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REVIEW ARTICLE

Between the streets and the RAPS: Integrative review on the access of the homeless population to Mental Health Services

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Abstract *This integrative review systematized the factors that influence access to mental health services for the Homeless Population (HP) in harmful use of alcohol and other drugs in the Psychosocial Care Network (RAPS) in Brazil by categorizing the factors into access "barriers" and "facilitators". We selected 13 corresponding articles and subsequently assessed their methodological quality. We identified 19 access barriers and 22 access facilitators, observing a convergence and complementarity of the factors identified, with no disagreements between authors. Although there are specific barriers and facilitators related to substance use, most are connected to HP's conditions and lifestyles or how services address the HP. Discrimination, bureaucratic rigidity of services, and a lack of intra- and intersectoral integration were identified as significant barriers. On the other hand, Street Outreach Clinics and practices such as harm reduction and matrix-based support emerged as notable facilitators, adapting to patients' needs. Future studies should explore specific factors and the relationships between these factors.*

Key words *Homeless population, Health Services Accessibility, Mental Health Services, Substance-Related Disorders*

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Introduction

Guiding access to mental health care in the Psychosocial Care Network (RAPS) for the Homeless Population (HP) who engage in the harmful use of alcohol and other drugs requires recognizing the complex factors that permeate the lives of these service users and their interactions with the network and its services. Among the multiple factors that complicate this relationship are barriers and facilitators affecting these individuals' access to services, which is imperative to guide more inclusive and effective public policies and health practices.

The HP is defined as a heterogeneous population group. However, it is characterized as a group that lives in extreme poverty, with weak or broken family ties, without conventional housing, and uses urban public spaces as a place of residence and sustenance. Some may use shelters or hostels to spend the night, which does not exclude them as the HP[1].

The National Survey on the Homeless Population revealed the profile of these individuals as predominantly male (82%), racialized (67% Black), and with incomplete primary education (63.5%)[2]. These and other structural determinants of health, such as social class, gender identity, and migration, contribute to the health inequalities observed in unequal societies such as Brazil[3,4].

Regarding the HP's health, mental health conditions stand out as one of the main demands for treatment. In the National Survey mentioned above, 17% of respondents reported having a history of psychiatric hospitalization and 28% having spent time in recovery homes or clinics related to the harmful use of alcohol and other drugs[2]. Martins *et al.*[5] present the main complaints of this population as mental and behavioral disorders due to the use of multiple drugs, alcohol use-related disorders, and schizophrenia. Mental health-related issues appear as a motivation for these people to end up living on the streets, along with unemployment, family conflicts, and, to a lesser extent, other health issues[2,5]. Furthermore, data from the federal government's Single Registry for Social Programs (*CadÚnico*), which identifies the registered population living in poverty and extreme poverty, identified the use of alcohol and other drugs in 29% of the HP in Brazil[6].

Mental health care focused on the needs arising from the use of alcohol and other drugs is one of the priority points in the care of the HP. In the Unified Health System (SUS), health services are provided in the Psychosocial Care Network (RAPS), which includes specific services like the Psychosocial Care Centers for Alcohol and Drugs (CAPS-AD) and the Street Outreach Clinic (eCR) teams[7]. These services must be guided by the SUS principles to guarantee comprehensive, universal, and equitable access to health.

The National Policy for the Homeless Population (PNPSR) reinforces the State's obligation to guarantee the HP broad, simplified, and safe access to programs and services that make up public policies, including health[1,8], considering that 18% of the HP mentioned impediments to receiving care in the health network[2]. However, the literature points to persistent barriers to these individuals' access to SUS services[6,9,10]. Regarding the challenges faced in caring for the HP in RAPS, an integrative review study mentions stigma, inflexible protocols, insufficient integration of the healthcare network, and lack of co-accountability, for example[11].

If we consider the principle of equity as a guiding characteristic of the SUS, we should consider access to health equity as a process of permanent transformation[12]. However, such transformation only becomes effective when a proper understanding of the factors that affect service user access exists.

This study aimed to gather the main published contributions on the subject and identify gaps in the field of care for these individuals, mainly to organize the results of studies on the access of HP who use alcohol and other drugs to the Mental Health Services of the Brazilian RAPS from an integrative literature review, focusing on the access barriers and facilitators. Moreover, the study used criteria to assess the quality of the selected articles, allowing a discussion of the results found with greater reliability of the information presented.

Methods

This integrative review study's guiding question was: "What are the barriers and facilitators to accessing Brazilian mental health services for homeless individuals who engage in harmful use of alcohol and other drugs?".

In order to answer this question, a bibliographic survey was conducted in September and October 2023 on the SciELO, LILACS, and PubMed platforms in English, Portuguese, and Spanish, using the descriptors The HP, Homeless population, People living on the street, Psy-

chosocial Care Center, Access, CAPS, RAPS, Street Outreach Clinic, and Alcohol and Drugs, using the Boolean operators "AND" and "OR".

The articles located were subject to the following inclusion criteria: (i) Full articles with open access; (ii) Articles available in English, Spanish, and Portuguese; (iii) Articles with results related to Brazil. The following were excluded: (i) Articles repeated in the databases or duplicated within the same database; (ii) Experience reports and integrative, systematic, or scoping literature review articles; (iii) Technical notes; (iv) Theses and dissertations.

The articles were first selected by reading the title and abstract of the article to see if they had characteristics related to the guiding question of the research. After this first stage of exclusion, those whose information answered the guiding question of the research or supporting elements that would do it were read in full. In the end, those who answered our question or opened a broad discussion on the topic remained for analysis of the results.

All steps were conducted independently by two evaluators. When disagreement occurred, the article was presented to a third evaluator to result in a consensus on its exclusion or inclusion in the study.

Microsoft Office Excel was adopted to compile the results of the selected articles. The following information was recorded for all articles: article title, authors, journal, and year of publication; methodological aspects of the studies (place of study, unit of analysis [national, regional or local], study objectives, temporality [study period], type of design, and results' analysis method), and the article's conclusion. Finally, the article's evidence was recorded regarding barriers and facilitators of access for the HP who use alcohol and other drugs to Brazilian mental health services, which allowed us to answer the guiding question of the current study.

Finally, the final selected articles[13-25] were evaluated per their methodological quality, adapting the validated methods of Downs and Black[26] and Patias and Hohendorff[27] for non-experimental studies, using 12 evaluation items, namely: (i) Title consistent with the study presented; (ii) Abstract summarizes the main elements of the study (problem, objective, method and main results); (iii) Introduction includes a description of the study topic, with a critical and relevant review of theoretical and empirical literature; (iv) Objectives described clearly and align with the development of the article; (v) Clarity in the presentation of results, with consistency between excerpts and themes/categories presented, demonstrating the researcher's understanding of the results; (vi) Methodological design described coherently as per the qualitative design used in the study; (vii) Discussion with description of the study findings, with the leading results summarized and discussed according to a theory, model or previous research; (viii) Well-defined sample definition criterion; (ix) Data collection instruments appropriate to the article's objective; (x) Study limitations clearly defined and reported; (xi) Description of the main contributions to the area or discipline and to public policies, with practical application and suggestions for new studies; (xii) Results consistent with the data presented. For each of these categories, the value "1" was computed when the criterion evaluated was found, and "0" when absent. The computed score value was "1" when the criterion was not applied. The closer to the total value (12/100%), the better the quality of the study.

Results and discussion

Figure 1 presents the selection steps for structuring the review, in which we initially identified 972 articles. We removed 595 duplicate articles (61.2%) based on the exclusion criteria, along with 32 documents selected in the search identified as literature review articles, technical notes, theses, or dissertations (3.3%), resulting in 345 articles. After this stage, 332 articles were excluded after reading the title, abstract, or full text (34.2%), leaving 13 articles (1.3%) comprising the final review.

Chart 1 shows the methodological quality of the selected articles, assessed from the adaptation of validated methods[26,27]. Considering the 12 evaluation criteria already displayed in the methods section, five articles were classified with a value above 90%, two with values between 70% and 89%, and six between 50% and 69%. The primary limitations identified in the studies are related to the lack of description of the main contributions to the area or discipline, public policies with practical application and presentation of suggestions for new studies, lack of well-defined criteria for sample definition, and lack of a well-defined presentation of the study's limitations. The general characteristics of the articles are shown in Chart 2.

Among the articles analyzed, one (7.7%) conducted an international comparative analysis between mobile services for assisting the HP in Portugal, the USA, and Brazil. Twelve (92.3%)

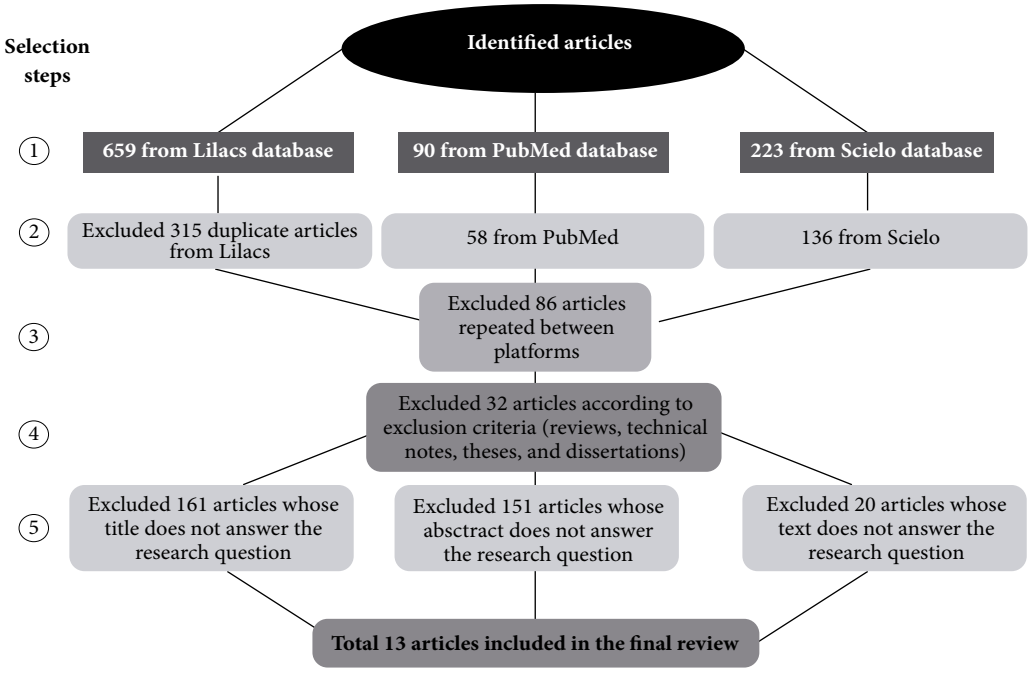

Figure 1. Flowchart of selection steps for structuring review studies.

Source: Authors.

were developed at the municipal level. All 13 (100%) articles were qualitative research, with multiple methodologies and analysis instruments, published in national (Brazilian) journals and dated between 2015 and 2022. Four articles (30.8%) did not reveal the months in which the data were collected, which compromised the evaluation of some results (Chart 2).

Regarding the articles' objectives, all those selected directly or indirectly aimed to evaluate therapeutic itineraries, the production of care for the HP, and the barriers that interfere with these individuals' access to health services (Chart 2).

Some of the selected articles did not directly address the access of the HP to municipal health services that specifically address mental healthcare for the HP who use alcohol and other drugs. Even so, positive and negative characteristics related to access to health services in general were identified in all the selected articles, categorized in the current article as "barriers" or "facilitators" (Chart 3).

The following paragraphs will present and discuss, by category, the access barriers and facilitators of the HP who use alcohol and other drugs harmfully to mental health services provided by the Brazilian RAPS from the most cited to the least cited factors.

Access barriers

Discrimination

The discrimination category was identified in most articles through themes such as racism, stigma, and prejudice directed at the HP[13-18,20-25]. These barriers are related to prejudice based on stereotypes about these individuals, discriminatory and exclusionary actions regarding the use of alcohol and other drugs, poverty, poor hygiene conditions, and the racial marker of this mostly Black population[2,5]. The notion of ethnicity/race identified in this context is a sociopolitical construct that reveals markers of social inequalities and injustices, reflecting on the distribution of power between social groups, with

Chart 1. Percentage of hits under the criteria of the adapted scale from Downs and Black[26] and Patias and Hohendorff[27].

	Evaluation criteria	Hits
1	The title is consistent with the study presented	92%
2	The abstract summarizes the main elements of the study (problem, objective, method, and main results)	76%
3	The introduction includes a description of the study topic, with a critical and relevant review of theoretical and empirical literature	76%
4	Objectives described clearly and align with the development of the article	100%
5	Clarity in the presentation of results, with consistency between excerpts and themes/categories presented, demonstrating the researcher's understanding of the results	84%
6	The methodological design is described coherently as per the qualitative design used in the study	76%
7	Discussion with a description of the study findings, with the leading results summarized and discussed according to a theory, model, or previous research	69%
8	Well-defined sample definition criterion	46%
9	Data collection instruments appropriate to the article's objective	84%
10	Study limitations clearly defined and reported	53%
11	Description of the main contributions to the area or discipline and public policies with practical application and presentation of suggestions for new studies	46%
12	Results consistent with the data presented	84%

Source: Authors.

a recognized impact on health conditions and access to services[28].

Discrimination in health services can contribute to social humiliation[13], produce a feeling of inferiority in the HP[14], weaken the relationship of trust between individuals and health services, jeopardize social ties, and generate fear of being poorly served or not being recognized in services[17]. This fear is based on the discrimination process experienced in an even more severe way by the HP who use alcohol and other drugs, which results in a double stigma[15]. From a prohibitionist logic outlook, the person who engage in harmful use of alcohol and other drugs is recognized as sick or criminal. This stigma prevents people from seeing the subject beyond drugs and establishing forms of agency for this use[29].

Stigmatization involves reducing the social identity of homeless individuals to a position of discredit and inferiority due to the imposition of the perspective of those who conform to the current social norms, which legitimizes social exclusion and discrimination and establishes barriers to equal access to services since those who are stigmatized are not seen on an equal footing with "normal" people[30].

This stigmatized identity influences the homeless person's self-perception and the perception of healthcare providers. The stigma associated with homeless individuals, rooted in sociohistorical distinctions of normality and deviance[30], erects significant barriers to equitable access to healthcare services. This stigma is perpetuated by society and healthcare institutions, discouraging the HP from seeking healthcare for fear of discrimination and receiving inadequate treatment.

Racism appears in a veiled manner in the health service, and workers may not realize that they are practicing it, as it is a "subtler" violence that can be characterized as institutional violence[14], which sometimes manifests itself in the refusal of care[21,22] or a police-like attitude of professionals towards service users[14]. The situations mentioned in health services, as a space for reproducing social relationships, refer to racism's structural and institutional conceptions. In other words, they result from the social structure and materialize in institutions[31,32]. Thus, institutional racism compromises the quality of care and the professional-service_user relationship, limits individuals' access, and weakens the principle of equity in the SUS[32].

Service rigidity

This category encompasses several aspects that influence and result in barriers to access by the HP who use alcohol and other drugs to health services, including the dissonance between the lifestyles of the HP and how care is offered by health services, or even the difficulty or

Chart 2. Description of studies selected for the integrative review.

Authors	Year	Study objective	Analysis methodologies, locality, and temporality
Vale and Vecchia[13]	2019	Identify and analyze the HP therapeutic itineraries in a small municipality	Analysis of therapeutic itineraries with triangulation of qualitative methods/ municipality in the inland region of Minas Gerais/Sep/2016 to Apr/2017
Oliveira *et al.*[14]	2022	Reflect on the production of care for the HP in a CAPS-AD through situations of violence in this service	Cartography/Salvador-BA/Jul/2019 to Dec/2019
Rossi and Tucci[15]	2020	Assess access to/use of health services for drug addiction treatment for homeless crack users	Analysis methodology not informed/ Baixada Santista-SP/temporality not informed
Borysow *et al.*[16]	2017	Contrast what is familiar and different between the regulations aimed at itinerant healthcare for HP, relating to the national socioeconomic and institutional context.	Comparative analysis/Multiple case study of Brazil, Portugal, and the United States
Friedrich *et al.*[17]	2019	Understand the perspective of the CnaR team on barriers that interfere with access to health services by drug users under the programmatic dimension of the vulnerability concept	Thematic analysis/Descriptive study in Porto Alegre-RS/2012
Lima and Seidl[18]	2015	To investigate the modes of action and characteristics of intervention work with young homeless adults and users of psychoactive substances, per the perceptions of CnaR professionals in Goiânia-GO and people served.	Descriptive exploratory study/Content analysis/Goiânia-GO/Temporality not informed
Lima and Seidl[19]	2017	Describe Harm Reduction (HR) actions developed at the CnaR in Goiânia per reports from professionals and people served	Content analysis/Goiânia-GO/ Temporality not informed
Engstrom and Teixeira[20]	2016	Discuss the practices of a CnaR team for the HP and users of alcohol, crack, and other drugs to provide comprehensive care implemented per the attributes of PHC and Health Promotion.	Exploratory study and case study/ Thematic analysis in the Manguinhos neighborhood of Rio de Janeiro-RJ/2011 to 2013
Oliveira *et al.*[21]	2021	To describe the perception of the HP who live on Avenida Paulista in São Paulo regarding access to health facilities in the region.	Hermeneutics–dialectics/São Paulo-SP/Jan/2019
Wijk and Mângia[22]	2017	Learn about the actions aimed at the HP with mental disorders, developed by two services of the RAPS da Sé in São Paulo	"Ethnographically inspired" study/São Paulo-SP/Feb/2016 to Apr/2016
Teixeira *et al.*[23]	2019	Analyze the care provided by eCnaR professionals who identify the stigma of health professionals towards the HP.	Analysis methodology not informed/ Rio de Janeiro-RJ/Temporality not informed
Paiva and Guimarães[24]	2022	Analyze how health care for the HP is provided within the scope of the Psychosocial Care Network in Natal-RN	Field research with a qualitative approach and descriptive-exploratory nature/Thematic content analysis/ Natal-RN/Aug/2018 to Jan/2019
Bittencourt *et al.*[25]	2019	Analyze care practices of eCnaR professionals regarding the care provided to users of alcohol and other drugs in Macapá-AP	Descriptive study/Thematic content analysis/Macapá-AP/Apr/2017 to Jun/2017

Source: Authors.

Chart 3. Barriers and facilitators of HP access to health services identified in the integrative review.

Categories	Barriers
Discrimination	Discrimination, including stigma and racism[13-18,20-25]
	Institutional violence[14,22]
Service rigidity	HP lifestyles differ from the modes offered by the service[13-15,17,21,22,24]
	Excessive bureaucracy/bureaucratic administrative logic[15,17,18,21,23,24]
	Requirement of identification documents for services[17,18,21,23,24]
	Lack of flexibility/Inability to adapt to the HP reality[16,17,21,22,24]
	The institutional notion of services centered on the physical structure[14,16,24]
	Wrong definition of the scope of services/Services focused within institutional walls[17,24]
	Imposition of abstinence or need for abstinence[15,23]
	Denial of service due to not being accompanied by an eCR or some other service[23]
Service weaknesses	Inability or weakness of services to coordinate with the intra-sectoral or inter-sectoral network[16-18,22,24]
	A structural deficit in service or HR[16,18,25]
	Distance between services and places where the HP people lives[21]
	Lack of a health system that allows for more concrete and immediate responses to user demand[17]
	Impersonal health offers[17]
	Interpersonal violence within services[14]
	Weakness in the health communication process with the public using the service[15]
Categories	Facilitators
Relational	Bond[15,16,18-22,24,25]
	Listening and receptive posture[15,17-20,22]
	Mediation of other professionals or coordination between eCR professionals and professionals from other services[22,24]
	Active search[16,22]
	Negotiation stance of professionals with users[17]
	Recognition of the service as a protective place[14]
Acting from the perspective of equity	Traveling to territories/Conducting territorialized actions in the street space/ itinerancy[16,18,22-24]
	Referrals to the health and intersectoral network/Capacity for intersectoral coordination[16,21,24,25]
	Ability to incorporate the unpredictable or unplanned based on user demand or desire[17,18,20]
	Flexibility of services from the perspective of equity, considering the HP lifestyles[17,20]
	Ability to respond to the request for care on demand[22]
	Being an "open door" service[22]
Assistance-related	Mobile teams/eCR[14-25]
	Multidisciplinarity/interprofessionality/integration between different professional categories[16,20,24]
	Offer from a harm reduction perspective/Offers for care regarding the use of alcohol and other drugs[16,18]
	Availability of a car for the transportation of the service team and users[16]
	Providing care from the perspective of comprehensive health[16]
	Access to Oral Health[20]
	Supply of medications[20]
	Knowledge about STIs and drugs[18]
	Have previously defined opening hours so that users know how to look for the service[18]
	Quality of care received[21]
	Realization of matrix-based support[23]
	Artistic and Recreational Activities[20]

Source: Authors.

lack of consideration of the lifestyles of this population when considering the services offered or the need to adapt care provision[13-15,17,21,22,24]. A study showed that the HP depend on other services, such as food and shelter, which have rigid and inflexible arrival and departure times, which means that these individuals do not have autonomy over their time[21].

Furthermore, the lack of a daily routine linked to precise times and a clock or calendar can prevent the HP from organizing the day and time of their appointment, for example, leading to a lack of temporal orientation[22]. The daily demands of these individuals require agility and are very different from the needs of the general population, which requires strategies for operationalizing health services from the perspective of equity[33].

Six articles[15,17,18,21,23,24] highlighted the bureaucratic administrative logic or excessive bureaucracy, emphasizing the requirement for identification documents or an SUS card to receive care[17,18,21,23,24]. This practice contradicts national legislation, which provides that comprehensive health care must be provided regardless of the presentation of documents proving domicile or registration in the SUS registry[33].

The lack of flexibility in service rigidity was highlighted as a barrier to access. Some of the situations described were related to flows, rules, and times for appointments and tests that often do not include the lifestyles of the HP and are inflexible[17,21], evidencing the service's inability to adapt to the HP's needs[16,22,24]. Low-threshold services are an essential driving force for adequate care for those who use alcohol and other drugs. Active and unrestricted support by an eCR, support during a crisis at CAPS-AD, or social reintegration programs with flexible organizational methods and schedules are possible by establishing a subjective position regarding the harmful use of drugs[34].

The institutional concept of services centered on the physical structure[14,16,24] is a barrier to access. It shows an explicit separation between life within the services and life on the street as if these spaces were disconnected[14]. This hurdle is related to another complication, which concerns the conceptions of the service's territorial action, often based on arbitrary lines drawn on the map or with the delimitation of the service's action within its institutional walls[17,24], without considering the possibilities of external action, such as active search and planned actions in the street environment. In this regard, there is often an understanding in SUS services of territorialization based only on geographic and administrative divisions, leaving aside the concept of territory that encompasses its fluidity and intrinsic relationship with the ways of life of the people who inhabit it[35].

Imposed abstinence is highlighted as another barrier to access to health services[15,23]. It is essential to highlight that it is also related to the category of discrimination based on the reproduction of stigmas that permeate drug users. There is a perceived disconnection between the provision of some health services and the guidelines of the Ministry of Health, which provides for action under the logic of harm reduction. From this perspective, we should recognize that some people cannot, are unable, or do not wish to stop using, and, therefore, the aim should be to reduce the risks associated with use without necessarily intervening in supply or consumption[36].

Furthermore, care is denied to the HP because they are not accompanied by a mobile team, such as the eCR, or because they have been referred by another service, whether a health or social assistance facility[23]. Although this barrier reflects service rigidity, it is also related to the discrimination that the HP experience. Situations like this disregard the SUS doctrinal principles of universality and equity.

Services weaknesses

In the category of service weaknesses, some barriers identified were due to the inability or ineffectiveness of services to conduct network coordination, whether between the intrasectoral or intersectoral network, also considering the lack of integration and misalignment alignment of care among the stakeholders that make up these networks[16-18,22,24].

In this regard, one of the articles highlights that although CAPS is the main instrument for implementing RAPS, this policy is not confined to CAPS alone and must be implemented by establishing a network with well-defined referral flows that contribute to the comprehensive care of service users[24].

Other factors identified includes structural and human resource deficiencies[16,18,25], which were shown as barriers and weakened the work process and the provision of care, besides the physical distance between health services and the places the HP occupy[21].

A barrier identified is the lack of a system that enables more concrete and immediate responses to service_user demand[17], evidencing that resources in the health network are lacking

at the appropriate time for service user demand now and then. The impersonal provision of procedures was also pointed out as a barrier[17], identifying that the services operate predominantly based on biomedical logic without considering the social determinant of health[37]. We should emphasize the relevance of organizing care based on technical guidelines and include the interests and desires of the subjects to whom the care is directed[17].

Another barrier highlighted was interpersonal violence, both between service users and between service users and health service workers, which stems from the relationships established in these environments[14]. Finally, the last barrier concerns a weak health communication process with the service's public, which can generate a lack of knowledge about the services[15], their functions, the care offered, and how to access them.

Access facilitators

Relational

Regarding relational facilitators, the relationship between service_users and workers or services was highlighted in nine articles[15,16,18-22,24,25] and the listening and receptive attitude_of professionals in six works[15,17-20,22], revealing themselves as crucial soft technology healthcare tools[38], considering the relevance of a non-judgmental reception that considers the subjects' reality.

Another facilitator was the mediation of other professionals or coordination between eCR professionals and professionals from other services[22,24] to promote access, considering the personal "partnerships" established among service workers. While presented as a facilitator, this situation also exposes access barriers by indicating that service user access sometimes relies on informal and non-institutionalized arrangements. This attempt to build arrangements with some professionals in the health network can be interpreted as a favor, and despite being strategic or even subversive in guaranteeing service_user access to the SUS, it does not ensure care continuity and does not solve the problems of the homeless access to the SUS[39].

The active search for service users is identified as access facilitator[16,22]. It is one of the Family Health Strategy (ESF) activities, which refers to the service professional visiting the service user as a strategy to increase resolution, operating as a possibility of expanding access and promoting equity[40]. This practice must be at the heart of CAPS assistance, which must organize care for people with mental health issues and their families based on an expanded notion of territory, consisting mainly of "people who live there, their conflicts, interests, friends, neighbors, family, institutions, and settings (church, religious services, school, work, and bar)"[41].

The professionals' negotiating stance with service_users was described as access facilitator[17] and is directly related to the receptive and listening posture to preserve and encourage the service user's autonomy. This practice aligns with the SUS guidelines that point to harm reduction as a care strategy for service users of psychoactive substances (PAS), respecting their choices and autonomy in the care process with information, education, and counseling actions that contribute to adopting safer behaviors[36]. This posture incorporates the recognition of the service user as a subject in their healthcare process to establish standards for conducting their lives[17].

Finally, recognizing the service as a place of protection was identified as a facilitator of access[14]. Regarding life on the streets, vulnerability to the risk of violence is part of everyday life, which generates insecurity and fear of sleeping, directly affecting the quality of sleep and well-being. In this sense, recognizing services as a place of protection favors access and the permanence and continuity of care in health services.

Acting from the perspective of equity

Equity is one of the doctrinal principles of the SUS, conceived from the need to reduce inequalities in access to health services[42]. In the category that addresses action from the perspective of equity, we identified strategies that can operate as facilitators of access for the HP; among them, the possibility of itinerancy with deployment of services to the territory was pointed out in five articles[16,18,22-24], which dialogues with the category of active search, from the establishment of a service deployment to the place where service_users stay.

Another facilitator identified is referral systems within the health network (intrasectoral)[16,24,25] and the capacity for intersectoral coordination, establishing partnerships between different public policies[16,21,24], thus enabling a network of alliances and agreements for the care of the HP. Considering that poverty and social exclusion are the central axes for thinking about HP's health, the need to implement structural and intersectoral public policies is fundamen-

tal for a concrete process of guaranteeing rights and overcoming the ills that violently affect these bodies[39].

The capacity to incorporate the unpredictable or unplanned based on the demand and desire of service_users[17,18,20], the flexibility of services with the possibility of adapting flows and protocols based on the recognition of the HP's lifestyles[17,20], the capacity to respond to the request for care on demand[22], operate as facilitators based on equitable practices that consider the different access needs.

The characteristic of being an open-access service[22], referring to the care of the person based on walk-in demand, is identified as a facilitator that contributes to the opportunity for care without the need to establish a prior referral.

Assistance-related

Regarding care aspects, twelve of the thirteen selected articles point to the role of mobile teams as facilitators of access[14-25] when moving to offer care on-site, exemplified in these articles through eCRs' work.

Another important aspect highlighted as a facilitator refers to multidisciplinarity, interprofessionality, or integration between different professional categories[16,20,24], identified as a potentiating factor of the offers based on the possibility of integrated action from several knowledge domains for the construction of plural care prepared to address the different problems and needs of people living on the streets.

In contrast to the imposed abstinence shown as a barrier in the services rigidity, the offer from the perspective of harm reduction and specific offers for care concerning the use of alcohol and other drugs[16,18] were indicated as facilitators of access, as they recognize this subject in their needs and provide care to the extent that the subject allows, considering the service user's knowledge. The available car for the team's deployment is a physical structure that facilitates access to services for the HP[16].

The provision of care from the perspective of comprehensive healthcare[16], access to oral health[20], recognizing the HP's difficulties to maintaining satisfactory oral hygiene due to substandard living conditions, and the provision of medications are also identified as facilitators[20], also considering the possibility of dispensing medication to the HP without the requirement for an identification document. Another facilitator was workers' technical knowledge about sexually transmitted infections (STIs) and drugs[18], contributing to an efficient care approach for the HP.

In contrast to the weak health communication in the barriers, previously defined and publicized opening hours so that service users know how to seek the service[18] facilitates the HP's access to healthcare. Quality of care received[21] is a differential that brings the population closer to the services, and matrix-based support[23] is a facilitator of access and reveals the potential for shared construction for intervention with people experiencing homelessness, considering overlapping vulnerabilities.

Finally, artistic and recreational activities[20] are also shown as facilitators. Such actions may broaden the view of these subjects and their singularities, considering the biopsychosocial aspects, which can result in a better response to healthcare.

An important limitation of the results shown is that all studies are linked, to varying degrees, to therapeutic itineraries. Studies on therapeutic itineraries face significant limitations, as they often establish a directional nature supported by a negative health conception, partly due to how the respondents rebuild the itinerary[43]. Furthermore, this approach does not usually achieve effective interdisciplinary and transdisciplinary integration, restricted by paradigms prioritizing the lack of disease as the leading indicator of health. Adopting broader theoretical perspectives and analytical frameworks that broaden the debate on a positive conception of health, the effectiveness of comprehensiveness, and the symbolic efficacy of care[43] is necessary.

Conclusion

Although this integrative review specifically focused on understanding access to mental health services, the results pointed to barriers and facilitators primarily found in the HP's access to health services in general, even considering the public that uses alcohol and other drugs. This indicates the recognition that the RAPS comprises diverse services that exceed CAPS and CAPS-AD's work. This perspective becomes fundamental for us to think that the care of the HP who use alcohol and other drugs should be provided in an expanded and integrated manner.

Furthermore, it offers implications that the main barriers and facilitators of access for this public are instead related to the fact that they are homeless rather than to the harmful use of

alcohol and other drugs. Among the 19 categorized barriers, only imposing abstinence was exclusively linked to the use of alcohol and other drugs. Among the 22 facilitators, only technical knowledge about drugs and the harm reduction approach were exclusive to use. Part of this result can be attributed to the limited scope of these articles, whose exclusive target audience is the HP. The relevance of studies that allow comparing or differentiating between circumstances and factors linked to the different social groups that access mental health is noted for the more precise identification of the differences and commonalities in access due to their condition of being homeless or the harmful use of alcohol and drug.

Regarding the results, we should underscore that the multiple contributions of the articles were convergent or added new factors to be considered in the study of access. No disagreements were found among the authors regarding the different barriers and facilitators. We expect that the categorization effort in this review will enable progress in the systematization and understanding of these factors linked to barriers and facilitators. Future studies are needed to deepen the analysis of specific factors and understand the relationships between these factors. Furthermore, research must focus on identifying these factors and studying strategies that seek pragmatic solutions to be implemented in healthcare in a feasible manner and with some urgency, considering the several pieces of evidence of barriers that prevent the fulfillment of HP's right to equal access to healthcare.

Discrimination has been identified as a critical barrier to access. It adversely affects individuals' self-perception and interaction with health services and reflects broader structural failures. These systemic failures prevent services from effectively and inclusively meeting the complex needs of these service users.

Street Outreach Clinics were highlighted as key facilitators in accessing health services, particularly because of their ability to adapt to service users' lifestyles and needs. Their team stands out for its multidisciplinary composition and approach of listening and being receptive, which is essential to building a relationship of trust with service users. These results reinforce the importance of ensuring that all components of the Psychosocial Care Network (RAPS) are equipped to provide care that is accessible, ethically sound, equitable, and free of bias in order to truly meet the needs of the population served.

Finally, the study also points to the need for reforming health service flows, routines, and protocols to increase access and improve the quality of care. Adopting harm reduction strategies and implementing_matrix-based support are promising practices that can guide care, particularly for vulnerable patients. These approaches enable more personalized and co-participatory care, which is crucial for treatment adherence and effectiveness. The coordination of the care network within and between sectors is also vital to meet the complex needs of this population, highlighting the importance of a holistic and empathetic approach within health systems.

Collaborations

PVR Fraga contributed to the design of the article, data collection, analysis and interpretation, writing of the article, final approval of the version to be published. MCA Araújo contributed to the collection, analysis and interpretation of data, writing of the article, final approval of the version to be published. AA Souza contributed to the project design, design of the article, data collection, analysis and interpretation, writing and critical review of the article. ALJ Martins contributed to the writing, analysis and interpretation of the results. ACMTV Dantas contributed to the writing, analysis and interpretation of the results. RA Marinho contributed to the writing, analysis and interpretation of the results. DM Rodrigues contributed to the collection, data analysis, writing, analysis and interpretation of the results. R Paes-Sousa contributed to the project design and critical review of the article.

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