Original Article

TEXTO & CONTEXTO ENFERMAGEM
TEXT & CONTEXT NURSING TEXTO & CONTEXTO ENFERMERÍA

PEOPLE EXPERIENCING HOMELESSNESS: ALCOHOL AND/OR OTHER DRUG USE, MENTAL HEALTH ISSUES, AND VIOLENCE

Diellison Layson dos Santos Lima[1]
Jefferson Abraão Caetano Lira[1]
Ítalo Arão Pereira Ribeiro[2]
Sandra Cristina Pillon[3]
Márcia Astrês Fernandes[1]

[1]Universidade Federal do Piauí, Programa de Pós-Graduação em Enfermagem. Teresina, PI, Brasil.
[2]Universidade Federal de Mato Grosso do Sul. Coxim, MS, Brasil.
[3]Universidade de São Paulo, Programa de Pós-Graduação em Enfermagem Psiquiátrica. Ribeirão Preto, SP, Brasil.

ABSTRACT

Objective: to analyze the association between alcohol and/or other drug use, mental distress, and violence among homeless people.
Method: an analytical cross-sectional study was conducted in a capital city in Northeast Brazil with 127 homeless people. Data were collected using a questionnaire to characterize sociodemographic, economic, and living conditions and violence, the Alcohol, Smoking and Substance Involvement Screening Test, and the Self-Reporting Questionnaire between October 2019 and March 2020. The Chi-squared and Fisher's exact tests of association were performed in the inferential analysis, considering $p<0.05$ as significant.
Results: the majority reported that living on the street is a predisposing factor for the use of psychoactive substances (69.3%). The prevalence of mental distress among homeless people was 63%. Among the types of violence, 36.3% self-reported having suffered psychological violence, 32.7% physical violence, 20.2% property violence, and 5.4% sexual violence or other types of violence. There was a significant association between sexual violence and mental distress ($p=0.02$), problematic tobacco use and other violence ($p=0.01$), problematic alcohol use and physical violence ($p=0.04$) and property violence ($p=0.005$), as well as problematic marijuana use with other violence ($p=0.01$). Self-directed violence also showed an association with physical violence ($p=0.048$), sexual violence ($p=0.033$), and mental distress ($p=0.017$).
Conclusion: violence had implications for mental distress, problematic use of psychoactive substances, and self-directed violence among homeless people.

DESCRIPTORS: Poorly housed persons. Excessive alcohol consumption. Drug users. Mental health. Violence.

HOW CITED: Lima DLS, Lira JAC, Ribeiro IAP, Pillon SC, Fernandes MA. People experiencing homelessness: Alcohol and/or other drug use, mental health issues, and violence. Texto Contexto Enferm [Internet]. 2026 [cited YEAR MONTH DAY]; 35:e20250204. Available from: https://doi.org/10.1590/1980-265X-TCE-2025-0204en

PESSOAS EM SITUAÇÃO DE RUA: USO DE ÁLCOOL E/OU OUTRAS DROGAS, SOFRIMENTO MENTAL E VIOLÊNCIA

RESUMO

Objetivo: analisar a associação entre o uso de álcool e/ou outras drogas, o sofrimento mental e a violência entre Pessoas em Situação de Rua.
Método: estudo transversal analítico realizado em uma capital do Nordeste do Brasil com 127 Pessoas em Situação de Rua. Os dados foram coletados mediante questionário para caracterização sociodemográfica, econômica e das condições de vida e de violência, aplicação do *Alcohol, Smoking and Substance Involvement Screening Test* e do *Self-Reporting Questionnaire* no período de outubro de 2019 a março de 2020. Na análise inferencial, foram realizados os testes de associação Qui-quadrado e Exato de *Fisher*, considerando significativo p<0,05.
Resultados: a maioria relatou que viver na rua é um fator predisponente para o consumo de substâncias psicoativas (69,3%). A prevalência de sofrimento mental nas Pessoas em Situação de Rua foi de 63%. Entre os tipos de violências, 36,3% autorreferiram ter sofrido violência psicológica, 32,7% violência física, 20,2% violência patrimonial e 5,4% violência sexual ou outro tipo de violência. Houve associação significativa entre a violência sexual e o sofrimento mental (p=0,02), uso problemático de tabaco e outras violências (p=0,01), uso problemático de álcool e a violência física (p=0,04) e patrimonial (p=0,005), bem como o uso problemático da maconha com outras violências (p=0,01). A violência autodirigida também apresentou associação com a violência física (p=0,048), violência sexual (p=0,033) e o sofrimento mental (p=0,017).
Conclusão: a violência apresentou implicações no sofrimento mental, no uso problemático de substâncias psicoativas e na violência autodirigida entre Pessoas em Situação de Rua.

DESCRITORES: Pessoas mal alojadas. Consumo excessivo de bebidas alcoólicas. Usuários de drogas. Saúde mental. Violência.

PERSONAS SIN HOGAR: CONSUMO DE ALCOHOL Y/O OTRAS DROGAS, PROBLEMAS DE SALUD MENTAL Y VIOLENCIA

RESUMEN

Objetivo: analizar la asociación entre el consumo de alcohol y/u otras drogas, el distrés mental y la violencia en personas en situación de calle.
Método: se realizó un estudio transversal analítico en una capital del noreste de Brasil con 127 personas en situación de calle. Los datos se recopilaron mediante un cuestionario para caracterizar las condiciones sociodemográficas, económicas y de vida, así como la violencia, la *Alcohol, Smoking and Substance Involvement Screening Test*, y el *Self-Reporting Questionnaire* entre octubre de 2019 y marzo de 2020. En el análisis inferencial, se realizaron las pruebas de asociación de Chi-cuadrado y la prueba exacta de Fisher, considerando un valor p<0,05 como significativo.
Resultados: la mayoría reportó que vivir en la calle es un factor predisponente para el consumo de sustancias psicoactivas (69,3%). La prevalencia de distrés mental entre las personas en situación de calle fue del 63%. Entre los tipos de violencia, el 36,3% autoreportó haber sufrido violencia psicológica, el 32,7% violencia física, el 20,2% violencia contra la propiedad y el 5,4% violencia sexual u otros tipos de violencia. Se observó una asociación significativa entre la violencia sexual y el distrés mental (p=0,02), el consumo problemático de tabaco y otros tipos de violencia (p=0,01), el consumo problemático de alcohol y la violencia física (p=0,04) y la violencia contra la propiedad (p=0,005), así como el consumo problemático de marihuana con otros tipos de violencia (p=0,01). La violencia autoinfligida también mostró una asociación con la violencia física (p=0,048), la violencia sexual (p=0,033) y el distrés mental (p=0,017).
Conclusión: la violencia tuvo implicaciones en el distrés mental, el consumo problemático de sustancias psicoactivas y la violencia autoinfligida entre las personas sin hogar.

DESCRIPTORES: Personas en situación de pobreza. Consumo excesivo de alcohol. Consumidores de drogas. Salud mental. Violencia.

INTRODUCTION

People experiencing homelessness (PEH) are exposed to vulnerabilities in individual, social, and programmatic dimensions[1] which directly impact the living and health conditions of this population, since these people are more susceptible to the abusive use of psychoactive substances, mental suffering, and situations of violence[2–3]. Thus, it is essential that social, mental health, and substance abuse treatment services be coordinated to meet the needs of this population and offer comprehensive care[4].

The number of PEH registered in the *CadÚnico* in Brazil almost doubled between 2018 and July 2023, reaching 221, 113 people, in addition to finding worsening living conditions for these individuals with the Covid-19 pandemic, which reinforces the need for efficient public policies for this population group[5].

A study showed that 17.5% of homeless people in Spain reported risky alcohol use and 14.5% alcohol dependence, while 32.3% showed harmful or risky drug use and 26.5% drug dependence[6]. Tobacco (84.6%) and alcohol (84.7%) were the most commonly used psychoactive substances throughout life among homeless people in Brazil. In contrast, the most commonly used illicit drugs were marijuana (67.9%), crack (63.9%), and powdered cocaine (44.1%), and 47.2% reported that homelessness was due to drug use[7].

Homelessness is a critical obstacle affecting the mental health and well-being of homeless people, as this population group has a high prevalence of depressive, anxiety, psychotic, neurocognitive, bipolar disorders, and substance use disorders, in addition to considerable rates of suicidal behavior. In this sense, understanding the psychosocial and epidemiological aspects involved in this condition is crucial in order to adopt effective measures to prevent, identify, and treat mental disorders in PEH[8].

Violence among PEH is influenced by the social context itself, as well as by beliefs, values, lived experiences, leisure, mood, inherent characteristics of some people, and as a result of the effect of the use of psychoactive substances. In addition, violent acts may be perpetrated with the intention of self-defense to prevent the violence from recurring, out of personal pride, reciprocity of actions, or due to the demand from others for a response to the violence that occurred[9].

From this perspective, PEH are vulnerable and exposed to various types of violence. Thus, studying this problem, along with mental suffering and the use of psychoactive substances, is fundamental to stimulating implementation of effective public policies and care pathways aiming to provide better living and health conditions, reduce harm, and improve health equity for this population, which has increased considerably in various parts of the world after the COVID-19 pandemic.

Therefore, this study aimed to analyze the association between alcohol and/or other drug use, mental distress, and violence among people experiencing homelessness.

METHOD

This is an analytical cross-sectional study conducted in the services and locations which compose the network of integrated actions for Medium Complexity Special Social Protection (*Proteção Social Especial de Média Complexidade*) in a capital city in the Northeast region of Brazil. Data were collected at the Specialized Reference Center for the Homeless Population (*Centro de Referência Especializado para População em Situação de Rua – Centro POP*), the Specialized Social Outreach Service, and the *Casa do Caminho* Municipal Shelter, as well as in public spaces, squares, and pastoral centers.

The study population was estimated at 500 people living on the streets, taking into account the service records from 2018 provided by the *Centro POP* coordination, since it is an unstable population segment in terms of the exact number of people in this situation. The population proportion estimation

formula for finite populations was adopted for the sample size calculation, with a 95% confidence level, a presumed prevalence of 25%, and a maximum error of 5%, totaling a representative sample of 127 participants.

The sample was selected using a non-probabilistic convenience sampling technique due to the difficulty of accessing the study participants. The inclusion criteria were: participants aged 18 years or older, of both sexes, with a minimum of six months living on the streets. Those who did not present the physical and emotional conditions to answer the researcher's questions and those who were visibly under the influence of any psychoactive substance were excluded.

Data collection was conducted from October 2019 to March 2020 and involved a team composed of one master's student and four undergraduate students, previously trained in the use of the data collection instruments. Initial contact was made with the coordinators responsible for the referral services for the homeless population in order to present the research proposal and operationalize data collection, determine the number of the population studied, and define the visit times for conducting the interviews. A pre-test was conducted with 30 participants to evaluate the instruments regarding their presentation, comprehension, completion time, and suitability to the suggested objectives. Adaptations were subsequently made to the participant characterization questionnaire based on this analysis.

Data collection took place at the Specialized Referral Center for the Homeless Population and during field monitoring by the Specialized Social Outreach Service teams in the morning, while it was conducted at the Shelter in the afternoon. The interviews for applying the data collection instruments took place in spaces provided by these services, except when they were conducted with the Specialized Social Approach Service teams, since the approach to the participants occurred directly in the street setting. The average duration of each interview was 20 minutes.

The data were collected using a questionnaire adapted for sociodemographic, economic, and living conditions characterization[10] and self-reported violence[11], as well as through the application of the Alcohol, Smoking and Substance Involvement Screening Test (ASSIST), used to assess the consumption of alcohol, tobacco, and other drugs[12] and the Self-Reporting Questionnaire (SRQ-20), applied to identify mental distress[13]. The act of suffering or committing violence was considered from the beginning of the individual's homelessness. Mental distress was assessed based on the instrument's four specific dimensions: anxious and depressive mood; somatic symptoms; decreased energy; and depressive thoughts[14].

The data were tabulated in Microsoft Excel 2016 with double entry for error correction and database cleanup. Next, the data were exported to the Statistical Package for the Social Sciences (SPSS) version 22.0 for analysis. Absolute and percentage frequencies were calculated in the descriptive statistical analysis for categorical variables, and means, medians, standard deviations, minimum and maximum values were calculated for quantitative variables. The Chi-squared and Fisher's Exact tests of association were performed in the inferential analysis, considering a p-value <0.05 as significant.

The study complied with the ethical precepts of resolution no. 466 of 2012 of the National Health Council (CNS), and was approved by the Research Ethics Committee of the Federal University of Piauí. All participants signed the Informed Consent Form (ICF). It should be noted that no Artificial Intelligence tools were used in the production of this manuscript.

RESULTS

Regarding the sociodemographic and economic characteristics of the homeless, age ranged from 19 to 72 years, with a predominance of males (85%), single marital status (59.1%), and mixed race (60.6%). The majority had incomplete or complete primary education (58.2%), 38.6% had no income, and 54.3% had children. A large proportion were from the state capital city of Piauí (41.7%). Family conflicts were the main motivation for living on the streets (39.4%), followed by alcohol and

other drug use (24.4%). Furthermore, the majority reported that living on the streets is a predisposing factor for the use of psychoactive substances (69.3%). The length of time people had been living on the streets ranged from 1 to 2 years (Table 1).

The prevalence of mental distress among PEH was 63% (n=80). Regarding symptoms related to depressive and anxious mood, 52.8% reported being easily startled, 70.1% felt nervous, tense, and worried, and 78.7% felt sad lately (Table 2). Concerning somatic symptoms, the majority reported poor sleep (63%). Moreover, the majority reported feeling tired all the time (54.3%) and easily (51.2%) for the vital energy assessment, and 39.4% highlighted a loss of interest in things regarding depressive thoughts.

Among the types of violence, 36.3% of PEH self-reported having suffered psychological violence, 32.7% physical violence, 20.2% property violence, and 5.4% sexual violence or other types of violence. Sexual violence was associated with mental distress among PEH (Table 3).

Tobacco use was associated with other types of violence, while alcohol use was associated with physical and property violence. Additionally, marijuana was associated with other types of violence (Table 4)

There was an association between self-directed violence and physical and sexual violence, as well as mental distress. No association was found between the use of psychoactive substances and self-directed violence among the PEH according to Table 5.

Table 1 – Sociodemographic and economic characterization and living conditions of people experiencing homelessness. Teresina, PI, Brazil, 2020. (n=127).

Variables	Sociodemographic and economic characteristics			
	n (%)	Minimum and Maximum	Mean ± SD*	Median
Age (years)		19 - 72	39.2±11.9	37
Sex				
Male	108 (85)			
Female	19 (15)			
Marital Status				
Single	75 (59.1)			
Married	8 (6.3)			
Separated/Divorced	28 (22)			
Widowed	4 (3.1)			
Stable Relationship	12 (9.4)			
Race/Color				
White	22 (17.3)			
Black	27 (21.3)			
Yellow	1 (0.8)			
Brown	77 (60.6)			

Table 1 – Cont.

Variables	Sociodemographic and economic characteristics			
	n (%)	Minimum and Maximum	Mean ± SD*	Median
Education Level				
Illiterate	9 (7.1)			
Elementary School (Completed/Incomplete)	74 (58.2)			
High School (Completed/Incomplete)	40 (31.5)			
Higher Education (Completed/Incomplete)	4 (3.1)			
Income				
Pension (minimum wage)	11(8.7)			
Government Benefit	37 (29.1)			
Self-Employed	30 (23.6)			
None	49 (38.6)			
Children				
Yes	69 (54.3)			
No	58 (45.7)			
Living conditions				
Origin				
State capital	53 (41.7)			
Interior	25 (19.7)			
Other state	49 (38.6)			
Motivation for living on the street				
Alcohol and other drugs	44.4 (24.4)			
Unemployment	35 (19.4)			
Family conflicts	71 (39.4)			
Violence	11 (6.1)			
Mental illness	3 (1.7)			
Natural disasters	1 (0.6)			
Other	15 (8.3)			
Is living on the streets a predisposing factor for the use of psychoactive substances?				
Yes	88 (69.3)			
No	38 (29.9)			
Did not respond	1 (0.8)			
Time spent living on the streets	1 – 2 years	1.70±0.46	2	

*SD = standard deviation.

Table 2 – Characterization of symptom groups from the Self-Reporting Questionnaire (SRQ-20) in homeless individuals. Teresina, PI, Brazil, 2020. (n=127).

Groups of symptoms	Yes	No
	n (%)	n (%)
Depressed mood/anxious		
Are you easily startled?	67 (52.8)	60 (47.2)
Do you feel nervous, tense, or worried?	89 (70.1)	38 (29.9)
Have you been feeling sad lately?	100 (78.7)	27 (21.3)
Have you been crying more than usual?	62 (48.8)	65 (51.2)
Somatic symptoms		
Do you have frequent headaches?	57 (44.9)	70 (55.1)
Do you have a lack of appetite?	51 (40.2)	76 (59.8)
Do you sleep poorly?	80 (63.0)	47 (37.0)
Do you have hand tremors?	55 (43.3)	72 (56.7)
Do you have indigestion?	22 (17.3)	105 (82.7)
Do you have unpleasant sensations in your stomach?	37 (29.1)	90(70.9)
Decrease in vital energy		
Do you have difficulty thinking clearly?	55 (43.3)	72 (56.7)
Do you find it difficult to perform your daily activities with satisfaction?	47 (37.3)	79 (62.7)
Do you have difficulty making decisions?	54 (42.5)	73 (57.5)
Do you have difficulties at work (is your work arduous, does it cause suffering)?	24 (18.9)	103 (81.1)
Do you feel tired all the time?	69 (54.3)	58 (45.7)
Do you tire easily?	65 (51.2)	62 (48.8)
Depressive thoughts		
Are you unable to play a useful role in your life?	28 (22.0)	99(78.0)
Have you lost interest in things?	50 (39.4)	77(60.6)
Do you feel like a useless, worthless person?	29 (23.0)	97(77.0)
Have you had thoughts of ending your life?	36 (28.3)	91(71.7)

Table 3 – Classification of mental distress (SRQ-20) and self-reported instances of violence among homeless people. Teresina, PI, Brazil, 2020. (n=127).

Self-reported violence	Mental Distress (SRQ-20)		p-value*
	Yes	No	
	n (%)	n (%)	
Physical			0.50
Yes	46 (63.0)	27 (37.0)	
No	33 (64.7)	18 (35.3)	
Sexual			**0.02**
Yes	11 (91.7)	1 (8.3)	
No	68 (60.7)	44 (39.3)	
Psychological			0.11
Yes	48 (59.3)	33 (40.7)	
No	31 (72.1)	12 (27.9)	
Patrimonial			0.37
Yes	30 (66.7)	15 (33.3)	
No	49 (62.0)	30 (38.0)	
Other			0.30
Yes	9 (75.3)	3 (25.0)	
No	70 (62.5)	42(0.9)	
Is experiencing violence a predisposing factor for the use of psychoactive substances?			0.06
Yes	44 (71.0)	18 (29.0)	
No	36 (55.4)	29 (44.6)	
Have you ever committed violence while under the influence of psychoactive substances?			0.14
Yes	42 (70.0)	18 (30.0)	
No	38 (56.7)	29 (43.3)	

* Fisher's Exact Test.

Table 4 – Association between types of violence and the Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) classification in homeless people. Teresina, PI, Brazil, 2020. (n=127).

	Types of violence n (%)														
	Physical			Sexual			Psychological			Patrimonial			Others		
	Yes	No	p-value†	Yes	No	p-value†	Yes	No	p-value†	Yes	No	p-value†	Yes	No	p-value†
Tobacco			0.16			0.62			0.83			0.19			**0.01**
Problematic use	57 (62.0)	35 (38.0)		9 (9.8)	83 (90.2)		61(66.3)	31 (33.7)		39 (42.4)	53 (57.6)		5 (5.4)	87 (94.6)	
Low risk/N.I.*	16 (50.0)	16 (50.0)		3 (9.4)	29 (90.6)		20(62.5)	12 (37.5)		6 (18.8)	26 (81.2)		7 (21.9)	25 (78.1)	
Alcohol			**0.04**			0.80			0.10			**0.005**			0.19
Problematic use	55 (64.7)	30 (35.3)		8 (9.4)	77 (90.6)		60(70.6)	25 (29.4)		38 (44.7)	47 (53.3)		6 (7.1)	79 (92.9)	
Low risk/N.I.*	18 (46.2)	21 (53.8)		4 (10.3)	35 (89.7)		21(53.8)	18 (46.2)		7 (17.9)	32 (55.3)		6 (15.4)	33 (84.6)	
Marijuana			0.15			0.53			0.05			0.05			**0.01**
Problematic use	48 (63.2)	28 (36.8)		6 (7.9)	70 (92.1)		55(72.4)	21 (27.6)		33 (43.4)	43 (56.6)		3 (3.9)	73 (96.1)	
Low risk/N.I.*	25 (52.1)	23 (47.9)		6 (12.5)	42 (87.5)		26(54.2)	22 (45.8)		12 (25.0)	36 (75.0)		9 (18.8)	39 (81.2)	
Cocaine/Crack			0.06			1.00			0.25			0.44			0.07
Problematic use	48 (65.8)	25 (34.2)		7 (9.6)	66 (90.4)		51(69.9)	22 (30.1)		16 (31.4)	35 (68.6)		4 (5.5)	69 (94.5)	
Low risk/N.I.*	25 (49.0)	26 (51.0)		5 (9.8)	46 (90.2)		30(58.8)	21 (41.2)		29 (30.7)	44 (60.3)		8 (15.7)	43 (84.3)	
Amphetamines/ Ecstasy			0.29			1.00			1.00			0.72			0.59
Problematic use	4 (44.4)	5 (55.6)		1 (11.1)	8 (88.9)		6 (66.7)	3 (33.3)		4 (44.4)	5 (55.6)		0 (0.0)	9 (100.0)	
Low risk/N.I.*	68 (59.6)	46 (40.4)		11 (9.6)	103 (90.4)		74 (64.9)	40 (35.1)		41 (36.0)	73 (64.0)		12 (10.5)	102 (89.5)	
Inhalants			0.52			0.21			1.00			1.00			0.21
Problematic use	11 (61.1)	7 (38.9)		0 (0.0)	18 (100.0)		12 (66.7)	6 (33.3)		6 (33.3)	12 (66.7)		0 (0.0)	18 (100.0)	
Low risk/N.I.*	62 (58.5)	44 (41.5)		23 (9.8)	94 (88.7)		69 (65.1)	37 (34.9)		39 (36.8)	67 (63.2)		12 (11.3)	94 (88.7)	

Table 4 – Cont.

	Types of violence n (%)														
	Physical			Sexual			Psychological			Patrimonial			Others		
	Yes	No	p-value†	Yes	No	p-value†	Yes	No	p-value†	Yes	No	p-value†	Yes	No	p-value†
Hypnotics/ Sedatives			0.09			1.00			0.14			0.25			1.00
Problematic use	6 (40.0)	9 (60.0)		1 (6.7)	14 (93.3)		7 (46.7)	8 (53.3)		3 (20.0)	12 (80.0)		1 (6.7)	14 (93.3)	
Low risk/N.I.*	45 (55.6)	22 (27.2)		11(10.1)	98 (89.9)		74 (67.9)	35 (32.1)		42 (38.5)	67 (61.5)		11 (10.1)	98 (89.9)	
Hallucinogens			0.56			0.56			1.00			1.00			1.00
Problematic use	5 (62.5)	3 (37.5)		1 (12.5)	7 (87.5)		5 (62.5)	3 (37.5)		3 (37.5)	5 (62.5)		0 (0.0)	8 (100.0)	
Low risk/N.I.*	68 (58.6)	48 (41.4)		11 (9.5)	105 (90.5)		76 (65.5)	40 (34.5)		42 (36.2)	74 (63.8)		12 (10.3)	104 (89.7)	
Opioids/Opiates			0.48			0.21			0.71			0.15			0.59
Problematic use	4 (44.4)	5 (55.6)		2 (22.2)	7 (77.8)		5 (55.6)	4 (44.4)		1 (11.1)	8 (88.9)		0 (0.0)	9 (100)	
Low risk/N.I.*	69 (60.0)	46 (40.0)		10 (8.7)	105 (91.3)		76 (66.1)	39 (33.9)		44 (38.3)	71 (61.7)		12 (10.4)	103 (89.6)	
Others			0.06			1.00			1.00			0.55			1.00
Problematic use	0 (0.0)	3 (100.0)		0 (0.0)	3 (100.0)		2 (66.7)	1 (33.3)		0 (0.0)	3 (100.0)		0 (0.0)	3 (100.0)	
Low risk/N.I.*	73 (60.3)	48 (39.7)		12 (9.9)	109 (90.1)		79 (65.3)	42 (34.7)		45 (37.2)	76 (62.8)		12 (9.9)	109 (90.1)	

* N.I. = no intervention; †Fisher's Exact Test.

Table 5 – Association between types of violence suffered, mental suffering, and use of psychoactive substances with self-directed violence in homeless people (n=127). Teresina, PI, Brazil, 2020.

Variables	Self-directed violence		p-value
	Yes	No	
	n (%)	n (%)	
Physical violence			**0.048***
Yes	44 (60.3)	29 (39.7)	
No	23 (42.6)	31 (57.4)	
Sexual violence			**0.033†**
Yes	10 (83.3)	2 (16.7)	
No	57 (49.6%)	58 (50.4)	
Psychological violence			0.227*
Yes	46 (56.8)	35 (43.2)	
No	21 (45.7)	25 (54.3)	
Patrimonial violence			0.138†
Yes	28 (62.2)	17 (37.8)	
No	39 (47.6)	43 (52.4)	
Other violence			1.000*
Yes	6 (50)	6 (50)	
No	61 (53)	54 (47)	
Mental distress			**0.017†**
Yes	49 (61.3)	31 (38.8)	
No	18 (38.3)	29 (61.7)	
Tobacco			0.47†
Problematic use	51 (54.3)	43 (45.7)	
Low risk/No intervention	15 (46.9)	17 (53.1)	
Alcohol			1.00†
Problematic use	46 (52.9)	41 (47.1)	
Low risk/No intervention	20 (51.3)	19 (48.7)	
Marijuana			1.00†
Problematic use	40 (51.9)	37 (48.1)	
Low risk/No intervention	26 (53.1)	23 (46.9)	
Cocaine/Crack			0.11†
Problematic use	42 (56.8)	32 (43.2)	
Low risk/No intervention	24 (46.2)	28 (53.8)	
Amphetamines or Ecstasy			1.00†
Problematic use	5 (50.0)	5 (50.0)	
Low risk/No intervention	60 (52.2)	55 (47.8)	

Table 5 – Cont.

Variables	Self-directed violence		p-value
	Yes	No	
	n (%)	n (%)	
Inhalants			0.8†
Problematic use	9 (47.4)	10 (52.6)	
Low risk/No intervention	57 (53.3)	50 (45.7)	
Hypnotics/Sedatives			0.59†
Problematic use	9 (60.0)	6 (40.0)	
Low risk/No intervention	57 (51.4)	54 (48.6)	
Hallucinogens			0.38†
Problematic use	3 (37.5)	5 (62.5)	
Low risk/No intervention	63 (53.4)	55 (46.6)	
Opioids/Opiates			0.73†
Problematic use	4 (44.4)	5 (55.6)	
Low risk/No intervention	62 (53.0)	55 (47.0)	
Others			1.00†
Problematic use	2 (50.0)	2 (50.0)	
Low risk/No intervention	64 (52.5)	58 (47.5)	

*Chi-squared test; †Fisher's Exact Test.

DISCUSSION

Most of the homeless were brown-skinned, with low education levels and no income. Thus, low education and income are factors which contribute to these people living on the streets, since unemployment in this study was the third main motivation for living on the streets, and low education, associated with reduced qualifications, makes it difficult to obtain formal employment. In this respect, the importance of inclusive public policies aimed at social reintegration of this population stands out in order to improve their living and health conditions.

Family conflicts and the consumption of alcohol and other drugs were the main reasons that led people to live on the streets. It should be noted that such conflicts can cause mental suffering, which can be a predictive factor for the abusive consumption of psychoactive substances. From this perspective, a study conducted in Spain identified that traumatic events in the lives of homeless people, such as the presence of parents in prison, illnesses, disabilities and alcohol problems in the family or in themselves, are risk factors for alcohol consumption[15]. This reinforces the importance of the timely identification of mental suffering, as well as the expansion and accessibility of mental health services to the entire population, aiming to prevent and treat mental illness and disorders resulting from the abuse of psychoactive substances, in addition to contributing to these people being able to give new meaning to their lives.

Having been a victim of violence was also one of the reasons that led a significant portion of the study participants to live on the streets. In addition, it was evident that homeless people are vulnerable to various types of violence, especially psychological and physical violence. A study in Minas

Gerais, Brazil, identified that the overall prevalence of violence was 62.3%, being higher in women (76.2%) and in non-whites (66.7%), and the types of violence most reported for women during the daytime were verbal aggression (57.1%) and physical aggression (38%), while physical aggression (25%) and threats (20.3%) prevailed among men. This highlights that the problem of violence faced by homeless people is common in various settings due to frequent exposure, but it should not be normalized or treated as something invisible; therefore, effective public policies are needed to both generate better life opportunities for people in order to reduce the number of people experiencing homelessness, and to address the structural causes of violence[16–17].

Regarding mental suffering, a high prevalence of depressive and anxious symptoms was identified, as most of the PEH felt sad lately, nervous, tense, worried, and easily frightened, which can be justified by the scenario of uncertainties, discrimination, prejudices, and vulnerabilities experienced by this population. A systematic review demonstrated considerably higher prevalence rates of depressive symptoms (46.72%), dysthymia (8.25%), and major depressive disorder (26.24%) in PEH, with a higher prevalence of depressive symptoms in younger people (under 25 years of age). These rates are notably higher than those reported in the general population, which reinforces the need for adequate mental health prevention and treatment strategies for this population group[18].

Corroborating these results, research found that homeless people presented high levels of mental health impairment and showed that approximately half of the participants suffered discrimination and violence when homeless, with experiences of discrimination being associated with higher levels of mental health impairment and the general health status of the participants[19].

The problem of self-inflicted violence was observed in England, as 1.1% of suicide victims were homeless people, in addition to finding that this population was significantly more likely to have a history of suicidal thoughts, attempts, and disclosure of suicidal intentions[20]. A loss of interest in things and suicidal ideation were reported by a considerable portion of the participants in this study, which confirms the existence of mental suffering in this population, highlighting the importance of integration between social assistance services and the psychosocial care network in order to provide more dignity and timely mental healthcare to homeless people.

In turn, sexual violence was associated with mental suffering among the types of violence self-reported by homeless people. This type of violence was also evidenced in Madrid, Spain, where homeless women suffered more stressful life events than men, notably childhood sexual violence, sexual abuse in adulthood, and abuse by a spouse or partner. This reinforces the need for interventions to promote social inclusion, as well as actions directed at women to overcome the trauma and mental suffering resulting from sexual abuse, which can lead to psychiatric problems if not properly treated[21].

Although having suffered violence was not associated with the use of psychoactive substances in homeless women, a study conducted in Ghana identified that survivors of physical or emotional violence and sexual violence were more likely to engage in high-risk use of psychoactive substances, especially alcohol, cocaine, and cannabis. In addition, the likelihood of involvement in substance use was more prevalent in men and those with low incomes, highlighting that substance use can be influenced by sociodemographic factors and traumatic situations, such as the violence suffered[22].

There was a high prevalence of problematic tobacco use among PEH, as well as an association with other types of violence. The high prevalence of cigarette use can be explained by the considerable rates of anxious and depressive symptoms evidenced, in which cigarette consumption can be a strategy to escape these emotions. High-risk or problematic tobacco use was also identified in the literature, with 11.3% of PEH presenting a high risk for tobacco use[22].

Problematic alcohol use was associated with physical violence, which can be explained by the fact that this substance generates disinhibition and euphoria at the beginning of ingestion, which may encourage the performance of violent acts, or by the fact that it is a depressant drug, which decreases the ability to think, plan and defend oneself, increasing susceptibility to violence. Problematic alcohol use was also portrayed in another study in which 68% of PEH fell into the classification of probable dependence, emphasizing the importance of interventions, such as health education actions, in order to reduce harm, contribute to the self-preservation of health and enable the referral of problematic cases to specialized care[23].

Patrimonial violence, which consists of any conduct that retains, subtracts, partially or totally destroys their objects, work tools, personal documents, assets, values and rights or economic resources, including those intended to satisfy their own needs[24], was also associated with alcohol consumption. Thus, patrimonial violence can lead people to live on the streets, in addition to causing mental suffering and contributing to the use of psychoactive substances, such as alcoholic beverages.

A high level of psychoactive substance abuse was observed among PEH in Nicaragua, with the most consumed drugs at some point in life being marijuana, inhalable glue and cocaine. Furthermore, these individuals presented very negative health and disability statuses when compared to other socially excluded groups[25], reinforcing that PEH experience various vulnerabilities, including being more exposed to violent situations. Marijuana use was associated with other types of violence in the present study, and this relationship between marijuana use and other forms of violence can be justified by the fact that this psychoactive substance is one of the most consumed by this population, which experiences various situations of violence daily.

The association between self-directed violence and self-reported physical violence can be explained by the fact that this type of violence suffered causes psychological trauma and mental suffering. From this perspective, a study identified that women experiencing homelessness reported suffering rights violations and violence that, in the long term, generate suffering, hopelessness, physical and psychological exhaustion[26]. A study in Sydney, Australia, found that 36.7% of deaths in homeless populations were from unnatural causes, which included drug overdose (24.1%), suicide (6.8%) and other injuries (5.9%)[27], emphasizing that the abuse of psychoactive substances, along with self-inflicted violence and physical violence, are some of the main causes of mortality in this population.

Mental suffering was associated with self-directed violence. In this context, a study conducted in six Brazilian state capitals identified that having lived on the streets at some point in life was associated with hospitalizations for psychological and psychiatric problems, depressive symptoms and suicidal ideation[28]. Furthermore, 1.1% of all suicides in the United States were among homeless people, and 40.9% of the total victims for whom additional information was known had a history of suicidal thoughts or plans, 29.1% had revealed an intention to die by suicide, and 21.7% were receiving treatment for a mental health condition. Although there is evidence of effective suicide prevention interventions, such as safety planning, cognitive behavioral therapy, and the use of psychotropic drugs, research is needed to investigate the extent to which these interventions can be effective in reducing the suicide rate among homeless people[29].

Although the use of psychoactive substances was not associated with self-directed violence, a study conducted in São Paulo at a Psychosocial Care Center for Alcohol and Other Drugs (*Centro de Atenção Psicossocial Álcool e outras Drogas - CAPS AD*) found that 75.3% of users who sought care at the service due to a crisis were homeless, and attempted suicide[30] was among the reasons for some users to seek care. This reinforces the importance of services which are part of the Psychosocial Care Network being prepared and coordinated to meet these demands evidenced among homeless people in a humanized, comprehensive and equitable way in order to contribute to giving new meaning to life and improving the mental health of these users.

Limitations of this study include the cross-sectional method, which makes it impossible to establish a cause-and-effect relationship; the non-probabilistic sampling due to the difficulty of accessing this population, which mostly has an itinerant profile; and the resistance of some participants to participating in the study. From this perspective, the need for further studies with probabilistic sampling and a larger number of participants is highlighted, as well as longitudinal and intervention studies, in order to enable a better understanding of the study object and evaluate concrete actions which contribute to transforming this reality, providing applicable evidence for public policies and health and care services aimed at PEH.

CONCLUSION

The type of violence suffered by PEH which showed an association with mental suffering was sexual violence, highlighting the impact of this type of violence on the mental health of these people. Regarding the problematic use of psychoactive substances, tobacco use was associated with other forms of violence, while alcohol abuse was related to physical and property violence, and marijuana was associated with other forms of violence, emphasizing that the use of psychoactive substances makes this population more susceptible to suffering or committing violent acts. In addition, self-directed violence was associated with self-reported physical and sexual violence and mental suffering, reinforcing that self-harm with or without suicidal ideation and suicide attempts by PEH may result from mental illness stemming from violence suffered.

Therefore, it was observed that violence had implications for mental suffering, problematic use of psychoactive substances, and self-directed violence among PEH. Therefore, it is essential to implement public policies aimed at these individuals in order to reduce these vulnerabilities with the goal of providing better living conditions, as well as ensuring the effectiveness of the services that comprise the Psychosocial Care Network to offer adequate care for the promotion of mental health and treatment and/or reduction of harm resulting from the problematic use of psychoactive substances in people living with mental health problems.

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NOTES

ORIGIN OF THE ARTICLE

Extracted from the dissertation "*Uso de álcool e outras drogas, transtorno mental e violência entre a população em situação de rua*", presented to the Postgraduate Program in Nursing of Universidade Federal do Piauí, in 2020.

CONTRIBUTION OF AUTHORITY

Study design: Lima DLS, Lira JAC, Ribeiro IAP, Fernandes MA.
Data collection: Lima DLS, Fernandes MA
Data analysis and interpretation: Lima DLS, Lira JAC, Ribeiro IAP, Fernandes MA, Pillon SC.
Discussion of results: Lima DLS, Lira JAC, Ribeiro IAP, Fernandes MA, Pillon SC
Writing and/or critical review of the content: Lima DLS, Lira JAC, Ribeiro IAP, Fernandes MA, Pillon SC.
Final review and approval of the final version: Lima DLS, Lira JAC, Ribeiro IAP, Fernandes MA, Pillon SC.

FUNDING INFORMATION

Coordenação de Aperfeiçoamento de Pessoal de Nível Superior (*CAPES*)/Brasil. Financing code 001.

APPROVAL OF ETHICS COMMITTEE IN RESEARCH

Approved by the Ethics Committee in Research of the Universidade Federal do Piauí, opinion no. 3.152.268/2019, Certificate of Presentation for Ethical Review no. 05755119.9.0000.5214.

CONFLICT OF INTEREST

No conflict of interest.

TRANSLATED BY

Christopher J. Quinn**.**

HISTORICAL

Received: July 23, 2025.
Approved: September 22, 2025.

DATA AVAILABILITY

All the data supporting the results of this study were published in the article itself.

CORRESPONDING AUTHOR

Jefferson Abraão Caetano Lira.
j.abraaolira@gmail.com