

## HOUSING FIRST OR TREATMENT FIRST?

What the EU Can Learn from the US Department of  
Veterans Affairs' Homelessness Programs about  
Mortality, Housing Stability, and Treatment

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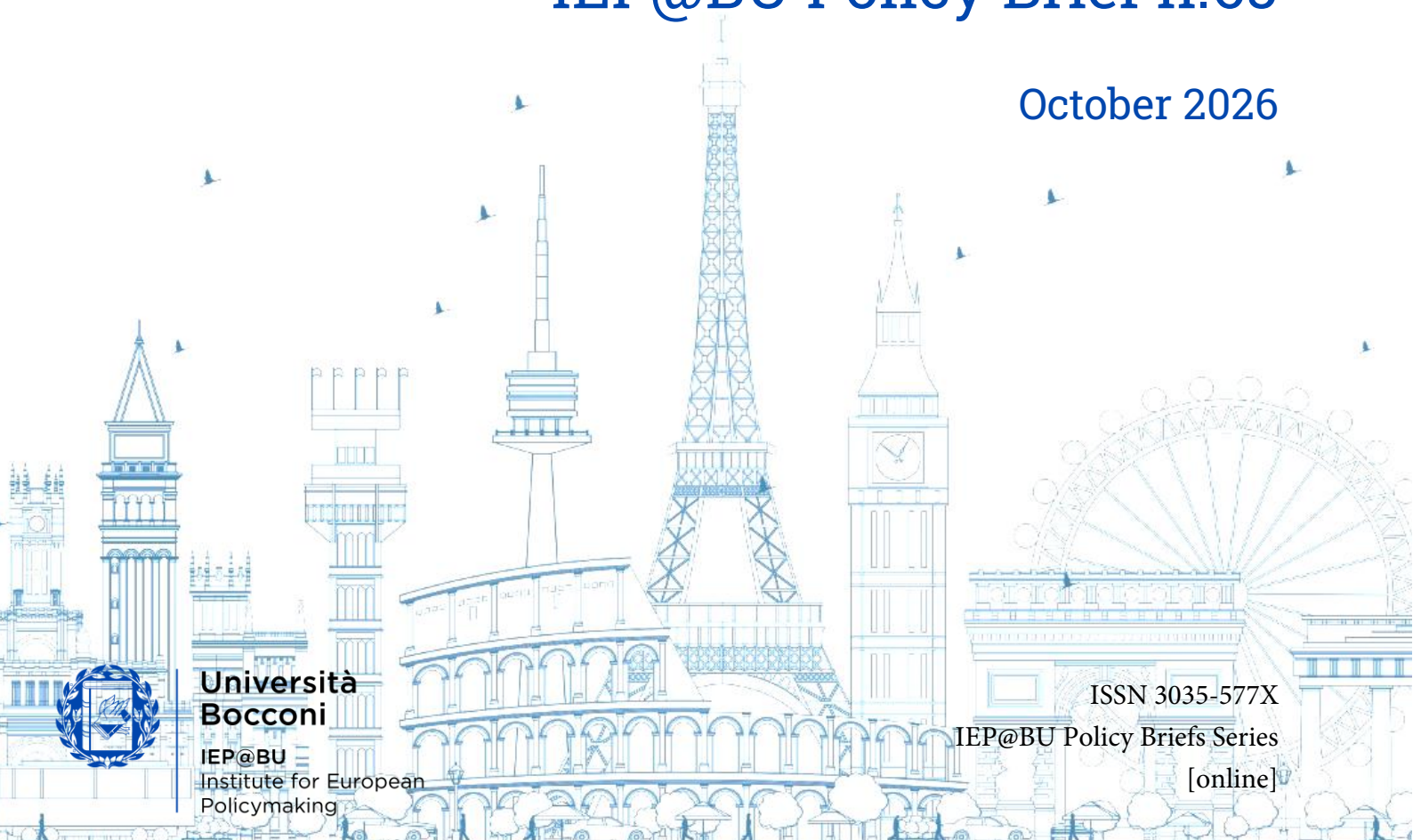


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## **Evidence at a glance**

A national study of 289,932 Veterans uses variation in voucher and caseworker availability to compare the causal effects of the two most common homelessness interventions: Housing First and transitional housing. The empirical evidence shows that Housing First dominates Treatment First approaches to homelessness: it saves both lives and money. The EU should redirect funding away from transitional housing or Treatment First type programs towards ones that operate from a Housing First model.



## Background and current policy context

Nearly 1.4 million individuals across the EU experienced homelessness in 2026 (FEANTSA and Fondation pour le Logement des Défavorisés 2026). The visible presence of homeless people – many who are dealing with mental health or substance use issues – is a source of vehement debate.

Some policymakers argue that homelessness is purely a housing problem, with permanent housing solutions required to help those most in need. Others argue that those who are chronically unhoused have underlying mental health or substance use issues that must be addressed first in order to make progress in reducing homelessness.

In the 1990s, researchers and service providers developed the concept of Housing First, or that for those most in need, highly-subsidized permanent housing should be given unconditionally and immediately (Tsemberis, Gulcur and Nakae 2004; Padgett, Henwood and Tsemberis 2016).

Advocates argue that requiring pre-conditions to housing merely acts as a barrier to seeking care, and that it is hard to address underlying mental health issues without having a stable home first.

Housing First programs are pitted against Treatment First approaches – which require people to address mental health and addiction before finding permanent, unsubsidized housing on their own. In these models, individuals generally enter transitional housing, or temporary communal housing in which substance use and mental health treatment are required, sometimes along with sobriety.

After a one to two-year stay in these transitional homes, individuals are deemed ready to enter regular, generally unsubsidized housing. Proponents of Treatment First argue that mental health or substance use issues are often the root cause of homelessness, and that programs emphasizing treatment can help put homeless individuals on a path towards self-sufficiency.

With homelessness numbers growing throughout the developed world, the policy debate over these different models has intensified.

In the United States, the Trump administration has explicitly moved away from Housing First towards homelessness interventions that emphasize mental health treatment. In an executive order from summer 2025, the administration directed federal agencies to end support for Housing First policies, which it described as policies that “deprioritize accountability and fail to promote treatment, recovery, and self-sufficiency” (Executive Order 14321, 2025).

Europe has so far moved in the opposite direction. In the 2021 Lisbon Declaration, all 27 EU Member States committed to working towards ending homelessness by 2030 and endorsed housing-led approaches as the most effective way to get there (European Platform on



Combatting Homelessness 2021).

Finland, which built its national strategy around Housing First from 2008, is widely cited as the European country that has made the most progress in reducing long-term homelessness (Pleace et al. 2015), and

Italy has used its Recovery and Resilience Plan to fund Housing First projects (Ministero del Lavoro e delle Politiche Sociali). Yet many European homelessness systems still rely heavily on emergency shelters and transitional accommodations organized as a “staircase” – the European counterpart of Treatment First – in which people must progress through successive stages before being offered a regular tenancy (Sahlin 2005; FEANTSA and Fondation pour le Logement des Défavorisés 2025).

With the United States now moving away from Housing First, rigorous evidence on which model works best is directly relevant to the choices European governments face.

Which homelessness intervention is more effective – Housing First or Treatment First? Randomized trials in the United States, Canada and France have shown that Housing First improves housing stability (Tsemberis, Gulcur and Nakae 2004; Aubry, Nelson and Tsemberis 2015; Baxter et al. 2019; Loubière et al. 2022).

Much less is known about its effects on mortality and public budgets, or how it compares directly with transitional housing programs.

This brief summarizes causal evidence from the Department of Veterans Affairs (VA), where both approaches operate at scale. The VA provides homelessness services to US Veterans. Since the 1990s, the VA, along with the US Department of Housing and Urban Development (HUD), have run a joint Housing First program. Known as HUD-VASH (VA Supportive Housing), the program offers housing vouchers to chronically homeless veterans.

Concurrently, the VA has a large transitional housing program – called the Grant and Per Diem (GPD) program – which contracts out third-party agencies to run short-term, Treatment First-style housing, where veterans can stay up to two years.

New research follows 289,932 US Veterans with a mental health or substance use condition for three years following their first VA homelessness intake (Costantini 2026). The study compares the VA’s Housing First program, HUD-VASH, with the VA’s transitional housing program, Grant and Per Diem (GPD).

Using variation in voucher availability and caseworker availability to identify causal effects, it looks at the long run impacts of these two programs on housing stability and health outcomes.



## Key Findings

1

**Housing First lowers three-year mortality.**

Enrollment in Housing First reduces three-year mortality by 4.6 percentage points relative to receiving neither housing program. The estimated effect of transitional housing on mortality is much smaller and statistically indistinguishable from zero. Overall, Housing First is more effective than Treatment First at reducing mortality.

2

**Treatment First only raises behavioral healthcare engagement temporarily.**

Transitional housing increases behavioral health visits in the short run, but effects fade as participants leave the program. These results imply that short-run behavioral health interventions may not be enough to set homeless individuals on a better long-term path.

3

**The mortality pattern is consistent with housing itself mattering.**

Housing First reduces mortality from exposure to extreme temperatures, violence, and HIV/Hepatitis. It seems to protect individuals from unsheltered homelessness, as well as risky injection drug use behavior.

4

**Housing First is cheaper than Treatment First once indirect costs are considered.**

Housing First has higher direct costs than transitional housing, as the housing subsidy is permanent. However, individuals enrolled in Housing First spend fewer days in inpatient mental health facilities, making Housing First cheaper than Treatment First over three years.

## Comparing homelessness models

The VA offers an unusually useful setting for comparing homelessness interventions, as its Housing First and Treatment First programs operate side by side and target similar, high-needs populations.

HUD-VASH operates using a standard Housing First model: individuals rent apartments using vouchers, which pay for individuals' entire monthly rent, and vouchers are explicitly not tied



to any required treatment. Individuals can keep this voucher permanently.

Alternatively, the Grant & Per Diem program finances transitional housing units for veterans, which bundle short-term communal housing with required mental health treatment. After a one to two year stay in these transitional housing units, individuals need to find their own housing arrangements. Table 1 shows the set-up of both programs.

## Two Program Models

|                             | HUD-VASH                                                                                     | Grant & Per Diem (GPD)                                                                                          |
|-----------------------------|----------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|
| <b>Program model</b>        | Housing First (permanent supportive housing)                                                 | Treatment First (transitional housing)                                                                          |
| <b>Housing arrangement</b>  | Permanent rental voucher                                                                     | Temporary communal housing; generally 6 months–2 years                                                          |
| <b>Treatment conditions</b> | Case management required; sobriety and mental-health treatment are not conditions of housing | Behavioral-health treatment is commonly part of the program; requirements vary by site and may include sobriety |
| <b>Long-run objective</b>   | Maintain permanent housing                                                                   | Transition from temporary housing to a permanent arrangement                                                    |

Table 1. The two VA homelessness programs.

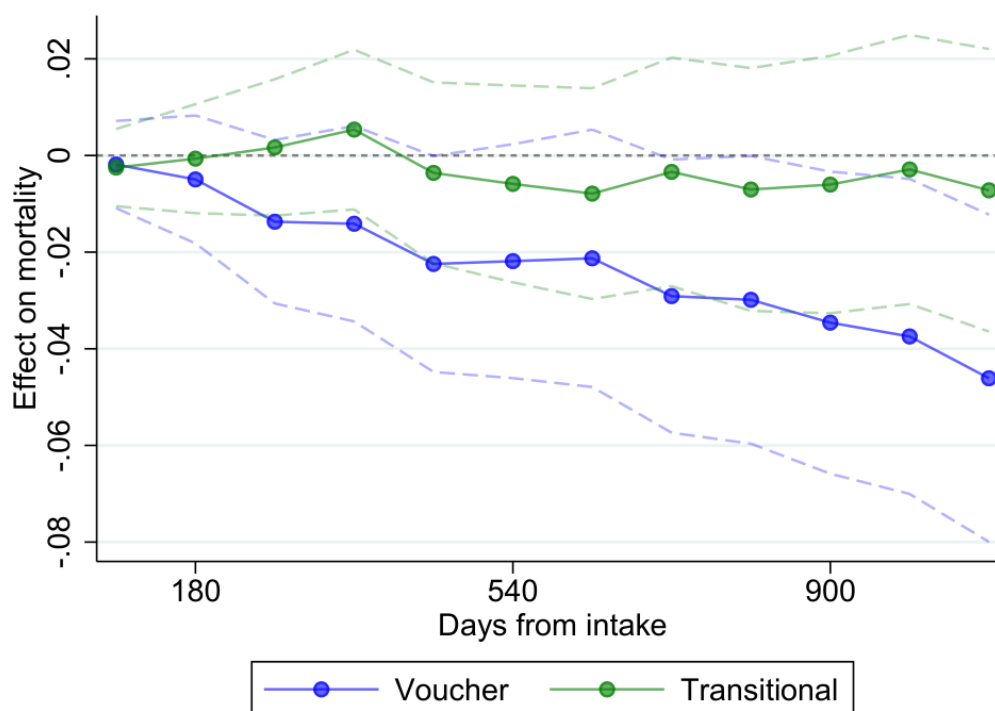
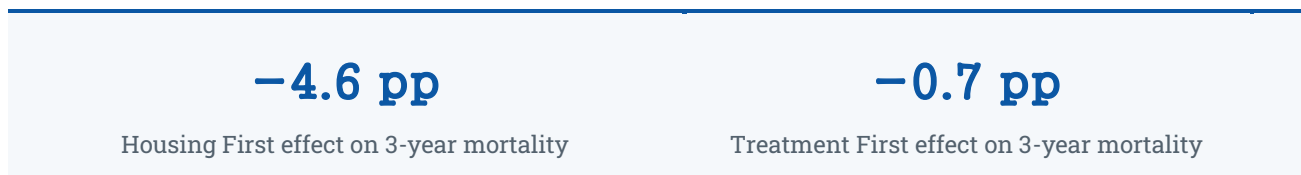
## Housing First reduces long-run mortality

People experiencing homelessness die far earlier than the general population, from causes ranging from infections and overdoses to injuries and exposure (Fazel, Geddes and Kushel 2014). Using variation in voucher and caseworker availability to identify causal effects, the study looks at the impact of Housing First and transitional housing on long-term mortality.

Figure 1 shows the causal effect of Housing First (voucher) and transitional housing on mortality over time. Housing First enrollment reduces three-year mortality by 4.6 percentage points compared with receiving neither housing intervention. In other words, Housing First averts about 1 death for every 22 individuals housed.



The corresponding estimate for transitional housing is  $-0.7$  percentage points and is not statistically distinguishable from zero.



**Figure 1. The estimated mortality effect of Housing First and Treatment First over time.**

*Note:* Blue shows the effect of the voucher program (Housing First) and green shows the effect of transitional housing (Treatment First). Dashed lines show upper and lower confidence intervals.

## The housing trajectories diverge quickly

Figure 2 shows the effect of the voucher program (Housing First) and transitional housing (Treatment First) on long-term housing stability.

Individuals who enroll in transitional housing are given a bed almost immediately, while those receiving a housing voucher through HUD-VASH must find an apartment on the private market that will accept their voucher.

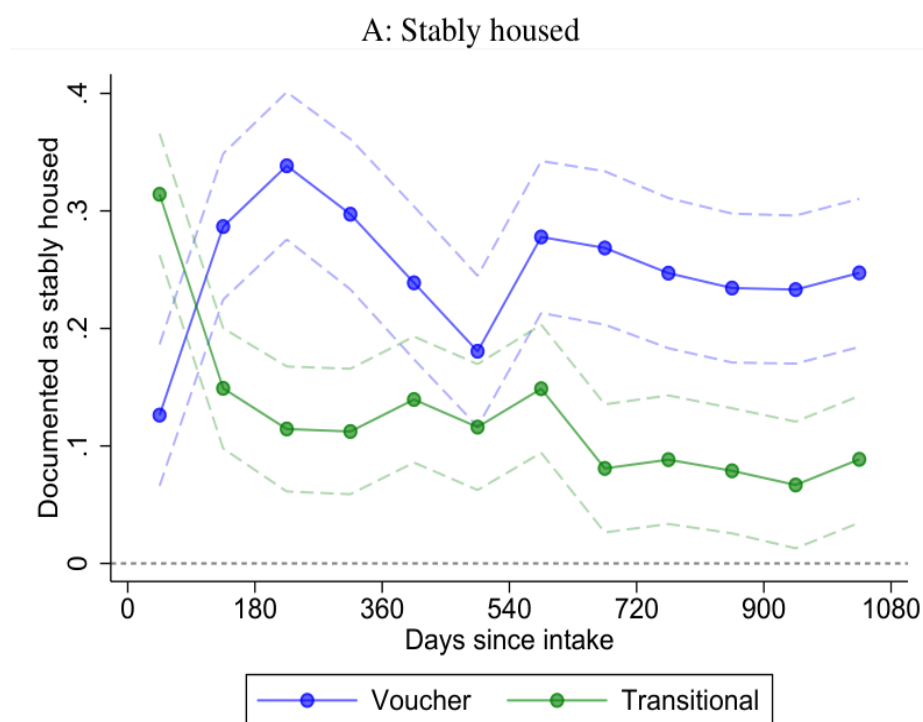


Consequently, in the short-run, transitional housing actually leads to higher housing stability. However, this pattern quickly reverses. By quarter 3, Housing First increases one's documented housing stability by 34 percentage points. The program's effect on housing stability is relatively stable: by quarter 12, Housing First continues to increase documented housing stability by around 25 percentage points.

On the other hand, the effect of transitional housing on housing stability declines rapidly, reaching only 9 percentage points by quarter 12.

These results suggest that individuals leave transitional housing units relatively quickly, and once they exit these programs, they are not always able to find a more permanent housing solution.

Overall, Housing First is much more effective than transitional housing at keeping individuals stably housed.



**Figure 2. Permanent vouchers produce more durable documented housing stability.**

**Note:** The outcome is the probability of being documented as stably housed in each quarter, identified via clinical and social-worker notes. Dashed lines show 95% confidence intervals.



## Changes in behavioral healthcare utilization

Advocates of Treatment First models argue that mental health and substance use treatment should be required and precede permanent housing. Following this framework, many transitional housing units require mental health treatment as a condition for staying in the program.

On the other hand, Housing First advocates argue that having a stable home is a necessary pre-condition to successfully addressing mental health and substance use.

Proponents often hypothesize that once individuals are put into stable housing units, they may voluntarily seek out more mental health treatment.

This study weighs in on this debate directly by looking at the effects of the two programs on behavioral healthcare utilization over time.

These results should be interpreted in the context of a population that already has access to healthcare through the VA, including mental health treatment; the scope for Housing First to increase access to care may therefore be more limited than in settings where unhoused individuals are disconnected from the healthcare system.

### Mental Health Care

1

#### **Transitional housing changes treatment engagement in the short run.**

Transitional housing increases the number of mental health visits in the first year following program intake. However, effects fade to zero by year two as participants leave transitional housing units. Requiring mental health treatment in the short-term does not lead to long term behavioral changes, as individuals do not stay attached to mental healthcare after the program ends.

2

#### **Housing First does not measurably increase mental-health care use.**

Despite a large effect on survival, Housing First has little effect on mental-health visits or appointment attendance.

These results suggest that mortality reductions from Housing First are not driven by changes in mental health treatment. On the other hand, although transitional housing increases short-term behavioral healthcare use, it does not generate long-term mortality benefits.



## Cause of death

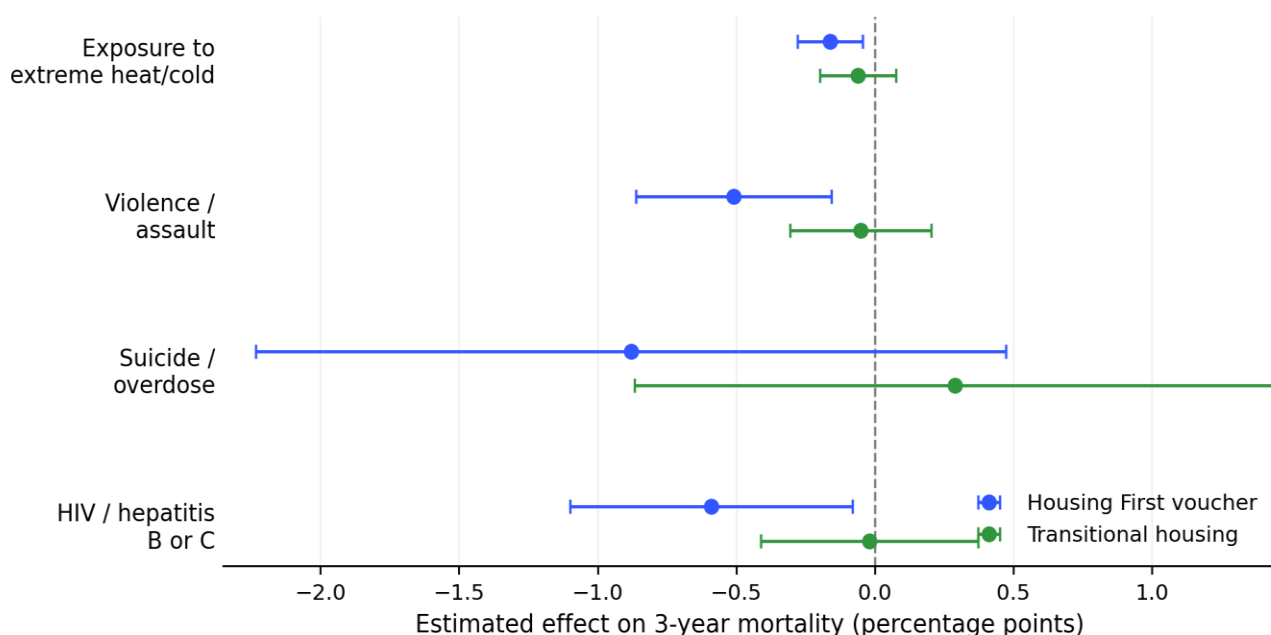
To understand why Housing First saves lives, the study separates death into different underlying causes and looks at the effect of both programs on cause-specific mortality. Figure 3 shows the effect of Housing First and transitional housing on specific causes of death.

The results are consistent with Housing First having a pure shelter effect: it decreases death from exposure to dangerous weather. Additionally, those living on the street are highly vulnerable to being attacked, and Housing First reduces deaths from assault.

Are mental health and substance use outcomes improving among Housing First participants, even without more behavioral healthcare?

The cause of death results suggest that this is also the case. In particular, Housing First reduces mortality due to HIV, Hepatitis B, and Hepatitis C, infections often related to unsafe drug injection practices.

These conditions can be particularly dangerous if an individual is living on the street, making them especially vulnerable to contracting a new infection. In other words, Housing First mitigates dangerous interactions between unsafe injection practices and homelessness.



**Figure 3. Housing First reduces mortality from exposure, violence, and bloodborne infections.**

**Note:** Blue shows the effect of Housing First on cause-specific mortality in percentage points, and green shows the effect of transitional housing. Whiskers are 95% confidence intervals.



## Budget impact

The study also compares the direct and indirect costs of funding both Housing First and transitional housing over the three-year study period. Although Housing First has higher direct costs, it generates substantial savings in inpatient care, driven primarily by shorter stays in residential programs related to homelessness and mental health.

These results suggest that in the absence of stable housing, mental health inpatient facilities may act as a partial – and much more expensive – substitute.

Over three years, Housing First is cost-saving compared to transitional housing.

**-\$10,430**

Public cost of Housing First compared to transitional housing per participant over 3 years

**\$7,435**

Net public cost of Housing First versus no housing intervention over 3 years

## Where The Savings Come From

| Budget component            | Housing First  | Transitional Housing |
|-----------------------------|----------------|----------------------|
| Direct program costs        | \$13,380       | \$9,740              |
| Social worker visits        | \$4,779        | \$2,483              |
| Other homelessness services | \$683          | \$2,177              |
| Outpatient care             | -\$1,906       | \$3,879              |
| Inpatient care              | -\$10,192      | -\$639               |
| <b>Total public cost</b>    | <b>\$7,435</b> | <b>\$17,865</b>      |

*Note: Positive values are additional public costs and negative values are savings. Costs are those observed over the three-year study period.*



## Conclusion

The empirical evidence shows that Housing First dominates Treatment First approaches to homelessness: it saves both lives and money. The EU should redirect funding away from transitional housing or Treatment First type programs towards ones that operate from a Housing First model.

Housing First protects individuals from extreme circumstances generated by unsheltered homelessness: death from extreme weather and violence. It also protects an especially vulnerable group: homeless injection drug users, who are much more likely to die if they are living on the streets.

Despite the effectiveness of Housing First, policymakers still have a long way to go to solve the problems of this extremely disadvantaged population. In particular, Housing First is not enough to address the mental health needs of these individuals: it does not lead to an increase in mental health treatment nor improve the rate of appointment attendance.

In contrast, Treatment First models do improve adherence to mental health treatment in the short term, but effects are short-lasting and do not translate into large health gains. Thus, for the large population of unhoused, mentally ill individuals, additional interventions are necessary to improve long term engagement with mental health care.

Nevertheless, Housing First is the essential starting point, keeping individuals stably housed and shielded from the most severe consequences of homelessness.



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