation with reference service; access monitoring; reassessment in the territory. At any stage, the refusal must be registered and respected when there is no situation that requires exceptional measures provided for in the law, maintaining a future offer of care. (Brasil, 2009b; Brasil, 2026a)

The implantation can occur in three months. In the first, the team reviews flows and identifies bottlenecks. In the second, it performs training and tests a brief screening instrument. In the third, it begins regular meetings with the network and monitors indicators. After this period, the protocol should be reviewed based on the experience of professionals and, whenever possible, on the participation of users and social movements. (Brasil, 2012b)

The permanent education proposed should start from real problems of the work process. Instead of classes disconnected from the territory, monthly meetings are suggested with discussion of anonymized cases, review of flows and study of themes selected by the team. The modules can address stigma and language, risk assessment, harm reduction, trauma, articulation with RAPS, rights and intersectoriality. (Brasil, 2012b; Brasil, 2026a)

Each encounter must end with a small and verifiable practical change. For example, review the way to register substance use, define who contacts CAPS in a given flow or create a return script after hospital discharge. Permanent education differs from punctual training because it transforms the work process itself and returns to discuss the results of the changes made. (Brasil, 2009b)

The participation of people with street situation experience, when organized in an ethical and institutionally appropriate way, can qualify the training. Users and social movements identify barriers that professionals often do not perceive. Participation should not be symbolic; it needs to have real space to influence decisions and assess whether changes have produced more respectful access. (Brasil, 2026a)

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Indicators and monitoring of the proposal

The evaluation should favor process and continuity indicators, avoiding measuring success only by abstinence. Examples include referrals with confirmed access, revised therapeutic projects, return after discharge, participation in network meetings and identification of risk situations with a documented plan. These indicators help to see how the network works and breakpoints. (Haggerty et al., 2003; Brasil, 2026a)

User-centered results may include perception of respect, ease of access and participation in decisions, provided that any systematic collection for research is submitted to relevant ethical requirements. In the care routine, feedback can guide improvement without turning the service into an informal academic investigation. The distinction between assistance and research should remain clear. (Brasil, 2016)

The proposal should be reviewed periodically. A protocol that does not adapt can become a new barrier. The team needs to identify items that are not useful, steps that delay care and needs not contemplated. The quality of care depends less on the existence of a perfect form and more on the collective ability to learn from the territory and correct the process. (Brasil, 2017)

Final considerations

This work started from a question raised by the author's territorial experience: how can the mental health of homeless people be secondary when the use of alcohol and other drugs dominates the interpretation of care? The literature review, official documents and published qualitative research indicate that stigma, barriers to access and fragmentation are relevant issues for this care (Brito; Silva, 2022; Marques et al., 2022; Silva et al., 2026). It is not concluded, from this article, what is the frequency of this phenomenon in the services in which the author acts.

The analysis also demonstrates that integrality is not only an abstract ideal. The guidelines of the Street Outreach Clinic establish multiprofessional action on different health needs, integration with UBS, CAPS, urgency and other points of attention, in addition to reducing damage. Therefore, broadening the view of mental health is consistent with the very purpose of the strategy. (Brasil, 2012a; Brasil, 2026a)

The stigma appears as a clinical and institutional barrier. It interferes with language, expectations about the user and interpretation of symptoms. Combat stigma requires training,

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supervision, discussion of cases and organization of flows. It is not enough to ask professionals to be more empathetic if the network remains fragmented and if the user continues to be sent from one service to another without shared accountability. (Goffman, 1988; Brito; Silva, 2022)

The Psychiatric Reform and the Anti-Manicomial Struggle offer an ethical foundation for this care by defending rights, freedom and community insertion. The contemporary challenge is to ensure that care in freedom has sufficient territorial support. For homeless people, this means articulating mental health with housing, social protection, documentation, work, bonds and security, without reducing the clinic to social assistance or reducing social problems to diagnoses. (Amarante, 2007; Brasil, 2001; Brasil, 2026a)

The professional experience was mobilized as a point of problematization, not as epidemiological evidence. The empirical support of the discussions derives from published research, identified by authors, year and method; the population numbers derive from official documents with explicit periods and limits. This separation preserves methodological rigor and secrecy, while valuing the questions constructed in the daily life of the Street Outreach Clinic.

It is concluded that caring for homeless people requires sustained complexity. It is necessary to recognize harm related to drugs without transforming the drug into the identity of the subject; to evaluate mental suffering without pathologizing responses to violence and poverty; to respect autonomy without confusing it with abandonment; and to build a network without transferring responsibilities. The person comes before the diagnosis, before the medical record and before the label. Taking care means seeing the person before addiction — recognizing his pain, his history and his humanity. (Saraceno, 2001; Organização Mundial da Saúde, 2022)

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