11. Housing First and the reduction of homelessness in Finland among people with substance abuse problems

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INTRODUCTION

Homelessness is a persistent social challenge globally, affecting individuals across various demographic and socioeconomic backgrounds. Finland's Housing First approach has been widely recognized as a successful model for addressing homelessness by providing permanent housing without preconditions, coupled with individualized support services. The model contrasts with traditional treatment-first approaches by prioritizing stable housing as a foundation for recovery and social rehabilitation. Finland's experience with Housing First offers an almost unique case for studying the long-term impacts of such policies.

Among the most vulnerable subpopulations experiencing homelessness are people with substance use problems, who often face compounded difficulties related to health, employment, and social integration. This subgroup is often seen as problematic in respect to the Housing First system as they are clearly in need of extensive support for problems that provided housing might not be able to solve. Despite extensive international research on the effectiveness of Housing First showing positive impacts, people with substance use disorder (SUD) are one of the subgroups for whom the effectiveness of the system is debated (Aubry et al., 2015; Baxter et al., 2019; Saldanha et al., 2024). Here we provide an excellent long-term follow-up study based on register data to assess the long-term impacts on this subgroup.

Finnish evaluations of Housing First have primarily relied on qualitative studies, survey data, and small-scale mixed-methods analyses. While these approaches have provided valuable insights, they have not fully leveraged national register data, which allows for a more precise and longitudinal analysis of homelessness trends and outcomes. Especially regarding groups, such

as people with substance use problems, register-based information provides excellent long-term follow-up possibilities that would otherwise be almost impossible. The results will enhance our understanding of the broader implications of the Housing First system and improve its implementation.

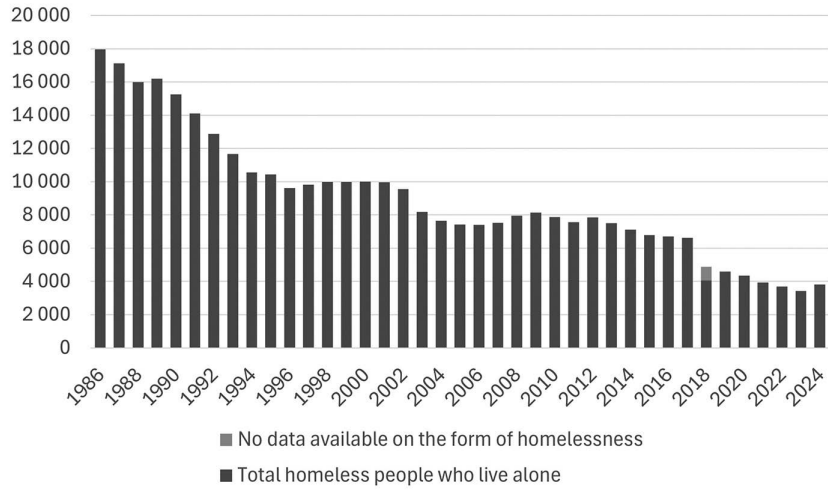
In this chapter, we examine the effectiveness of Housing First on people with substance use problems in reducing homelessness, increasing the likelihood for them to be alive two years after the treatment period, and increasing the likelihood for them to reside in permanent housing two years after the treatment period by utilizing national register data. We identify homeless people with substance use problems based on their visits to substance use treatment services. We analyze the years from 2000 to 2017 spanning a period before and after the implementation of the PAAVO I, PAAVO II, and AUNE Housing First programs. Our study contributes to the literature by offering robust register-based evidence on the effectiveness of Housing First for a particularly marginalized and debated subgroup. Furthermore, our findings provide a foundation for future research on the systematic evaluation of Housing First policies and their various components.

BACKGROUND

Finnish National Homelessness Strategies

Finland has achieved international recognition as a model country in the fight against homelessness. Unlike many other countries where homelessness is a persistent and growing issue, Finland has managed to reduce homelessness steadily between 2012 and until 2023 (ARA, 2025). This success is the result of a long-term national strategy that has evolved over decades. The eradication of homelessness was first included as a goal in the government program in 1987 and, since then, every government program has included the goal of reducing or eradicating homelessness or long-term homelessness. 1987 was also the year that homeless statistics started to be published. Homelessness has been measured once a year for almost 40 years, and this data provides important evidence in support of the effectiveness of the Finnish homeless policies (see Figure 11.1).

Initially, the homelessness strategy focused on ensuring the provision of affordable housing, with direct investment from the state, and the development of financial instruments to support the construction, renovation, and acquisition of housing for the homeless (Fredriksson, 2018). This approach led to a steady and significant reduction in the number of homeless people that in 10 years (from 1986 to 1996) was almost cut in half (from 17,958 to 9,610). Nonetheless, for many homeless people, night shelters remained the only option as tenant selection in affordable housing was prioritizing other



Source: ARA (2025).

Figure 11.1 Homelessness in Finland 1986–2024

categories—such as families with children—and there was a general lack of small dwellings (Fredriksson, 2018). Another obstacle for many was that the supported housing services offered by the municipalities were often requesting a change in lifestyle—e.g., sobriety or positive steps toward rehabilitation (Alkila & Rinta-Panttila, 2018).

Until 2007, the mainstream operating model was the so-called ”staircase system”—or ”treatment first”—where a homeless person had to be deemed housing ready before being offered an apartment (e.g., Padgett et al., 2011; Tsai et al., 2010; Tsemberis et al., 2004). The entire process might begin in a shelter, with the person then moving to temporary housing and finally receiving a permanent home. Typically, homeless people are required to abstain from taking substances or attend treatment during the process and in order to maintain housing. However, many things can go wrong. It is very difficult to abstain while sleeping in a shelter, and people can easily get stuck in the system (e.g., Greenwood et al., 2013; Fredriksson & Kaakinen, 2018). Sometimes people relapse and go back to square one. This means that they use the same institutional services again and again, in a kind of “revolving door”. The model proves costly, because long-term homeless people often have complex support needs that require an intense use of health and substance use treatment services (see, e.g., Culhane, 2008; Latimer et al., 2017).

Over time, it became increasingly clear that this approach was not able to reduce long-term homelessness (Fredriksson, 2018). Despite decades of efforts, long-term homelessness remained high, and shelters were overflowing. In October 2007, the Ministry of Environment—which in Finland is responsible for housing—appointed a working group of four experts representing different sectors of society to prepare a report on homelessness and to provide a basis for a new policy to reduce long-term homelessness. The "Name on the Door" report (Voutilainen et al., 2007) is considered a turning point in Finnish homelessness policy. It provided a new theoretical perspective to the discussion around homelessness and how to combat it. In particular, the report proposed the adoption of the Housing First principle, which states that housing is a human right and should be offered unconditionally and immediately to anyone experiencing homelessness (Voutilainen et al., 2007). According to the authors of the report, stable housing should be seen as the foundation necessary for addressing other personal challenges. Once people have a secure place to live, they are more likely to engage with support services, maintain employment, and reintegrate into society. The "Name on the Door" report was pivotal to obtaining governmental support and enabling the widespread adoption of the Housing First approach in Finland. A consistent political consensus across governments has enabled them to set long-term strategies beyond election cycles (Benjaminsen & Knutagård, 2016; Kaakinen & Turunen, 2021).

In 2008, the "Program for ending long-term homelessness by 2015" or PAAVO (for a description see Tainio & Fredriksson, 2009) was based on the recommendations and principles laid out in the "Name on the Door" report. The program was implemented in two phases: PAAVO I (2008–2011) and PAAVO II (2012–2015). The primary objective of PAAVO I was to halve long-term homelessness by 2011, and PAAVO II aimed to eradicate it entirely by 2015. The program promoted converting shelters into supported housing units, creating new housing and service units, and developing new competences for the staff. It also proposed measures to prevent homelessness. The plan was executed through a robust collaboration between central government departments and key stakeholders, including major social housing providers. Local governments, including Finland's largest cities, signed letters of intent, helping to establish political consensus across all levels of government (Pleace et al., 2016). The PAAVO programs were closely aligned with the Housing First principle, driving substantial practical transformations and receiving a high level of national resources.

Housing was central in PAAVO programs: clear targets on the number of housing units and scattered apartments needed to achieve the objectives were set and funds were secured to increase the housing supply and run the support services (Benjaminsen & Knutagård, 2016; Fredriksson & Kaakinen, 2018). In Table 11.1, we can see that this was indeed achieved, but the number of

Table 11.1 The housing built for the homeless during PAAVO I and II in the biggest Finnish cities

Municipality	Homeless living alone – 2008	Homeless living alone – 2020	Homeless living alone / 1000 inhabitants – 2008	Homeless living alone / 1000 inhabitants – 2020	Total flats created within the programs	Apartments in supported housing units PAAVO I	Apartments in supported housing units PAAVO II	Scattered apartments PAAVO I	Scattered apartments PAAVO II
Helsinki	3150	1534	5.5	2.3	1530	427	472	405	226
Espoo	486	429	2	1.5	652	146	181	46	279
Vantaa	611	227	3.1	1	257	61	136	57	3
Tampere	608	294	2.9	1.2	445	109	26	39	271
Turku	347	384	2	2	262	0	0	59	203

Source: Kaakinen (2012); Karppinen & Fredriksson (2016); Helsingin kaupunki, sosiaalivirasto (2011).

apartments in supported housing units created varies a lot between cities and PAAVO periods. This relates to both how strongly cities started to implement the programs, but also to what kind of homelessness programs were already in action in different cities. For example, in Helsinki, where the rate of homelessness is higher, 1,530 places in supported housing units were created: 427 during PAAVO I and 472 during PAAVO II with a further 405 and 226 respectively in scattered housing. Some cities, such as Turku, concentrated more on the scattered housing and some like Helsinki prioritized the construction or renovation of housing units.

The following national homelessness program (AUNE 2016–2019) shifted focus toward prevention, as well as the construction and allocation of housing for individuals experiencing or at risk of homelessness. The subsequent program (2019–2023) emphasized collaboration among major cities, municipalities, service providers, and the third sector. The current program (2024–2026) seeks to end long-term homelessness by 2027, with a particular emphasis on cooperation between cities and the newly established wellbeing services counties, which are responsible for providing public social and health services in Finland since the beginning of 2023. Since 2020, national homelessness strategies have no longer had a designated national program leader, and the responsibility for coordinating the implementation of Housing First has largely shifted to municipalities. This has led to increasing disparities in how the model is applied across different regions (Kaakinen, 2023; Kaakinen & Turunen, 2021).

The Finnish Model of Housing First

Housing First is a term that is often associated with two different yet closely linked models to respond to homelessness: Pathway Housing First and Finnish Housing First. The first was developed in New York during the 1990s by the organization Pathways to Housing under the leadership of Sam Tsemberis. The goal was to provide individualized solutions for people experiencing homelessness who had severe psychiatric and substance use disorders. This was achieved with the Housing First model that offered housing without requiring recovery or abstinence as a precondition (Tsemberis, 2010; Greenwood et al., 2013). This model emphasized that housing should be given first since it is the foundation upon which all the other life issues can be tackled. Housing First revolutionized the mainstream approach at that time, which was based on a treatment-first concept that saw housing as the final step in a recovery process. The Pathways Housing First has inspired several small-scale initiatives, particularly in the UK. Finland and Denmark became the first countries to implement a national-level homelessness strategy based on the Housing First principle (Benjaminsen & Knutagård, 2016).

The Finnish Housing First model was conceptualized later, in 2007, and shares the core principle of Pathway Housing First: that housing is the basis upon which other life issues can be addressed. Since the initial formulation in the "Name on the Door" report, the Housing First concept has evolved and now includes an emphasis on the separation between housing and support, and specific client-work practices (e.g., non-coercive recovery orientation, harm reduction approach) (see, for example, Kaakinen et al., 2022; Y-Foundation, 2017). While the Pathways Housing First is designed as a model to be followed with a high degree of fidelity (see, for example, the fidelity scales developed by Gilmer et al., 2013; Stefancic et al., 2013), the Finnish Housing First is based on a set of principles that are intended to guide large-scale homelessness initiatives. There is a strong emphasis on the right to housing as well as recommendations for adapting to the local context and specific needs of the homeless population (Leni, 2024).

Finnish Housing First is available to anyone experiencing homelessness, regardless of the severity of needs. In essence, its implementation involves the provision of housing based on rental law legislation (without other conditions) and tailored support. Support services are structured around the concept of housing social work (Granfelt, 2022). This approach primarily aims to secure housing stability and prevent homelessness from recurring while also promoting residents' rehabilitation. A key function of housing social work is connecting clients with mainstream services while upholding their autonomy and right to make their own choices. While emphasizing autonomy and choice, the Finnish model places less focus on voluntary service use and more on providing diverse service options with high resident participation in planning (Kaakinen et al., 2022; Y-Foundation, 2017; Kettunen, 2013). Support services are available but voluntary, ensuring housing remains unconditional and fostering more equal, participatory worker-client relationships (Löfstrand & Juhila, 2021; Pleace et al., 2015). Finnish Housing First also highlights empowering worker-resident interactions (Ranta & Perälä, 2022) and systematic neighborhood engagement (Kaakinen & Turunen, 2021).

A special feature of the Finnish Housing First approach is the reliance on different housing options: approximately 20% of the housing options created during PAAVO I and II were congregate units (i.e. apartment buildings where all residents experienced homelessness) while the rest were scattered housing (i.e., single flats in normal apartment blocks) (Kaakinen & Turunen 2021) (see Table 11.1). Congregate housing defies a tenet of Pathways Housing First according to which Housing First residents should live in scattered-site apartments to foster community integration (Tsemberis, 2010). Finland has thus adapted Housing First to congregate housing (Kaakinen et al., 2022; Pleace et al. 2015) by creating supported housing units where staff are present on-site (either during the day or 24/7) but support services and housing are separate. Residents sign a rental contract, which gives them legal rights, and can use the

support available on-site but they are not forced to. Great attention has to be placed on ensuring privacy, legal rights, and resident autonomy (Kaakinen & Turunen, 2021; Pleace et al., 2015). Supported housing units are the Finnish Housing First options for people with the highest support needs and/or when the safety of the clients is of concern (Leni, 2024). They are thus particularly important for people with severe substance abuse problems.

Housing First shares many overlapping areas with the theoretical approach of harm reduction, which focuses on policies and services that address the social and health problems associated with substance use rather than aiming to reduce the substance use itself. This focus is evident at both the individual and societal levels (Pates & Riley, 2012). Both approaches emphasize support without requiring predetermined conditions for recovery, abstinence, or other life changes. Harm reduction is considered one of the core principles of the Housing First ideology (Andvig et al., 2018). In Finland, Housing First was initially introduced within the housing policy debate, separately from harm reduction policies (Ranta & Perälä, 2022).

In Finland, the exceptionally low levels of homelessness are partly explained by a comprehensive and legally defined last-resort income protection system that safeguards housing costs even for those with minimal or no earned income. The Finnish housing benefit (general housing allowance, housing allowance for pensioners, and housing supplement for students) and social assistance schemes are integrated into a broader universal safety net that ensures housing stability for low-income residents regardless of their employment status. Comparative studies have shown that Nordic integrated and rules-based systems tend to produce more coherent and equitable outcomes than the segmented and discretionary models common in many other European countries (Frazer & Marlier, 2016; Immervoll, 2009; Tervola et al., 2023). Unlike systems where access to housing support is conditional, locally discretionary, or restricted to narrow population groups, Finland's model demonstrates how clear legal entitlements and national coverage can function as structural interventions in themselves. The Nordic universal safety net provides a stable platform upon which targeted homelessness policies—such as Housing First—can operate effectively.

Substance Abuse and Homelessness

Substance abuse issues are more prevalent among people experiencing homelessness than in the general population. It is estimated that the prevalence of alcohol and drug-related disorders within the homeless population is around ten-fold greater than general population estimates in high-income countries (for a review and meta analysis see Gutwinski et al., 2021). There is substantial variation in the prevalence estimates across studies due, for example, to differences in sampling methods and country. A study conducted in France

estimated that the prevalence of addictions is three to five times higher among the homeless population than in the general population (Laporte et al., 2018). In Germany, the prevalence of substance-related disorders was estimated to be 21 times higher than in the general population, and that of alcohol dependency was 22 times higher (Schreiter et al., 2017).

The relationship between homelessness and substance use problems is complex and deeply intertwined. Theoretical perspectives on this issue diverge and the nature of the relationship remains controversial: some scholars argue that substance abuse leads to homelessness, while others suggest that it often emerges or intensifies as a response to the hardships of life without stable shelter. The social selection theory posits that substance use problems can be a primary driver of homelessness (Baum & Burnes, 1993) or a contributing factor (Johnson & Chamberlain, 2011; Vangeest & Johnson, 2002). According to this perspective, substance abuse can lead to homelessness directly or indirectly. As addiction escalates, it can drain personal resources, erode social support networks, and exacerbate socioeconomic difficulties such as financial instability, job loss, and mental health deterioration. Over time, these cumulative challenges increase an individual's vulnerability to homelessness. In contrast, the social adaptation model suggests that substance use is often a coping mechanism for the extreme physical and psychological stressors of homelessness (Neale, 2001; Teesson et al., 2003). Individuals facing exposure to harsh weather, unsafe living conditions, social isolation, and the constant uncertainty of food and shelter may turn to alcohol or drugs as a form of self-medication. Additionally, the homeless environment itself can reinforce substance dependence, as individuals living on the streets or in shelters are more likely to be surrounded by others who engage in substance use, making access and exposure more frequent. Empirical evidence supports the idea that homelessness and substance abuse reinforce one another in a bidirectional cycle. Research indicates that substance abuse can lead to homelessness (Allgood & Warren Jr., 2003; Early, 2005; Shinn et al., 1998) while also showing that homelessness increases the likelihood of substance use (Johnson & Chamberlain, 2008; Shinn et al., 1998). Some studies suggest that these dynamics can occur at the same time (Johnson et al., 1997; McNaughton, 2008; Neale, 2001; Shinn et al., 1998).

Survey data from homeless populations confirm that substance abuse constitutes a risk factor for homelessness. In Denmark's latest homelessness survey, approximately one-third of homeless individuals identified drug or alcohol addiction as the primary cause of their homelessness (Benjaminsen, 2024). Similarly, in Sweden's most recent national count, 55% of people experiencing homelessness reported addiction as a contributing factor (Socialstyrelsen, 2024). It is also important to note that even if substance abuse can increase the risk of becoming homeless, only a small minority of individuals with even severe addiction ever become homeless. In Finland, 9% of drug service clients

are homeless (Kovanen, 2024), though the rate may be higher among those who are not engaged with any services (Ranta & Perälä, 2022). Recent literature widely agrees that so-called individual causes of homelessness, such as addiction, should be seen as structural issues—for example, due to the lack of accessible and effective addiction services (Johnson & Light, 2024; Buch-Geertsema et al., 2014).

It has been argued that the prevalence of substance abuse and mental health issues amongst the homeless is higher in the Nordic countries compared to countries with a less extensive welfare system (Benjaminsen & Andrade, 2015). In Denmark, more than 74% of the transitional homeless (i.e., a temporary and short-term experience of homelessness) have a drug or alcohol abuse problem while less than 31.8% of the transitionally homeless in New York City suffer from a mental illness or substance abuse problem (Benjaminsen & Andrade, 2015). A study in Sweden reported that 42% of men and 41% of women experiencing homelessness were diagnosed with problematic alcohol or illicit drug use (Beijer & Andréasson, 2010). In a study involving homeless people from eight different EU countries (France, Ireland, Italy, Netherlands, Poland, Portugal, Spain, and Sweden), 39% reported having addiction or substance abuse problems (Greenwood et al., 2020). As homelessness rises globally due to increasing housing and living costs, economic factors are playing a growing role, influencing the proportion of homelessness linked to addiction or other social issues (Foundation Abbé Pierre & Feantsa, 2024).

Finland's national homelessness count does not collect data on related social problems. However, its definition of long-term homelessness prioritizes the need for support due to social or health issues over the duration of homelessness. In the latest count, 27% of homeless people living alone were classified as long-term homeless (ARA, 2025). One of the few quantitative analyses of the psychosocial profiles of the homeless in Finland was conducted by Kostiainen & Laakso (2015), surveying 1,515 formerly homeless Helsinki residents with a 17% response rate. One in ten respondents cited substance abuse as a partial cause of their homelessness. Another study examined young homeless income support recipients in Helsinki and showed that 31% of those who had been homeless for at least one month during 2008–2010 also had clienthood in substance abuse services (Niemi & Ahola, 2017).

The empirical evidence underscores the pressing need for integrated strategies that address both substance abuse and homelessness concurrently. The stigma associated with both homelessness and addiction can create additional barriers to seeking help, as homeless individuals struggling with substance use often face discrimination in healthcare settings and difficulty accessing rehabilitation services (Cunningham et al., 2023; Leni, 2024; Vihreäsalo et al., 2025). As a result, the cycle of addiction and homelessness becomes self-perpetuating, making it increasingly difficult for individuals to escape without targeted intervention.

Effectiveness of Housing First

Finnish Housing First was inspired by some pilot interventions that were conducted in the 1990s (Tiivola, 2018; Fredriksson & Kaakinen, 2018), where long-term homeless people with complex needs were housed without requiring them to abstain from using substances or change their lifestyle. These pilots succeeded in ensuring housing stability for a very difficult group of clients and thus provided suggestive evidence that a Housing First approach could be successfully implemented on a large scale.

Since the launch of the PAAVO program, the Finnish Housing First approach has been evaluated using a mix of quantitative and qualitative data. Although these evaluations have not provided strong causal evidence, they offer robust support for the effectiveness of the approach. One of the primary data sources is the annual homelessness count conducted by ARA since 1986 (see e.g., ARA, 2025). These data show a consistent decline in homelessness figures following the implementation of the program, continuing through to 2023 (see Figure 11.1). In addition, the programs incorporated self-assessment reports in which the achievement of strategic targets was reviewed and commented on by Finnish experts (Kaakinen, 2012; Karppinen, 2020; Karppinen & Fredriksson, 2016). Furthermore, both PAAVO and AUNE were subject to external evaluations by internationally recognized homelessness researchers with expertise in Housing First (Pitkänen et al., 2019; Pleace et al., 2015). Regarding PAAVO, Pleace et al. (2015) concluded that its central goal—achieving a lasting national reduction in long-term homelessness—had been met, largely due to a well-designed and comprehensive inter-agency cooperation strategy. Two additional studies examined potential cost offsets associated with Housing First in Finland (Sillanpää, 2013; Ympäristöministeriö, 2011). These analyses used linked administrative data to assess the changes in the use of health, substance abuse, police, and homelessness services before and after staying in supported housing units. The findings were mixed and suggest that the extent of cost savings depends significantly on the resident profile. Sillanpää (2013) also conducted a qualitative assessment which revealed an improvement in quality of life when people moved into the supported housing units.

At the international level, there is a substantial body of research looking at the effectiveness of Housing First as a homelessness intervention inspired by the Pathways model (Tsemberis, 2010). These investigations employ both qualitative and quantitative methods and are based on extensive empirical evidence. Among the outcomes considered, housing stability is the main one and is explored by almost all impact evaluations concerning Housing First. Additional outcomes frequently examined include improvements in physical and mental health, functional recovery, quality of life, and patterns of service use and associated costs across healthcare, social services, and the criminal

justice system (Goering et al., 2011; Saldanha et al., 2024). Data collection for these evaluations typically involves multiple waves of surveys and structured interviews. Register data is often used to enhance the validity and reliability of findings, particularly in relation to service utilization and cost-effectiveness. Qualitative research plays an essential role in capturing the complexity and contextual dimensions of social work interventions. Techniques such as in-depth interviews provide nuanced accounts of the lived experiences of individuals affected by homelessness as well as insight into subjective perceptions of support, barriers to service engagement, and the social and emotional consequences of intervention participation. Importantly, qualitative findings complement quantitative results by offering a more holistic understanding of the effectiveness of the program.

Evidence from randomized controlled trials (RCTs)—the gold standard for impact evaluation—provide strong evidence in support of the effectiveness of Housing First on housing stability. In the Pathways to Housing evaluation, participants who were randomly assigned to the Housing First program spent more time stably housed than those in alternative programs (Gulcur et al., 2003). In the Canadian At Home/Chez Soi trial protocol (Goering et al., 2011), 73% of Housing First participants and 31% of treatment-as-usual participants resided in stable housing at one-year follow-up (Aubry et al., 2015). In the French Chez Soi d'Abord trial, it was estimated that individuals from the Housing First group spent significantly more days in independent housing than individuals in alternative treatment (Loubière et al., 2022). A meta-analysis of RCTs on Housing First concluded that participants receiving Housing First are two and a half times more likely to be stably housed after 18–24 months (Baxter et al., 2019). In recent years, research has increasingly focused on individuals who "fail" in Housing First, meaning that even in supported housing, living and rental contracts may be terminated despite active efforts to address issues among residents and between residents and staff. This group is often referred to in the literature as the "10–20%" (Kaakinen & Turunen, 2021). In some studies examining experiences and perspectives of frontline workers, the support offered in the Housing First-supported housing units has been evaluated as insufficient, especially among the youngest homeless people (Perälä & Jurvansuu, 2016).

While Housing First effectively addresses homelessness and housing stability, its influence on other life outcomes varies, especially when it comes to substance use or substance-related problems (Aubry et al., 2015; Baxter et al., 2019; Loubière et al., 2022). Unsurprisingly, the literature suggests that the average lifespan of a homeless person is shorter than that recorded for the general population and people who have experienced homelessness face excess mortality in comparison to members of the general population (Feodor Nilsson et al., 2018; Henwood et al., 2015; Meyer et al., 2025; Romaszko et al., 2017; Seastres et al., 2020; Stenius-Ayoade et al., 2017). There is a dearth of studies

looking at the effect of Housing First on mortality. The available findings suggest that Housing First residents have higher mortality rates than members of the general homeless population even though the comparison might be biased since only chronic homeless people are considered for Housing First programs (Henwood et al., 2015). Interestingly, causes of death may differ between Housing First participants and their homeless counterparts. Specifically, chronic diseases appear to be more prominent causes of death among Housing First participants (Henwood et al., 2015).

DATA AND METHODS

Our study sample consists of homeless individuals who received substance abuse treatment services between 2000 and 2017. These individuals are identified using the national Care Register for Social Welfare (Sosiaalihuollon hoitoilmoitusrekisteri, Sosiaalihilmo). From the national register, we observe both the type of treatment received and the type of permanent residence, one category of which is homelessness. As a caveat to our research, it is possible that the registration of the substance abuse treatment clients might have changed over time. This relates especially to our findings related to the first research question, and we will return to this in the discussion section.

In the analysis, we use information on receiving any housing benefit from the National Pensions Institute (Kela) registers (Statistics Finland data module FOLK Income) and information on housing tenure from population registers to identify people in permanent housing (Statistics Finland data module FOLK Basic data). During the timespan of our analysis, Finland had two main housing allowance benefits: the general housing allowance and the housing allowance for pensioners. Also, there are separate housing support benefits for students and military conscripts. Our measure of housing benefits includes all types of allowances available in Finland. In general, individuals are entitled to receive housing support if their income does not sufficiently cover their verified and approved housing costs. This implies that receiving housing benefit presupposes that the person has a residence. We combined the information of receiving any housing benefits with the information on tenure type at the end of the year from population registers. The tenure type information relies mainly on move declarations that are mandatory in Finland but corrects this information based on building registers that indicate certain buildings as designated to, for example, subsidized rental or homeownership. This combination measure of having permanent housing is likely to have errors in both directions; some people might have registered housing although be homeless in reality (mainly through tenure type), and some might have housing although it is not in the registers (neither measure is perfect in this regard). These errors are, however, unlikely to change over time. As an outcome, we also use the

mortality information derived directly from the population registers (Statistics Finland data module Basic data).

Regarding the control variables, age, gender, and municipality of residence are based on the national population registers (FOLK Basic data module). Regarding gender, one should note that this refers to the last recorded gender. There is possibly a small number of people who have changed their at-birth registered gender. Education information is based on the national educational registers. Information on foster care is obtained from the Finnish Institute for Health and Welfare's Register of Child Welfare.

One caveat of using register data to identify homeless individuals with substance use disorders is that we can only include those who have sought and received treatment. It is likely that not everyone in need of treatment actually seeks help. Furthermore, some of the information regarding the type of permanent residence in the Care Register for Social Welfare is missing (ranging from 0 to 6% annually). Therefore, our data represents only a subset of all homeless individuals with substance use disorders.

Despite these limitations, the combination of national coverage, detailed treatment records, and the ability to link across registers makes this dataset exceptionally valuable for studying marginalized populations in a robust and comprehensive way. Moreover, the individuals captured in our data represent a particularly relevant group: they have not only experienced homelessness but have also, at some level, sought help for their substance use—indicating a potential motivation or readiness for change. This makes them a particularly meaningful group to study in terms of service use and outcomes. At the same time, it also means that those with the most severe marginalization—who do not seek treatment at all—remain outside the scope of this analysis.

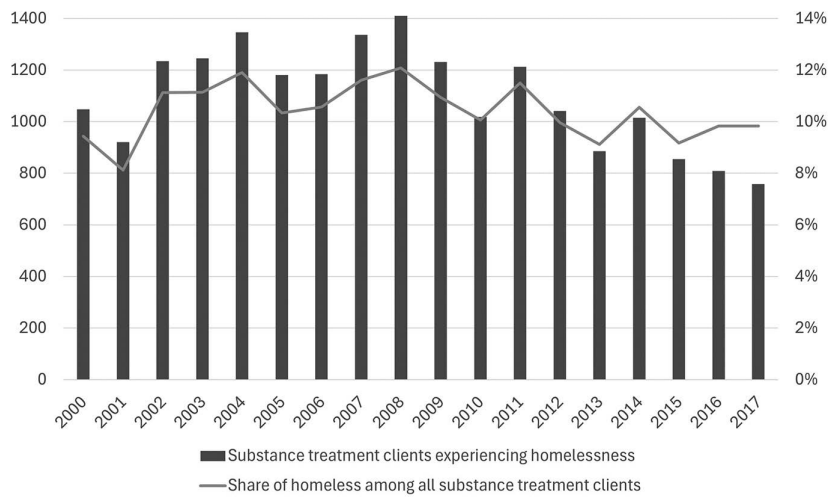
The same individual may have experienced homelessness and received treatment for substance use in multiple years, and thus may appear more than once in our study sample. In total, our research sample contains around 19,000 yearly-person observations (around 11,400 unique persons), which are roughly equally divided between before and after the launch of PAAVOs (shown with full details in Tables 11.2a, b, and c).

Regarding methodology, we first rely on very basic analysis with direct counts and shares (Figure 11.2). To further study the outcomes two years after the situation of being homeless with substance use problems in treatment, we constructed simple linear probability models for both being alive two years after and having registered stable housing two years after. In this register follow-up, we especially concentrated on changes over the years that could possibly be related to PAAVOs and AUNE. We constructed models with just the years as an independent variable (M0), models with city controls (M1), and models with individual level controls (M2) to account for the effect of changes in geographical distribution and background variables across the years (see

Table 11.A1 in the Appendix). In the main text, only the results from the final model with all the controls are illustrated (see Figures 11.3 and 11.4).

RESULTS

Figure 11.2 shows both the absolute number of substance treatment clients experiencing homelessness and the relative share of this group among all substance treatment clients. Throughout the 2000s, the share of homeless clients among all substance treatment clients has remained fairly stable at around 10%. After the implementation of the Housing First programs in 2008, we can see a slight decrease in the share; in 2008, it was almost 12%, but in 2017 a little over 9%. In absolute terms, the number of homeless substance treatment clients remained relatively stable during the early 2000s, with a slight increase peaking around the financial crisis in 2008. Since then, both the number of homeless substance treatment clients and the total number of substance treatment clients have steadily decreased. The change among homeless clients is quite substantial: their number declined from approximately 1,400 in 2008 to fewer than 800 in 2017. This could indicate that the PAAVO and AUNE Housing First programs have indeed been at least somewhat successful in



Source: Own calculations based on the national Care Register for Social Welfare.

Figure 11.2 *Prevalence of homelessness among substance treatment clients*

reducing the number of people with substance use problems who end up homeless in the first place. Still, the persistence of both homelessness and substance use problems remains high: around 25 to 30%—slightly less in some years—of homeless substance treatment clients remain both homeless and in treatment in the following year.

Turning to our other two outcomes of interest in Tables 11.2a–c, we can see the situation of the homeless people with substance use problems two years after being observed as homeless and receiving substance abuse rehabilitation. Two years after, we examine two outcomes: (1) likely stable housing measured in having a registered housing tenure or recipiency of any housing benefit, and (2) being alive at the end of the following two-year period. The outcomes are observed for the period 2002–2019. Tables 11.2a–c describe our study sample by presenting the proportions of key variables across the entire study period, as well as separately for the periods before and after the launch of the PAAVO I program (in 2008).

As a whole, the homeless people with substance use problems in Finland are a very disadvantaged group, as can be seen from Tables 11.2a–c. The mortality rate is high: over 6% of the individuals have died within two years of the observation. On a more positive note, approximately 79% have a place to live, conditional on being alive. One should note that this information is based on two things: either registered housing tenure or recipiency of housing benefits, and is not a perfect measure of permanent housing; it should be taken as a rough indicator (see details in "Data and Methods" section above).

Further, within the study sample, around 82% are men, whereas only 18% are women. As many as 14% have a history of foster care some time in their childhood, contrasting strongly with rates of under 1% in the cohorts we are studying (Forsell, 2024). The share is larger in the latter part of the time span, which may be related to the fact that information on foster care is only available from 1991 onwards and may therefore be more incomplete for earlier birth cohorts.

Table 11.2a Descriptive statistics of the sample used in the regression analysis two years later

	Share whole time span	Share: before PAAVO (2007)	Share: after/during PAAVO
Alive	0.938	0.938	0.938
Any tenure or receiving housing allowance	0.788	0.751	0.822
Observations, total	19,008	9,232	9,776

Table 11.2b Descriptive statistics of the sample used in the regression analysis: observation year

	Share: whole time span	Share: before PAAVO (2007)	Share: after/during PAAVO (2008 onwards)
Male	0.824	0.828	0.821
Helsinki	0.129	0.181	0.080
Espoo	0.117	0.115	0.119
Vantaa	0.081	0.082	0.080
Tampere	0.090	0.093	0.087
Turku	0.066	0.048	0.083
Other PAAVO municipalities	0.146	0.137	0.154
Other municipality	0.371	0.344	0.397
With history of foster homes	0.144	0.0988	0.186
Any secondary degree (or higher)	0.368	0.363	0.373
Observations, total	19,008	9,232	9,776

Note: The same individual may appear more than once in the sample. Other PAAVO municipalities are Joensuu, Kuopio, Lahti, Oulu, Jyväskylä and Pori. Pori joined for PAAVO II.

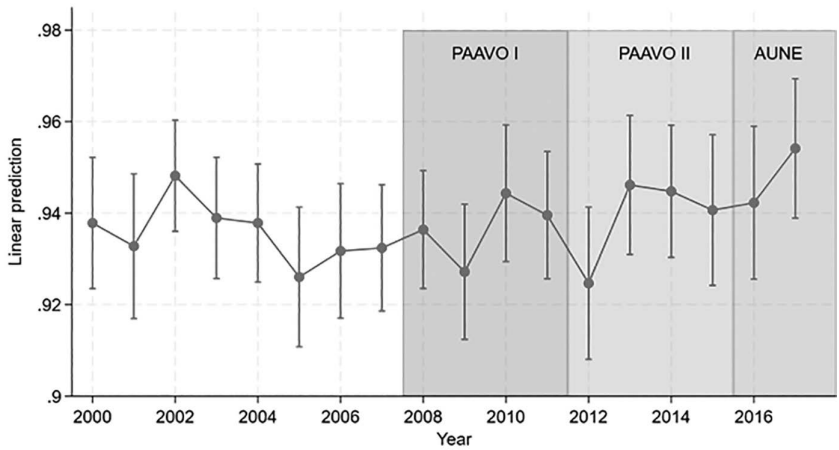
Table 11.2c Descriptive statistics of the sample used in the regression analysis: age groups

-	Share: whole time span	Share: before PAAVO (2007)	Share: after/during PAAVO (2008 onwards)
0–24	0.146	0.149	0.144
25–34	0.287	0.262	0.310
35–44	0.251	0.276	0.228
45–54	0.206	0.223	0.190
55–64	0.094	0.079	0.108
65+	0.016	0.011	0.021
Observations, total	19,008	9,232	9,776

This suggests that the true share may in fact be even higher. Further, only 37% have any kind of degree after primary school. In general 90% of the Finns tend to have a secondary degree and around half attain a general secondary degree (Kilpi-Jakonen et al., 2016). These individuals are more likely to be younger, as only 10% of them are at least 55 years old.

The municipal distribution of homeless people with substance use problems shows notable changes over time. Helsinki had the highest share overall, but also experienced the most significant decline: from 18.1% before 2008 to 8% after. In contrast, the shares in Espoo, Vantaa, and Tampere remained relatively stable. Turku is an exception, showing an increase in its share after 2008. The proportion of homeless people with substance use problems in other municipalities increased from 48.1 to 55.1%, suggesting a possible geographical dispersion of homelessness over time.

In Figure 11.3, we illustrate the results of the changes in being alive two years after being homeless in substance abuse treatment services from the most extensive model with all the control variables. We can observe that there has been very little change in this regard. The homeless people with substance

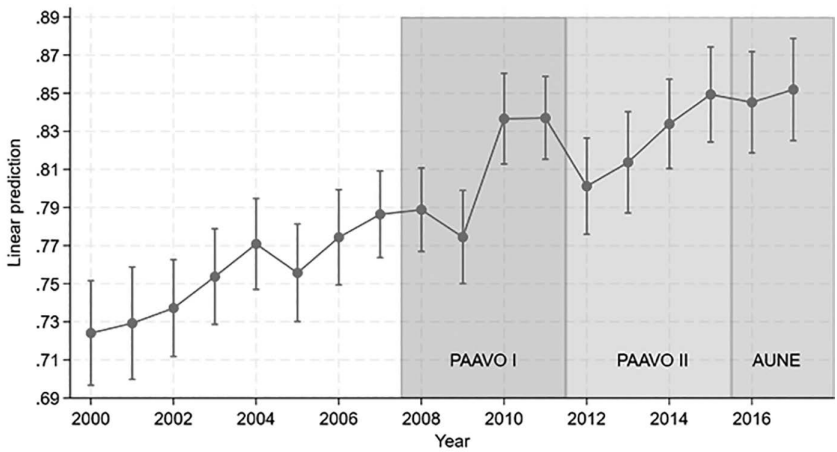


Note: The figure presents predictive margins for each year for the probability of being alive two years later, accompanied by 95% confidence intervals.
Source: Own calculations based on the study sample.

Figure 11.3 *The yearly variation in the likelihood of being alive two years after being a homeless client at the substance abuse treatment services (Table 11.A1, M2)*

use problems have remained a group with high mortality. During the PAAVO and AUNE periods, there is a slight increase in the probability of staying alive, but this is small and not statistically significant. As an additional robustness check, we ran models for different age groups, but all the age groups showed similar patterns over time (results available upon request from the authors).

In the interpretation of the results, one should note that our findings are conditional on individuals being both homeless and receiving substance abuse treatment. It should also be noted that the number of homeless people in substance abuse treatment has been decreasing during the PAAVO and AUNE programs, as shown in Figure 11.2. Although we have some controls of the situation of homeless people in the models, there is a possibility that homeless people with substance use problems have become a more negatively selected group during the period. This in turn might bias our results to be



Note: The figure presents predictive margins for each year for the probability of having permanent housing two years later, accompanied by 95% confidence intervals. Our measure for having permanent housing is likely to have errors in both directions. Some people might have registered housing although be homeless in reality, and some might have housing although it is not in the registers. However, these errors are unlikely to change over time.
Source: Own calculations based on the study sample.

Figure 11.4 *The yearly variation in the likelihood of having permanent housing two years after being a homeless client at the substance abuse treatment services based on the registered tenure type and the recipiency of any housing benefit (Table 11.A1, M2)*

more negative. When we observe no changes, it is thus possible that positive effects of the programs might not be observed because of more negative selection into the group.

The main goal of Housing First systems has been to provide housing. This is why we next turn to the question of whether or not PAAVO and AUNE have had any effect on how many of the homeless people in substance abuse treatment are in permanent housing two years after the treatment in Figure 11.4. Here we can see clear changes. Even before PAAVO and AUNE, the situation has been getting better with a 6 percentage point statistically significant increase from 2000 to 2007 in the number of homeless people with substance use problems having a permanent apartment based on the housing and benefit registers. During PAAVO and AUNE, the increase continued with a 13 percentage point increase from 2000 to 2017, and even a 6.6 percentage point increase from 2007 to 2017. There is a big jump in the two years after the first PAAVO program started, and this would make sense as it has taken cities some time to implement the program and build new housing units.

If our first results concerning mortality might be negatively biased considering the possible effects of PAAVO and AUNE, our more positive results on housing outcomes might in turn be too positive. This is due to the fact that the housing situation of the homeless people with substance use problems had already been clearly improving before the programs. The increases we see during the programs might also reflect this positive trend over time instead of the effect of the programs. However, it is also possible that the positive trends before the national programs might have resulted from some city-level programs implemented earlier.

DISCUSSION

In this chapter, we have given a short description of Housing First with emphasis on the Finnish model. We further provided some empirical examinations of how the model's implementation has been connected to the fates of homeless people with substance use problems in Finland. Housing First is usually regarded as a success story, but people with substance use problems are one of the groups discussed where the results are still debated (Baxter et al., 2019; Saldanha et al., 2024).

As our first result, we showed that during PAAVO and AUNE, the number of homeless people in substance abuse treatment services decreased, rapidly going down from over 1,400 in 2008 to less than 800 in 2017. This decline happened at the same time as PAAVO and AUNE's implementation. As Finland experienced a downturn of the economy in 2008 and 2009, it is likely that this turn was not fueled by macroeconomic circumstances, but rather the Housing First programs. Of course, our temporal associations are not causal estimates

and one should understand the uncertainty behind them. Further, the share of homeless people remained much more stable at around 10% of the substance abuse treatment clients with only a slight decline during the Housing First programs from a little less than 12% in 2008 to less than 10% in 2017. The one caveat to this result is also the possibility that the registration practices of substance abuse clients would have changed over time regardless. We tried to verify the integrity of the data, but it is still possible that there are biases left in the analysis.

Our results highlight that, on average, the housing situation two years after substance abuse treatment for homeless people improved significantly during the PAAVO and AUNE programs. The homeless people were clearly more likely to have permanent housing based on the register information on tenures and housing allowances. However, it remains somewhat unclear if this development was caused by the Housing First programs as we can already see clear increases before the implementation of the programs. However, as the absolute number of homeless clients in substance abuse treatment has been radically declining, we could have expected more negative results due to increased selection of the subgroup. We did not observe anything of the sort.

When it comes to the mortality of homeless people with substance use problems we see no clear trends before or after the Housing First programs were implemented. This might be related to increased selection mentioned above, but it might also mean that Housing First is not effective in combating the mortality of this subgroup. What should be noted is that we do not see radical increases in the mortality either, something that the most radical doubters of Housing First might have expected to see; it does not seem that Housing First increases the mortality of the homeless with substance abuse problems.

Overall, our results highlight the positive associations between the implementation of the programs and observed outcomes, especially regarding the absolute number of homeless people with substance use problems. Further, considering the mortality and housing situation two years later for people who still ended up homeless, it seems that the implementation of Housing First had at least a positive association with the number of people in permanent housing. Regarding mortality, no clear trend was evident.

Our findings support the view that the Housing First approach is effective not only in reducing homelessness but also in sustaining long-term housing. Within the Housing First framework, housing is considered a fundamental starting point that can lead to further positive outcomes in recovery and overall life circumstances. Access to housing and the elimination of homelessness are assessed as valuable goals in themselves, regardless of their broader individual or social impacts.

This study underscores the importance of large-scale, long-term longitudinal research in evaluating such societal initiatives. While the effectiveness

of Housing First has been widely studied, there is limited research utilizing population-level register data, as we have done in this chapter. Finland presents a particularly valuable context for this kind of analysis due to its consistent national implementation of Housing First policies and its notable success in reducing homelessness. Further, research with more casual settings would be crucial. As highlighted here, the temporal association between changes and implementation of Housing First programs has definite value, but to concretely estimate the effects of the programs, we would need better empirical setups.

The Finnish Housing First program stands as an example of how targeted and evidence-based interventions can address acute social problems while being embedded within broader welfare state services and benefits. It represents a textbook case of the investment-intervention approach described in Chapter 2 of this volume. Its impact illustrates the potential of such interventions to both complement and compensate for the limitations of long-term investments, especially when dealing with marginalized and vulnerable segments of the population who may not benefit from mainstream social investment policies alone. Crucially, the effectiveness of Housing First in Finland is supported by a universal and legally defined safety net that guarantees access to housing-related benefits regardless of employment status or life situation. This integrated system functions as a structural foundation, reducing the risk of exclusion and enabling tailored interventions to succeed. The Finnish experience thus strengthens the case for integrating reactive interventions into the broader welfare policy toolbox. It highlights the importance of pairing inclusive universalist approaches with tailored, low-threshold services for marginalized groups—an essential strategy for maintaining both social sustainability and equity in the Nordic welfare state model.

REFERENCES

Allgood, S., & Warren Jr., R. S. (2003). The duration of homelessness: Evidence from a national survey. *Journal of Housing Economics*, *12*(4), 273–290.

Alkila, H., & Rinta-Panttila, K. (2018). Paavo Voutilainen – 'Niille, jotka ovat menettäneet kaiken, vain paras on kyllin hyvää' [Paavo Voutilainen – 'For those who have lost everything, only the best is good enough.']. In P. Fredriksson (Ed.), *Yömajasta omaan asuntoon: Suomalaisen asunnotto- muuspolitiikan murros* (pp.73–92). Into.

Andvig, E. S., Sælør, K. T., & Ogundipe, E. (2018). Harm reduction in a Norwegian Housing First project: A qualitative study of the treatment providers' practice. *Advances in Dual Diagnosis*, *11*(1), 4–15.

ARA (The Housing Finance and Development Centre of Finland) (2025). *Homeless people 2024 – Report 2/2025.*

Aubry, T., Tsemberis, S., Adair, C. E., Veldhuizen, S., Streiner, D., Latimer, E., Sareen, J., Patterson, M., McGarvey, K., Kopp, B., Hume, C., & Goering, P. (2015). One-year outcomes of a randomized controlled trial of Housing First with ACT in five

Canadian cities. *Psychiatric Services*, *66*(5), 463–469. https://doi.org/10.1176/appi.ps.201400167

Baum, A., & Burnes, D. (1993). Facing the facts about homelessness. *Public Welfare*, *51*, 1–10.

Baxter, A. J., Tweed, E. J., Katikireddi, S. V., & Thomson, H. (2019). Effects of Housing First approaches on health and well-being of adults who are homeless or at risk of homelessness: Systematic review and meta-analysis of randomised controlled trials. *Journal of Epidemiology and Community Health*, *73*(5), 379–387.

Beijer, U., & Andréasson, S. (2010). Gender, hospitalization and mental disorders among homeless people compared with the general population in Stockholm. *European Journal of Public Health*, *20*(5), 511–516.

Benjaminsen, L. (2024). *Hjemløshed i Danmark 2024 – National kortlægning*. Social- of Boliministeriet.

Benjaminsen, L., & Andrade, S. B. (2015). Testing a typology of homelessness across welfare regimes: Shelter use in Denmark and the USA. *Housing Studies*, *30*(6), 858–876. https://doi.org/10.1080/02673037.2014.982517

Benjaminsen, L., & Knutagård, M. (2016). Homelessness research and policy development: Examples from the Nordic countries. *European Journal of Homelessness*, *10*(3). https://www.researchgate.net/profile/Marcus-Knutagard-2/publication/312593500_Homelessness_Research_and_Policy_Development_Examples_from_the_Nordic_Countries/links/5885386faca272b7b44a88ce/Homelessness-Research-and-Policy-Development-Examples-from-the-Nordic-Countries.pdf

Buch-Geertsema, V., Benjaminsen, L., Hrast, M., and Pleace, N. (2014). *Extent and profile of homelessness in European Member States: A statistical update*. European Observatory on Homelessness.

Culhane, D. P. (2008). The cost of homelessness: A perspective from the United States. *European Journal of Homelessness*, *148*, 97–114.

Cunningham, R., Imlach, F., Haitana, T., Every-Palmer, S., Lacey, C., Lockett, H., & Peterson, D. (2023). It's not in my head: A qualitative analysis of experiences of discrimination in people with mental health and substance use conditions seeking physical healthcare. *Frontiers in Psychiatry*, *14*, 1285431.

Early, D. W. (2005). An empirical investigation of the determinants of street homelessness. *Journal of Housing Economics*, *14*(1), 27–47.

Feodor Nilsson, S., Laursen, T. M., Hjorthøj, C., & Nordentoft, M. (2018). Homelessness as a predictor of mortality: An 11-year register-based cohort study. *Social Psychiatry and Psychiatric Epidemiology*, *53*(1), 63–75. https://doi.org/10.1007/s00127-017-1456-z

Forsell, M. (2024). *Lastensuojelu 2023: Joka kuudennesta teinistä tehtiin lastensuojeluilmoitus vuonna 2023*. https://www.julkari.fi/bitstream/handle/10024/148992/Lastensuojelu_2023.pdf

Foundation Abbé Pierre & Feantsa (2024). *Ninth overview of housing exclusion in Europe 2024*. https://www.feantsa.org/public/user/Activities/events/2024/9th_overview/Rapport_-_EN.pdf

Frazer, H., & Marlier, E. (2016). *Minimum income schemes in Europe: A study of national policies 2015*. European Commission. https://data.europa.eu/doi/10.2767/860513

Fredriksson, P. (2018). Modernin asunnottomuuspolitiikan synty [The birth of a modern homelessness policy]. In P. Fredriksson (Ed.), *Yömajasta omaan asuntoon: Suomalaisen asunnotto- muuspolitiikan murros* (pp. 73–92). Into.

Fredriksson, P., & Kaakinen, J. (2018). Asunto ensin -politiikan läpimurto [The breakthrough of the Housing First policy]. In: P. Fredriksson (Ed.), *Yömajasta omaan asuntoon. Suomalaisen asunnotto- muuspolitiikan murros* (pp. 113–136). Into.

Gilmer, T. P., Stefancic, A., Sklar, M., & Tsemberis, S. (2013). Development and Validation of a Housing First fidelity survey. *Psychiatric Services*, *64*(9), 911–914. https://doi.org/10.1176/appi.ps.201200500

Goering, P. N., Streiner, D. L., Adair, C., Aubry, T., Barker, J., Distasio, J., Hwang, S. W., Komaroff, J., Latimer, E., & Somers, J. (2011). The At Home/Chez Soi trial protocol: A pragmatic, multi-site, randomised controlled trial of a Housing First intervention for homeless individuals with mental illness in five Canadian cities. *BMJ Open*, *1*(2), e000323.

Granfelt, R. (2022). *Asumissosiaalinen Työ: Asunnottomuudesta Irti Ja Asunnosta Kodiksi* [*Housing social work: Moving out of homelessness and from housing to home*]. Y-Säätiö.

Greenwood, R. M., Manning, R. M., & O'Shaughnessy, B. R. (2020). Homeless services users' reports of problem-related alcohol and illicit substance use in eight European countries. *European Journal of Homelessness*, *14*(4). https://www.researchgate.net/profile/Ronni_Greenwood/publication/353072344_Homeless_Services_Users'_Reports_of_Problem-Related_Alcohol_and_Illicit_Substance_Use_in_Eight_European_Countries/links/60e6b2a430e8e50c01ec1f76/Homeless-Services-Users-Reports-of-Problem-Related-Alcohol-and-Illicit-Substance-Use-in-Eight-European-Countries.pdf

Greenwood, R. M., Stefancic, A., & Tsemberis, S. (2013). Pathways Housing First for homeless persons with psychiatric disabilities: Program innovation, research, and advocacy. *Journal of Social Issues*, *69*(4), 645–663. https://doi.org/10.1111/josi.12034

Gulcur, L., Stefancic, A., Shinn, M., Tsemberis, S., & Fischer, S. N. (2003). Housing, hospitalization, and cost outcomes for homeless individuals with psychiatric disabilities participating in continuum of care and Housing First programmes. *Journal of Community & Applied Social Psychology*, *13*(2), 171–186. https://doi.org/10.1002/casp.723

Gutwinski, S., Schreiter, S., Deutscher, K., & Fazel, S. (2021). The prevalence of mental disorders among homeless people in high-income countries: An updated systematic review and meta-regression analysis. *PLOS Medicine*, *18*(8), e1003750. https://doi.org/10.1371/journal.pmed.1003750

Henwood, B. F., Byrne, T., & Scriber, B. (2015). Examining mortality among formerly homeless adults enrolled in Housing First: An observational study. *BMC Public Health*, *15*(1), 1209. https://doi.org/10.1186/s12889-015-2552-1

Immervoll, H. (2009). Minimum-income benefits in OECD countries: Policy design, effectiveness and challenges. *IZA Discussion Paper* No. 4627. Institute for the Study of Labor. https://hdl.handle.net/10419/36265

Johnson, G., & Chamberlain, C. (2008). Homelessness and substance abuse: Which comes first? *Australian Social Work*, *61*(4), 342–356. https://doi.org/10.1080/03124070802428191

Johnson, G., & Chamberlain, C. (2011). Are the homeless mentally ill? *Australian Journal of Social Issues*, *46*(1), 29–48. https://doi.org/10.1002/j.1839-4655.2011.tb00204.x

Johnson, I. M., & Light, M. A. (2024). Meaningful healthcare and social service access for homeless populations: Generating alliances through theories of therapeutic

landscape. *Journal of Progressive Human Services*, *35*(1–2), 120–141. https://doi.org/10.1080/10428232.2024.2368324

Johnson, T. P., Freels, S. A., Parsons, J. A., & Vangeest, J. B. (1997). Substance abuse and homelessness: Social selection or social adaptation? *Addiction*, *92*(4), 437–445. https://doi.org/10.1111/j.13600443.1997.tb03375.x

Kaakinen, J. (2012). *Loppuraportti. Pitkäaikaisasunnottomuuden Vähentämisohjelma 2008–2011.* [*Final report. Program for reducing long-term homelessness 2008–2011*] Ympäristöhallinto.

Kaakinen, J. (2023). *Kotiin. Selvitysraportti tarvittavista toimenpiteistä asunnottomuuden poistamiseksi vuoteen 2027 mennessä.* Ympäristöministeriö.

Kaakinen, J., Raitakari, S., & Ranta, J. (2022). Housing First. Combatting long-term homelessness in Finland. In C. La Porte (Ed.), *Successful public policy in the Nordic countries: cases, lessons, challenges* (pp. 495–513). Oxford University Press.

Kaakinen, J., & Turunen, S. (2021). Finnish but not yet finished – successes and challenges of Housing First in Finland. *European Journal of Homelessness*, *15*(3). https://www.feantsaresearch.org/public/user/Observatory/2021/EJH_15-3/EJH_15-3_A5_v02.pdf

Karppinen, J. (2020). *Varmista asumisen turva! Asunnottomuuden ennaltaehkäisyn toimenpideohjelman (AUNE) loppuraportti*. [*Ensure housing security! Final report on the Action Plan for the Prevention of Homelessness (AUNE)*]. Ministry of Environment.

Karppinen, J., & Fredriksson, P. (2016). *Loppuraportti. Pitkäaikaisasunnottomuuden Vähentämisohjelma 2012–2015. Paavo II* [*Final report. Program for reducing long-term homelessness 2012–2015. Paavo II*]. Helsinki, Ministry of Environment.

Kettunen, M. (2013). Asunto ensin -malli Yhdysvalloista ja soveltaminen Suomessa. *Yhteiskuntapolitiikka*, *78*(5), 562–570.

Kilpi-Jakonen, E., Erola, J., & Karhula, A. (2016). Inequalities in the haven of equality? Upper secondary education and entry into tertiary education in Finland. In Buchholz, S., H.-P. Blossfeld, & J. Skopek (Eds.), *Models of Secondary Education and Social Inequality: An International Comparison* (pp. 181–196). Edward Elgar Publishing. https://doi.org/10.4337/9781785367267.00021

Kostiainen, E., & Laakso, S. (2015). Helsinkiläisten asunnottomuuspolut. Report of Housing Finance and Development Centre of Finland I.

Kovanen, L. (2024). *Huumehoidon ja kuntoutuksen asiakkaat 2023. Statistical report 43/2024*. THL.

Laporte, A., Vandentorren, S., Détrez, M.-A., Douay, C., Le Strat, Y., Le Méner, E., Chauvin, P., & The Samenta Research Group (2018). Prevalence of mental disorders and addictions among homeless people in the greater Paris area, France. *International Journal of Environmental Research and Public Health*, *15*(2), https://doi.org/10.3390/ijerph15020241

Latimer, E. A., Rabouin, D., Cao, Z., Ly, A., Powell, G., Aubry, T., Distasio, J., Hwang, S. W., Somers, J. M., & Stergiopoulos, V. (2017). Costs of services for homeless people with mental illness in 5 Canadian cities: A large prospective follow-up study. *Canadian Medical Association Open Access Journal*, *5*(3), E576–E585.

Leni, E. (2024). Finnish homelessness deinstitutionalization policy: Housing first and frontline perspectives. *European Journal of Homelessness*, *18*(1). https://www.feantsa.org/public/user/Observatory/2024/EJH_18-1_A07.pdf

Löfstrand, C. H., & Juhila, K. (2021). Transforming worker–client identities: From shelters to Housing First. *Social Inclusion*, *9*(3), 214–222.

Loubière, S., Lemoine, C., Boucekine, M., Boyer, L., Girard, V., Tinland, A., Auquier, P., & French Housing First Study Group (2022). Housing First for homeless people with severe mental illness: Extended 4-year follow-up and analysis of recovery and housing stability from the randomized Un Chez Soi d'Abord trial. *Epidemiology and Psychiatric Sciences*, *31*, e14.

McNaughton, C. C. (2008). Transitions through homelessness, substance use, and the effect of material marginalization and psychological trauma. *Drugs: Education, Prevention and Policy*, *15*(2), 177–188. https://doi.org/10.1080/09687630701377587

Meyer, B. D., Wyse, A., & Logani, I. (2025). Life and death at the margins of society: The mortality of the US homeless population. *Review of Economics and Statistics*, forthcoming.

Neale, J. (2001). Homelessness amongst drug users: A double jeopardy explored. *International Journal of Drug Policy*, *12*(4), 353–369.

Niemi, V., & Ahola, E. (2017). Pathways between housing and homelessness of young income support recipients in Helsinki, Finland. *European Journal of Homelessness*, *11*(2). https://www.utupub.fi/bitstream/handle/10024/158551/Article%202.pdf?sequence=1

Padgett, D. K., Stanhope, V., Henwood, B. F., & Stefancic, A. (2011). Substance use outcomes among homeless clients with serious mental illness: Comparing Housing First with treatment first programs. *Community Mental Health Journal*, *47*(2), 227–232. https://doi.org/10.1007/s10597-009-9283-7

Pates, R., & Riley, D. M. (2012). *Harm reduction in substance use and high-risk behaviour : International policy and practice* (1st ed.). Wiley-Blackwell.

Perälä, R., & Jurvansuu, S. (2016). *Politiikasta käytännöksi. Asunto ensin-politiikan arkea asumisyksiköiden työntekijöiden kertomana*. https://www.julkari.fi/bitstream/handle/10024/131934/YP1605_Perala&Jurvansuu.pdf

Pitkänen, J., Remes, H., Moustgaard, H., & Martikainen, P. (2019). Parental socioeconomic resources and adverse childhood experiences as predictors of not in education, employment, or training: A Finnish register-based longitudinal study. *Journal of Youth Studies*, *0*(0), 1–18. https://doi.org/10.1080/13676261.2019.1679745

Pleace, N., Culhane, D., Granfelt, R., & Knutagard, M. (2015). *The Finnish homelessness strategy: An international review*. https://pure.york.ac.uk/portal/en/publications/the-finnish-homelessness-strategy-an-international-review

Pleace, N., Knutagård, M., Culhane, D. P., & Granfelt, R. (2016). The strategic response to homelessness in Finland: Exploring innovation and coordination within a national plan to reduce and prevent homelessness. *Exploring Effective Systems Responses to Homelessness*, 425–441.

Ranta, J. & Perälä, R. (2022). Haittojen vähentäminen ja Asunto ensin -malli huumeita käyttävien asumisen tuessa. In S. Raitakari, K. Günther, & J.-M. Räsänen (Eds.), *Koti, hyvinvointityö ja haavoittuvuus*. Tampere University Press.

Romaszko, J., Cymes, I., Dragańska, E., Kuchta, R., & Glińska-Lewczuk, K. (2017). Mortality among the homeless: Causes and meteorological relationships. *PloS One*, *12*(12), e0189938.

Saldanha, S., Tavitian, N., Lehman, E., Carey, L., & Higgs, P. (2024). Effectiveness of the Housing First model among substance users: A scoping review. *Housing, Care and Support*, *27*(2), 90–105.

Schreiter, S., Bermpohl, F., Krausz, M., Leucht, S., Rössler, W., Schouler-Ocak, M., & Gutwinski, S. (2017). The prevalence of mental illness in homeless people in Germany: A systematic review and meta-analysis. *Deutsches Ärzteblatt International*, *114*(40), 665. https://doi.org/10.3238/arztebl.2017.0665

Seastres, R. J., Hutton, J., Zordan, R., Moore, G., Mackelprang, J., Kiburg, K. V., & Sundararajan, V. (2020). Long-term effects of homelessness on mortality: A 15-year Australian cohort study. *Australian and New Zealand Journal of Public Health*, *44*(6), 476–481.

Shinn, M., Weitzman, B. C., Stojanovic, D., Knickman, J. R., Jiménez, L., Duchon, L., James, S., & Krantz, D. H. (1998). Predictors of homelessness among families in New York City: From shelter request to housing stability. *American Journal of Public Health*, *88*(11), 1651–1657. https://doi.org/10.2105/AJPH.88.11.1651

Sillanpää, V. (2013). *Asunto ensin-yksiköiden kustannusvaikuttavuus-vertailussa mielenterveys- ja päihdekuntoutujien yksiköt* [*Cost-effectiveness of Housing First units – a comparison of units for people with mental health issues and substance abuse problems*]. Tampereen Teknillinen Yliopisto.

Socialstyrelsen (2024). *Kartläggning av hemlösheten 2023. Personer i hemlöshet i behov av socialtjänsten*. Socialstyrelsen.

Stefancic, A., Tsemberis, S., Messeri, P., Drake, R., & Goering, P. (2013). The Pathways Housing First fidelity scale for individuals with psychiatric disabilities. *American Journal of Psychiatric Rehabilitation*, *16*(4), 240–261. https://doi.org/10.1080/15487768.2013.847741

Stenius-Ayoade, A., Haaramo, P., Kautiainen, H., Gissler, M., Wahlbeck, K., & Eriksson, J. G. (2017). Mortality and causes of death among homeless in Finland: A 10-year follow-up study. *Journal of Epidemiology and Community Health*, *71*(9), 841–848.

Tainio, H., & Fredriksson, P. (2009). The Finnish homelessness strategy: From a 'staircase' model to a 'Housing First' approach to tackling long-term homelessness. *European Journal of Homelessness*, *3*(2009). https://www.feantsa.org/download/feantsa-ejh2009-evaluation-16622178144273146290.pdf

Teesson, M., Hodder, T., & Buhrich, N. (2003). Alcohol and other drug use disorders among homeless people in Australia. *Substance Use & Misuse*, *38*(3–6), 463–474. https://doi.org/10.1081/JA-120017382

Tervola, J., Mesiäislehto, M., & Ollonqvist, J. (2023). Smaller net or just fewer to catch? Disentangling the causes for the varying sizes of minimum income schemes. *International Journal of Social Welfare*, *32*(2), 133–148. https://doi.org/10.1111/ijsw.12553

Tiivola, S. (2018). Juhani Roiha Ja Vailla Vakinaista Asuntoa Ry – Laitapuolen Kulkijan Puolesta. [Juhani Roiha and the No Fixed Abode association – On behalf of those on the margins of society] In P. Fredriksson (Ed.), *Yömajasta omaan asuntoon: Suomalaisen asunnotto- muuspolitiikan murros* (pp. 107–11). Into.

Tsai, J., Mares, A. S., & Rosenheck, R. A. (2010). A multisite comparison of supported housing for chronically homeless adults: "Housing First" versus "residential treatment first". *Psychological Services*, *7*(4), 219.

Tsemberis, S. (2010). Housing First: Ending homelessness, promoting recovery and reducing costs. In E. Gould & B. O'Flaherty (Eds.), *How to house the homeless*. Russell Sage Foundation.

Tsemberis, S., Gulcur, L., & Nakae, M. (2004). Housing First, consumer choice, and harm reduction for homeless individuals with a dual diagnosis. *American Journal of Public Health*, *94*(4), 651–656. https://doi.org/10.2105/AJPH.94.4.651

Vangeest, J. B., & Johnson, T. P. (2002). Substance abuse and homelessness: Direct or indirect effects? *Annals of Epidemiology*, *12*(7), 455–461.

Vihreäsalo, K., Leppo, A., & Perälä, R. (2025). Toimeentulo, velka, vastikkeellisuus: Huumeita käyttävien asunnottomien nuorten siteet yhteiskuntaan ja sen marginaaleihin. *Sosiologia*, *62*(2), 97–194.

Voutilainen, P., Huovinen, E., Puttonen, H., and Taipale, I. (2007, 21 May). *Name on the door. Report of the Working Group set up by the Ministry of the Environment on the preparation of an action plan to reduce long-term homelessness.*

Y-Foundation (2017). *A home of your own. Housing First and ending homelessness in Finland*.

Ympäristöministeriö (2011). *Asunnottomuuden vähentämisen taloudelliset vaikutukset* [*Economic impacts of reducing homelessness*]. Reports of the Ministry of Environment, Vol. 7.

APPENDIX

Table 11.A1 Linear probability models on being alive and having permanent housing two years after being a homeless client at the substance abuse treatment services

Category	Outcome: being alive – M0: No controls	Outcome: being alive – M1: M0 + cities	Outcome: being alive – M2: M1 + individual controls	Outcome: having housing – M0: No controls	Outcome: having housing – M1: M0 + cities	Outcome: having housing – M2: M1 + individual controls
Year (ref. 2000): 2001	-0.00576 (0.0108)	-0.00791 (0.0108)	-0.00506 (0.0108)	0.0191 (0.0210)	0.0250 (0.0208)	0.00515 (0.0205)
Year (ref. 2000): 2002	0.00912 (0.00941)	0.00604 (0.00940)	0.0103 (0.00947)	0.0212 (0.0195)	0.0329 (0.0193)	0.0131 (0.0190)
Year (ref. 2000): 2003	-0.00251 (0.00982)	-0.00500 (0.00982)	0.00111 (0.00987)	0.0383* (0.0193)	0.0482* (0.0192)	0.0296 (0.0189)
Year (ref. 2000): 2004	-0.00345 (0.00971)	-0.00620 (0.00973)	-2.20e-06 (0.00977)	0.0487* (0.0189)	0.0653*** (0.0187)	0.0468* (0.0185)
Year (ref. 2000): 2005	-0.0197 (0.0106)	-0.0185 (0.0107)	-0.0118 (0.0107)	0.0416* (0.0196)	0.0500** (0.0193)	0.0316 (0.0191)
Year (ref. 2000): 2006	-0.0137 (0.0104)	-0.0120 (0.0105)	-0.00611 (0.0105)	0.0607** (0.0193)	0.0671*** (0.0191)	0.0502** (0.0189)
Year (ref. 2000): 2007	-0.0124 (0.0101)	-0.0108 (0.0101)	-0.00543 (0.0102)	0.0754*** (0.0187)	0.0801*** (0.0184)	0.0623*** (0.0182)
Year (ref. 2000): 2008	-0.00646 (0.00973)	-0.00542 (0.00975)	-0.00144 (0.00981)	0.0763*** (0.0184)	0.0831*** (0.0182)	0.0647*** (0.0179)

Category	Outcome: being alive – M0: No controls	Outcome: being alive – M1: M0 + cities	Outcome: being alive – M2: M1 + individual controls	Outcome: having housing – M0: No controls	Outcome: having housing – M1: M0 + cities	Outcome: having housing – M2: M1 + individual controls
Year (ref. 2000): 2009	-0.0164	-0.0152	-0.0107	0.0623**	0.0667***	0.0504**
	(0.0104)	(0.0104)	(0.0105)	(0.0192)	(0.0190)	(0.0187)
Year (ref. 2000): 2010	-0.00321	-8.52e-05	0.00651	0.127***	0.129***	0.112***
	(0.0104)	(0.0105)	(0.0106)	(0.0189)	(0.0187)	(0.0185)
Year (ref. 2000): 2011	-0.00653	-0.00473	0.00172	0.128***	0.130***	0.113***
	(0.0101)	(0.0101)	(0.0102)	(0.0182)	(0.0180)	(0.0178)
Year (ref. 2000): 2012	-0.0217	-0.0188	-0.0132	0.101***	0.0935***	0.0771***
	(0.0111)	(0.0111)	(0.0112)	(0.0194)	(0.0191)	(0.0190)
Year (ref. 2000): 2013	0.00241	0.00422	0.00832	0.102***	0.106***	0.0896***
	(0.0105)	(0.0106)	(0.0107)	(0.0199)	(0.0197)	(0.0195)
Year (ref. 2000): 2014	-0.000418	0.00309	0.00693	0.130***	0.127***	0.110***
	(0.0103)	(0.0104)	(0.0104)	(0.0188)	(0.0186)	(0.0184)
Year (ref. 2000): 2015	-0.00467	-0.000438	0.00283	0.144***	0.139***	0.125***
	(0.0110)	(0.0110)	(0.0112)	(0.0192)	(0.0191)	(0.0189)
Year (ref. 2000): 2016	-0.00213	0.00149	0.00443	0.128***	0.131***	0.121***
	(0.0111)	(0.0112)	(0.0113)	(0.0199)	(0.0198)	(0.0196)
Year (ref. 2000): 2017	0.00956	0.0126	0.0163	0.133***	0.137***	0.128***
	(0.0106)	(0.0106)	(0.0107)	(0.0199)	(0.0198)	(0.0196)
Municipality (ref. Helsinki): Espoo	-	-0.00894	0.000717		-0.0206	-0.0206
		(0.00617)	(0.00614)	-	(0.0137)	(0.0137)
Municipality (ref. Helsinki): Vantaa	-	-0.0137	-0.00412	-	0.0452**	0.0430**
		(0.00707)	(0.00704)		(0.0145)	(0.0144)

Category	Outcome: being alive – M0: No controls	Outcome: being alive – M1: M0 + cities	Outcome: being alive – M2: M1 + individual controls	Outcome: having housing – M0: No controls	Outcome: having housing – M1: M0 + cities	Outcome: having housing – M2: M1 + individual controls
Municipality (ref. Helsinki): Tampere	-	-0.0154* (0.00695)	-0.00878 (0.00688)	-	0.0395** (0.0143)	0.0347* (0.0141)
Municipality (ref. Helsinki): Turku	-	-0.0282*** (0.00835)	-0.0152 (0.00830)	-	-0.0131 (0.0163)	-0.0161 (0.0162)
Municipality (ref. Helsinki): Other program municipalities	-	-0.0356*** (0.00648)	-0.0225*** (0.00645)	-	0.112*** (0.0120)	0.108*** (0.0120)
Municipality (ref. Helsinki): Other municipalities	-	-0.0321*** (0.00512)	-0.0204*** (0.00509)	-	0.109*** (0.0106)	0.109*** (0.0106)
History of foster homes: Yes	-	-	-0.00329 (0.00461)	-	-	-0.0490*** (0.00982)
Man-	-	-	0.0163*** (0.00401)	-	-	0.0808*** (0.00725)
Age group (ref. under 25 years old): 25 to 34 years old	-	-	-0.0122** (0.00437)	-	-	-0.0499*** (0.00963)
Age group (ref. under 25 years old): 35 to 44 years old	-	-	-0.0295*** (0.00520)	-	-	-0.0535*** (0.0105)

Category	Outcome: being alive – M0: No controls	Outcome: being alive – M1: M0 + cities	Outcome: being alive – M2: M1 + individual controls	Outcome: having housing – M0: No controls	Outcome: having housing – M1: M0 + cities	Outcome: having housing – M2: M1 + individual controls
Age group (ref. under 25 years old): 45 to 54 years old	-	-	-0.0556*** (0.00612)	-	-	-0.0417*** (0.0110)
Age group (ref. under 25 years old): 55 to 64 years old	-	-	-0.0815*** (0.00862)	-	-	-0.0301* (0.0131)
Age group (ref. under 25 years old): 65+ years old	-	-	-0.105*** (0.0202)	-	-	-0.0304 (0.0237)
Any secondary degree (or higher)	-	-	-0.00536 (0.00395)	-	-	0.0481*** (0.00637)
Constant	0.944*** (0.00714)	0.965*** (0.00783)	0.982*** (0.00866)	0.712*** (0.0144)	0.647*** (0.0167)	0.680*** (0.0183)
Observations	19,008	19,008	18,983	17,822	17,822	17,797
R-squared	0.001	0.004	0.017	0.011	0.028	0.040
Mean outcome	0.938	0.938	0.938	0.788	0.788	0.789

Note: Standard errors in parentheses, *** p<0.001, ** p<0.01, * p<0.05.
Source: Own calculations based on the study sample.