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Housing First or Treatment First Interventions for Mental Illness and Substance Abuse Disorders Among the Chronically Homeless? A Review of the Randomized Controlled Trial Evidence Base

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Abstract

The longstanding U.S. approach for treating chronically homeless people with mental illness and/or substance use disorders has been Housing First (HF): providing permanent supportive housing with wrap-around services, with no requirements on participants to engage in behavioral health support. The Trump Administration has recently reversed course, adopting an alternative strategy: Treatment First (TF). This research note addresses the question of which approach is more effective for treating mental illness and substance use disorders. My review of results from randomized controlled trials conducted in the United States demonstrates that neither HF nor TF approaches represent panaceas in helping the chronically homeless

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improve their mental health or free themselves from addiction. Results imply that we should adopt a more heterodox strategy that can better tailor treatments to individual circumstances—and build the requisite human, housing, and institutional resources in the public health domain to support such—if we are to fight the symbiotic challenges of chronic homelessness, mental illness, and substance use disorders successfully.

Keywords
Housing First, Treatment First, chronic homelessness, randomized controlled trials, mental illness, substance use disorder

Introduction

The longitudinal pattern of annual point-in-time counts of homelessness, which are sponsored by the US Department of Housing and Urban Development (HUD), reveals a distinct turning point in the trajectory of chronic homelessness (HUD 2024).[1] After a decade of steady declines, since 2016 the number of chronically homeless individuals—both sheltered and unsheltered—has been inexorably and dramatically increasing. Perhaps most worrisome is the fact that unsheltered chronic homelessness is rising most rapidly, now registering almost 100 thousand individuals, almost twice the number as those in shelters.

This turning point in chronic homelessness corresponds to the arrival of cheap, highly addictive fentanyl and the "new," more psychoses-inducing methamphetamine in American street drug markets around 2013–2014 or somewhat later, depending on geography (Millennium Health 2019; 2024). Methamphetamine use rose nationally 340 percent from 2014 to 2019 (LaRue et al. 2021). Fentanyl, methamphetamine, and their joint consumption have risen steadily since 2013 (Twillman et al. 2020).

This expansion in drug use also corresponds with increasing numbers of people suffering from mental illness. From 2014 to 2019,[2] the number of adults reporting any mental illness rose by over seven million (18 percent) and the number of adults with serious thoughts of suicide rose by almost three million (30 percent) (Mental Health America 2014; Reinert, Nguyen and Fritze 2021).

A nontrivial number of our chronically homeless population manifest substance use disorders and/or unresolved mental illnesses, though the precise figure has been contested (cf. Rees 2009; National Coalition for the Homeless 2017; Rountree, Hess and Lyke 2025; The White House 2025). This population is likely most disruptive of the civic spaces and neighborhoods that they frequent, challenging to house stably over the long term,

and costly to the public through high use of publicly funded health and criminal justice systems resources (Culhane et al. 2007).

How federal policy has responded to the issues of chronic homelessness has evolved through three distinct eras (Culhane 2026). The first strategy, begun in the 1980s, was a linear continuum of services that began with connecting social caseworkers (and associated service providers) and the homeless. As clients progressed to the point where they could agree to engage with appropriate social services and remain sober, they were placed in "transitional housing," where they could reside up to 24 months. When "housing readiness" was demonstrated, they could move (in principle) into permanent (typically, subsidized) housing. This could be labeled a "Treatment First" (TF) strategy, with achieved mental stability and sobriety preceding permanent housing. Criticisms of this early approach included: a shortage of subsidized housing for those exiting transitional housing; ineffective, inefficient providers of mental health and substance use services; and (perhaps most crucially) many chronically homeless people with mental health or substance use problems who remained essentially untreated because they failed to meet the requirements for transitional housing.

In the 1990s, a new "Housing First" (HF) strategy was pioneered (Woodhall-Melnik and Dunn 2016).[3] This strategy involved placing homeless individuals as quickly as possible in permanently subsidized housing with no requirements that they engage in behavioral health support or attain sobriety prior to or after placement (National Alliance to End Homeless 2022). An array of case management and other services aimed at sustaining individuals in their homes and improving their health, behavioral, and substance use outcomes was available (ideally) to people in their new homes, but only upon their request (Pleace and Bretherton 2013). In 2000, HF became institutionalized, with HUD reallocating funding from treatment and support services in shelters to HF-based strategies (Culhane 2026).

The HF approach was abruptly upended in July, 2025 by an Executive Order issued by President Trump (The White House 2025). After denigrating the effectiveness of HF in ameliorating the problem of chronically homeless individuals with substance use disorders and unresolved mental illnesses, it asserted the therapeutic superiority of the TF approach. Implicit in this shifting view was the notion that the required non-pharmaceutical, psychosocial treatment(s) prior to (or in conjunction with) assignment to permanent housing have become more sophisticated and effective since the 1980s. These TF treatments generally fall under the categories of intensive case management (ICM), assertive community treatment (ACT), critical time intervention (CTI), and peer support;[4] for details, see Wang et al. (2019), Hyun, Bae and Noh (2020), and Moledina et al. (2021). At this writing, the significant reallocations in federal funding associated with this change in strategy remain unresolved due to legislative and judicial issues (Culhane 2026).

Given the rise of chronic homelessness coupled with this recent transformation in federal policy, it is incumbent to ask: What does the evidence say about whether the HF or the TF strategy is more likely to reduce the prevalence and severity of substance use disorders and mental illnesses among the chronically homeless population?[5] This research note answers this question by reviewing results from randomized controlled trials (RCTs) conducted in the United States for HF or TF interventions for homeless populations. RCTs for both HF and TF strategies have, to my knowledge, never been comprehensively assembled and compared to ascertain which type of intervention is more efficacious for America's chronically homeless populations' mental and behavioral health. It is this RCT-based comparison of the effectiveness of HF and TF approaches in treating these challenges, coming at a time of transition in the U.S. homelessness policy landscape between the former and the latter, that distinguishes the contribution of this paper.

Methodology

I searched multiple bibliographic databases through the online search tool of my academic institution's library—including Medline, CINAHL**,** EMBASE, PsychINFO, Cochrane CENTRAL, and Google Scholar—from database inception to December 20, 2025, using keywords *homelessness* (or *homeless*) and *treatment* (or *clinical trial*) coupled with numerous other key words such as *supportive housing*, *health, mental health, behavioral health, substance use, drugs, and alcohol.* I also searched the reference lists of previous literature reviews.[6] Searches were limited to articles in English but had no limitations on publication year. I employed the standard "participants, interventions, controls, and outcomes" (PICO) framework to identify eligible studies for this paper. Study participants were limited to currently homeless populations living in the United States. I deemed results from studies of the homeless from other parts of the world of limited applicability to the United States since other nations have such disparate and typically non-comparable housing-/mental health-/substance use-/criminal justice-related institutions, laws, and social safety net contexts.[7] Eligible interventions included HF (sometimes called permanent supportive housing, PSH) and TF (including peer support, ACT, ICM, CTI, and other psychosocial interventions). To enhance cross-study comparability, minimize risk of bias and provide the strongest evidence of causal effects, I follow Baxter et al. (2019), Wang et al. (2019) and Hyun, Bae and Noh (2020) and limit eligible studies to those employing RCTs. Only studies reporting mental health and/or substance use outcomes were eligible for consideration. Mental health outcomes of interest involved any measures assessing psychological status and well-being, including but not limited to psychological distress, self-reported mental

health status, or mental illness symptoms. Drug and alcohol use outcomes included those measured by the number of days using alcohol or other substances, the rate and frequency of using alcohol or substances, number of days of abstinence from alcohol or substances, or physical and mental consequences of using alcohol or substances.

Application of these PICO criteria resulted in 16 studies involving HF and 49 studies involving TF.[8] For each of these studies, I examined the appropriate outcome indicator(s) and recorded the degree to which the HF or TF treatment resulted in a statistically significant change in the indicator during the study period compared to changes observed for the "treatment as usual" (TAU) control group and, if so, whether the result was favorable or unfavorable for the homeless treatment group.

At the outset, it is vital to recognize the multidimensional heterogeneity across these studies, not only across but also within the HF and TF sets. There are many inter-study variations in the homeless populations investigated, the outcome measures employed and when they are assessed, the characteristics of and potential services provided to the TAU control groups, and the details of the interventions themselves; see, e.g. the study descriptions summarized in Baxter et al. (2019); Wang et al. (2019); Hyun, Bae and Noh (2020); Aubry et al. (2020); Peng et al. (2020); and Moledina et al. (2021). Perhaps most confounding, many HF interventions also involve supportive services like ICM and ACT, depending on the severity of the participants' mental-health symptoms and other needs (Moledina et al. 2021). Moreover, given that most HF studies do not provide details about the "usual" sorts of service, counseling, case management, and other potential supports provided to some members of the TAU group, it is possible that the control groups in some studies may be "contaminated" with TF-like interventions. Analogous contamination may occur in TF RCTs, as the studies typically provide few details about whether any members of the TAU group receive transitional or supportive housing. The implication is that comparisons across individual HF evaluations and across individual TF evaluations—let alone across sets of HF and TF evaluations as I attempt here—are not strictly "apples to apples," but instead are inherently ambiguous and thus should be considered suggestive only. This shortcoming of the current literature thus produces a corresponding limitation in the conclusiveness of this research note; I offer a possible remedy below.

Results

U.S.-Based Randomized Controlled Trials of Housing First

The results of the individual U.S.-based RCT studies of HF effectiveness in changing mental health and substance use outcomes compared to TAU are

Table 1. Compilation of Mental Health and Substance Use Outcomes of U.S.-Based Randomized Controlled Trials of Housing First Interventions.

Outcome indicator employed in RCT	N	N*
Mental health of homeless individuals		
Changes in overall mental health status after 6–24 months	4	0
Changes in mental health symptom severity after 6–24 months	3	0
Office-based care for psychiatric diagnoses over 24–31 months	2	+2
Suicidal ideation after 21–24 months	1	0
Incidence of suicide attempts over 21–24 months	1	0
Psychological integration with one's community after 21–24 months	1	+1
Changes in mental health-related incidence of hospitalizations over 7 years	1	0
Number of psychiatric emergency department visits over 31 months	1	+1
Self-perceived level of recovery from severe and persistent mental illness after 24 months	1	+1
Number of unique psychiatric medications prescribed over 2 years	1	+1
Substance abuse disorders by homeless individuals		
Changes in substance use after 21–24 months	1	0
Changes in drug use after 24 months	1	0
Changes in alcohol use after 24 months	1	0
Changes in using alcohol on >28 days in 6 months after 48 months	1	+1
Use of substance use disorder treatment services	1	−1
Total	21	+7; −1

Source: author's compilations of findings from Kirst et al. (2020); Raven Maria, Niedzwiecki and Kushel (2020); Lachaud et al. (2021); Whisler et al. (2021); Mejia-Lancheros et al. (2021); Hanson and Gillespie (2024); and from all U.S.-based RCT studies with mental health and/or substance use outcomes reported in Baxter et al. (2019) and Aubry et al. (2020).

Note. N = number of RCT studies where given indicator employed; N* = number of RCT studies where treatment effect is statistically significant vs. TAU; signs on N* indicate if effect of HF was favorable (+) or unfavorable (−). HF = Housing First; RCT = randomized controlled trial; TAU = treatment as usual.

summarized in Table 1. Years shown in the table reflect the ranges of years when outcomes were measured across the relevant studies. The results in Table 1 show that HF (1) does not provide superior outcomes on general mental health or symptom severity indices; (2) inconsistently may provide superior outcomes regarding use of professional mental healthcare; and (3) does not consistently provide superior substance use outcomes, compared to TAU. Of the 21 outcome indicators tallied in these domains across multiple RCTs, only seven showed a statistically significant favorable outcome for HF; another statistically significant outcome was unfavorable for HF.

It is worth repeating the point made earlier that there is considerable heterogeneity across these RCTs in both the details of HF initiatives and the TAU groups and their associated supports being compared (Aubry et al.

2020). Some might argue that this implies that some evaluations do not provide a fair test of HF because they lack fidelity with the original HF archetype (Pleace and Bretherton 2013). On the contrary, I would argue that the fact that *all* variants of HF typically failed to outperform the variant of TAU against which it was compared on mental health or substance use outcomes suggest a robust, general conclusion. The caveat about the aforementioned potential contamination of the TAU control group with TF-like interventions remains, of course.

U.S.-Based Randomized Controlled Trials of Treatment First

Compared to HF, a larger number of TF interventions for the homeless have been evaluated by RCTs; results are summarized in Table 2. A sufficient number of studies focused on homeless adolescents and teens for them to be tallied separately. It is important to recall here that although TF approaches can be used in combination with HF, the RCTs summarized below were not. Rather, they were conducted with homeless populations drawn from shelters, transitional housing, or residential treatment/rehabilitation centers.

The results summarized in Table 2 indicate that TF, though sometimes successful, is not a panacea for mental illness and substance use disorder challenges of homeless adults and youth. Only in a minority of the RCTs were there statistically significant improvements in homeless adults' or youths' depression, anxiety, mental health status, or PTSD symptoms, compared to TAU. A higher share of RCTs showed the efficacy of TF in reducing homeless youths' use of alcohol and hard drugs, however.

Discussion

Generality of Results

This research note proceeds from the premise that evidence based on RCTs conducted on U.S. homeless populations is the most relevant for the current policy debate. It is thus appropriate to ask whether these exclusions significantly alter the conclusions above. Put differently, how general are the results presented in Tables 1 and 2? The answer appears to be "yes," based on results from broader literature reviews that relaxed one or both of these criteria.[9]

Baxter et al. (2019) examined the RCTs conducted in the United States and Canada before 2017 related to four different HF initiatives' impacts on homeless individuals with mental illness, substance use disorder, and/or chronic physical illness. Several indicators were sufficiently comparable that a meta-analysis of data pooled across studies was feasible. Their meta-analysis revealed that after 18–24 months of treatment, there were no statistically significant differences between HF-treated and TAU control groups in (1) changes in

Table 2. Compilation of Mental Health and Substance Use Outcomes of U.S.-Based Randomized Controlled Trials of Treatment First Interventions.

Outcome indicator employed in RCT	N	N*
Mental health of homeless adults		
Changes in overall psychiatric symptoms after 1–30 months	11	+2
Changes in overall mental health status after 1–15 months	9	+3
Changes in depression after 1–24 months	8	+2
Changes in anxiety after 1–24 months	6	+3
Changes in self-esteem after 1–24 months	4	0
Changes in thought disorder, unusual activity, or other negative psychiatric symptoms after 6–24 months	3	+3
Changes in psychological distress/symptom severity after 36 months	3	0
Changes in PTSD symptoms after 1–2.5 months	2	+1
Changes in self-efficacy after 3–18 months	2	0
Changes in disruptive and problematic behaviors after 1–14 months	2	+1
Changes in overall psychological well-being after 6 months	1	0
Changes in client-rated need for treatment after 18 months	1	0
Substance use disorders by homeless adults		
Changes in alcohol use after 1–36 months	10	+4
Changes in substance use index after 1–36 months	10	+3
Changes in drug use (general or specific) after 1–36 months	6	+2
Changes in addiction severity index after 1–12 months	2	−1
Abstinence from alcohol use after 12 months	1	0
Detox center admission after 18 months	1	0
Mental health of homeless adolescents and teens		
Changes in depression after 3–15 months	3	+1[a]
Changes in internalizing behaviors after 3–15 months	3	+1[a]
Changes in externalizing behaviors after 3–15 months	2	0
Changes in self-rated mental health after 6 months	1	0
Changes in number of psychiatric diagnoses after 15 months	1	0
Substance Use Disorders by Homeless Adolescents and Teens		
Changes in alcohol use after 3–24 months	8	+4[a]
Changes in hard drug use after 1–3 months	6	+4[a]
Changes in marijuana use after 1–3 months	4	−1[a]
Changes in drug and alcohol use overall after 3–24 months	1	0
Abstinence from alcohol and drugs after 1–3 months	1	0
Total	112	+24; −1; +10[a]; −1[a]

Source: author's compilations of findings from all U.S.-based RCT studies of TF interventions with mental health and/or substance use outcomes listed in: Wang et al. (2019), Hyun, Bae and Noh (2020), and Moledina et al. (2021).

Note. N = number of RCT studies where given indicator employed; N* = number of RCT studies where treatment effect is statistically significant; signs on N* indicate if effect of HF was favorable (+) or unfavorable (−). HF = Housing First; TF = Treatment First; RCT = randomized controlled trial.

[a]One (or more) statistically significant treatment effect applies to a subgroup only.

self-reported mental health; (2) changes in self-reported physical health; and (3) time spent hospitalized.[10] Baxter et al. (2019, p. 385) conclude their review by urging "caution in relying on this [HF] model for certainty in improved health outcomes."

Hyun, Bae and Noh (2020) conducted a meta-analysis based on RCTs from the United States and elsewhere with comparable outcome indicators for TF intervention impacts. They concluded that some psychosocial TF approaches showed significant positive effects on anxiety and the mental health status of homeless adults, but not on their depression, psychological distress, or self-efficacy. Specifically, they suggested that relaxation response training may be effective in improving anxiety and mental health status and cognitive behavioral therapy may reduce anxiety. Based on their synthesis of 18 RCTs and four published reviews of TF outcomes among homeless youth across several countries, Wang et al. (2019) concluded that cognitive behavioral therapy produced improvements in depression and substance use outcomes, and family-based therapies also decreased substance use.

In the most wide-ranging reviews, Woodhall-Melnik and Dunn (2016), The National Academies of Sciences, Engineering and Medicine (2018), Aubry et al. (2020), and Moledina et al. (2021) synthesized both RCTs and quasi-experimental studies of HF conducted across multiple national contexts. Woodhall-Melnik and Dunn (2016) noted (p. 296) that findings related to substance use were "inconclusive" (p. 295) and advocated for "additional research that evaluates the lesser understood outcomes (e.g. substance use and psychiatric symptoms) associated with HF." The National Academies (2018) concluded (p. 4), "Overall, except for some evidence that PSH improves health outcomes among individuals with HIV/AIDS, the committee finds that there is no substantial published evidence as yet to demonstrate that PSH improves health outcomes or reduces health care costs." Aubry et al. (2020) concluded (p. e432), "Permanent supportive housing (HF) had no measurable effect on the severity of psychiatric symptoms (ten studies), [or] substance use (nine studies),…when compared with usual social services." Moledina et al. (2021) concluded (p. 2) that, "Most permanent supportive housing [HF] studies found no significant benefit on mental-health or substance-use outcomes…[TF] Mental health interventions (ICM, ACT, CTI)…had varied effects on psychiatric symptoms, … and substance use over time."

Should Housing First be Evaluated on Mental Health and Substance Use Outcomes?

Some might reasonably argue that it is unfair to evaluate HF on the outcomes considered here because it was not designed to accomplish such (e.g. Culhane

2026). TF focuses on improving mental health and/or substance use outcomes as appropriate for the individual client, with housing stability a secondary (if desirable) outcome. By contrast, HF focuses on ending homelessness by providing PSH that hopefully provides the necessary (but not sufficient) conditions for improvements in mental health and substance use disorders. Based on numerous reviews and meta-analyses, there is little doubt that HF typically has been successful in improving housing stability for the homeless (Munthe-Kaas, Berg and Blaasvær 2018; Baxter et al. 2019; Aubry et al. 2020; Moledina et al. 2021). Nevertheless, the evidence is equally clear that this enhanced stability has not often led to noticeably improved mental health or substance use. This indeed is relevant evidence if the core issues facing the chronically homeless are to be addressed successfully.

Implications for Homelessness Researchers and Policymakers

This and other reviews reveal gaps in our knowledge about the most effective ways to treat mental health and substance use problems among the homeless. These gaps include (1) peer support programs; (2) community substance use interventions; (3) abstinence-contingent housing with case management or day treatment; (4) non-abstinence-contingent housing comparing group vs. independent living; and (5) interventions targeted toward special populations (Munthe-Kaas, Berg and Blaasvær 2018; Hyun, Bae and Noh 2020). Especially noteworthy is the paucity of evidence on substance use outcomes for HF treatments (Woodhall-Melnik and Dunn 2016), and several TF substance use interventions for homeless people (Moledina et al. 2021).

Besides these gaps, however, the core challenge in the field is the aforementioned multidimensional heterogeneity of extant studies that renders cross-study comparisons and general conclusions problematic. To address this challenge, I propose a major, federally and foundation-funded study that would directly compare the mental health and behavioral outcomes produced by the "best" HF and TF approaches administered to common homeless populations. Specifically, an expert panel would identify the most promising HF and TF approaches based on extant research. One or more multi-city, long-term RCTs would then be designed to test these approaches as alternative treatment streams compared to similar TAU controls, thereby reducing (if not eliminating) most of the key sources of cross-study heterogeneity currently bedeviling the field. I envision the famous Moving To Opportunity RCT of the 1990s as a useful prototype here, providing what was broadly seen as definitive evidence regarding the economic, health and behavioral effects of giving families living in public housing amid

concentrated poverty neighborhoods one of two alternative treatments: housing rental vouchers with "no strings attached" vs. vouchers that only could be used in low-poverty neighborhoods but came with case-managed relocation assistance. Admittedly, acquiring the requisite high-quality evidence base poses immense challenges inasmuch as there are so many different "flavors" of HF and TF interventions. Nevertheless, such a comprehensive array of evaluations must be undertaken if the public and private resources committed to fighting chronic homelessness are to be employed wisely.

In the absence of such a definitive study(ies), however, what can be said to policymakers? It is clear that relatively few U.S.-based RCTs (summarized in Tables 1 and 2) suggest that either HF or TF demonstrate significant efficacy in altering mental illness and substance use disorder outcomes for the homeless. This evidentiary ambiguity renders affirmative policy implications difficult; warnings about what *not* to do thus seem more appropriate. In this vein, the evidence here implies that neither HF nor TF strategies should be seen as a panacea for homelessness and its associated mental and behavioral health issues and become the sole focus of federal policymakers. Instead, what seems more prudent is a more balanced (and expanded) policy that encourages and financially supports the flexible pursuit of *both HF and TF strategies,* so that local officials and case managers can apply the treatment deemed most appropriate for the particular client at hand, as others have argued (e.g. Rosenheck 2010; Pleace 2011, 2018; Pleace and Bretherton 2013). After their extensive review, Moledina et al. (2021) conclude (p. 5), "Substantial research demonstrates that people with lived experience of homelessness benefit from receiving tailored, patient-centered care within inter-professional teams with an integrated approach to community and social services." Pleace (2018) summarizes well the need for a more *heterodox* strategy (p. 37): "Housing First is not necessarily the only effective, or appropriate, response to a homeless person with high and complex needs." To be successful, however, such a heterodox strategy requires several components.

Relieving the burdens of severe mental illness and substance use disorders among the chronically homelessness will require more than building more supportive housing, providing more rental vouchers, and enhancing tenant protections, as invaluable as these initiatives are. We will need to treat this epidemic as a public health problem. As such, it will take coordinated efforts among governmental and non-profit entities that often have been isolated in their own housing, mental health, and addiction recovery program silos. Pleace (2018) makes this point well (p. iii), "HF services need to be a part of an integrated homelessness strategy to be truly effective. An integrated homelessness strategy, characterized by extensive interagency working, uses preventative services and a range of homelessness

services (of which HF services are one group) to effectively meet the diverse needs of…homeless people."

Even such an integrated approach will fail, however, if the requisite physical and human resources in the public health domain are not in place. Sadly, this is too often the case in many places, where there are inadequate professional staff and facilities in both public and private sectors to provide adequate treatment and recovery opportunities for those who need them. Put differently, both HF and TF strategies will show only modest results if there are insufficient supportive human and institutional resources available to assist those with mental health and substance use challenges.

Conclusion

High rates of mental illness and substance use disorders among the chronically homelessness represent a national public health crisis. The goal of a humane community should not be to "get these people off our streets," but to help them obtain and maintain mental health, freedom from addiction, secure housing, and reintegration into society. The longtime orthodoxy dominating U.S. homelessness strategy, HF, has recently been supplanted by the Trump administration's renewed focus on TF. A comprehensive review of results from RCTs conducted in the United States demonstrates that neither HF nor TF approaches represent panaceas in helping the chronically homeless improve their mental health or free themselves from addiction. We therefore should adopt a more heterodox policy approach in which affordable housing, mental health care, and addiction treatment options are integrated within a portfolio of care opportunities tailored to the homeless individual's particular circumstances. This will require substantially expanding subsidized housing, institutional, and human resources in the public health domain, and providing public support for a wider variety of non-profit organizations that employ the most effective treatments.

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Data Availability

All articles cited herein are in the public domain.

Notes

1. HUD defines the *chronically homeless* as individuals with a disability who have been continuously homeless for a year or more, or have experienced four or more episodes of homelessness totaling a year or more over the past three years. Disability includes one or more of the following: substance use disorder, serious mental illness, developmental disability, post-traumatic stress disorder, cognitive impairment from brain injury, or chronic health condition (HUD, 2024: 59). In 2024, 30% of all individuals who experienced homelessness had chronic patterns of homelessness (HUD, 2024: 60).
2. The latest year for which longitudinally comparable incidence data were collected.
3. The prototype was Pathways to Housing, founded in New York City in 1992 by Sam Tsemberis.
4. Activities within these categories can include: cognitive behavioral therapy, motivational interviewing, contingency management, group and family therapies, skill-building, chronic care model-based intervention, cognitive remediation therapy, contingency management, frailty intervention, mindfulness-oriented recovery enhancement program, psychiatric rehabilitation model-based intervention, relaxation response training, self-compassion training, and strength-based intervention.
5. Prevalence and severity have been measured in a wide variety of ways in the literature; see Baxter et al. (2019); Wang et al. (2019); Aubry et al. (2020); Hyun, Bae and Noh (2020); and Moledina et al. (2021).
6. These included: Woodhall-Melnik and Dunn (2016); National Academies of Sciences, Engineering, and Medicine (2018); Baxter et al. (2019); Wang et al. (2019); Hyun, Bae and Noh (2020); Aubry et al. (2020); Peng et al. (2020); Moledina et al. (2021); Gouse et al. (2023).
7. Admittedly, the homelessness-related infrastructure and policies vary across the US as well. As explained later in the discussion of study generality, the main conclusions are insensitive to the limitation of U.S.-based populations.

8. The TF set was comprised of studies of these types of interventions: ICM (N=14); ACT (N=14); peer support (N=5); CTI (N=2); miscellaneous other psycho-social (N=14).
9. There is moderate-quality evidence that some earlier, non-RCT-based studies of HF yielded somewhat more favorable mental health and substance use outcomes than those reported here (Fitzpatrick-Lewis et al. 2011; Padgett et al. 2011). There are also some non-U.S.-based RCTs of HF demonstrating favorable impacts on outcomes considered here (e.g. Chung et al. 2017; Kerman et al. 2018; Aubry et al. 2019; Loubière et al. 2022).
10. There is RCT evidence from Kernan et al. (2018) that stably housed people (through whatever mechanism) with mental illness have less visits to psychiatric hospitals than the unstably housed. This does not speak to the efficacy of HF in particular, however.

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