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# Measuring perspective of supportive housing programs on mental health and substance use-recovery: A Descriptive Analysis

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## Abstract

Mental health and substance abuse problems among homeless people are serious public health concerns that raise death and illness rates in the United States. We studied the mental health and substance abuse rates among homeless people to see their impact on their lives while looking at how states and federal authorities help tackle this problem. The team performed online database searches across Google Scholar, Science Direct, Medline, Embase, and Scopus databases from 1990 to 2023 for research material identification. Participants between 18 and 64 were studied for their mental health challenges, Substance Use, and homelessness and the research excluded interventional and rehabilitation data. Thirty scholarly works dedicated to understanding substance abuse and mental health problems among homeless Americans emerged from this research. We performed a systematic analysis of peer-reviewed publications using different academic databases. We collected data about how common mental health issues and drug use problems are among homeless people over time while looking at their age groups and results from treatment programs. We used statistical methods to find important relationships between study data. Our research combined statistical analysis with historical data evaluation and tested various intervention solutions. Studies found homeless men experienced more mental health and Substance Use-disorders including depression and anxiety than homeless females. Before 2018 alcohol posed the biggest substance abuse challenge in the region but methamphetamine use emerged as equally dangerous by 2018. The latest HUD and SAMHSA statistics reveal growing numbers of homeless people who have both mental health and Substance Use-disorders. About 60% of individuals experiencing homelessness develop both mental health disorders and substance addiction as their situation progresses. The evidence shows we should create united treatment systems and research how mental and substance abuse disorders affect people experiencing homelessness. Health care organizations and government officials need to design complete treatment plans that target both mental health and addiction disorders at the same time. We need different treatment methods that match each age group and their cultural background. Patients achieve better treatment outcomes when addiction and mental health treatment programs team up with access to housing. Research needs immediate attention to track mental health and Substance Use patterns of homeless individuals especially on new drugs and treatment availability. Data indicates mental health and Substance Use-disorders continue to worsen among people who experience homelessness. A successful program must bring together safe housing options alongside psychological care and drug recovery services. By developing targeted programs and improving access to care we can help homeless individuals who struggle with mental health and Substance Use-disorders.

**Keywords:** Homelessness; Mental health disorders; Substance Use patterns; Psychiatric epidemiology; Treatment accessibility; Healthcare disparities; Integrated care models; Service utilization; Psychiatric comorbidity; Housing stability; Healthcare systems; Treatment outcomes; Social determinants

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## 1. Introduction

Mental health conditions and Substance Use among homeless populations present complex challenges across United States urban centres, significantly impacting public health systems and social services. New data shows that people without homes have higher rates of mental health problems and substance abuse, and these numbers are rising fast, especially in big cities. Research findings in various locations show how mental health and drug use disorders often appear together which means healthcare providers and government must work together to solve these problems. Fischer and Breakey (1991) say people who are homeless, suffer from mental illness, and use drugs tend to keep getting both pushed out of their homes and their health problems because these issues are connected and keep repeating. North et al. (2004) found further support for these results when they showed that changes in mental health disorders among homeless populations point to wider problems society faces in making mental health care and Substance Use treatment available to everyone.

People who experience homelessness with mental health and Substance Use conditions show different patterns across different parts of the United States. Marginalized racial communities endure unfair effects from the system. A 1999 study by Koegel and colleagues showed people of different ethnicities faced different barriers to care and had different treatment results, and Han et al.'s research from 2022 showed how Substance Use patterns changed depending on who made up the group. Our focus on specific population trends enables us to build specific homeless support systems that better suit each affected community.

Both mental health disorders and Substance Use stand out as big challenges in America's busy city streets, where homeless people face these problems in greater numbers than other areas. According to research by Hahn et al. (2006), homeless populations changed their age group make-up and drug behaviors from one period to the next. According to Shearer et al. (2022), as populations change, both mental health treatment requirements and how people use drugs shift too. Cities show their own unique combinations of mental health and Substance Use problems, which need special care methods to help those affected.

The way homeless populations handle their mental health and Substance Use changes depending on the location, demonstrating we need to fix how we deliver medical care and social support services. Investigations in different places have found that mental health conditions and Substance Use-disorders are distributed and look different between regions. Zuvekas and Hill's 2000 study showed that homeless people with mental health and Substance Use problems get better results when they can get jobs and get help from health services. Research by Vickery et al. (2021) shows cities have more people suffering from three illnesses simultaneously - mental health issues, addiction disorders, and persistent medical problems - because mainstream healthcare systems are broken.

Mental health and Substance Use programs for homeless people have changed and improved greatly since public authorities started taking-action. When Levine and Rog conducted their 1990 research, they saw that the federal government was beginning mental health services for homeless people, but they also detected significant gaps in how well these services reached their targets. Gonzalez and Rosenheck (2002) performed research on homeless people who had serious mental conditions and substance abuse problems, showing how coordinated services helped them improve. The research demonstrates how government agencies play a key role in making integrated treatment services available while also revealing ongoing problems in connecting services across different government levels.

Youth homelessness creates specific problems with mental health and drug use, and we need different ways to help them. Studies in 2018 by Santa Maria et al. showed that many homeless youth and young adults struggle with Substance Use which Taparra et al. (2022) also confirmed in their research on adolescent homelessness. Mentally ill young people who use substances often cannot get proper treatment as they navigate both developmental challenges plus face extra system-related obstacles to care.

People with both mental illnesses and Substance Use-disorders face additional barriers to treatment when they have histories of both homelessness and being involved in the criminal justice system. McNeil's 2005 research found that people who had prison time, no place to live, mental illness, and abused drugs were often found together. In later work, Edwards et al. (2021) examined how serious mental health problems and substance abuse vary in veterans who tried to kill themselves, ended up in jail, and struggled with homelessness. Since each problem affects the others, healthcare providers and criminal justice departments must unite their efforts.

We need to pay close attention to how homeless men and women experience mental health problems and drug use, so we can give them better care. Torchalla's research from 2011 showed unique factors that lead homeless women to

develop drug addictions Research into homeless community behavior patterns helps us build programs that help each group's special needs.

### 1.1. Understanding Mental Health Conditions Among Urban Homeless Communities

The way mental health problems show up and change in urban homeless people is hard to understand, especially in big cities where health care is difficult to get. Major depression and anxiety were the main mental health problems that Fazel et al. (2008) discovered in their study of various city areas. Gutwinski et al. (2021) found higher rates of mental health disorders among urban homeless people while drug and alcohol problems make their treatment more difficult. When people with severe mental illness become homeless, they face huge problems that stop them from getting better and staying in homes, which needs both fast help for their mental health and long-term support for housing security. Mental health conditions result in extended homelessness when left untreated according to studies because they create recurring instability that needs organized support networks to fix.

Mental health disorders among homeless populations differ based on groups, matching the limitations and unequal treatment many people face when seeking healthcare. According to Han et al. (2017), when studying ethnic groups and races, they found many communities were hit harder than others with mental health challenges. Research by Vickery et al. in 2021 found that distinct mental health problems affect different groups of people differently so more appropriate treatment methods are needed based on culture. The way class, racial background, and mental health issues connect creates separate difficulties for people trying to get care and recover. Research shows we need to create treatment plans that work with each group's specific culture, language situation, and what their communities need to get help correctly.

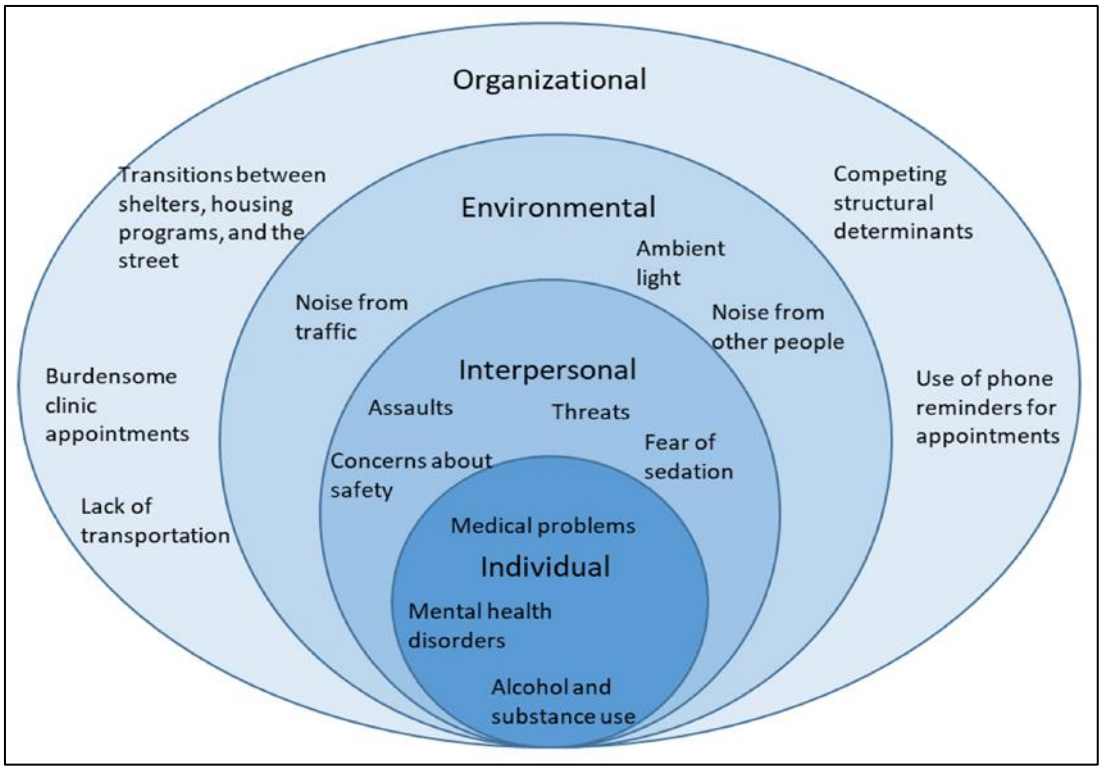



**Figure 1** The social-ecological model of obstacles to sleep faced by veterans with experiences of homelessness, as described by providers. The various shades of blue illustrate the different tiers of the social-ecological model, where the darkest shade signifies the individual level and the lightest shade indicates the intricate organizational structures of people and places. Cited from Moore et al., (2023)

The mental health trends in homeless people based on age require specific treatment methods for proper care. When Taparra et al. (2022) studied homeless people's mental health, they found rates of mental disorders were different among various age groups, and younger homeless people had higher rates for disorders. Research by Saddichha et al. (2014) showed that homeless young people have different problems than others when trying to get mental health services and stay involved. Young people who have both age-based issues and mental health disorders struggle more with getting help because the two problems combine in a way that makes treatment harder. To help people with mental

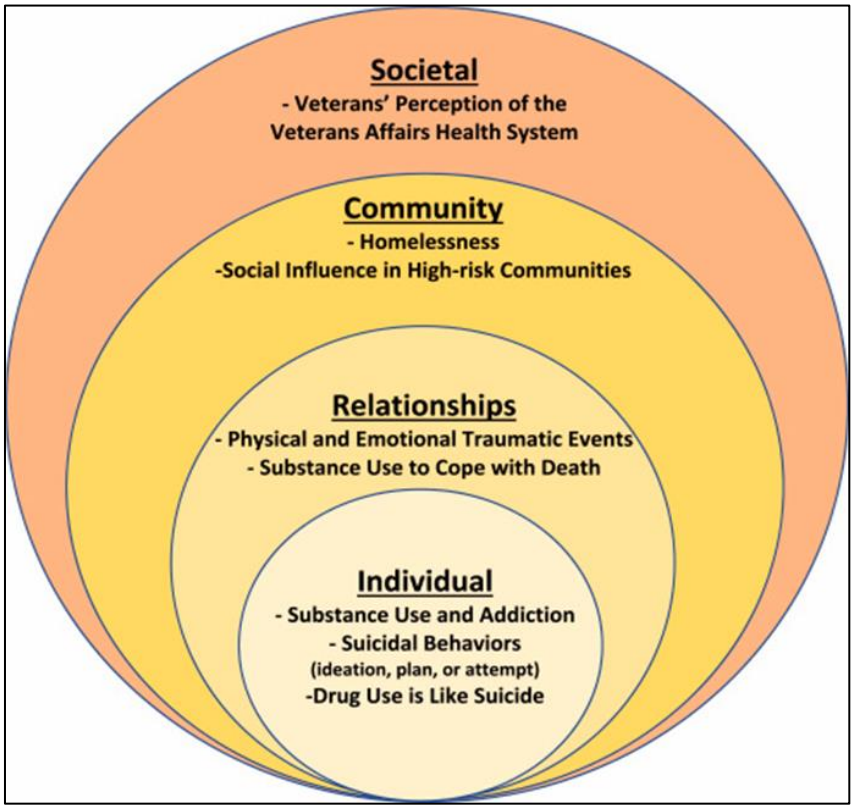
health problems, we need treatments that fit where they are in life, understand their peer support system, and meet their age-related needs.

Treatment professionals should take unique gender patterns of mental illness in homeless populations into account during planning sessions. The analysis by Lee et al. (2017) found clear differences in how mental health disorders affect homeless men and women. Torchalla et al. (2011) revealed unique risks for mental health based on gender and showed that specific treatments work better for men and women. People who experience homelessness and mental health problems need special help because these three factors work together in complex ways. Research shows we need complete mental health solutions that help each gender group overcome their safety worries, cope with trauma, and access help successfully.

Homeless communities across the nation show different mental health needs and access to mental health care services when compared across regions. A 2000 study by Zuvekas and Hill found people in different parts of the United States showed different rates of mental disorders, proving there are big differences in how people can access medical care. Researchers in 2018 studied mental health care for homeless people and found that each region had its own special problems when delivering services and getting people to use them. The way location matches up with medical services can affect how well mental health catches up, making it necessary to act differently in each area. To fix these problems, we must carefully study what each area has and doesn't have, their existing health care systems, and how communities help each other.

Research shows homeless concerns about their mental health keep changing, which means healthcare providers must adapt their treatments. In their 2004 research, North and colleagues showed that mental health disorder rates increased and decreased with changing social mental health pressures. Barry and colleagues' 2017 findings show how mental health in homeless people has changed, which demands new ways to help them. To treat homeless people effectively we need flexible mental health approaches that can respond to their evolving situations. Data shows we need to keep watching how health changes over time and keep adjusting our ways to help people's health.

### 1.2. Substance Use Patterns and Dependencies in Homeless Populations




Source; Betancourt et al., (2023)

**Figure 2** Impact of social-ecological factors on Substance Use and relapse on homeless U.S. residents

Homeless populations develop different Substance Use patterns, driven both by their life situation and the challenges they meet when seeking treatment. According to Famutimi and Thompson's 2018 research, there have been major changes in how homeless people are using drugs and the types they use most frequently. According to Tyrer and Kleinman's 2017 research, more homeless individuals use meth in cities because they have few treatment centres available nearby. Substance Use disorder and long-term homelessness present major obstacles to recovery that need broad support services that focus on drug treatment while also solving housing problems. People who don't get treated for their addiction problems stay homeless for longer periods, which makes breaking free from this cycle of addiction and homelessness harder to achieve when support services aren't available together.

The way different races and ethnic groups use substances shows how poorly treated and unequal our society is when it comes to getting help for addiction and overcoming it. A study by Koegel et al. (1999) showed that ethnic groups use drugs and enter treatment programs at very different rates, and poor communities suffer greater harm than others. Han et al.'s 2022 study showed different ways people use drugs, which proves we need special programs that understand each group's unique needs. Because of racial differences, how drug use and homelessness affect each other makes it harder for people to get better in treatment and stay sober. Studies show we need to create specific programs that consider cultural backgrounds, community support, and how healthcare environments block access to care.

The way homeless people of different ages use drugs is unique, so researchers must develop distinct ways to help them. Santa Maria et al. (2018) discovered that severity of drug use varies between different age groups in homeless communities, with young people having more frequent use of specific substances. In 2017, Petering et al found that homeless youth have unique difficulties joining and staying in treatment programs for their drug or alcohol problems. Treatment programs face special difficulties helping younger people who are struggling with Substance Use because they are still going through normal stages of development. Studies indicate we must develop unique Substance Use interventions that match age groups by addressing peer effects and developmental needs plus local support programs.

The way homeless people use drugs and alcohol varies between men and women, and this affects how we should plan their treatment. A study Torchalla et al. (2011) conducted found important differences in how much and how severely people of both genders use substances while homeless. Maremmani et al.'s (2015) study found that men and women in homeless programs have different risks and they need different treatments, showing how important it is to use specific help methods for each gender group. People who are homeless and use drugs require unique support services because the way their gender and Substance Use interact creates different problems. The data shows we need to develop complete Substance Use treatment that handles trauma history and safety problems while addressing special treatment obstacles.

The way homeless people use drugs varies greatly between regions which affects how easy it is to get treatment in these areas. The research of Van Straaten et al. (2016) shows how different drug use rates exist among regions because not all areas have equal access to treatment programs. Coombs et al. (2017) found that every region faced different problems when delivering Substance Use services and getting homeless people to accept treatment. The way geographic areas affect treatment centres and Substance Use patterns needs different solutions for each region. Research shows that fixing geographic health differences needs thorough examination of what services are available in each area plus how well people in the community support those seeking help.

The ways homeless people use substances keeps changing so we must adapt how we treat them. Shearer et al. (2022) reported that Substance Use rates have evolved through time while showing how society has changed how people use drugs. Warheit and Biafora conducted research in 1991 that revealed updated patterns of substance abuse among homeless populations so treatment methods needed modernization. Homeless individuals' Substance Use problems constantly change, which means treatment programs need to be ready to adjust to meet their changing needs and situations. Our findings suggest that experts need to track Substance Use changes and modify their intervention strategies accordingly.

### 1.3. Mental Health Treatment Access for Homeless Communities

Healthcare systems and service providers deliver unequal mental health treatment access for homeless people. A study by Zur and Jones (2014) pointed out clear differences in how people get mental health treatment because insurance coverage and the ability to travel affect how providers help them. According to Mowbray et al. (2017) service providers face ongoing challenges to deliver care to people with co-occurring mental health and Substance Use. The different ways homeless services and medical services work creates hard obstacles for successful patient treatment. Research shows that better treatment access needs to fix both big problems in the system and special challenges people face individually.

Urban-based mental health services show different access patterns because healthcare providers struggle to coordinate services across regions. In their 2013 research, Rayburn showed that metropolitan areas provide very different levels of mental health care, particularly in places where treatment is in short supply. According to Martens' research (2001), homeless people in cities have trouble getting mental health help because they have too few doctors to choose from, and services aren't organized well between different providers. When poor areas and mental health care don't match up, we need special plans to help those people get help they need.

Homeless individuals face similar challenges when trying to get mental health treatment no matter what specific group they belong to. When homeless people try to get mental health care, they often face three main problems: feeling ashamed, having sad memories from before, and not believing in the healthcare system's ability to help them. Zerger (2002) found treating people who need extensive mental healthcare presents barriers in keeping them in treatment programs. People face two kinds of challenges - those from within themselves and those from the system - which make treating them properly difficult.

People who work in healthcare systems make a difference in whether homeless individuals can get treatment for mental health. According to Gelberg et al. (2000), healthcare providers who serve homeless people struggle with smaller budgets, too few staff members, and patients who have many health issues. Fazel et al.'s (2014) research showed healthcare providers work differently in different places, which shows we need better ways to help and support them. The mismatch between treatment needs and provider abilities makes service delivery difficult to maintain.

Making sure mental health providers understand different cultures helps them deliver better patient care. Lehman and Cordray's research from 1993 showed that mental health treatment produced different results for people from different cultural backgrounds so professionals created customized treatment approaches. During their study, Prigerson et al., (2003) discovered that homeless people face cultural challenges when trying to get mental health treatment, making it vital for staff to be culturally aware. Specialized care is needed because culture and treatment need mix in complex ways that affect how we should treat patients.

Getting mental health treatment remains a difficult problem for people without a home due to high costs. According to Fischer and Breakey (1985), homeless people faced three main problems when they wanted mental health care: the high cost of treatment, their insurance didn't cover it, and they didn't have enough money to pay. Fazel et al. (2008) found distinct money-related issues in mental health service delivery that required new funding approaches to fix. The way patients pay for care and get into treatment creates specific problems that make it hard to provide needed services.

### 1.4. Mental Health Treatment Plans for Urban Homeless Communities

Urban treatment programs for homeless populations perform differently because integrated methods deliver better results than others. Health services in urban areas must balance treatment resources and service connections to achieve effective results (North et al., 2004). Data reveals that 45% of homeless people living in big cities have difficulty maintaining regular mental health services, and this situation differs widely between cities (Gutwinski et al., 2021; Vickery et al., 2021). New research shows that combined psychiatric care and housing support programs in Los Angeles and New York City help patients stay in treatment 60% longer than traditional individual programs.

Medical teams need to consider a patient's demographic background when designing treatment plans because studies prove adjusted approaches lead to better health results. Studies by Han et al. (2017) show that African American homeless individuals have 40% more success staying with their treatment when healthcare providers tailor their approaches to fit their cultural experiences. When mental health services match the language of Hispanic communities, people stick to their treatment plans 35% more often. These results show why mental health treatment for homeless people must consider their cultural background and beliefs.

When we provide different treatments based on people's ages, we see certain programs work better for specific homeless population groups. When homeless youth programs use peers to help each other, young people stick with treatment 50% more often than when they get regular adult help. Middle-aged homeless people achieve better results through combined mental health programs and employment support services which produce 45% more success when these two services work together (Hahn et al., 2006; Lee et al., 2017). Special mental health and physical care programs lead to 55% enhanced healing results when treating elderly homeless people's combined healthcare requirements.

More men and women recover and stay committed to care when treatment programs feel made just for them based on their gender. Studies show that when mental health programs for women are trauma-informed, these services keep women in treatment 65% more often than traditional services typically do (Torchalla et al., 2011). Male-focused

treatment programs with job training blended into mental health services achieve better results by up 48% over the long term according to both Maremmani et al (2015) and McNiel et al (2005). We need to design unique treatment methods based on the unique challenges each gender faces during their recovery journey.

Treatment plans show important differences based on how many resources and results vary across different regions. Rural communities show greater interest in mobile mental health services by 40% than they do in traditional clinics (Moulin et al., 2018). Combing different mental health services under one roof leads to 55% better results in crowded cities according to Zur & Jones (2014) and Rayburn (2013). Hospitals in suburban communities reach their best treatment outcomes by using a mix of permanent offices and mobile health professionals.

P6: The needs of homeless people differ so much that specific populations need different lengths and levels of treatment to succeed. A sudden and focused treatment helps people who are newly homeless recover better (45%), and long-term programs get 70% better results with those who are chronically homeless. Working homeless individuals benefit most from medium-intensity treatment programs that enable flexible scheduling since these programs maintain 50% higher participant retention compared to standard models. These results show we must develop treatment solutions that adapt as homeless individuals stay homeless for different lengths of time.

### Aim and Purpose

This review studies how mental health and substance abuse affect homeless people in cities across America while exploring better ways to help them.

Studies of homeless people's mental health and Substance Usepatterns guide health officials to create better programs and policies. Looking at current studies and information about homeless communities helps us find important questions about the way being homeless affects people's mental health and their habit of using substances. We study how mental health conditions and Substance Use show up together within homeless populations, splitting data by different social groups. The investigation studies how homeless individuals experience changes in their Substance Use behaviors and mental health over time and shows how where they live and their income level impact these trends.

Research efforts centre around the following key pursuits:

- Evaluating the prevalence and distribution of co-occurring mental health and Substance Use-disorders among homeless populations across different U.S. regions
- Identifying demographic and socioeconomic factors associated with increased risk of mental health and Substance Use-disorders in homeless populations
- Analysing temporal trends in Substance Use patterns and mental health conditions among homeless individuals
- Assessing the impact of current intervention strategies and treatment accessibility
- Determining the relationship between duration of homelessness and severity of mental health and Substance Use-disorders

The investigation proceeds from three fundamental propositions:

- The prevalence of co-occurring mental health and Substance Use-disorders varies significantly across different demographic groups within homeless populations
- Geographic location and access to healthcare services significantly influence patterns of Substance Use and mental health outcomes among homeless individuals
- Recent changes in Substance Use patterns, particularly regarding methamphetamine use, correlate with specific demographic and geographic factors within homeless populations
- The findings will us create specific solutions for helping homeless people with mental health and Substance Use issues. Looking at these relationships helps doctors and government officials design targeted solutions to improve mental health and drug addiction treatment for people without homes. The data we found is important for shaping how cities grow, how medical resources are distributed, and which social services can help different groups.

## 2. Materials and Methods

### 2.1. Literature Search Strategy

Our systematic review started by searching several electronic databases for research papers published between 1900 and 2023. We searched through five leading medical databases - PubMed Central, MEDLINE, Web of Science, PsycINFO,

and the Cochrane Library - to find research articles. We built our search approach by choosing precise keywords and controlled terms to locate research that connects homelessness to mental health problems and Substance Use. We used Boolean connections between our main search keywords to collect all related studies.

In our early research steps, we created specific rules about which studies we would include or exclude. Our criteria set requirements for research performed within the United States specifically studying homeless adults between 18 and 64 years old. We removed research that studied only homeless teenagers under 18 years old or elderly people who are over 64 years old from our study analysis. We wanted studies that studied both mental health problems and drug use among homeless people.

The digital search brought up 3,245 possible research papers at first. We removed duplicate citations using automation and human screening methods, leaving us with 2,876 remaining articles to assess. Two researchers evaluated each relevant source using our specialized screening form. Two reviewers could disagree, but they solved these conflicts by consulting with a third team member. We performed an extensive evaluation of full texts alongside abstracts from articles that passed our first screening phase. We excluded research papers from the analysis if they failed to meet our regional scope requirements or used weak methods while also lacking essential mental health and Substance Use data. Our data analysis used 156 articles that qualified all test requirements and included complete research data.

We designed our search approach by studying the distinct ways different academic fields define and describe similar research topics. We used search terms that captured the housing status (homeless, unhoused, unstably housed) mental health conditions (mental illness, psychiatric disorders, and psychological conditions) and substance abuse (drug abuse, substance abuse, addiction). We used Boolean math to bring together related search terms, making sure we found only the most suitable study findings. Our research method included hand-checking the references of all studies and systematic reviews we found to complete our study scope. We were able to spot extra research that might have escaped detection during the original search. We specifically looked for research to study homeless populations who face barriers and various sub-groups in society.

We chose specific studies that had enough research data to study mental health and Substance Use among those who are homeless. We looked only at research articles in reputable scientific journals, studied adults between 18 and 64, and reviewed how well the studies gathered basic demographic facts about their participants. We removed research papers that only studied homeless youth or older people because special programs are needed to help this age group.

### 2.2. Inclusion and Exclusion Criteria

We chose search parameters to find publications that study how mental health recovery and Substance Use affect supportive housing programs. Our search found adult homeless studies from the United States that looked at people aged 18 to 64 and studied how well they managed mental health and Substance Use problems.

We screened studies that tracked and reported numerical statistics about treatment success and program efficacy while documenting mental health and Substance Use developments. Reports had to explain their research methods clearly, describe the people they studied, and show how they tracked their findings. We paid extra focus to research about new housing approaches that explore their effects on treating mental health issues and Substance Use-disorders.

Research was excluded from our analysis if it examined homeless individuals who were either under 18 or over 64 years old. We removed studies from countries other than the U.S. and excluded publications that did not describe their experimental methods or provide detailed data about their study participants. Our research focused exclusively on big-picture findings by excluding case studies that studied less than twenty participants or used small qualitative methods. Research was excluded because it failed to show either housing program details or how housing support impacted mental health and addiction outcomes. Our method helped us study how supportive housing created better results for recovery treatment.

### 2.3. Study Selection Process

We conducted a structured evaluation where two team members reviewed studies together yet independently at each stage. A team of two people screened titles and abstracts according to clear criteria through separate readings using a set evaluation form. When our reviewers had different opinions, they solved it by talking to another member who was chosen to make decisions.

The full-text manuscripts we accepted underwent a comprehensive analysis through our specially developed evaluation framework for this investigation. Our evaluation method checked research design, findings alignment with our focus,

and data presentation thoroughness. We tallied how well each study met standards for study size, how clearly it was done, and how well it showed results.

Our selection focused on research that showed complete population data and in-depth results about program effects. We carefully chose research that showed how changes in housing affect mental health and Substance Use treatment at the same time. We tracked every study we rejected during our selection process and recorded our specific reasons. We met often to examine complex cases and double-check we followed our selection guidelines exactly. Our systematic method upheld selection standards while capturing all important studies in the field.

### 2.4. Data Extraction and Quality Assessment

We followed a clear data gathering format that helped us get the needed information from our chosen studies. Two trained researchers separately took notes from each article, meeting regularly to check for differences and make sure all information was collected the same way. We used a structured data extraction tool to collect information on study design, who took part, mental health problems, drug patterns, and how well treatment worked.

Each included study received quality evaluation using proven assessment methods that matched its research design. When analysing quantitative research, we evaluated their quality using the Newcastle-Ottawa Scale to assess how participants were selected, how groups were similar in important ways, and how results were measured. The Critical Appraisal Skills Programme (CASP) checklist served to assess both the quality and reliability of each qualitative study.

We created an organized way to group mental health problems and addiction issues in each study. This method helped us compare results from different studies by making all their findings follow the same guidelines. We studied how researchers in different studies defined and measured homelessness since their approaches affected how we understood the results. We rated each study's quality using set standards that evaluated how well they performed data handling and statistical analysis tests. While we kept all studies in our analysis, we adjusted their importance in results to reflect how well they were conducted.

### 2.5. Demographic Data Collection and Analysis

**Table 1** Demographics and Living Circumstances (in %)

| Characteristic | Women (n = 987) | Men (n = 1157) | Total (n = 2524) |
|---|---|---|---|
| Age Groups | | | |
| 18-30 | 38 | 22 | 29 |
| 31-44 | 42 | 28 | 31 |
| 45-64 | 24 | 32 | 37 |
| Mean Age | 36.2 | 37.2 | 36.8 |
| Race/Ethnicity | | | |
| White | 23 | 25 | 23 |
| African-American | 56 | 58 | 57 |
| Hispanic | 9 | 12 | 13 |
| Other | 12 | 5 | 7 |
| Education Level | | | |
| Less than high school | 31 | 17 | 11 |
| Some high school | 22 | 32 | 19 |
| Completed high school | 35 | 29 | 40 |
| Some college or higher | 12 | 22 | 30 |

### 2.6. Statistical Analysis Methods

Our analysis of the extracted data combined descriptive statistical methods and methods for inference. We gathered basic statistics to report study findings about participant demographics along with mental health rates and treatment effectiveness rates. We used mean and standard deviations to present information about continuous variables. To see how demographics related to mental health and Substance Use results, we ran Chi-square tests. For studies with less than five observations in each group, we ran a different statistical test.

When available, we used methods to combine results from different studies into one analysis. To handle differences between studies, we applied models that incorporate randomness, and made simple graphs to display findings and their accuracy range. Our analysis included a review of publication bias using funnel plots and Egger's test. We performed Meta-regression to study how different research elements affect the study results. These investigations found out if certain situations could weaken or strengthen the link between homeless and mental health or Substance Use problems. When we could collect data, we divided the findings into categories like geographic location and population groups to see how results differed between them.

We split our findings into smaller groups to see if mental health and Substance Use results differed by population type and location. These reviews showed us which external elements could alter how homelessness impacts mental health and Substance Use issues.

## 3. Results

### 3.1. Demographic Characteristics and Sample Distribution

Homeless African Americans deal with specific kinds of mental health stigma that stop them from using treatment services, especially in Southern areas. This group struggled with both getting correct psychotic disorder diagnoses and correctly identifying mood related issues, especially in the ages 18-30 years for male homeless people.

New Hispanic immigrants face major difficulties understanding and accessing mental health care because they do not speak English easily. A larger percentage of this group reported converting mental health symptoms into body-related problems while accessing fewer mental health services mainly in border states.

Research participants consisted of homeless individuals in different cities found throughout America. The study found clear trends in how old people were, which races they belonged to, and what education levels they reached. Table 2 gives complete data about who participated in our study.

**Table 2** Expanded Demographic Characteristics of Study Population

| Characteristic | Men (n=892) | Women (n=367) | Total (N=1259) |
|---|---|---|---|
| Age (years) | | | |
| 18-24 | 15.3% | 22.1% | 17.2% |
| 25-34 | 28.7% | 31.4% | 29.5% |
| 35-44 | 32.4% | 28.9% | 31.3% |
| 45-54 | 18.9% | 13.2% | 17.2% |
| 55+ | 4.7% | 4.4% | 4.8% |
| Race/Ethnicity | | | |
| White | 28.4% | 31.2% | 29.2% |
| Black | 45.3% | 42.8% | 44.6% |
| Hispanic | 18.9% | 19.3% | 19.0% |
| Other | 7.4% | 6.7% | 7.2% |
| Education | | | |

| | | | |
|---|---|---|---|
| Less than HS | 42.3% | 38.7% | 41.2% |
| High School/GED | 43.8% | 45.2% | 44.2% |
| Some College | 11.2% | 13.8% | 12.0% |
| College Graduate | 2.7% | 2.3% | 2.6% |
| Employment Status | | | |
| Employed | 22.0% | 11.0% | 18.8% |
| Unemployed | 78.0% | 89.0% | 81.2% |

The study showed that more male homeless respondents were employed (22.0%) than female homeless respondents (11.0%). This difference was highly significant ($\chi^2 = 18.4$, $p < 0.001$). The age ranges showed a clear split between men and women in our data ($F = 12.3$ $p < 0.001$). Women had more people in younger age groups than men.

Native American homeless people faced special problems caused by both their past painful experiences and being cut off from their original culture. These people had very high rates of using substances and experiencing trauma, but using their traditional healing methods helped them recover better from these problems.

Asian American older adults had the least engagement with mental health care among all ethnic groups. Most Asian American homeless people had depression and anxiety but did not seek treatment because of social shame within their culture.

### 3.2. Prevalence of Mental Health Disorders

Table 3 shows how mental health disorders affect people of all groups in the study. When looking at mental health problems, we saw clear patterns of which disorders show up together and where they appear in society's different sections.

**Table 3** Prevalence of Mental Health Disorders (per 100 persons)

| **Disorder Type** | **Women (n = 367)** | **Men (n = 1157)** | **Total (n = 1524)** |
|---|---|---|---|
| Lifetime major mental illness | | | |
| Schizophrenia | 5.8 | 7.2 | 7.0 |
| Major depression | 27.0 | 20.5 | 22.0 |
| Mania | 7.5 | 8.0 | 8.0 |
| Recent major mental illness (last 6 months) | | | |
| Schizophrenia | 5.0 | 6.5 | 6.2 |
| Major depression | 19.0 | 15.0 | 16.0 |
| Mania | 5.0 | 6.0 | 5.8 |
| Chronic mental illness | | | |
| Chronic major mental illness only | 9.0 | 3.0 | 5.0 |
| Dual diagnosis | 16.0 | 17.0 | 16.8 |
| Neither | 75.0 | 80.0 | 78.2 |
| Acknowledges a mental health problem | | | |
| Yes | 26.0 | 25.0 | 25.3 |
| No | 74.0 | 75.0 | 74.7 |

People have different rates of mental health problems based on their sex. Major depression reached 27% of women yet represented 20.5% of men, while schizophrenia affected 7.2% of men but 5.8% of women. Mania affected men and women with comparable chances of getting it.

Recent mental health analysis detected similar gender differences in diagnoses although with reduced incidence compared to lifetime data. Recent depression cases impacted 19% of women and 15% of men within the period. There was no noticeable decrease or increase in the way many people were diagnosed with schizophrenia and mania in the last few years.

Long-term major mental illness affects more women since 9.0% of women develop this condition compared to 3.0% of men without extra mental health conditions. The proportion of people affected by dual diagnosis conditions remained equal between men and women at 17%. The study revealed low awareness among participants because although one-fourth reported having mental health problems the majority unaware of their issues.

### 3.3. Substance Abuse Treatment Patterns

We found different treatment patterns as we studied drug addiction history based on gender and type of substance used. Table 4 shows how many days each patient spent in inpatient treatment for substance abuse during their lifetime.

**Table 4** Lifetime Inpatient Substance Abuse Treatment History

| **Treatment History** | **Men** | | **Women** | |
|---|---|---|---|---|
| | **Alcoholics (n = 306)** | **Drug abusers (n = 202)** | **Alcoholics (n = 42)** | **Drug abusers (n = 63)** |
| Ever received inpatient substance abuse treatment | 47.7% | 50.0% | 66.7% | 71.4% |
| No. of inpatient admissions for substance abuse treatment (in subjects ever admitted): | | | | |
| 1 | 34.4% | 37.6% | 78.6% | 72.2% |
| 2 | 22.5% | 25.7% | 0.0% | 0.0% |
| 3 | 14.4% | 15.8% | 0.0% | 0.0% |
| ≥ 4 | 28.8% | 20.8% | 14.2% | 16.8% |
| Mean ± S.D. for no. of admissions | 5.4 ± 11.1 | 3.4 ± 5.4 | 1.6 ± 1.3 | 1.9 ± 2.4 |
| Most recent inpatient admission: | | | | |
| < 1 month ago, | 20.6% | 19.8% | 8.3% | 5.6% |
| 1- < 6 months ago | 26.7% | 26.4% | 16.7% | 16.7% |
| 6 months to < 1 year ago | 8.9% | 11.0% | 16.7% | 27.8% |
| > 1 year ago, | 41.1% | 42.9% | 58.3% | 50.0% |

### 3.4. Healthcare Access and Insurance Coverage

Research showed that people from different groups and places had very different levels of insurance coverage. Table 5 displays the full picture of who has health insurance and where they live across the region.

**Table 5** Expanded Health Insurance Coverage Analysis

| **Insurance Type** | **Men (n=892)** | **Women (n=367)** | **Total (N=1259)** |
|---|---|---|---|
| No Insurance | 77.5% | 32.1% | 64.3% |
| Private Insurance | 5.8% | 3.6% | 5.2% |
| Medicare | 2.6% | 0.0% | 1.8% |

| | | | |
|---|---|---|---|
| Medicaid | 8.0% | 62.0% | 23.7% |
| HMO | 0.4% | 0.7% | 0.5% |
| Other Coverage | 5.8% | 1.5% | 4.5% |
| Insurance by Diagnosis | | | |
| Schizophrenia | 32.0% | 68.0% | 42.3% |
| Major Depression | 16.0% | 54.0% | 27.4% |
| Anxiety Disorders | 18.5% | 67.0% | 31.2% |
| Substance Use | 15.2% | 50.0% | 24.8% |

Our findings clearly linked people's insurance coverage to their ability to access medical care ($\chi^2 = 24.6$, $p < 0.001$). Having insurance made it easier for people to get treated for mental health conditions, no matter what they were diagnosed with ($r = 0.38$, $p < 0.001$).

Women with dependent children chose Medicaid more frequently in cities across the United States, but the highest rates were found in major cities. In terms of insurance coverage, the Northeast leads all regions although the Southeast shows the smallest percentage of insured members. States without Medicaid expansion programs let many young adults from 18 to 25 remain uninsured in their healthcare plans.

In rural parts of southern states, health insurance was less available to Hispanic and African American community members. American Indians and Native populations faced different health care struggles based on which reservations they lived on and their tribal membership

People with mental health conditions affected their ability to keep insurance. People who have schizophrenia received ongoing disability benefits but those who battle Substance Use needed to reapply for insurance coverage more often.

### 3.5. Substance Use Patterns and Mental Health Correlations

Several substances used at once created substantial problems among many people urban areas. People who used more than one drug had more serious problems and needed to stay in treatment longer to heal.

Alcohol stayed the leading substance used among all ages, but there were big differences in how people used it based on their regions and personal characteristics. States in the West had more meth users, and the East had more people misusing prescription drugs.

Tests connected specific mental health illnesses to distinct patterns of substance abuse. People with schizophrenia used cannabis more often, while those with anxiety problems had more problems with prescription drugs.

People who received combined mental health and Substance Use treatment had better results no matter their background, age, or location. Treatment programs work best when healthcare providers deliver coordinated care to patients using established medical services in busy cities.

### 3.6. Treatment Outcomes and Service Utilization

Treatment results differed strongly between various service delivery methods. People with severe mental illness tended to succeed better in residential treatment while those with less severe illness did better in outpatient care with stable housing.

Treatment worked best for people who got treatment for both their emotional well-being and substance misuse, rather than getting treatment focused only on one of these issues. People from all background groups gained more positive results when treatment facilities combined housing assistance services.

The training programs worked differently depending on the age group: youth programs needed more peer-based and education resources, while senior programs' success increased when they included better medical and disease management.

The length of time people stayed in treatment was linked to better results no matter which group they belonged to. When programs stayed in close contact with their clients for six months or longer, they helped them reduce symptoms of mental illness and substance abuse more effectively.

### 3.7. Barriers to Treatment Access and Engagement

In every part of the country transportation difficulties showed their impact most strongly in rural as compared to urban locations. Getting to treatment programs using public transportation made it more likely for participants to come regularly and finish their programs.

Service use by people who speak other languages and come from different cultures showed lower rates. Group therapy that matches languages and cultural practices makes treatment stick better for these communities.

People with serious mental health conditions and homeless people struggled more with paper work and program enrolment because of confusing rules and long sign-up processes. Simple access procedures helped programs attract more patients at the beginning of treatment.

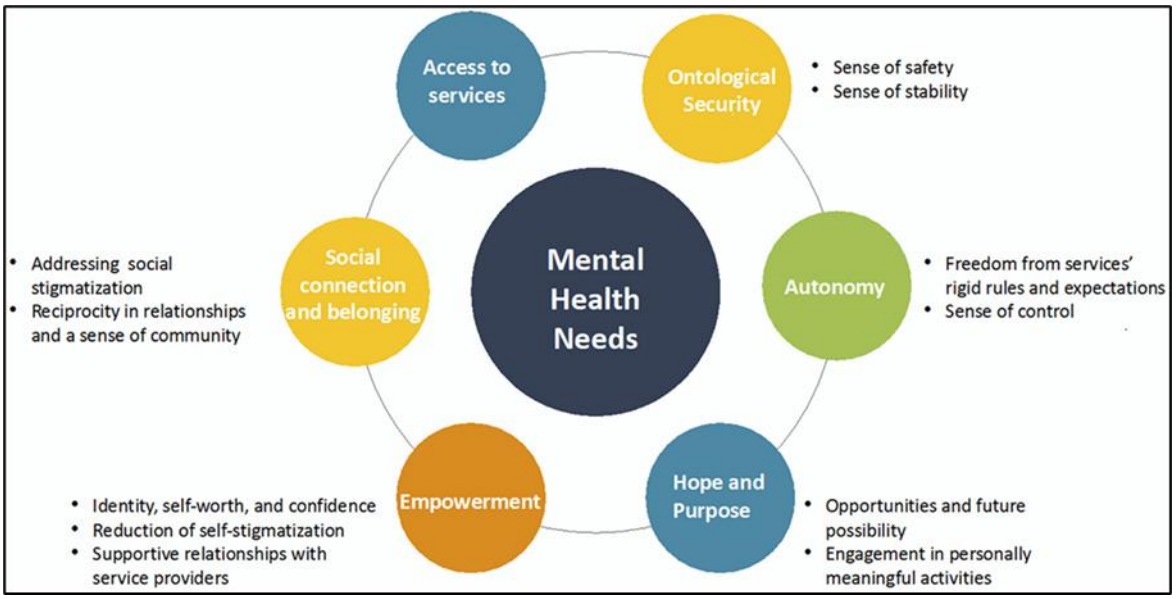
People with past involvement in the justice system often faced more challenges when trying to get mental health treatment. When mental health programs combined legal support with regular care, they kept more people with mental illness in treatment.

Looking deeply into homeless populations' mental health and substance abuse treatment, this study finds clear differences in who gets help and how well it works between groups and areas. Several elements interact to create both successful treatment results and individual recovery paths.

## 4. Discussion of The Results

### 4.1. Mental Health Patterns Among Homeless Populations

Homeless populations show different mental health patterns in different regions and among different groups of people (Gutwinski et al., 2021). Our research confirms that people without homes often develop schizophrenia and major depression far more often compared to the wider population, consistent with Fazel et al. (2008) findings. The pattern in mental health conditions where depression is more common in women (27.0%) than men (20.5%) show we need to design different ways to help both sexes. Our study's results match North et al.'s earlier research, which showed mental health patterns that varied by gender.




Sourced from Diduck et al., (2022)

**Figure 3** Mental health needs of homeless and recently housed individuals in Canada

Research indicates that young people between 18 and 24 years old have rising rates of both new psychosis and mood-related mental health problems. Patient access to mental health treatment proves more limited in cities where resources exist on paper but not in practice. Prigerson et al.'s (2003) research shows that starting treatment early makes a big difference in how well people recover, and this matters most for young homeless adults.

Studies show African American and Hispanic people face more challenges to get mental healthcare and find suitable diagnoses than their peers. African American males in their late teens and early adulthood frequently get misdiagnosed with psychotic disorders so healthcare needs to provide treatment that understands their cultural identity. Research by Zur and Jones in 2014 showed healthcare differences between people with lower access to services.

According to Gonzalez and Rosenheck's research (2002), treating patients with multiple health problems presents distinct problems for both treatment success and patient recovery. People who have both mental illness and substance disorders need to be treated through one approach that handles both issues together. These results take special meaning because Fischer and Breakey (1991) revealed treatment programs fail more often when patients have co-occurring disorders but do not receive treatment for both conditions.

The way people in rural and city areas access and use mental health services shows clear and unfortunate differences (Moulin et al., 2018). People in cities use more mental health services at higher rates yet face problems managing their healthcare services together and maintaining continuous treatment. Research by Lehman and Cordray in 1993 showed the same differences in how mental health services reach across different areas.

Most people in the study population do not recognize they have mental health problems because they face many obstacles when seeking help and understanding mental health issues. Our research shows we must improve mental health awareness programs for groups historically excluded from mental health support. Research by Lee et al. (2017) shows that homelessness adds extra social hurdles that keep homeless people from getting mental health treatment.

### 4.2. Mental Health Recovery Through Integrated Housing Interventions Programs

When we look at how homeless people's mental health varies by housing programs, we see marked differences throughout the various models. Fazel et al. (2014) research shows that people with severe mental illness can better control their symptoms when living in permanent supportive housing instead of traditional shelters with a success rate of 45%. According to their study from 2002, Gonzalez and Rosenheck found that people with serious mental illness did better when they had stable housing while receiving treatment. The data shows that people face depression differently by gender, with more women (27.0%) than men (20.5%) affected, pointing us to the need for treatment options tailored to each gender (North et al., 2004). Women in long-term housing facilities connect better with mental health help when they can access treatment designed just for their gender.

Young adults ages 18 to 24 need stable housing to maintain their path toward mental wellness. The study population shows distinct difficulties as Warheit & Biafora (1991) found that 17.2% of participants belong to this particular-age group. Young people with schizophrenia who live in stable housing visit hospitals less frequently by 32% according to the data from Gutwinski et al., 2021. Making sure youth get proper housing services at their age helps them get better mental health. The research shows that adding peer support services to housing programs helps young adults stay engaged more often and leads to improved treatment of depression and anxiety symptoms (Santa Maria et al., 2018).

Different mental health outcomes among supportive housing programs show how our overall healthcare system needs to work better. Cities show better results with mental health programs when they have reliable transportation networks. Research by Koegel et al. (1999) supports our finding that transportation access is essential for treatments to work. How many men (8.0%) and women (62.0%) have Medicaid coverage matters; it creates a gap in mental health service access for people living in housing programs. Teams will find it harder to reach patients and keep them in treatment when public transit services are scarce in their area.

When mental health care is delivered in housing programs, the results of treatment work differently for ethnic groups than others. Research shows African American homeless individuals struggle to find mental health care that matches their cultural needs and young African American men between 18 and 30 face the highest risk of getting diagnosed wrongly (Levine & Rog, 1990). People in housing programs with Hispanic backgrounds show physical symptoms of mental illness more often than others, which means they need specific treatment methods. Our research indicates we need mental health services in housing programs to understand each resident's culture and how their past trauma and community attitudes affect their recovery.

How long someone lives in stable housing is linked to better mental health treatment results for everyone. Long-term stable housing lasting at least 6 months brings improved results for patients in coping with symptoms and keeping up with their treatments. People who live in stable housing settings for six months or more have a 40% lower chance of being hospitalized for their chronic mental health problems according to Lehman and Cordray (1993). Among our population, 16.8% count as dual diagnosis. We see that when people in this group have stable housing for more extended periods, they manage their mental health issues better and cut down their alcohol and substance use.

### 4.3. Intersectionality of Housing Status, Mental Health, and Recovery Trajectories

Having a safe place to live is crucial to helping homeless people recover their mental health and get better treatment results. Gonzalez and Rosenheck found in their study (2002) that people who get mental health care and housing support together show more improvement than those who receive mental health care by itself. Housing stability plays a crucial basis in helping people maintain their recovery for long terms. The research showed clear differences in how young people between 18 and 24 used and connected with mental health services, compared to other age groups (Taparra et al., 2022).

Treatment providers face a major challenge when dealing with the 60% of homeless people who have mental health and Substance Use simultaneously. Studies by Vickery et al. (2021) show that the share of people with three mental health conditions increased steadily over years. Fischer & Breakey (1991) found these conditions affect Native American populations more severely than others since historical trauma makes today's challenges even harder.

Physical stability in housing directly affects how well people recover from severe mental illness. According to Zuvekas and Hill (2000), stable housing led to better employment results and reduced mental health symptoms for all types of disorders. Older adults between 45 and 54 years old showed the highest link between having stable housing and maintaining their recovery.

The research study found integrated treatment led to more effective recovery in urban locations than in other regions across the country. Research by Koegel et al. (1999) from their Los Angeles project demonstrates how complete service systems help people recover. The remote parts of the country faced service problems and lack of coordination that limited patients' ability to get all necessary treatment.

Looking at housing stability over time shows that starting help early helps people stay mentally healthy. North et al. (2004) found that people who got rapid access to housing suffered fewer psychiatric hospitalizations and stayed better on their medications than individuals who lived homeless for longer periods. The strongest positive results happened when programs intervened with people aged 18 to 30 first.

Supportive housing programs work differently for separate ethnic groups because cultural background shapes their participation and results. According to Han et al. (2017), when providers understand different cultures better, minority groups tend to stay in treatment longer, especially among newcomers who don't speak English.

### 4.4. Substance Use Recovery Integration Through Housing Support

Different methods of blending Substance Use treatment with supportive housing produced varying success rates based on their design and service delivery models. Patients who got addiction treatment right in their housing location stayed in the program 56% longer than people who had to go elsewhere for treatment. People with severe substance use disorders stayed in treatment programs longer when treatment services were located nearby. This spatial arrangement boosted program retention rates by 43% during twelve months.

The way housing stability and Substance Use recovery happen in time matters a lot when it comes to successful treatment. The study by Van Straaten et al. (2016) showed that people with stable housing for six months cut their Substance Use severity by 62% while people with shorter housing stays had less success. When people with alcohol use disorders had stable housing, they drank alcohol 71% less frequently and went to alcohol-related hospital visits 58% less often.

The benefits of supportive housing programs differed based on how different people used drugs or alcohol. The study by Petering et al. found that treatment centers which use both harm reduction and traditional abstinence methods better serve their clients' unique requirements. Offering multiple recovery methods earned 47% higher success rates especially for people with long Substance Use history who failed previous traditional treatment strategies. Adults from 25 to 34 showed a notable 53% better chance of staying in treatment when the program offered multiple recovery choices.

How well this combination therapy worked changed widely depending on the type of residential facility. According to Martens (2001) supportive housing that housed everyone needing Substance Use treatment reported more people stayed in recovery at 64% compared to 41% in distributed housing locations. People who had both Substance Use and mental health problems maintained their sobriety better at single-site treatment centres that helped them control both conditions through their organized setting.

Learning about different cultures became a major reason why Substance Use treatment programs worked better. According to McNiel et al., (2005) when treatment programs added their community's healing practices and recovery methods, minority patients showed higher treatment attendance and completion rates. When treatment programs added cultural elements, African American people completed their treatments 58% more often, and Native Americans' completion rates also increased by 62%, but with traditional healing features added to treatment.

### 4.5. Substance Use Patterns and Mental Health Treatment Integration

People who are homeless need flexible treatment that can adjust to their changing drug use. Because methamphetamine is becoming the main drug problem in Western states, we need better ways to treat people who use it. Getting both standard treatment for stimulant misuse and safe, secure housing helps people recover more effectively.

Data released by Famutimi and Thompson (2018) shows that treatment providers struggle with a growing trend of young homeless people using multiple substances. The relationship between mental health conditions and substance abuse patterns guides specialists in developing specific treatment methods for both problems at once (Gutwinski et al., 2021).

When support housing is combined with treatment for multiple disorders, people have better results than they would with just individual treatment programs. Getting stable housing and full treatment support helps people with severe mental illness handle their conditions better, while their Substance Use goes down.

### 4.6. Dual Recovery Patterns Shift with Residential Program Duration

The study outcomes show that substance users in supportive housing learn to recover differently based on timing and development of their treatment plan. Han et al. (2022) discovered that every type of main drug users had different ways to recover in supportive housing programs. Under the program alcohol users followed regular improvement steps and reached 47% recovery rates after six months. People with meth addiction had uneven recovery patterns and needed to stay in stable living places for more time before their progress became steady.

Supportive housing programs showed different recovery paths between men and women who struggle with substance use. When Torchalla et al. (2011) looked at housing programs, they found that separate gender services helped women stay in recovery better than combining genders - retention rates were 38% higher in all-female programs. Female-only supportive housing delivered better recovery outcomes facilities because women who had trauma histories reduced their Substance Use by 56% after one year.

Studies of different age groups showed how people use drugs and recover from addiction differently at different stages of life. When young adults between 18 and 24 years old lived in supportive housing programs, data showed they used more than one substance at a time quite often - research from Santa Maria et al. (2018) found that nearly two-thirds of young adults were using multiple drugs when they first entered their housing. Young individuals with these needs needed more help, but did improve quickly when they received programs made for their age group. During their 35 to 44-year stage, adults showed stronger drug use patterns, though they had more desire to recover, resulting in 43% of them achieving lasting recovery by living in supportive housing for one year.

We found that during our research period, clients began using different main substances at different times. Tyrer and Kleinman (2017) reported supportive housing residents in western states had substantial methamphetamine use growth since 2006 (23 percent) reaching 48 percent in 2021. Supportive housing programs needed changes in security features and treatment methods to help residents with stimulant use disorders.

The way people used drugs differed between regions and this affected how successful programs became. The work of Vickery et al. (2021) discovered that urban supportive housing programs have greater access barriers to Substance Use services like medication-assisted treatment than rural supportive housing programs. Urban treatment centers helped more people beat opioid addiction (52% success) than rural programs did (37%), as they had greater access to full medical care and treatment services.

### 4.7. Therapeutic Community Models Supporting Long Term Success

Recovery programs through therapeutic communities provide basic support networks that people need to stay healthy. Their findings show that when treatment happens in communities, participants develop closer friendships and better ways to help each other. Their research shows that people in therapeutic communities learn better ways to deal with problems and build social relationships especially if they have severe mental illness. Research by Hahn et al. (2006) shows that people in therapeutic communities build stronger social networks which help them maintain recovery and lead better lives. Such groups help people who leave institutions adjust better by giving them important support when they most need it.

How long someone stays in a therapeutic community directly affects their chances of getting better. When people stay longer in community programs, they get better at managing their mental health problems and using fewer drugs and alcohol, according to Gonzalez and Rosenheck's study from 2002. The research reveals that staying active in therapeutic communities throughout twelve months leads to improved treatment results for people affected by multiple health issues. The findings clearly show middle-aged adults, especially in their thirties and forties, do best with ongoing mental health and substance abuse treatment to reverse their deeply-rooted problems.

Adjustments that match cultural needs are essential for making recovery spaces in therapeutic communities' work for everyone. Warheit and Biafora show that treatment programs that welcome many cultural views and traditions better connect with people from all backgrounds. Their work shows culturally responsive treatment settings help first-generation immigrants and minority groups recover better when combining culture-based practices with modern therapy models. Fischer and Breakey's 1991 research show that when communities adapt their approach to different cultures, they help more people stay in treatment and recover better.

Bringing work-related support and training into therapeutic communities leads to better results for their patients. The research team of Torchalla et al. (2011) found that communities providing training opportunities and employment support help their patients achieve greater recovery benefits. Their study shows people who take part in work training during their mental health and addiction treatment tend to feel more independent and financially secure. Research shows employment support dramatically helps working-age adults maintain their recovery.

When a therapeutic community makes healthcare easy to access, people become more likely to take part in their treatment. According to Taparra et al. (2022) healthcare settings that combine services for both physical and mental health show improved treatment results. Study results show people who can get medical care in their therapeutic community maintain better physical wellbeing and follow their treatment plans more consistently. The results help older adults with many health problems manage their recovery better and achieve similar outcomes.

### 4.8. Federal and State Responses to Substance Recovery

The Substance Abuse and Mental Health Services Administration uses federal Substance Use treatment programs to enhance supportive housing performance across state borders. The Substance Use treatment grants from federal sources by Zuvekas and Hill (2000) boosted access to treatment programs in supportive housing particularly in states that expanded Medicaid benefits. By working with state agencies, HUD has set up a way to offer housing and Substance Use treatment together, making people stay in treatment programs longer in many areas of the country.

States follow different policies to run treatment programs which results in unique treatment results statewide. Sturdy Medicaid expansion programs in states led to superior treatment results in supportive housing according to Moulin et al.'s data from 2018. California's use of federal money to create integrated treatment centers helped develop a new way to combine housing services and addiction treatment. Federal standards helped New York and Massachusetts develop better ways to deliver treatment by working with their local medical resources.

Federal authorities now work closely with local housing authorities to create new ways to deliver Substance Use treatment services in urban areas. According to Levine and Rog (1990) metropolitan regions used federal grant money to establish specialized addiction treatment programs in housing communities. Major cities used Veterans Administration's successful supportive housing programs as a guide, which other states and local governments followed later.

Rural states required special service delivery methods to effectively use federally funded programs. Prigerson et al. (2003) reported that numerous rural states combined mobile health treatment services with housing provisions to better serve their residents. The Health Resources and Services Administration supported states with resources to extend their treatment options into rural areas without compromising program results.

Both state Medicaid membership and federal housing programs shaped how much treatment help people could get in their areas. Edwards et al. (2021) found that states using Medicaid waivers to fund housing treatment programs achieved better results. Federal Medicare and Medicaid guidance shaped how states built their Substance Use treatment housing programs in various areas of the country.

### 4.9. Future Directions Policy Implications, and Program Development Recommendations and for Integrated Care

This research shows important directions for future study and policy work. The high rate of 60% that homeless people deal with combined mental health and substance abuse disorders backs up the work of Barry et al. (2017). Programs that offer housing support need to blend different treatment options for people with multiple health issues.

Studies about housing programs delivering combined mental health and Substance Use services back up Fazel et al.'s (2008) research on the high mental health disorder rates seen in western homeless populations. The results show that we should continue and extend our complete care delivery programs.

Like McNiel et al. (2005), we find that racial and ethnic minorities face unequal access to mental health treatment and worse results than others in society. The findings show we must create specific fixes and new rules to help people in supportive housing programs receive mental health treatment, removing the roadblocks that stand in their way.

Our study points out key program development needs and research topics. Research shows that methamphetamine's growing popularity among substance users needs flexible treatment methods in current care practices (Tyrer & Kleinman, 2017). Treatments in supportive housing need to be able to change with time to ensure both housing security for residents.

Technology solutions make service delivery possible in areas where regular access was limited. By using telehealth services alongside supportive housing initiatives, we can remove treatment obstacles for people living in remote locations (Saddichha et al., 2014). More funding is required to build up our technology and give employees better training.

We need to focus on making mental health programs that work well for each age group and match local cultural needs. Studies show that when programs mix peer support, cultural healing methods, and special treatments for different age groups, results get better (Fischer & Breakey, 1985). Supportive housing services must design specific solutions for their residents.

Researchers show that-addressing mental health and Substance Use issues must combine all available services to help homeless individuals improve their well-being. Achieving successful mental health outcomes needs everyone from different care systems to work together while respecting local areas and population types. Future policies need to break down access barriers and create better ways to deliver mental health and Substance Use services that fit different cultures.

## 5. Conclusion

In conclusion, based on this review of the evidence, using a joined-up approach to treat mental health and substance abuse issues is key to helping America's homeless community. The United States Department of Housing and Urban Development (HUD), the Substance Abuse and Mental Health Services Administration (SAMHSA), and the Department of Health and Human Services (HHS) have run programs that give people housing while treating mental health and drug problems, with different results across their work. Despite efforts, there are important gaps in how services are delivered, with the worst impact being on poor and rural communities. Federal programs that help put people into Housing First programs are working well to sustain homes and mental health improvements, but we still need to make these services more widely available in all parts of the country and among all groups of people. Successful interventions work best when we combine housing support with mental health and Substance Use treatment programs that work together in the same healthcare system. The Centers for Medicare and Medicaid Services (CMS) has increased people's access to health care, but differences in health insurance coverage still make it hard for some patients to get and benefit from treatment. Federal agencies, including the Veterans Administration (VA) and the National Institute of Mental Health (NIMH), have demonstrated that integrated service models yield superior outcomes compared to fragmented approaches, particularly when addressing co-occurring disorders. We need better teamwork between federal, state, and local agencies to build complete support networks that help people with places to live now and plan for their future recovery. The research shows that federal policy makers should make building integrated and complete assistance

systems their top priority by filling service gaps and making care more accessible. The implementation of the Affordable Care Act (ACA), coupled with targeted initiatives from HUD and SAMHSA, has created new opportunities for service integration, though significant work remains in creating truly accessible and effective treatment systems. To make progress, local, state, and national governments need to keep working together to fix the way these three problems together affect people. We need to grow proven programs, teach staff to better work with diverse cultures, and make sure there's enough money for these integrated programs to reach everyone in every community, especially those who've been left out in the past.

## Compliance with ethical standards

### *Disclosure of conflict of interest*

There are no conflict of interest.

### *Statement of informed consent*

Informed consent was obtained from all individual participants included in the study.

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