

Review

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[Elena Andina-Díaz](#), [Bárbara Santamarta-Fernández](#)^{*}, [Elena Fernández-Martínez](#)

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Systematic Review

Community-Based Social and Health Interventions and Their Impact on Mental Health and Social Integration Among People Experiencing Homelessness: A Systematic Review

Elena Andina-Díaz ¹, Bárbara Santamarta-Fernández ^{2,*} and Elena Fernández-Martínez ³

¹ HeQoL Research Group. Senior Lecturer, Department of Nursing and Physiotherapy, University of León, Spain. CECAVIS Research Group, León Institute of Biosanitary Research IBIOLEÓN. EYCC Research Group

² Associate Professor, Department of Nursing and Physiotherapy, University of León. Registered Nurse, University Hospital of León, Spain. CECAVIS Research Group, León Institute of Biosanitary Research IBIOLEÓN

³ HeQoL Research Group. Full Professor, Department of Nursing and Physiotherapy, University of León, Spain. CECAVIS Research Group, León Institute of Biosanitary Research IBIOLEÓN

* Correspondence: bsanf@unileon.es

Abstract

Background: Community-based mental health and social interventions focusing on housing stability, integrated care and psychosocial support are increasingly recognised as essential for improving the mental health and wellbeing of people experiencing homelessness. This review synthesizes how these interventions address mental health and social determinants of health. **Methods:** Following PRISMA 2020 guidelines, a search of six electronic databases (2019–2025) was conducted (PROSPERO: CRD420250653260). The review included 29 quantitative, qualitative, and mixed-methods studies examining community-based interventions for people experiencing homelessness and mental health conditions. **Results:** Community-based interventions, particularly Housing First models, were consistently associated with improved housing stability, mental health outcomes, and programme retention. Integrated multidisciplinary services and outreach promote psychosocial wellbeing, continuity of care and reducing emergency service use. Peer-led programs support social integration, although evidence for technology-based tools remains mixed. **Conclusions:** Addressing social determinants of health through structured community-based interventions is essential to tackle mental health inequalities. The findings highlight the importance of multidisciplinary and mental health nursing approaches that support continuity of care, psychosocial wellbeing, and social inclusion within vulnerable populations.

Keywords: homelessness; community-based interventions; mental health; psychosocial wellbeing; social determinants of health

1. Introduction

Homelessness is a growing global public health concern, with the United Nations estimating that 150 million people experience homelessness worldwide. In Europe, the situation is equally alarming. According to the 2024 European Federation of National Organisations Working with the Homeless (FEANTSA) report (1), approximately 1,287,000 people across Europe are homeless, including those sleeping rough, staying in night shelters, or living in temporary accommodation. Mental illness affects approximately 30–50% of people experiencing homelessness, often in combination with substance use and chronic physical health conditions (2).

Homelessness is often categorised into different types, including chronic, episodic, and transitional homelessness (3). Chronic homelessness refers to long-term, repeated experiences of homelessness, often associated with severe mental health disorders and substance use. Episodic homelessness involves recurrent periods of housing instability, while transitional homelessness is temporary and frequently linked to economic hardship. Mental health disorders are disproportionately prevalent among homeless populations, with studies indicating that between 30% and 50% of homeless individuals suffer from severe mental health conditions such as schizophrenia, bipolar disorder, and major depressive disorder. Comorbid conditions, including substance use disorders, further complicate access to and effectiveness of mental health care and social interventions (2,4).

The relationship between homelessness and mental illness is bidirectional. According to a recent review (5), mental health conditions can contribute to housing instability, while homelessness exacerbates psychological distress, creating barriers to treatment and recovery. Social determinants of health, including poverty, unemployment, and lack of access to healthcare, further perpetuate this cycle (6). As a result, interventions addressing both housing and mental health support are essential for sustainable improvements in well-being. Given the complex and multidimensional needs of people experiencing homelessness, mental health nurses play a key role in delivering community-based, trauma-informed, and recovery-oriented care through outreach, psychosocial support, therapeutic relationships, and care coordination (7–9).

Over the past two decades, recent reviews (10,11) have documented various interventions implemented to improve mental health outcomes for homeless individuals. Housing First (HF) programs, which prioritise stable housing without preconditions, have gained extensive recognition for their effectiveness in reducing homelessness and improving their mental health (12). Integrated healthcare services, including street medicine and mobile outreach programs, aim to bridge the gap between healthcare providers and homeless individuals. Peer-support models and psychosocial interventions leverage community engagement to enhance service uptake and adherence (13). Nurse-led interventions have also emerged as crucial components of care, addressing both physical and mental health needs through outreach and holistic support services (14).

Despite these efforts, challenges remain in evaluating the effectiveness of interventions and identifying best practices for long-term success. Studies often vary in their methodologies, making cross-comparisons difficult. Additionally, gaps in research exist regarding the sustainability of interventions, the role of health literacy, and the impact of social policies on homelessness and mental health (6,15). A recent review highlights that access to mental health services and secure housing is critical for promoting recovery and social inclusion, reinforcing the importance of integrated strategies to address the complex needs of this population (5).

This review aligns with several Sustainable Development Goals (SDGs)(16), particularly SDG 1 (No Poverty), SDG 3 (Good Health and Well-being), SDG 8 (Decent Work and Economic Growth), SDG 10 (Reduced Inequalities), and SDG 11 (Sustainable Cities and Communities). Specifically, SDG 3 aims to ensure healthy lives and promote well-being for all, including the promotion of mental health and access to care. This highlights the importance of equitable and integrated approaches to mental health and homelessness.

Additionally, this review represents a comprehensive synthesis of community-based social and health interventions targeting people experiencing homelessness and mental health conditions across diverse implementation contexts. By integrating evidence from multiple disciplines and community settings, the review seeks to identify patterns of effectiveness and key contextual mechanisms that shape mental health outcomes, psychological wellbeing, and social integration. This interdisciplinary and ecological perspective aims to inform the development of adaptable, community-informed intervention approaches applicable across varied social and institutional environments.

Mental health outcomes among people experiencing homelessness are influenced by multiple structural and social determinants, including housing stability, access to healthcare services and social integration. Previous research has shown that interventions addressing these determinants

may indirectly improve psychological wellbeing and mental health outcomes. Therefore, this review focuses on community-based social and health interventions and examines their impact on outcomes related to mental health, housing stability, healthcare utilisation and social integration.

Therefore, this systematic review aimed to synthesise existing evidence on the effectiveness of community-based mental health, social, and health interventions for people experiencing homelessness and mental health conditions. Specifically, the review examined the impact of these interventions on mental health outcomes, psychosocial wellbeing, housing stability, service utilisation, and social integration across diverse community and healthcare settings.

2. Materials and Methods

This systematic review was conducted following the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines to ensure transparency and replicability (17). This review included studies from 2019 to 2025 evaluating health and social interventions targeting homeless individuals with mental illness. The search was limited to studies published from 2019 onwards to capture the most recent evidence following the expansion of Housing First models and integrated community health interventions during the past decade.

Literature search

A comprehensive search was conducted in six major electronic databases: Web of Science, Scopus, PubMed, CINAHL, MEDLINE and PSICODOC. The search strategy used is as follows:

“homeless” OR “homeless*” OR “unhoused” OR “houseless” (Topic) and “community intervention*” OR “community treatment” OR “housing” OR “street outreach” OR “health intervention*” (Topic) and “mental health” OR “mental” OR “mental illness” and 2025 or 2024 or 2023 or 2022 or 2021 or 2020 or 2019 (Publication Years) and Review Article (Exclude – Document Types)

The search terms included a combination of controlled vocabulary (MeSH terms) and free-text keywords related to homelessness, mental health disorders, community-based health and social interventions, and effectiveness outcomes. Boolean operators (AND, OR) were used to refine the search. Grey literature, conference proceedings, and unpublished studies were excluded to maintain methodological rigor.

The database searches were complemented by a manual screening of references from relevant systematic reviews and meta-analyses to ensure that no key studies were overlooked. Searches were limited to studies published in English between 2019 and 2025 to ensure relevance to contemporary intervention strategies.

The following criteria was followed:

2.1. Data Retrieval

Studies meeting the predefined inclusion criteria were retrieved and assessed for eligibility. These criteria included intervention studies targeting people experiencing homelessness with mental health outcomes published between 2019 and 2025.

2.2. Screening and Selection

Initially, 2235 references were screened, with 1274 duplicates removed, leaving 961 studies for title and abstract screening. Of these, 916 were excluded based on relevance to the research question. The remaining 45 studies were assessed for full-text eligibility by two reviewers (EF and EA). After a thorough evaluation, 16 studies were excluded: two were not empirical research, four did not focus on targeted interventions, one lacked full-text availability, eight did not target the intended population and one had misaligned outcomes. Ultimately, twenty-nine studies (5 mixed-methods—both quantitative and qualitative interventions—, 12 RCT, 2 quantitative, 4 qualitative 5 quasi-experimental quantitative and 1 quasi experimental qualitative) met all the inclusive criteria. The complete screening and selection process is illustrated in the PRISMA flowchart (Figure 1).

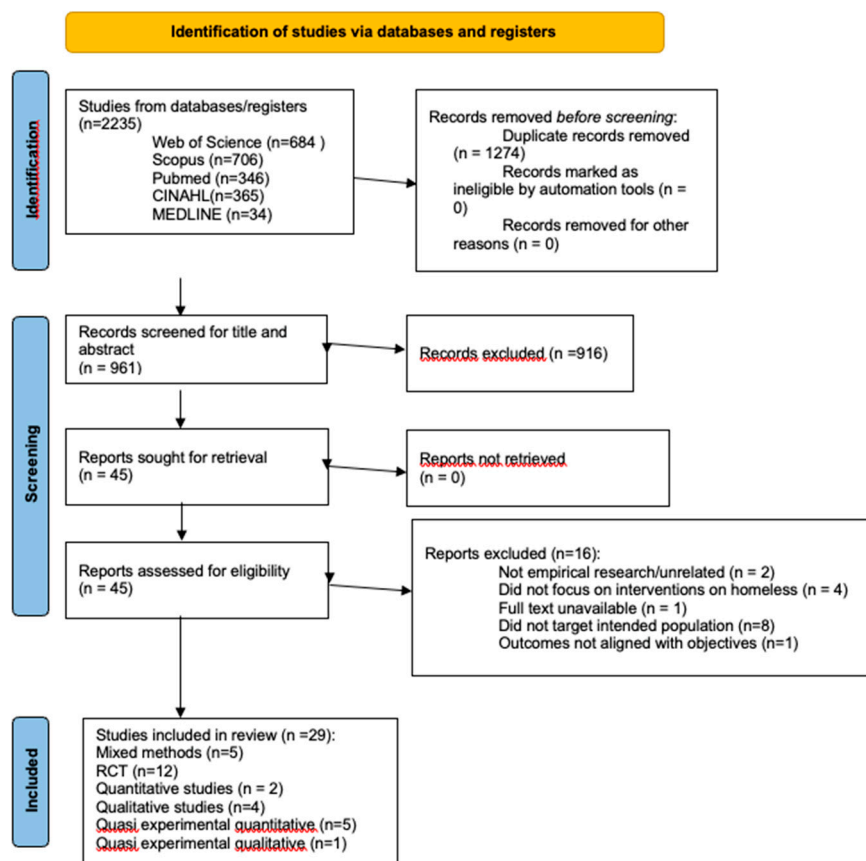


Figure 1. Prisma Flowchart (17).

2.3. Data Extraction

Relevant information was directly input into a spreadsheet during this process. The extracted data consisted of publication details, study design, population characteristics, intervention type, primary outcomes measured and pertinent findings. A summary of the extracted data for each included study is presented in *Supplementary material Table S1*. Additionally, the MMAT % scores were recorded for each study each study (18). Data were extracted independently by two reviewers, any discrepancies during the extraction process were resolved through discussion or by consulting a third reviewer.

2.4. Study Risk of Bias Assessment

To minimize potential bias, the study implemented various strategies: (a) the entire research team participated in refining the study protocol (CRD420250653260); (b) two researchers independently conducted the literature search; (c) data extraction was performed independently by two researchers, supervised by the senior researcher; (d) the methodological quality of the studies was assessed independently by two researchers; and (e) decisions at each stage were made collectively, with meetings held to decide on progression to the next stage.

2.5. Quality Appraisal of the Studies

The methodological quality of the included studies was assessed using the Mixed Methods Appraisal Tool (MMAT) (18). All studies included in the systematic review fulfilled the predefined quality assessment criteria, indicating overall methodological rigor. The detailed results of the quality appraisal and the MMAT scores are displayed in *Supplementary material Table S2*. Two independent researchers assessed the methodological quality of the studies, resolving any disagreements through discussion until consensus was achieved (19). Overall, the methodological quality was variable.

Eleven studies (20–30) achieved a perfect MMAT score of 100%, indicating high methodological rigor and minimal risk of bias, regardless of whether they employed qualitative, quantitative, or mixed-methods designs.

An additional nine studies (31–39) scored 80%, suggesting moderate to high quality with some minor limitations, such as unclear reporting of sampling methods or partial fulfillment of representativeness criteria. Nine studies (40–48) scored between 40 to 60%, often due to incomplete reporting of participant follow-up, lack of justification for methodological choices, or weaknesses in outcome measures. These limitations were noted but did not significantly compromise their validity or reliability.

2.6. Data Analysis and Synthesis

A convergent integrated approach was employed to merge qualitative and quantitative data, including findings from mixed-methods studies (19). In this systematic literature review, Mayring's analysis (QCA, (49)) was utilized as a method to categorize and interpret textual data, identifying common patterns, themes, and implicit meanings.

The QCA process involved numerous systematic steps: initially coding the text to identify themes and assign relevant excerpts was carried out, defining these themes to select pertinent material, revising categories and themes in relation to the research questions, conducting final coding to refine and develop main themes, and presenting the results in a narrative and summary form, offering a comprehensive overview of the findings (49). Regarding the quantitative data, we applied qualitation to translate the findings into narrative interpretations (19). This was meant to minimize potential errors from assigning numerical values to qualitative data, ensuring a more accurate representation of the findings (50).

3. Results

A total of 29 studies were included, the characteristics of which are summarized in Table 1. These studies cover a wide range of community-based health and social interventions targeting homeless populations with mental health issues. Methodological quality across these studies varied as shown in Table 2. Among the studies, 12 were randomized controlled trials (RCTs), 5 used mixed-methods in their interventions, 2 were quantitative, 4 were qualitative and 6 were quasi-experimental. Across the 29 studies, participants ranged from adolescents to older adults, with ages spanning from 14 to 65 years. Most participants were male, with proportions ranging from 55% to 80%, although several studies specifically targeted women (34,35) and youth (39,45,46). Most participants had a history of severe mental illness, including schizophrenia, bipolar disorder, depression, and PTSD, often co-occurring with substance use disorders. Ethnically diverse populations were represented, particularly in studies from Canada and the United States, where participants included people from Indigenous communities, African American populations, and other minority ethnic groups. Additionally, many participants reported chronic physical health conditions, histories of trauma, and long-term or repeated episodes of homelessness.

Table 1. Inclusion criteria.

| Criteria | Description |
|--------------|--|
| Population | People experiencing homelessness with mental health conditions |
| Intervention | Community-based health or social interventions |
| Outcomes | Mental health, psychological wellbeing, housing stability, quality of life |

| | |
|--------------|--|
| Study design | Quantitative, qualitative or mixed methods |
| Language | English |
| Timeframe | 2019–2025 |

¹ Tables may have a footer.

The results of this review are structured around key themes identified through content allowing for a comprehensive synthesis of the evidence. The themes—Housing First, Integrated Healthcare Services, Technology-Based Interventions, Peer Support and Psychological Interventions, and Outreach programmes—were determined through consensus among the researchers to ensure analytical rigor and thematic coherence.

3.1. Housing First Interventions

Housing First (HF) programs emerged as the most extensively studied intervention type across 11 included studies (22,23,25,26,28,30,32,35,40,47,48). Overall, HF interventions were consistently associated with improved housing stability, reductions in emergency department utilisation and psychiatric hospitalisations, and improvements in quality of life and psychosocial wellbeing. Several randomised controlled trials (22,23,47) reported significant reductions in emergency service use and improved retention rates among participants receiving HF interventions. Studies conducted in Canada, Spain, France, and the United States also demonstrated improvements in community integration, reductions in substance use, and increased access to mental health support services (25,28,32,34). Martín-Fernández et al. (25) reported a 96.06% retention rate in a Spanish HF programme, alongside improvements in mental health status and quality of life. Long-term findings from Lachaud et al. (40) and Mejia-Lancheros et al. (26) suggested that HF interventions may reduce acute healthcare utilisation over time, although improvements in mental health outcomes and outpatient engagement remained variable. Studies focusing on specific populations, including women and individuals with cognitive impairment, further supported the feasibility and adaptability of HF models within diverse community settings (30,35). Overall, the findings suggest that HF interventions are effective in promoting housing stability and service engagement, although their direct impact on mental health symptoms alone appears more inconsistent.

3.2. Integrated Healthcare Services

This category includes studies where the interventions are combined collaborations between professionals, facilities or health support systems, continuous over time. Chan et al. (21) evaluated an outpatient ambulatory intensive care unit model that provided intensive primary and behavioural healthcare to patients with unstable accommodation and complex needs. The study reported reductions in emergency department use and improvements in depression scores as well as an increase in primary care visits. Similarly, Arbour et al. (31) assessed a model integrating co-housing, psychiatric care, and case management, reporting significant improvements in both treatment adherence and housing stability. Vallesi et al. (48) reinforces this approach by combining medical, housing, and social services into a single coordinated team. Malden et al. (24), while focusing primarily on physical activity and peer support, incorporated mental health screening and referral processes, underlining the benefit of integrated support networks. Lowrie et al. (41) demonstrated that a pharmacist- and nurse-led outreach model, delivered at the point of hospital discharge, effectively bridged acute medical care with housing and social support, reducing readmissions and improving continuity for people experiencing homelessness.

3.3. Technology-Based Interventions

Two studies evaluated technology-mediated interventions. Nyamathi et al. (43) found modest improvements in stress levels through heart rate variability-biofeedback (HRV-BF), with Cohen's d

= 0.37 and health promotion reporting reductions in PTSD symptoms and improved mental wellbeing. However, Schueller et al. (46) examined mobile technology support programmes for homeless youth but reported no significant mental health improvements despite increased engagement and user satisfaction.

3.4. Peer-Support and Psychosocial Interventions

Several studies highlighted the importance of peer-support models in fostering engagement, reducing stigma, and improving trust in care providers. Malden et al. (24) reported improvements in self-esteem and social interaction among youth participants in peer-led physical activity and support groups. However, evidence of direct symptom reduction was limited, and studies varied widely in methodological rigor. Similarly, peer mentoring (20) enhanced service engagement and self-confidence among young adults. Integrated models combining housing, health, and social support demonstrated stronger mental health impacts. Parkes et al. (27) found that when support came from peers' trust grew and engagement followed. This study evaluated a peer navigator harm reduction program, reporting reduced substance use, improved trust in services, and enhanced mental wellbeing. Similarly, Holding et al. (33) and Isaak et al. (34) found peer support key in fostering service engagement and improving emotional wellbeing. Nyamathi et al. (43) implemented trauma-informed cognitive behavioural therapy (CBT) for women in shelters, finding reductions in PTSD symptoms and improved empowerment scores. Multi-component interventions like those studied by Vallesi et al. (48) and Savaglio et al. (36) focused on combining accommodation with psychosocial rehabilitation, achieving reductions in psychiatric symptoms, and improved social functioning. In Spain, Martín-Fernández et al. (25) evaluated psychosocial interventions in temporary housing settings, showing reductions in anxiety and improved quality of life, particularly when peer-led support took place. Santa María et al. (45) used a mindfulness intervention to approach youth perspectives on group therapy. Participants reported benefits including emotional regulation, safety, and identity.

3.5. Outreach Programmes

Interventions offering financial incentives (e.g., for attending appointments) showed mixed effectiveness. Reid et al. (29) found that incentives increased short-term engagement but were insufficient for long-term behavioral change in users unless it was paired with psychosocial support. Street medicine models, such as those described by Perna et al. (28), showed promise in enhancing access to care, especially for individuals with complex comorbidities. Wetherill et al. (38) examined the impact of offering nutritional interventions in a soup kitchen setting on attendees' self-rated health and engagement, demonstrating that non-clinical programs can also act as vital entry points to care. Health outreach programs (28,38) improved physical and mental health service engagement but showed limited quantitative evidence on mental health symptom reduction. Lowrie et al. (41) also describes the use of community outreach visits also aligned with elements seen in dedicated outreach interventions. Comparably, Winiarski et al. (39) showed that bringing clinical support directly into shelters helped people who might otherwise go unseen to access mental health care or addiction treatment. Similarly, Savaglio et al. (36) reached individuals in urban areas who were disconnected from services, using mobile outreach teams that offered support where people felt safest. Together, all these studies highlight the role of outreach in overcoming access barriers through flexible, community-embedded approaches.

4. Discussion

The results of this systematic review confirm that interventions combining stable housing with integrated health and psychosocial services yield the most substantial benefits for homeless individuals with mental illness, though the extent and sustainability of these improvements vary. These findings also reinforce the importance of recovery-oriented and relationship-based approaches

frequently associated with community mental health nursing practice. When compared to other reviews (51), this study reaffirms the key role of stable housing but highlights that mental health benefits are maximized when interventions are holistic. In many of the included studies, sustained engagement appeared to depend not only on housing provision itself, but also on continuity of care, therapeutic relationships, and ongoing psychosocial support.

The “Housing First” model remains the most evidence-based approach for improving housing stability, as consistently shown in recent reviews (11). This review corroborates those findings, as studies like Tinland et al. (47) and Latimer et al. (23) also report consistent improvements in housing retention and reductions in emergency visits. Moreover, the findings regarding mental health symptom reduction were mixed. While some studies (32,40) found reductions in depressive symptoms and anxiety, others observed no significant changes in mental health despite stable housing (35). The present review highlights the limited and inconsistent effects of housing alone on mental health symptoms, as noted in studies like O’Campo et al. (35) and Lachaud et al. (40), where housing alone does not consistently lead to substantial reductions in psychiatric symptoms, emphasizing the need of adjunct mental health services.

Additionally, there is a diversity on the different profiles of the participants included in each study of the review, which underscores the complexity of health and social needs in homeless populations and highlights the need for tailored, culturally competent interventions.

Despite the evident importance of multidisciplinary approaches, our review identified a significant gap in the literature regarding nursing-led interventions. Only one study explicitly described a nurse-led model of care, despite mental health nurses being central to community outreach, therapeutic engagement, trauma-informed practice, and continuity of care for vulnerable populations. This underrepresentation is particularly concerning given the recognised role of mental health nurses in delivering recovery-oriented and person-centred care within community settings. This gap is particularly concerning given the key role of health professionals including nurses in delivering integrated, person-centered care, as emphasized by the International Council of Nursing (7) and the World Health Organization (8). Strengthening the evidence base for nurse-led interventions is essential to inform practice and ensure that nurses are empowered to address the complex needs of this vulnerable population. Furthermore, investing in nursing leadership and research in this field aligns with the SDGs, particularly SDG 3 and SDG 10, which emphasize health equity and the reduction of disparities.

The findings suggest that community-based psychosocial and health-focused interventions may contribute to improvements in mental health outcomes among people experiencing homelessness, although the evidence remains limited and heterogeneous. Programs such as mindfulness (45), biofeedback (43), and physical activity (24) were found feasible and acceptable but provided only modest symptom reduction, a finding consistent with other reviews (52) indicating that while mental health programs for homeless populations are generally well-received, their effectiveness is limited by social instability, short intervention duration, and challenges in sustaining engagement.

Peer-delivered services were highlighted in the studies of Parkes et al. (27) Isaak et al. (34) and Holding et al. (33) particularly effective in promoting trust-building, therapeutic engagement, service accessibility, and emotional wellbeing. These findings support earlier conceptual analyses on the benefits of peer involvement in mental health care and align with recent reviews emphasising the therapeutic value of peer support (53). Collectively, they highlight the importance of relational, trust-building, and recovery-oriented approaches to care frequently embedded within community mental health nursing practice. These models may offer a relational element absent in purely clinical interventions, addressing barriers like stigma and mistrust identified in prior qualitative studies. Additionally, these results echo the findings of Carver et al. (53), who stressed the role of lived experience in fostering therapeutic alliances and addressing stigma in mental health service delivery for homeless populations.

Despite positive findings, the review identifies ongoing gaps in sustaining mental health improvements beyond housing outcomes, echoing concerns raised in previous work (11).

Interestingly, most studies reported follow-up periods of less than two years. However, the 7-year follow-up study by Mejia-Lancheros (26) offers a more comprehensive long-term perspective, demonstrating that while housing stability was largely maintained, improvements in mental health outcomes were variable and sometimes diminished over time without sustained psychosocial support. This contrasts with the findings of Lachaud et al. (40), who reported reductions in emergency and inpatient care, highlighting that although HF may decrease the use of acute services, it does not necessarily lead to increased engagement with outpatient care, as shown by the reduced primary and specialist visits observed by Mejia-Lancheros (26). These findings suggest that chronic homelessness and mental illness require continuous, long-term interventions, and that short-term solutions are insufficient to address the enduring community-based health and social care needs of this population.

Importantly, several studies addressed subgroups such as youth (39,45,46) and women (34,35), who face additional barriers. Interventions tailored to homeless youth (39,45,46) emphasised the need for age-appropriate, engaging, and accessible approaches, such as mobile technology and mindfulness, though mental health improvements were moderate. Studies focusing on women (34,35) and as reviewed in “Interventions to improve the mental health of women experiencing homelessness” (51), highlighted the importance of gender-specific and trauma-informed care. These findings reinforce prior conclusions and advocate for case management, integrated services, and prioritisation of psychosocial wellbeing in homeless women and other vulnerable groups (51).

In terms of service delivery, this review highlights an increased use of community-based and outreach models, such as street medicine (28) and mobile mental health services (46). These interventions meet individuals where they are, consistent with recommendations from the National Health Care for the Homeless Council (54) and others who advocate for low-threshold, harm-reduction-oriented services. The findings also resonate with discussions on social determinants of health, addressing mental health in homelessness requires systemic interventions that go beyond clinical care, tackling poverty, trauma, and social exclusion. Interventions addressing only clinical aspects without tackling these broader determinants may achieve limited results.

Technology-based and incentive-driven interventions present opportunities for innovation, particularly in urban settings. Yet, current evidence suggests that these approaches require careful integration into broader support systems to achieve meaningful outcomes and they may not be appropriate for individuals with severe psychiatric symptoms or cognitive impairments (55).

Comparing methodologies across studies, RCTs provided the most robust evidence for housing interventions but often lacked qualitative insight into participants' experiences. Conversely, qualitative and mixed-methods studies, (20, 24, 27) enriched the understanding of how participants experienced these interventions, particularly regarding the relational aspects of care.

4.1. Study Limitations and Recommendations

Limitations of this review include variability in study quality and heterogeneity in intervention components and outcome measures. This diversity complicates direct comparisons and meta-analysis. Nonetheless, the content synthesis offers valuable insights into effective intervention design and implementation. Several critical gaps persist. First, long-term follow-up data are sparse. Most studies report outcomes over 6 to 24 month-periods, limiting insights into sustainability. Second, cultural, gender, and age-specific needs are underexplored. Women, youth, and individuals with dual diagnoses may benefit from tailored interventions not yet reflected in the evidence base found. Third, health literacy—although recognised as a determinant of access and engagement—is rarely assessed (15). This aligns with broader concerns about the lack of formal psychotherapeutic nursing roles in countries like Spain, where the implementation of structured advanced clinical practice could help address such gaps by improving communication, supporting patient understanding, and encourage sustained engagement (9).

4.2. Implications for Mental Health Nursing Practice and Research

This review underscores the essential role of psychiatric and mental health nurses in implementing integrated, trauma-informed, recovery-oriented, and community-based models of care for people experiencing homelessness and mental illness.

Mental health nurses and allied professionals play a crucial role in delivering psychological support, outreach engagement, therapeutic relationships, continuity of care, and interdisciplinary coordination within holistic care models. Training in trauma-informed care, harm-reduction approaches, cultural competence, and case management is essential to support effective engagement with vulnerable populations experiencing homelessness and mental illness. Policy and service development should strengthen interdisciplinary collaboration, continuity of support, and accessible community-based care pathways.

The limited presence of explicitly nurse-led interventions identified in this review highlights a critical gap in current research. Given the central role of mental health nurses in community and recovery-oriented practice, further evidence is urgently needed to evaluate and strengthen nursing-led models of care aligned with global mental health and health equity goals (7).

5. Conclusions

This systematic review highlights the importance of integrated, community-based interventions in addressing the complex mental health and psychosocial needs of people experiencing homelessness. Housing First models consistently improved housing stability and engagement with support services, while integrated psychosocial, outreach, and peer-support interventions demonstrated potential benefits for psychosocial wellbeing, social integration, and continuity of care.

The findings suggest that interventions addressing both structural and psychosocial determinants of health are more effective than isolated psychosocial approaches alone. Recovery-oriented, trauma-informed, and person-centred models appear particularly important for sustaining engagement and promoting wellbeing among vulnerable populations experiencing homelessness and mental illness.

Mental health nurses are well positioned to support integrated and community-based approaches through outreach engagement, therapeutic relationships, continuity of care, and multidisciplinary collaboration. Future research should prioritise long-term follow-up studies and further evaluate nursing-led and trauma-informed interventions targeting diverse subgroups within homeless populations.

Ultimately, reducing mental health inequalities among people experiencing homelessness requires coordinated policies and community-based systems of care that prioritise stable housing, accessible mental health support, and meaningful social inclusion

Supplementary Materials: The following supporting information can be downloaded at the website of this paper posted on Preprints.org. Table S1, Tab S2.

Author Contributions: Conceptualization, B.S.-F., E.A.-D. and E.F.-M.; methodology, B.S.-F., E.A.-D. and E.F.-M.; formal analysis, B.S.-F.; investigation, B.S.-F.; data curation, B.S.-F.; writing—original draft preparation, B.S.-F.; writing—review and editing, E.A.-D. and E.F.-M.; supervision, E.A.-D. and E.F.-M. All authors have read and agreed to the published version of the manuscript.

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Use of Artificial Intelligence: AI or AI-assisted tools were used for translation purposes.

Abbreviations

The following abbreviations are used in this manuscript:

| | |
|--------|--|
| CBT | Cognitive Behavioural Theory |
| ED | Emergency Department |
| HF | Housing First |
| MMAT | Mixed Methods Appraisal Tool |
| PRISMA | Preferred Reporting Items for Systematic Reviews and Meta-Analyses |
| PCP | Primary Care Physician |
| PTSD | Post-Traumatic Stress Disorder |
| QCA | Qualitative Content Analysis |
| RCT | Randomized Controlled Trial |
| SDGs | Sustainable Development Goals |

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