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Treatment First, Evidence Later: Examining the Research Behind the Federal Homelessness Toolkit

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In mid-2025, the Trump Administration began signaling a move away from Housing First toward a "Treatment First" model for people experiencing homelessness and struggling with addiction. This evidence brief examines the research behind the Administration's policy shift, which was recently articulated in a new federal toolkit. A review of the toolkit and its underlying evidence reveals a lack of empirical support for Treatment First as an overarching solution to homelessness. At the same time, the toolkit fails to fairly gauge the evidence base for Housing First, and it offers multiple mischaracterizations of the approach. While Housing First has gaps in its evidence, the Administration's push toward a recovery-oriented model seems ill-equipped to tackle the broader and more diverse complexities of homelessness.

In August 2026, the Substance Abuse and Mental Health Services Administration (SAMHSA) published its *Best Practices Toolkit: Addressing Homelessness and Addiction through "Treatment First,"* developed with the White House Office of National Drug Control Policy and the U.S. Department of Housing and Urban Development (HUD). The toolkit operationalizes elements of President Trump's Executive Order 14321, signed July 24, 2025, which directed the Department of Health and Human Services (HHS) and HUD to increase accountability in homelessness programs with actions that shall include, "to the extent permitted by law, ending support for 'housing first' policies." The executive order marked a formal federal shift away from Housing First principles, which had guided federal homelessness policy since the mid-2000s. HUD has since promoted Treatment First and the toolkit alongside its latest homelessness figures, with the toolkit arguing that "Housing First" and "Housing Only" models "fail to prevent overdoses, increase access to addiction treatment, or help people establish and sustain self-sufficiency." In their place, it proposes that treatment and recovery come first, with housing phased in as people progress.

This review analyzes the toolkit's main empirical claims and asks three fundamental questions: 1) What evidence does the toolkit offer for Treatment First? 2) Does the evidence against Housing First hold up? and 3) What does a shift toward Treatment First mean for policy and funding?

Assessing the Toolkit's Underlying Premise

The toolkit opens by stating that "a substantial portion of homeless individuals have co-occurring substance use disorders, often compounded by untreated mental illness." The toolkit uses this claim to justify treatment as the primary gateway to housing, but the cited data do not substantiate its justification.

The first citation points to HUD's 2025 point-in-time (PIT) subpopulation report, which includes separate counts for people with a severe mental illness and those with chronic substance abuse. The PIT count data do not illustrate the prevalence of co-occurring disorders. As seen in the table below, the share of all adults counted who report severe mental illness (~24%) and chronic substance abuse (~18%) demonstrates a clear need for treatment interventions, especially for adults experiencing unsheltered homelessness. Even if the PIT count underestimates these conditions, the data certainly support expanding treatment access. But the data do not justify making treatment a condition of housing for everyone, when most homeless adults are counted with neither condition. The second citation, a KFF analysis of the 2024 count, provides similar statistics from the prior year's HUD data.

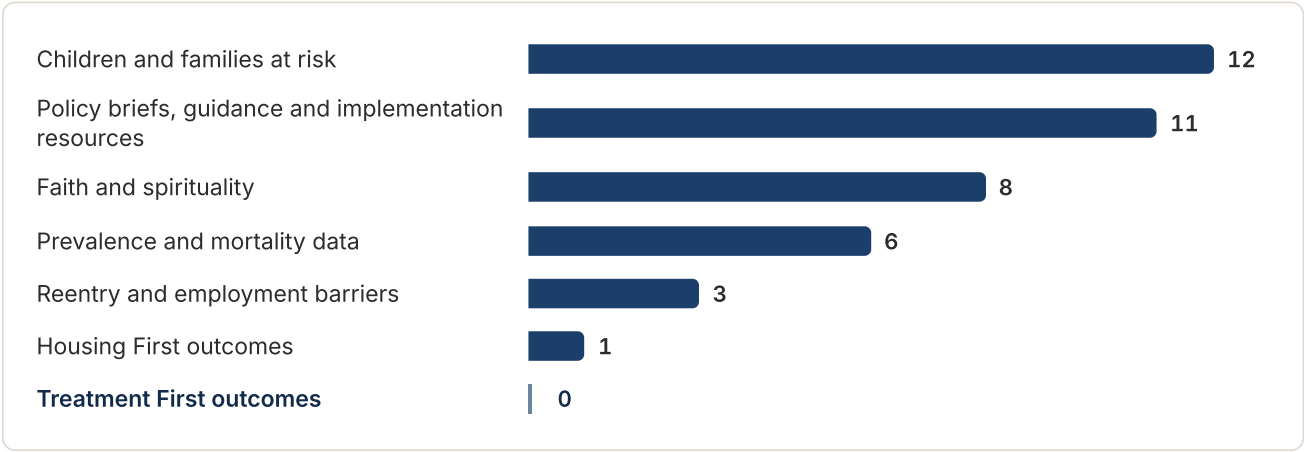
ADULTS COUNTED, 2025	ADULTS	SEVERE MENTAL ILLNESS	CHRONIC SUBSTANCE ABUSE
All adults	611,690	**23.9%**	**18.2%**
Sheltered	354,945	**22.2%**	**13.3%**
Unsheltered	256,745	**26.2%**	**25.0%**

Shares calculated by DBH Consulting. Adults are people counted less children under 18 and households of only children (all adults: 745,652 people counted, less 133,962 under 18). People counted with severe mental illness: 146,176 (78,821 sheltered, 67,355 unsheltered); with chronic substance abuse: 111,564 (47,270 sheltered, 64,294 unsheltered). Sheltered includes emergency shelter, Safe Haven and transitional housing. Source: HUD, 2025 CoC Homeless Populations and Subpopulations Report.

The executive order behind the toolkit goes even further. It states that "the overwhelming majority" of the 274,224 people counted as unsheltered in HUD's 2024 count "are addicted to drugs, have a mental health condition, or both," a claim unsupported by HUD's own data. HUD's FY2026 funding notice acknowledges that in its 2024 count, "24.7% of unsheltered homeless individuals select to self-report substance abuse," and HUD's 2025 count found about a quarter of unsheltered adults with each condition. The executive order states, without citing any specific studies, that nearly two-thirds of homeless people report having regularly used "hard drugs" in their lifetimes. The 2026 funding notice cites the same figures, which come from two studies by California research groups. The first, UCSF's California Statewide Study of People Experiencing Homelessness, found that 65% of participants had regularly used methamphetamine, cocaine, or non-prescribed opioids at some point in their lives. But lifetime use is not current use: a later peer-reviewed analysis of the same survey found 37% were using illicit drugs regularly at the time. Among those who had ever used regularly, 64% started before they first became homeless. Only 6% of participants were receiving any substance use treatment, and 20% of those currently using regularly wanted treatment but could not get it. A 2019 California Policy Lab analysis found that 75% to 78% of unsheltered adults reported substance use or mental health conditions, but it drew on service-intake screenings that were never meant to be representative, and its authors have since warned against its results "being misused to make broad claims about the causes of homelessness."

Analyzing the Toolkit's Evidence Base

The toolkit's 41 references largely fall into six source type categories (see chart below), with none explicitly examining Treatment First model outcomes (also reflected in the chart). Most document the scale of the problem or point to resources, such as SAMHSA guidance on recovery housing, community asset-mapping guides, opioid settlement funding trackers, and guidance on responding to encampments. Only one reference examines Housing First outcomes (described further below).



Classification of the toolkit's reference list by DBH Consulting.

The practices promoted by the toolkit were largely derived from a White House summit held in April 2026, where 15 programs presented their work. It's worth noting that no Housing First researchers appear among the contributors. The toolkit cites no published outcome evaluation data for any of the 15 programs, largely conceding the point: "Future efforts must strengthen the evidence base through ... rigorous evaluation." On faith-based programs, it adds that "there needs to be a more systematic effort to scientifically study and publish the outcomes."

Cherry picking from the one Housing First study the toolkit cites

The toolkit's case against Housing First largely rests on a single claim: "A recent large-scale study found that veterans in supported housing were consistently more likely to die from drug overdose than homeless veterans." The quote does accurately describe one of several findings by Tsai, Peltzman and Beydoun, published in the *American Journal of Public Health*, but the toolkit ignores most of what else the study found.

The study followed all 60,888 veterans who moved into housing through HUD-VASH (VA Supportive Housing) between 2017 and 2019. HUD-VASH is a joint HUD and VA Housing First program that offers housing vouchers and case management to homeless veterans, with priority for those who are chronically homeless. Over two years, the study compared them with another 60,888 homeless veterans matched on age, sex, race, disability, comorbidity, and diagnosed substance use and mental health disorders.

The table below shows the hazard ratios for veterans in HUD-VASH compared with matched homeless veterans in the study. Values above 1.0 indicate higher risk for those in HUD-VASH; values below 1.0 indicate lower risk. As the toolkit states, the findings show a higher risk of overdose death in the HUD-VASH group compared with the comparison group throughout the 24 months of follow-up. The overdose finding is concerning and deserves to be taken seriously. It should also be noted that the study period, 2017 to 2021, spans the fentanyl surge and the COVID pandemic, when isolation was at its worst.

The toolkit ignores other notable findings. First, during the initial six months, veterans in housing were 12% less likely to die from any cause. Over two years, all-cause mortality was close to even, suggesting that the excess overdose deaths in the HUD-VASH group were largely offset by fewer deaths from other causes in the same group. Second, there was no statistically significant difference in suicide. In addition, the authors do not interpret the findings to suggest that Housing First was broadly ineffective, but rather that: "The timely provision of substance use treatment in supported housing could be important to prevent drug overdose deaths." Finally, the study does not examine housing outcomes at all, the primary goal of Housing First.

FOLLOW-UP	ALL-CAUSE DEATH	OVERDOSE DEATH	SUICIDE
6 months	0.88*	2.29*	0.61
12 months	1.05	2.22*	1.02
18 months	1.04	1.80*	1.01
24 months	1.05	1.79*	0.88

* Statistically significant (95% confidence interval excludes 1.0). Source: Tsai, Peltzman and Beydoun, *Am J Public Health* 2026;116(5):665–673, Table 3.

> The toolkit's one Housing First study ends with a call for **treatment *in housing***. The toolkit turns it into a case for **treatment *before housing***.

Treatment First vs. Housing First: What the Research Tells Us

The Administration is promoting a national model without presenting concrete evidence of its effectiveness. At the same time, the toolkit largely mischaracterizes the research behind Housing First. This section examines the evidence base for both approaches.

Before Housing First approaches emerged in the early 1990s, most homeless systems ran some version of a "continuum" or "staircase" model: treatment and sobriety first, then short-term or transitional housing, then permanent housing for those who progressed. The landmark Housing First trials used that model as their comparison group.

In the Pathways to Housing study in New York, people with both mental illness and substance use conditions who were randomly assigned to Housing First were housed sooner and spent more days stably housed than those whose housing was contingent on treatment and sobriety, with no significant difference in alcohol or drug use after two years. Canada's At Home/Chez Soi demonstration project, with 2,148 participants in five cities, found the same pattern: large gains in housing stability, and no clear difference in problem substance use, which fell in both groups. A 2019 systematic review of these and two other randomized trials found Housing First participants were about two and a half times as likely to be housed at 18 to 24 months, with fewer emergency department visits and hospitalizations.

Two major reviews reached the same conclusion. A 2020 systematic review by the CDC's Community Guide, conducted with a HUD co-author, reviewed 26 U.S. and Canadian studies comparing Housing First with Treatment First programs or usual care. Against Treatment First programs, Housing First improved housing stability by a median of 41% across six studies; in the Pathways trial, it reduced homelessness by 88%. A 2018 National Academies review found that the lack of difference in substance use across three randomized trials "suggests that substance use was not enabled by living in permanent supportive housing without requirements for treatment." The toolkit mentions none of this.

More recent evidence stems from research on veterans. A UC Berkeley study followed 289,932 homeless veterans with mental illness who accessed VA homeless services between 2011 and 2017, tracking each for three years. The study compared HUD-VASH with Grant and Per Diem (GPD), the VA's transitional housing program that funds community providers to offer up to two years of housing, often treatment-oriented and sometimes requiring sobriety.

Compared with no housing program, HUD-VASH raised stable housing by about 34 percentage points and kept it high for three years, and it reduced three-year mortality by 4.6 percentage points. GPD's housing gains faded to about 9 points by year three, and it had no effect on mortality; the study rules out that the two programs were equally effective at preventing deaths. HUD-VASH was shown to reduce deaths from exposure, assault, and infections tied to unsafe injection. Estimates for overdose leaned lower among voucher holders but were inconclusive, and the cohort largely predates the fentanyl years that Tsai et al. examine.

In the UC Berkeley study, Housing First also held up on cost. Over three years, HUD-VASH cost about $7,400 more per participant than the no housing group, but cut inpatient spending by about $10,200, and it cost $10,430 less per participant than transitional housing. The paper has not yet been peer reviewed, but its design is stronger than anything the toolkit cites.

Gaps in the Housing First evidence

A review of the Housing First evidence base reveals notable gaps, but none showing that the model has failed at its central goal of getting and keeping people housed.

Housing First does not, on its own, reduce substance use: trials and systematic reviews find no clear difference from comparison groups, though use does not worsen either. The major trials mostly enrolled people with serious mental illness, and a 2009 review cautioned against generalizing their results to people with severe addiction. Critics also point to weak measures of substance use, loosely defined

comparison groups, and a literature long dominated by a single New York program. The risk of overdose after moving in is real: beyond the Tsai findings, a French Housing First trial recorded 8 overdose deaths in its housing group and none in usual care, though its authors could not draw firm conclusions about mortality. Effects on employment and health are limited, cost savings are concentrated among the heaviest users of emergency and hospital care, and many programs labeled Housing First fall short of full fidelity. Finally, Housing First places people in housing rather than building the housing that people need, so it cannot by itself offset rising housing costs and the shortage of affordable housing.

Each of these gaps calls for the same response: add services inside housing — addiction treatment, overdose prevention, employment support — and fund them at the levels the model always intended. None of the evidence calls for making housing conditional on sobriety, and the clearest system-wide successes of the past fifteen years ran on Housing First. Veteran homelessness has fallen by 56% since 2010, and Houston, whose health department is among the toolkit's own featured programs, cut homelessness by more than 60% with a coordinated Housing First system.

Neither model was designed for everyone. Housing First's strongest evidence comes from people with chronic homelessness and serious mental illness, and many people who lose housing need only short-term help. The toolkit narrowly focuses on people struggling with addiction, roughly a fifth of homeless adults by HUD's own count. The question is not which model is suited to serve every person experiencing homelessness, but which belongs at the core of our homeless services system. Because every person experiencing homelessness shares a lack of housing, a housing-centered framework, with treatment offered alongside it, is the better fit.

A 2016 review by Douglas Polcin, a researcher who studies recovery housing and has criticized the methods behind much of the Housing First research, offers a more useful frame than choosing one model over the other. Polcin argues that Housing First "might be the best approach" for people who do not want to stop using, that people motivated to quit should be referred to treatment, and that abstinence-based recovery homes can fill a real gap for those who choose them. But he describes recovery homes as "not appropriate for all homeless persons," particularly for people with severe mental illness or who do not wish to abstain, and notes their residents are typically not chronically homeless — the population the toolkit most targets. His recommendation is "a cross referral process based on resident needs rather than competition between the two approaches," with Housing First "a readily available alternative to homelessness" when abstinence does not hold. He also identifies the linear model's central weakness: people who complete treatment often have no permanent housing to move into, leaving them "vulnerable to relapse and reoccurrence of homelessness."

Other Toolkit Claims That Lack Evidence

Beyond its underlying premise, the toolkit makes several other claims that lack rigorous substantiation.

Faith-based recovery. The toolkit states that "research indicates that recovery deepens when paired with faith." Its strongest source, a 2019 meta-analysis of 20 randomized trials, found a small advantage for spiritual interventions over other treatments, but each of those trials tested 12-step-oriented treatment, and the authors caution that findings do not apply to other faith-based approaches. Only four

small trials tested religious programs outside the 12-step model; two found benefits, two found none, and the authors concluded the research is "still in its infancy." The second source, a 2026 meta-analysis in *JAMA Psychiatry*, pools observational studies of personal spirituality, mostly measuring prevention in the general population. Its estimate for recovery was not statistically significant. These observations are meant to calibrate the toolkit's emphasis on faith integration and by no means suggest that religion and spirituality can't be critical factors in someone's journey to overcome homelessness or addiction.

Mandatory abstinence. The toolkit makes 12-month abstinence a core measure for every program and requires drug-free housing, with relapse triggering a move to "a different level of care." Overdose risk rises sharply after detox, incarceration, or leaving treatment, when tolerance has dropped. In the first two weeks after release from Washington State prisons, former inmates died of overdose at 129 times the rate of other state residents. The toolkit does not address that risk. It mentions medications for opioid use disorder, which cut the risk of death roughly in half for people treated long term, but defines recovery as "remaining drug free" and never says whether featured programs accept patients on methadone or buprenorphine. Naloxone, which has been shown to reduce overdose deaths, appears only once, as a grant-eligible expense; harm reduction does not appear at all.

Children and families. The toolkit states that "homelessness and substance use frequently co-occur within family systems, creating intergenerational cycles that expose children to instability, trauma, and long-term impacts that often remain hidden." Its source is a 2019 qualitative study of 16 parents and 25 staff in Los Angeles transitional housing programs, with parents recruited because they had experienced both. It documents heavy trauma and guilt among parents and real burdens on their children. But a sample selected for both conditions cannot show how often they co-occur, and the study does not follow families over time. It also shows what kept those burdens hidden: parents concealed their substance use for fear of child protective services and of losing their housing — the same child protective system the toolkit lists as an entry point. Many parents were abstinent only because their transitional housing banned use, with no treatment in place, and staff expected relapse once they left. The authors' own recommendations point toward more housing subsidies, more time to secure housing, and family-based prevention delivered within housing.

Some of the toolkit's components do have solid evidence: contingency management for stimulant use, peer support, warm handoffs, and drug courts for reducing recidivism. So does one form of conditional housing the toolkit does not cite: the Birmingham Homeless Cocaine Studies, in which housing and work were contingent on verified abstinence. A 2007 meta-analysis of four of these trials, with 644 homeless people addicted to crack cocaine, found that 58% of those offered abstinence-contingent housing and work were abstinent at six months, versus 26% with day treatment alone and 46% with neither. That is the strongest case for linking housing to sobriety, and it is itself a form of contingency management. Even its researchers noted that a "very significant proportion" of participants did not achieve long-term stable housing. It's worth noting that each of these components can be delivered within Housing First.

The Toolkit Has Its Strengths

Despite its questionable premise and several key unfounded claims, much of the rest of the toolkit's content is actually quite sound. It calls for trauma-informed, evidence-based, client-centered care; a "whole-of-community" approach; "no wrong door" entry; standardized assessments and individualized care planning; warm handoffs between programs; and peer recovery specialists in influential roles. It also names criminal records as a barrier to work and recommends contingency management and pet-friendly services. The toolkit frames recovery as long-term and nonlinear and says relapse is "part of the process, not a reason to give up." It acknowledges that 30- and 90-day treatment stays are too short.

To the toolkit's credit, it also calls for measuring transparent, long-term outcomes rather than simply counting services, and it lays out a detailed set of performance measures for each phase of recovery. It urges communities to map their assets and assess unmet needs before acting, starting with the question "Who is not being served?"

A Big Missing Piece: Affordable Housing

But both of these strengths share the same blind spot: housing. The toolkit never uses the word "affordable." Its housing measures treat public support as a sign of failure, and its needs assessment neither addresses the affordability crisis nor asks where people leaving treatment will live.

SPOTLIGHT

How the toolkit measures housing

"Thriving" is defined as unsubsidized housing. In the toolkit's outcome framework, the highest phase of recovery is marked by "non-subsidized housing," and the core measures it recommends for every program include "market rate or independent housing." It describes the goal as housing "not reliant on government assistance." That is out of reach for people who rely on public benefits like Supplemental Security Income (SSI), whose 2027 maximum federal rates are $1,029 a month for an individual and $1,544 for a couple, or on full-time minimum wage in most housing markets. By this standard, a formerly homeless person living stably with a housing voucher has not succeeded.

Some housed people are counted as part of the problem. The toolkit's opening statistic is that "1,456,923 people were homeless or living in taxpayer-subsidized/funded housing for the homeless" in 2025. That figure counts people who have left homelessness through supportive housing alongside those who are still experiencing homeless, turning the outcome Housing First is designed to produce into a measure of failure.

The needs assessment recommended by the toolkit has the same housing-related blind spot. It asks communities to identify "the most significant gaps in care," then offers its own list of "commonly identified system gaps." The list includes "incentives for continued homelessness" and "lack of deterrence for vagrancy and crime." It does not include a shortage of housing that people can actually afford. Nationally, there are 7.2 million too few rental homes affordable and available to extremely low-

income renters, or 35 for every 100 such households. Research comparing U.S. cities finds that rents and vacancy rates, not drug use or mental illness, explain why homelessness is higher in some places than others.

Shifting the focus to Treatment First does not remove housing from the equation. A model that moves people from shelter through treatment and recovery housing still needs somewhere for individuals to live at the end. As stated earlier, Polcin notes that this is where linear models have long broken down: people who complete treatment often have no permanent housing to move into. The toolkit offers no estimate of the capacity its model would require. HUD's own Housing Inventory Count shows that transitional housing beds fell 60% between 2007 and 2025, from 211,205 to 83,957, while permanent supportive housing beds more than doubled. Yet HUD is now moving to cut funding for permanent housing, as the next section describes.

Impact on Policy and Funding

The toolkit represents one step in a policy shift that began with the July 2025 executive order, and it accompanies sweeping changes to federal funding for homeless services. HUD's FY2025 Continuum of Care competition would have capped permanent housing renewals at 30% of a community's renewal demand; permanent housing accounted for 88% of the program's awards in FY2024. A federal court blocked that competition in December 2025, and Congress then required HUD to issue a new one. HUD's FY2026 competition, released June 1, 2026, sets first-tier renewal funding at 60% of renewal demand, down from 90% in 2024, and rewards communities that prioritize treatment, including involuntary treatment, and partnerships with law enforcement. The notice declares that "'Housing First' has been a profound failure by any measure" and sets aside $1.3 billion for new projects, with priority for transitional housing and services-only projects. It stops short of mandating sobriety ("This is not a requirement that projects condition assistance on sobriety or treatment"), but awards additional points to projects that require participation in services. The National Alliance to End Homelessness estimates that at least 97,000 people living in CoC-funded permanent housing will likely lose their housing. A district court suspended the competition in August 2026, but a federal appeals court allowed it to proceed in September, and HUD must make awards by December 1, 2026. For local communities, the toolkit is less a collection of best practices and more a preview of what federal funding now rewards.

Why this matters

Treatment First, as the toolkit describes it, is largely an untested hypothesis, and where its core idea has been tested — mainly as the comparison group in Housing First trials — it kept fewer people housed without improving substance use. At the same time, Housing First is not a panacea. It has real gaps: overdose risk after move-in, little effect on addiction or employment, and uneven fidelity in practice. Those gaps argue for funding the treatment, overdose prevention, and employment services the model always intended, not for making housing a reward for sobriety. Communities that adopt Treatment First practices should evaluate them rigorously, measure and report outcomes for everyone who enrolls, and carefully track who may be getting left out. The toolkit itself calls for that evidence. We should gather it before the model becomes national policy, not after.

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