

The Family Shelter System in Massachusetts:

A snapshot of program models, service needs, promising practices, and challenges

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Executive Summary

Family homelessness in Massachusetts has reached record levels over the past year, with an average of 4,800 families sleeping in shelter each night between July 2014 and January 2015. As the number of homeless families has grown, the emergency shelter system has expanded to meet the ongoing need. Massachusetts has operated as a “right to shelter” state since 1983, meaning that the state is obligated to provide shelter for all eligible families. Families are defined as households with children under the age of 21 or that include a pregnant woman. The system is funded through the State budget and has been overseen by the Department of Housing and Community Development (DHCD) since 2010. This report examines the state’s family shelter system in detail, with the goal of understanding family needs, services provided, and best practices. This report also offers recommendations for moving forward to address homelessness in Massachusetts.

This report utilized multiple data sources, including new data collected from a sample of shelter providers using a combination of surveys and site visits, monthly and quarterly reports from DHCD, and conversations with state agency employees, service providers, and advocates. Findings by section are summarized below.

The System and Family Demographics

- Family homelessness has increased by 257 percent since 2006. As of January 2015, 4,764 families were sleeping each night in the emergency shelter system.
- The largest percentage of families applying for shelter originates from Boston, followed by Springfield, Worcester, and Brockton.
- On average, only half of families applying for shelter are found eligible, but eligibility rates vary considerably by region.
- Shelter models vary by type and location. In the fall of 2014, families placed in Boston were more likely to be in a congregate or scattered-site unit, while families placed in Western MA were more likely to be in a motel or co-shelter unit, an expansion of shelter units during FY15 aimed to reduce reliance on motels across the state and especially in Western MA.

Services

- 63 percent of surveyed shelter programs had clinical staff on site
- 89 percent of surveyed programs had staff with at least one type of specialty training, including domestic violence, HIV/AIDS, trauma, substance abuse, and mental health.
- Services provided to families cover a relatively wide range and include case management, housing search, workforce development, childcare, mental health and substance abuse services, and workshops.
- Services are provided either directly on site, from an outside agency that comes on site, or by referral out.
- Community partners are vital to the success of service provision, but gaps in available services exist.

Family Needs

- The three largest needs of homeless families as identified by service providers were housing, childcare, and education
- Social service needs were consistently mentioned as critical, but secondary to these top three identified needs.

Housing Opportunities

- Housing opportunities for homeless families are dependent on annual policy decisions
- The majority of homeless families exit shelter without permanent subsidized housing

Promising Practices

Key strengths identified by shelter programs included:

- A focus on strong, individually tailored services
- Building relationships with families
- Effective staffing structure
- Strong partnerships with community-based organizations

Recommendations for service improvement and addressing family homelessness covered a range of topics, but can be summarized into those that are programmatic, or within the current scope of the emergency shelter system, and those that are systemic, or encompass larger issues that require inter-agency coordination.

Identified programmatic-level recommendations:

- Creating a balance between rules and service flexibility
- Maintaining a safe and effective co-sheltering model
- Continued focus on data collection and improving data quality

Identified systemic recommendations:

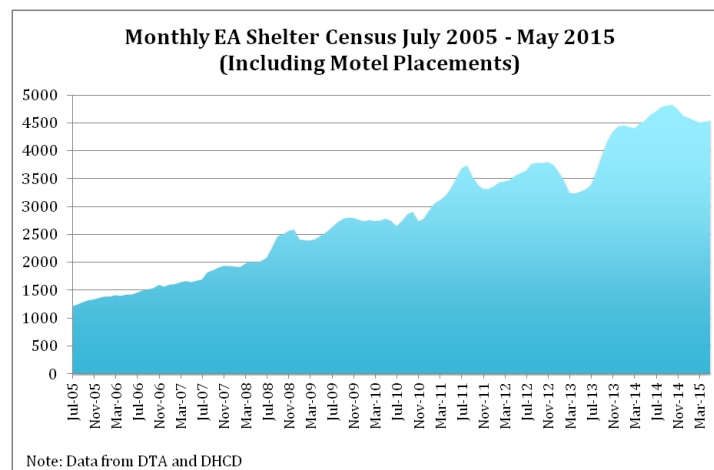
- Increasing the supply of affordable housing through subsidies and informed targeting
- Addressing generational effects of poverty
- Reducing the cliff effects of certain benefits associated with increases in income
- Improving access to shelter
- Preventing homelessness
- Filling gaps in community resources and partners

SECTION 1

The Family Shelter System in Massachusetts: The Current State

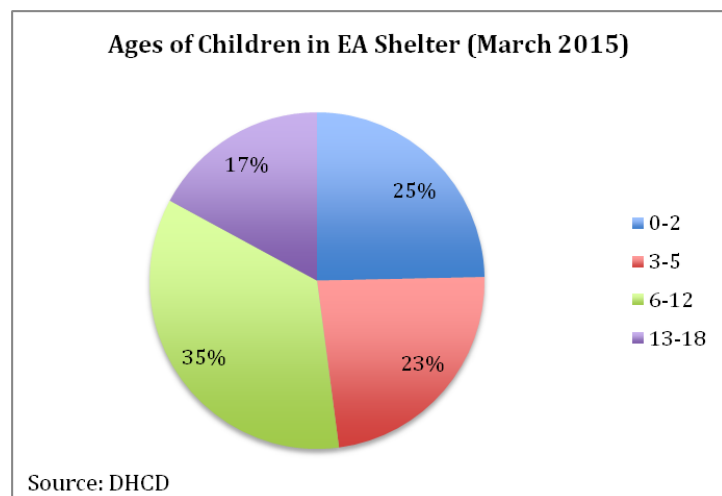
The Families

Family homelessness in Massachusetts reached record levels in the past year, with an average of 4,658 families sleeping in shelter each night in the first eleven months of fiscal year 2015, a 245 percent increase since 2006. This drastic increase has followed trends in other states and cities across the nation, including New York, Michigan, Texas, and Washington, D.C (Henry, Cortes, Shivji, & Buck, 2014; Markee, 2015).



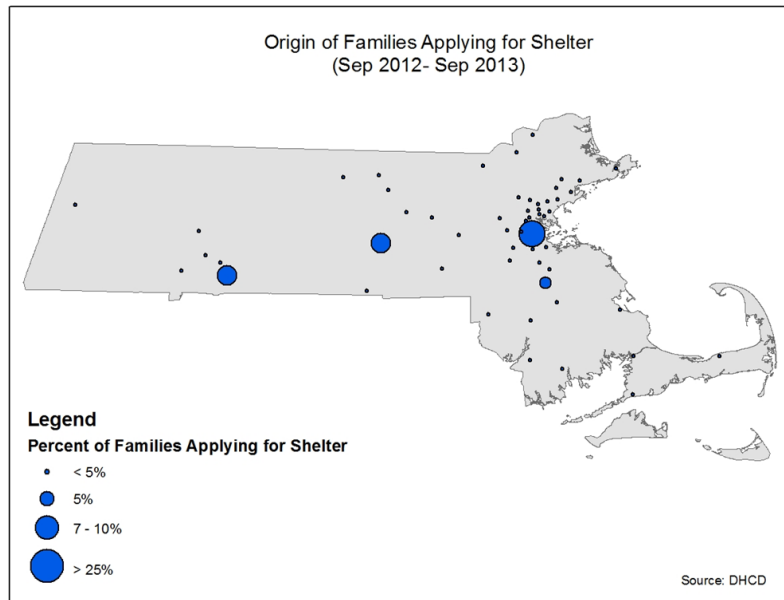
The characteristics of homeless families in Massachusetts follow larger trends of families living in poverty: they are disproportionately young, female-headed, and African American or Hispanic.

Over 90 percent of homeless families are headed by women, with an average age of 31. Just over 14 percent of all homeless families have a member with a disability. Homeless children are generally very young; just under half of all homeless children are under age 6 and 83 percent are under 13.

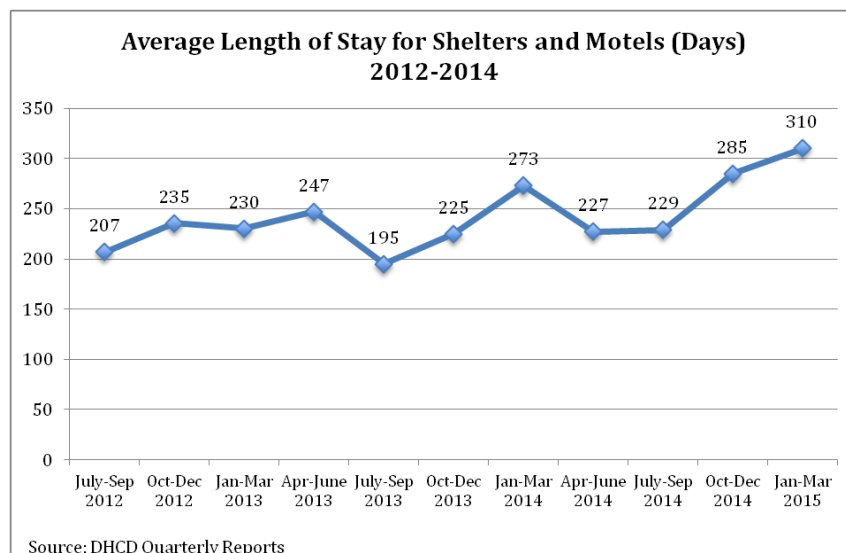


Homeless families originate from communities across the state, but a handful of cities compromise the largest percentage of applications.

Between 2012 and 2013, 28 percent of all families applying for shelter originated from Boston, followed by 10 percent from Springfield, 7 percent from Worcester, and 5 percent from Brockton.



The average time homeless families spend in emergency shelter has fluctuated over the past few years. Most recently, families were experiencing longer stays in shelter than at any point during the previous two years, spending an average of 310 days in shelter, or over 10 months.



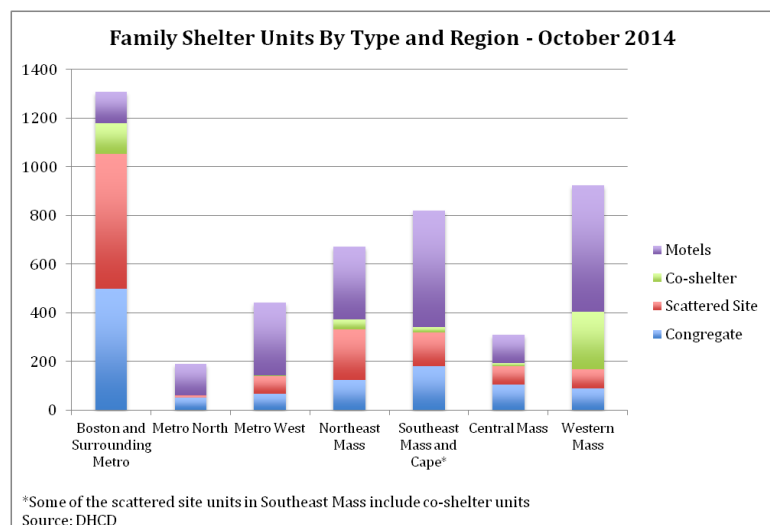
The System

Emergency shelter is provided to homeless families through non-profit service providers contracted by the state. The Department of Housing and Community Development (DHCD) oversees all emergency shelter providers and provides regulations for how the system is run. A detailed document outlines the scope of services that family shelters are contracted to provide. These include developing a re-housing and stabilization plan with each family, providing culturally competent services, providing proper assessment and case management, linking families with community-based services, and ensuring a specified percentage of all families exit into housing (Department of Housing and Community Development, 2015).

Massachusetts also operates as a “right to shelter” state, meaning that all homeless families found eligible for shelter are entitled to receive it. More details on the barriers to accessing shelter are discussed below. Nevertheless, as part of this process, DHCD as the oversight agency is responsible for determining eligibility, placing families at specific shelter sites, overseeing transfers, and making determinations on shelter terminations.

The state provides emergency shelter using four different models: congregate, scattered-site, co-sheltering, and motels.

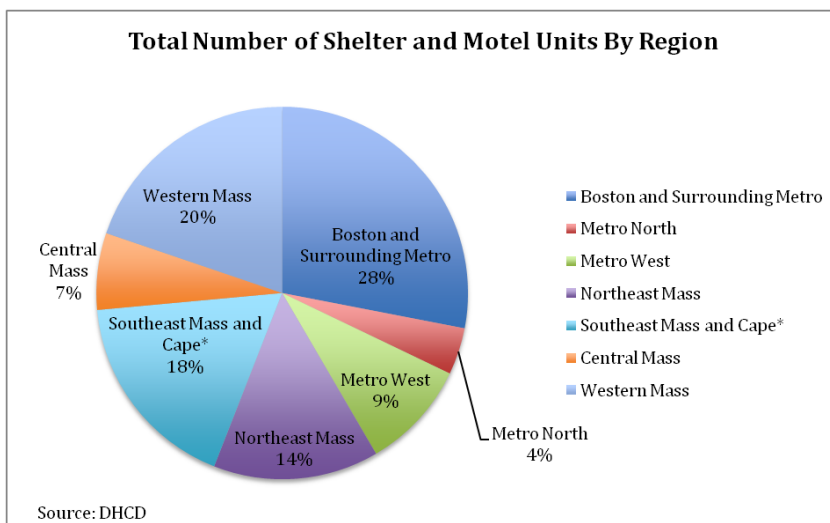
Congregate shelters are the most traditional model and vary slightly in their specific structure. However, they generally offer families their own bedrooms with shared living space, bathrooms and kitchens. Congregate shelters are staffed 24 hours and thus have onsite supervision at all times. Scattered site units are apartments located within the community but rented by the state for the provision of emergency shelter. Generally, they do not offer onsite staffing but provide services by case managers that come on site or through requiring families to go to a central office.



Co-sheltering is a new model, started in 2011 and brought to scale in 2013, which places 2-3 families in an apartment-style unit. Families are given their own bedroom but share the rest of the space with the other families. Co-shelters may or may not be staffed 24 hours, and as a result may operate more like a congregate or a scattered site depending on the staffing.

When the shelter census continued to rise in 2008, the state filled capacity needs by placing families in hotels and motels. Motels and hotels are treated as an overflow system for shelter space with one family per unit. Up until recently, motels offered little-to-no services for families and there is no staffing on site in motels. Over the past year, the state has aggressively expanded shelter capacity to reduce reliance on motels and has succeeded in bringing down the motel census from a high of 2,175 in December 2013 to 1,480 in January 2015.

The geographic breakdown of shelter units and motels as of fall 2014 is presented in the graph below. The majority of total shelter units are in the Boston metro area, followed by western Massachusetts, but the breakdown of available shelter models varies considerably by region. Families placed in Boston are much more likely to be placed in a congregate or scattered-site unit, while those in western Massachusetts are more likely to be placed in a motel or co-sheltering unit.¹



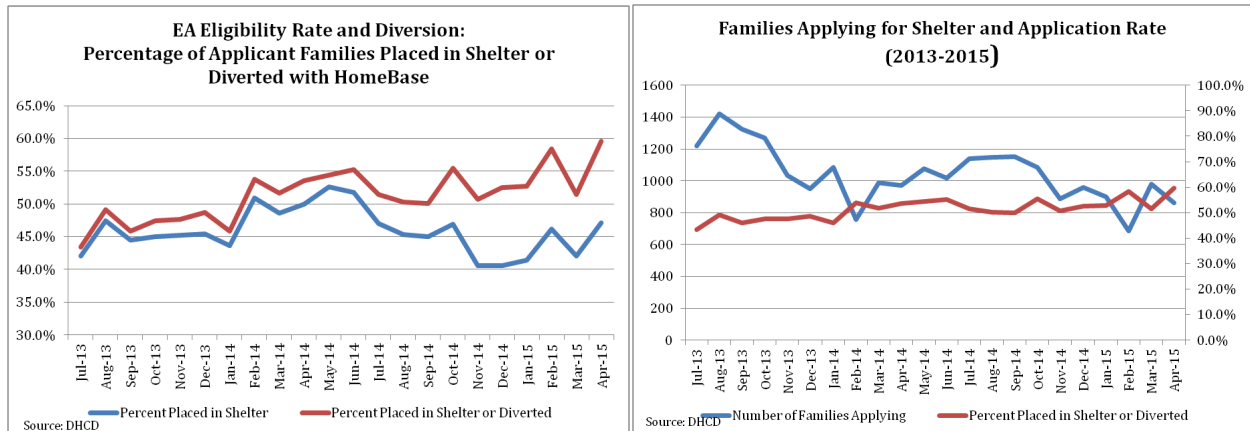
Gaining access to the shelter system poses a challenge for many families. Although Massachusetts operates as a “right to shelter” state, which guarantees emergency shelter to homeless families on paper, in practice there are many bureaucratic barriers to accessing shelter. Only families living below 115 percent of the federal poverty line are eligible to apply. After applying, families must then prove their homelessness and be found eligible under one of 4 categories, including homeless as a result of domestic violence, fire/natural disaster, eviction, or health and safety issues. Detailed documentation is required at every step to prove homelessness for one of these reasons. On average, only 40 to 50 percent of all families applying for shelter are found eligible and placed in a shelter unit. However, eligibility rates vary considerably by the offices where families apply. In total, there are 20 application offices across the state. Eligibility data is reported for these offices by region. In particular, the central Massachusetts region finds families eligible at a significantly lower rate than all other regions.

Table 1: Family Applications and Eligibility Rate By Regional Office (Source DHCD)
FY 2014 year-to-date

	Families Applying	Families Placed	Percent Found Eligible	Percent Eligible FY2014
Boston	1,606	1,026	63.8%	56.7%
Central Mass	825	223	27.0%	23.8%
North Shore	1,900	776	40.8%	56.2%
South Shore	1,561	634	40.6%	47.5%
Western Mass	1,183	545	46.1%	56.2%
<i>Total</i>	<i>7,268</i>	<i>3,204</i>	<i>44.1%</i>	<i>47.0%</i>

¹ Since these numbers were aggregated, the motel census has continued to decline alongside the expansion of traditional shelter units, as noted above.

After being determined eligible, families are entitled to diversion assistance to prevent the need for a shelter placement. Diversion is provided in the form of flexible cash assistance, [paid to approved vendors](#), up to \$6,000 through the HomeBASE program. In July 2014, a pilot program was launched, placing family shelter providers in 5 of the largest intake offices to meet with and provide more in-depth diversion assessment to eligible families. Other offices continued to provide diversion assistance through HomeBASE caseworkers. Since the pilot was launched, the total number of families diverted from shelter at intake with HomeBASE funds increased considerably, [with 16 percent of all eligible families](#) diverted from entering shelter in fiscal year 2015. A detailed exploration into the nature of shelter diversions and the stability of families after being diverted has not been conducted and is crucial in order to understand how successful diversion can be facilitated moving forward.



SECTION 2

Service Models, Family Needs, and Program Strengths

New Data Collection

For the remaining sections of this report, new data were collected in order to understand service models and practices, family needs and barriers, program strengths, and recommendations for improvement. Both quantitative and qualitative data were collected through surveys and site visits to programs across the state. A total of 47 surveys were completed by 43 shelter provider agencies (generating a response rate of 93 percent of shelter providers).² Completed surveys covered a range of shelter programs from across the state and of varying sizes.³ In addition to surveys, eight site visits were conducted to seven homeless service providers. The site visits covered shelters of varying sizes – from 10 units to 200 – and from four different regions of the state. The site visits provided an opportunity to gain more in-depth information about how shelters are run, service challenges, and recommendations for service improvement.

² Some providers filled out more than one survey if they ran more than one program. Some providers filled out one survey for all programs. All 46 contracted providers were contacted for the surveys.

³ Only one person from each agency completed the survey and agencies made their own determinations about who the respondent should be. As a result, some data may not reflect the opinions of an entire agency, but rather of the survey respondent.

A summary of basic shelter program characteristics as collected through the survey data is provided in the graph and tables below. The majority of sites had at least one congregate shelter. Slightly over half operated scattered-site units, while 38 percent operated co-shelters. A few providers were responsible for providing services in motel units through subcontracts with the HomeBASE program. However, the survey was not designed to gather accurate information about motel services, which operate differently than other forms of shelter, and until recently, have been extremely limited. Roughly half of providers operated more than one shelter model. In general, the medium and large shelters were more likely to operate scattered-site and co-sheltering models. While some new shelter capacity has been added recently, the majority of providers have been in operation for many years—22 years on average across all sites.

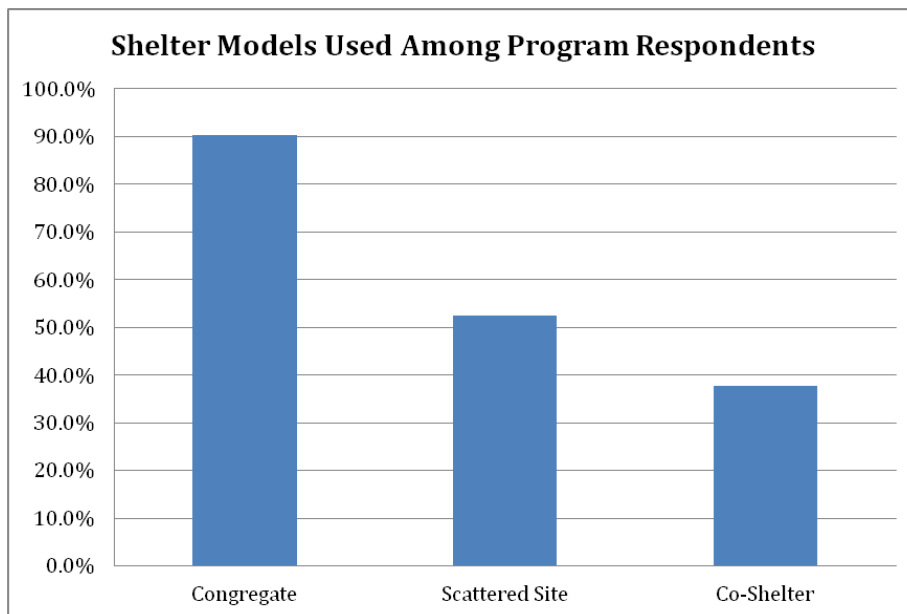


Table 2: Number, Size, and Type of Programs
Reported by Survey Data

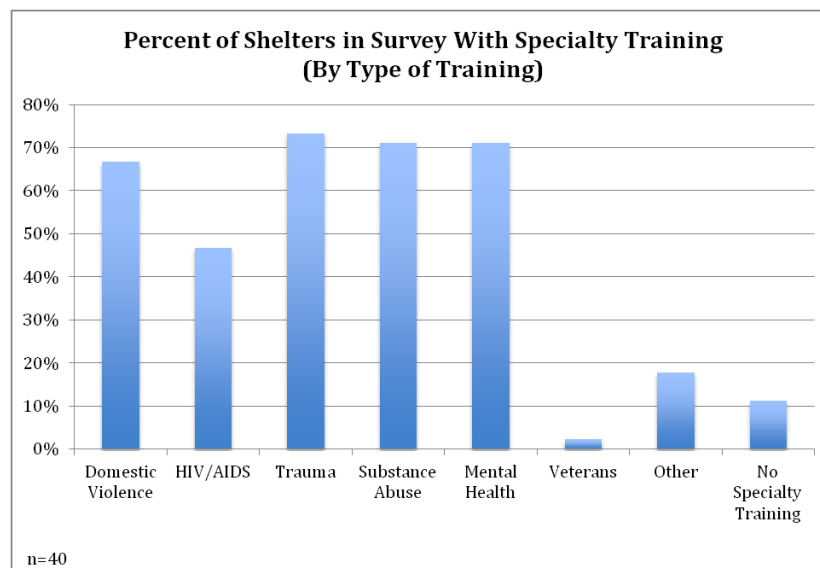
		Number	Congregate	Scattered	Co-Shelter
Very small	(≤20)	16	94%	19%	0%
Small	(21—50)	11	91%	36%	18%
Medium	(51—100)	8	75%	88%	75%
Large	(>100)	11	100%	82%	82%

Both the surveys and site visits were meant to gather data from all shelter models except motels. As the system currently stands, motels offer a limited amount of social services and are widely regarded as placements of last resort. The data collected from this project aims to understand service provision within non-motel shelter settings.

Services

Through these data collection methods, information was gathered about the number of social service staff, staff training, and the types of services provided to homeless families. As mentioned earlier, all emergency assistance shelters operate under a specific set of guidelines and with structured oversight from the Massachusetts Department of Housing and Community Development. Many services, including assessing a family's needs, developing a rehousing plan, providing case management, and referring families to needed services are all contract requirements for shelter providers. These new data aim to explore the specific types of services provided and the mode of service provision, with an emphasis on best practices and challenges.

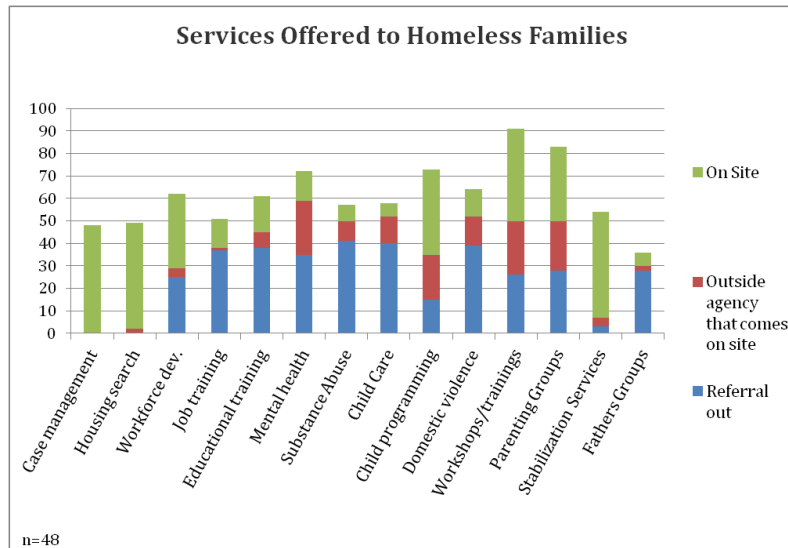
Across all survey sites, the average number of social service staff was 24, but as expected, the number of staff varied with the shelter size. About 63 percent of programs had clinical staff on site, although in most cases, it was only one or two staff members. The majority of on-site clinicians were either licensed social workers (LCSW, LICSW) or licensed mental health counselors (LMHC). Through interviews during site visits, the roles of clinical staff were detailed. In many cases, clinical staff take on supportive and advisory roles to the regular social service employees who have more interaction with families on a daily basis. This support is provided through regular team meetings. In other cases, clinical workers provide direct therapy to families in addition to providing staff support. For both sites with and without on-site clinical staff, it is also common for clinical services to be provided by referral or from an outside agency.



Staff at family shelters are also trained in a variety of specialized services. Roughly two-thirds of all shelter providers have some staff trained in domestic violence, trauma, substance abuse, and mental health service provision. Just under half of providers have training in HIV/AIDS service provision. Only one shelter had specialty training for serving veterans while several sites indicated other specialties such as parenting and nurturing, sexual exploitation, developmental disabilities, art therapy, and motivational interviewing. Eleven percent of sites indicated they had no specialty training.

Overall, the variety of training reported indicates that many shelters have tools to respond to multiple and varying needs of families. However, more research into the substance, depth, and usefulness of these trainings would be a valuable next step in assessing their true impact on service provision. Additionally, an examination of the frequency of training and procedures around training new staff would be salient, given that a significant amount of new shelter capacity, along with necessary staffing, has been added over the past year.

Like staff training, actual service provision reported by shelters covers a wide variety of areas, from general case management to child programming and workshops. The graph below summarizes the types of services available to homeless families as reported by survey-respondents. There is generally a wide variety in what services are offered as well as how services are provided. Services were available by direct provision on site, by an outside agency that came on site, by outside referral only, or by a combination of any of the three.



Predictably, general case management and housing search were almost exclusively provided directly by shelter staff. These constitute the core services provided to families in shelter and are expressly written into the scope of services required of DHCD-contracted family shelters. For the same reason, stabilization services for families that have moved out of shelter and into housing were also provided almost entirely by shelter staff. An array of other services including job search, mental health services, and child programming were provided by a mix of on-site staff, outside agencies, and referrals. Workforce development, child programming (such as activities and play space), workshops and parenting groups were all more likely than other services to be provided on site, either by shelter staff or an outside agency. Conversely, substance abuse services, childcare, educational training, and mental health services were all more likely to be referred out to other agencies.

During site visits, workshops and child programming were mentioned frequently. Workshops are provided on a variety of topics, including but not limited to housing search, budgeting, parenting, life skills, health issues, and contraception. Providers often described workshops as a way to engage families and attendance is often required. Child programming, such as providing activities and play space, was mentioned as important both for children and parents. Horizons for Homeless Children, a largely volunteer-run organization, comes on site to many shelters to help provide these services, especially while parents are engaged in workshops or other responsibilities.

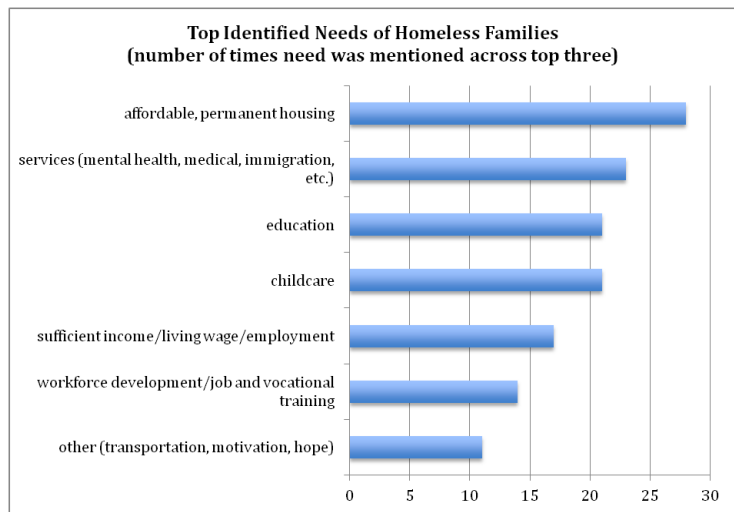
In addition to on-site services, community-based and off-site services were described as key resources for appropriately meeting the needs of families. Partnerships with other service agencies included educational institutions, early intervention agencies, religious organizations, childcare providers, financial institutions, and mental health and substance abuse providers. Partnerships varied based on the location of the shelter, availability of resources, and family needs. The term “partnerships” is used broadly in this context and may take the shape of formal partnerships or informal referrals, which were both used as techniques for accessing outside services. Overall, community resources were described as providing key services to meet many needs that cannot be fully addressed in an emergency shelter setting, including those related to health, mental health, child development, immigration, and employment. Yet at the same time, gaps in the availability of outside services also posed challenges. In western Massachusetts, the availability and reliability of public transportation posed problems for many families. In the Boston area, although rich with many health-related services, mental health and

substance abuse services were frequently mentioned as inadequate or difficult to access with long waiting lists. Childcare, immigration services, and a lack of affordable housing were also described as lacking across the state. An additional difficulty related to community-based services was the geographic placement of families. For example, if a homeless family had been placed in a shelter far from their community of origin, linking back with existing services and/or setting up new services was expressed as a real challenge.

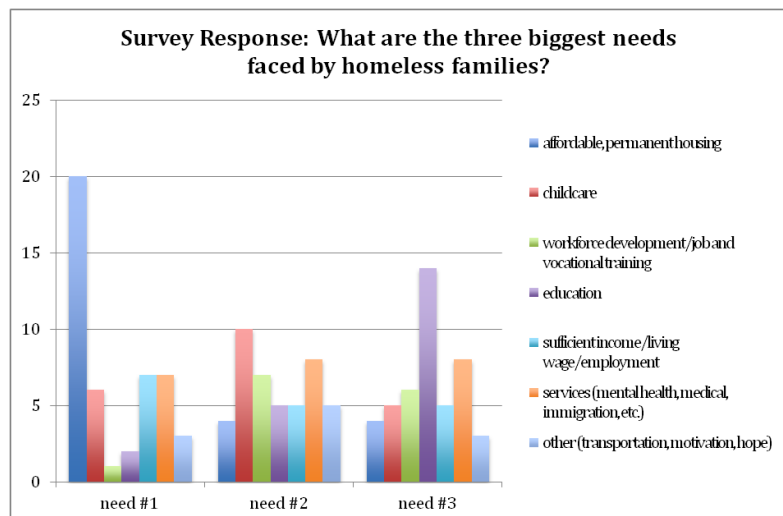
During site visits, many programs mentioned a service philosophy guided by a balance of rules (both state mandated and internal) and recognition of the benefits of flexibility and response to individual circumstances. Several sites mentioned they have their own internal rules on top of those required by the overseeing state agency. These may include mandatory attendance at workshops, helping with household chores, and requiring more frequent check-ins with staff. However, sites also frequently expressed overarching philosophies guided by flexibility and a strengths-based focus. These included supporting families in adapting to the myriad rules and structured environment of the shelter, a stated respect for families’ privacy, and providing multiple chances before issuing infractions (if such infractions were unrelated to immediate health and safety).

Family Needs and Barriers

Family shelter providers were also asked about their perceptions of the needs of homeless families. When asked to identify the top three needs in order, providers reported these as: housing, childcare, and education. However, when answers were examined across the top three (without respect to a needs hierarchy), the needs mentioned the most often were housing, social services, and tied for third: education and childcare. While social services did not make the top three needs, service provision was consistently the second most mentioned need in each category.



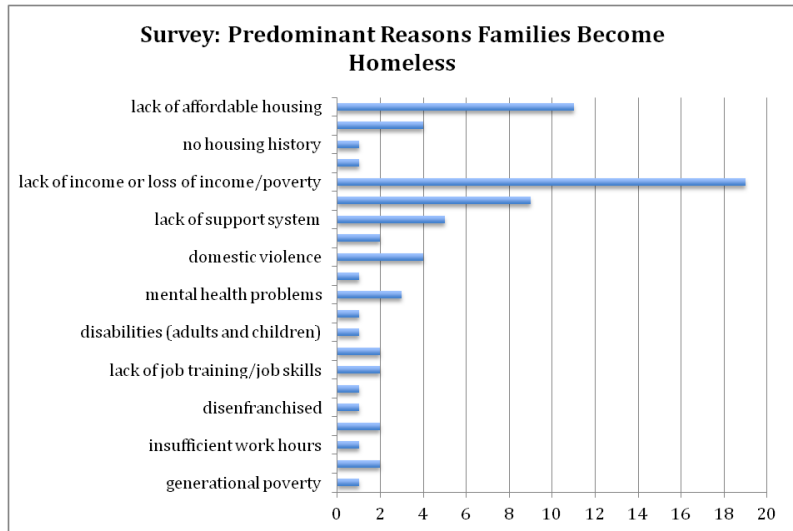
These results show that service needs are generally secondary when talking about the most crucial needs for homeless families, but are a constant underlying need to address specific challenges and barriers. In these responses, “services” were identified as mental health, medical, immigration, case management, debt reduction, parenting support/skills, financial literacy, legal services, and life skills. Nevertheless, the overall identified needs of homeless families centered on housing, with immediate secondary needs of education and childcare.



Aside from the immediate need of housing, the predominant theme of the other identified needs was economic stability. Taken together, education, workforce development, sufficient employment and childcare all facilitate economic independence. As seen in the chart above, these answers constituted a large portion of the responses to perceived needs.

More detailed discussions about family needs during site visits generally mirrored the survey results previously presented. The most commonly mentioned needs pointed to the systemic challenges of affordable housing, poverty, a lack of jobs, and a lack of childcare. But again, service needs also figured prominently. These included a lack of mental health and substance abuse services, non-profit job skills training providers, services geared to help young mothers, and immigration services.

In addition to identifying family needs, providers were also asked about the predominant reason families became homeless. The two most mentioned reasons were “lack of income or loss of income/poverty” and “lack of affordable housing.” In general, answers citing housing instability and poverty far surpassed other offered explanations.



Questions to providers about family needs highlighted some important themes. Notably, the needs identified as the most important for homeless families (housing, childcare, and education) are all largely outside of the scope of service provision within

the family shelter setting. Although many family shelter providers strive to meet these needs as best they can by providing child programming, intensive housing search, workshops and referrals to educational programming, the larger needs of affordable housing, consistent and affordable childcare, and educational attainment are all subject to other governmental agencies and decision makers, making partnerships and systems coordination all the more crucial. Nevertheless, shelter programs play an important role in both providing emergency services and linking families with available community-based services. Additionally, shelter providers have clear insights into the gaps in community-based services.

Non-Compliance

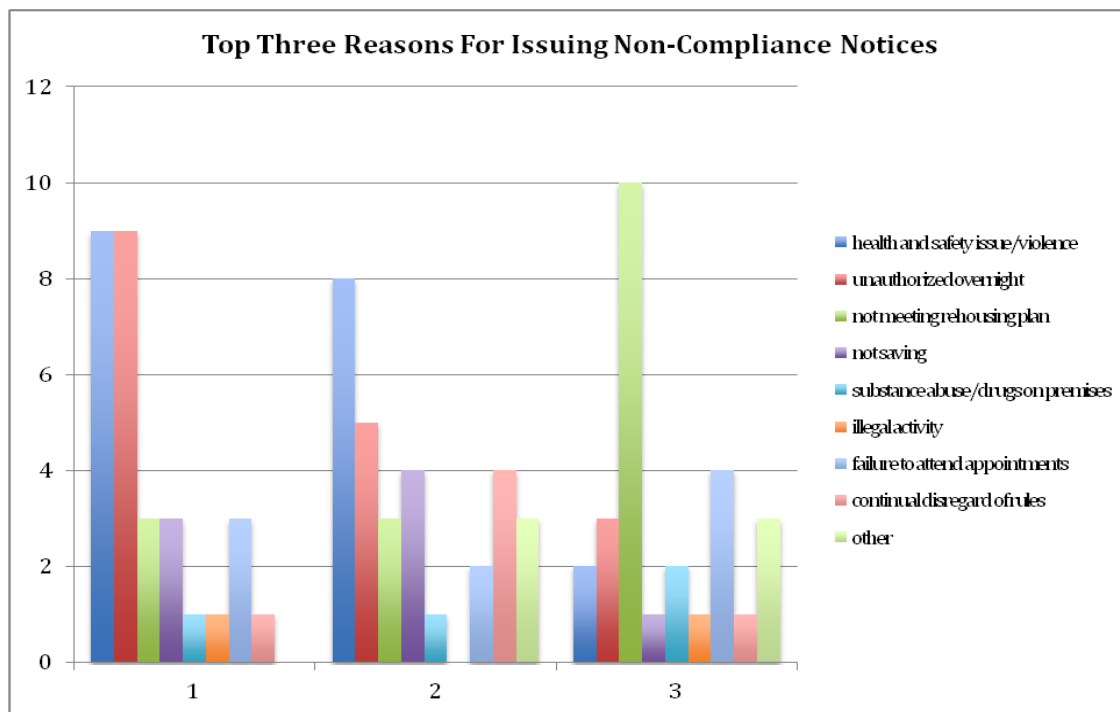
Although Massachusetts is a “right to shelter” state, families can still be terminated from their shelter placement for a variety of reasons. The process of terminating a shelter placement generally begins with the issue of a noncompliance notice. Understanding the extent to which noncompliance notices are issued, variations in the number of notices issued, and the reasons for noncompliance are all important for understanding how and why families may lose their shelter placement. This survey asked providers about the number of noncompliance notices they issued and the top reasons for issuing notices of non-compliance in an attempt to understand some of these issues.

Table 3: Number of Non-Compliance Notices Issued Within Past Year by Survey respondents (by Shelter Size)

		Average	Maximum at One Site	Total
Very Small	<20	5	25	54
Small	(21-50)	8	30	76
Medium	(51-100)	20	50	98
Large(>100)	17	50	134	362
Total		11	50	362

n=33

Overwhelmingly, health and safety violations and unauthorized overnights were the top two reasons for issuing non-compliance notices, followed by not meeting the rehousing plan (see graph below). However, the number of non-compliance notices varied greatly by shelter and did not seem to be tied to program size or other characteristics. For example, the range of noncompliance notices issued varied greatly even among shelters of the same size. The total number of non-compliance notices issued among shelters in the past year in this sample was 362. The large variation in the issuance of noncompliance notices may indicate service philosophy differences among shelters. Further examination into the characteristics of shelters that issued higher numbers of noncompliance notices would be an important next step in understanding the variation across sites.



Despite variations in the numbers, the reasons for issuing non-compliance notices largely matched discussions with shelter providers about flexibility. For some shelters, issuing non-compliance and termination notices is a last-resort tool, only given in response to serious safety issues or after multiple attempts to engage families. Moreover, during site visits, many providers expressed reservations about issuing them at all, noting that families would be worse off after being expelled from shelter.

Program Strengths & Challenges

Through site visits and open-ended survey responses, providers were asked about the specific strengths of their programs. These strengths can be categorized into those relating to services for families, relationships with families, and staffing structure.

Many sites pointed to “intense” and “comprehensive” case management as a key strength, including frequent contact with families, providing comprehensive housing search and employment specialists, and providing “empathetic” and “friendly” services. Providing holistic and wraparound services was also a key strength, with providers emphasizing the importance of linking individualized service provision with core services of housing search and case management. Partnerships with other organizations or other divisions of the shelter provider’s organization were often key parts of providing holistic and wraparound services.

Aside from service provision, building relationships with families also emerged as a common theme among shelter providers’ best practices. Taking the time to build trust and establish rapport with families constituted important practices for engaging and successfully helping families move out of shelter. Key to establishing trust and building relationships was creating a supportive environment, focusing on family strengths, and “getting to know a family” by spending time with them. Other successful practices included having formerly homeless families return to the shelter to speak with currently homeless families. However, building trust was acknowledged as a difficult task. Providers routinely acknowledged that families are going through a trauma, have likely experienced past traumas, are often young or new parents, and may be skeptical of the system. Providing consistency and allowing families to express frustrations and anger were some helpful strategies for moving through this process.

Lastly, staffing structure was also mentioned as a key strength. Particularly, collaboration among staff and strong, supportive leadership were key ingredients to successful staffing structures. Additionally, small shelter settings were noted as providing an “intimate setting that allows for maximum collaboration between staff and residents.” Finally, the perspective and attitudes of staff matter. One site noted that having staff that were formerly homeless helped with the process of assisting families, as did an attitude of empathy and valuing each individual. One provider noted that “every person has the ability to change and grow; every person is of value.”

Along with strengths, programmatic challenges were also expressed. Shelter models in particular posed some challenges, along with the balance between rules and flexibility. With co-sheltering, matching families to minimize conflict and safety issues was describe as difficult and sometimes not possible. Particularly, placing a family with a male head or partner along with a female-headed family posed concerns among residents and staff regarding safety and comfort. Some providers indicated they spent extra time trying to match families based on personality, but shelter capacity issues and family size sometimes prohibited thoughtful matching. Nevertheless, one provider did indicate the positive aspects of co-sheltering, including providing extra support for young families and opportunities for exiting together into shared permanent housing. Other providers also expressed a desire to utilize shelter models along a continuum, with more service intensive models (congregate shelters) reserved for those with greater needs and less service intensive models (scattered site) targeted to more independent families. But again, capacity issues and state mandates prohibited the ability of providers to utilize this process to its fullest extent. Moreover, only providers that operated more than one shelter model have the ability to make these types of assessed transfers.

Striking a balance between flexibility and adherence to myriad rules and regulations was a continual theme expressed by shelter providers, with most providers preferring a service model based on flexibility and individualized service provision, as noted in the example of the shelter model continuum. Across the board, providers recognized that no two families’ needs are the same and individualized service plans should reflect unique circumstances.

Multiple providers expressed a desire for families to play a bigger role in the development of their own re-housing plan, facilitating both empowerment and apt service provision.

Striking a balance between flexibility and adherence to myriad rules and regulations was a continual theme expressed by shelter providers, with most providers preferring a service model based on flexibility and individualized service provision, as noted in the example of the shelter model continuum. Across the board, providers recognized that no two families' needs are the same and individualized service plans should reflect unique circumstances. Multiple providers expressed a desire for families to play a bigger role in the development of their own re-housing plan, facilitating both empowerment and apt service provision.

Exits and Housing Opportunities

In the surveys, providers were asked how many families from their programs exited shelter over the past year and what types of assistance they received. Collecting accurate exit data has been an ongoing challenge for the Department of Housing and Community Development but data quality improvement has been a priority over the past year. More comprehensive and accurate exit data will be made available for fiscal year 2015 through dedicated funding for data collection and submission. Similarly, data quality on exits reported in the Homes for Families survey is not optimal and includes a substantial amount of missing data. Nevertheless, some discussion of the available DHCD data and the survey responses is presented here in order to gain some sense of how families are moving out of homelessness and where opportunities for improvement and action may lie.

According to DHCD, in fiscal year 2014, 5,518 families exited shelter. Families exited under a variety of programs, but the largest number exited with HomeBASE assistance, flexible cash assistance up to \$6,000 (with the option of an additional \$2,000 through the Housing and Stabilization Trust Fund). In 2014, 37 percent of families exited with HomeBASE. An additional 16 percent of families exited under the Massachusetts Rental Voucher Program (MRVP), a state run permanent rental subsidy. However, some families exiting with MRVP or to other programs and market rate housing may also have received some HomeBASE assistance to cover moving costs.

In this survey, several providers did not report information about exits. Consequently, a total of 1,383 exits were reported for fiscal year 2014, accounting for only a quarter of total exits reported by DHCD. However, the type of exits mirrored those in the full reported data as well as yielding some additional information. HomeBASE and MRVP exits were still the most common type of exits, although both were reported at higher rates than the official DHCD data. Market rate housing was the next most common exit. Public housing and other permanent housing subsidies (apart from MRVPs) accounted for only 16 percent of all reported exits. Nearly 12 percent of families exited to unknown circumstances.

Table 4: Number and Type of Exits as Reported by Survey Data
(Fiscal Year 2014)

	Total Number of Exits Across Programs	Percentage
MRVP	372	26.9%
Public Housing	137	9.9%
Other Permanent Subsidized	89	6.4%
HomeBASE Household Assistance	670	48.4%
Other Short Term Assistance	51	3.7%
Market Rate Housing	212	15.3%
Shared Housing	38	2.7%
Tax Credit	0	0
Other	142	10.3%
<i>Terminated from Program</i>	66	4.8%
Unknown	164	11.9%
Total Exits Reported	1383	

n=31

Note: Percentages add up to more than 100% because some families utilize HomeBASE assistance in addition to exiting under another category

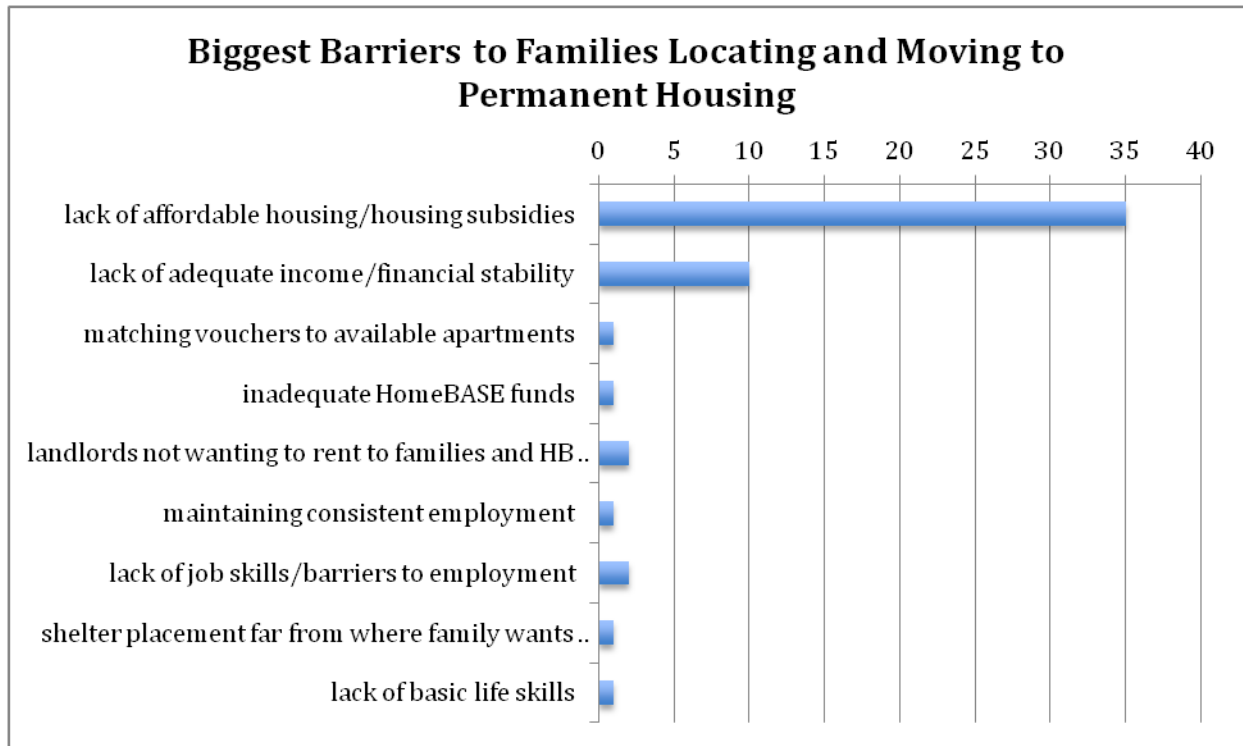
A preliminary analysis of official DHCD data from the first three months of fiscal year 2015 shows significant changes in the breakdown of family shelter exits from the previous year. MRVP vouchers accounted for just 3 percent of all exits between December 2014 and February 2015. Public housing and Section 8 accounted for 14 percent of exits, while Boston Housing Authority “Leading the Way Home” vouchers accounted for an additional 14 percent of exits. In total, subsidized exits accounted for 34 percent of exits, with HomeBase assistance used alone (i.e. not in conjunction with other assistance) accounted for 36 percent of exits. An additional 29 percent of families exited to unknown or unsubsidized housing. These differences reflect some key changes in policy made between 2014 and 2015. In 2014, the Department of Housing and Community Development created a distribution plan for MRVP vouchers that included specific targeting to homeless families. The 2015 MRVP plan specifically excludes any targeting to homeless families. These data highlight the importance of affordable housing programs in helping homeless families move out of shelter and into permanent housing as well as the importance of policies that allow families to access programs. Both availability and access should be key points in future discussions on creating affordable housing opportunities for homeless families.

Table 5: Preliminary DHCD Data on FY2015 Exits

(Dec 2014–Feb 2015)

	Number of Exits	Percentage
MRVP	21	2.9%
Public Housing	40	5.5%
Section 8	60	8.2%
BHA Vouchers (Leading Way Home)	100	13.7%
Private Subsidized	30	4.1%
HomeBASE Only	260	35.5%
Unknown/No Subsidy	212	29.0%
ESG	9	1.2%
Total	732	100%

In the survey, providers were also asked about the biggest barriers to families locating and moving to permanent housing. Predictably, the predominant answer was a “lack of affordable housing and housing subsidies.” In identifying what families need to get back on their feet, finding adequate, affordable housing was the overwhelmingly identified as the largest barrier, again highlighting the need for greater emphasize on availability and access.



SECTION 3

Conclusion: Promising Practices and Recommendations

Promising Practices

This report has highlighted some important characteristics of the family shelter system in Massachusetts, including methods of service provision, needs of families, and programmatic strengths and challenges. Moving forward with the goal of ending family homelessness, some recommendations for promising shelter-based practices can be made in addition to larger programmatic and systemic changes.

Promising shelter-based practices include a focus on strong, individually tailored services, building relationships with families, effective staffing, and strong partnerships with community organizations. As highlighted in the section on program strengths and challenges, providing empathetic and holistic services to families in shelter was a key self-identified strength of many programs. Moreover, the best way this could be achieved was by taking time to connect with and get to know families, building trust between staff and families, promoting staff collaboration, and developing relationships with community-based organizations and agency partners.

Recommendations for Programmatic and Systemic Change

In addition to highlighting promising practices, some important challenges and opportunities for improvement have been identified as a result of the survey data and conversations with providers. These can be categorized into those that are programmatic (within the current scope of the emergency shelter system) and those that are systemic (outside of the scope or larger in scale).

Some key identified programmatic recommendations include:

- Balancing rules and service flexibility
- Maintaining a safe and effective co-sheltering model
- Continued focus on data collection and improving data quality

As mentioned earlier, many providers expressed a desire for more flexibility and individually focused service provision, recognizing that family needs varied. Some families need very little support, while others cycle in and out of shelter or are involved in other service systems. Being able to effectively respond to the differing needs of families was a key desire expressed by providers. Some examples of flexible service provision not currently allowed by state rules included more comprehensive assessment of service needs, focusing on breaking the cycle of poverty with interventions focused on children, giving families a greater say in their re-housing and service plan, and creating flexible funds to be targeted based on need. Additionally, some providers expressed the desire to be able to triage and transfer families among different shelter models based on assessed needs, a practice that is not currently allowed due to capacity issues and the priority need to transfer families in motels with ADA accommodation requests.

Programmatic challenges relating to shelter models were also expressed, particularly with the newest model of co-sheltering. Many providers identified this model as posing unique challenges with respect to safety and conflict and requiring more intensive assessment for placing families.

However, proper assessments often cannot be made because of capacity issues and because shelters must fill any vacancies they have with families placed by the state. Despite these barriers to assessment, an important mediating factor in the operation of co-shelters was the structure of the shelter itself,

specifically having 24-hour staffing which allows co-shelters to be run more like congregates.

A final theme that came up during site visits involved the process of data collection and follow up. Providers felt they had strict and comprehensive requirements for data collection, but did not see any follow up or useful analysis of the data. Additionally, the quality of data collected could be improved in several areas, including housing resources and exits. This has been a priority for DHCD over the past year and continued efforts to improve and strengthen data should remain an important goal.

Larger, systemic-level recommendations to reduce and prevent homelessness aimed to address the top identified needs of families and included:

- Increasing the amount of affordable housing with more subsidies and better targeting
- Addressing poverty and its generational effects
- Reducing cliff effects of certain benefits, including childcare and healthcare
- Improving access to shelter
- Preventing homelessness
- Filling gaps in community resources and partners

Without question, the largest barrier to housing stability for families in Massachusetts is the lack of affordable housing. The stock of affordable housing in Massachusetts has consistently declined over several decades (Citizens' Housing and Planning Association, 2015). Combined with stagnating incomes, fewer and fewer low-income families are able to afford sufficient housing. This major gap was the most commonly mentioned challenge in serving families. Important remedies for addressing the need for affordable housing include increasing housing subsidies and better targeting subsidies specifically to homeless families in shelter. As highlighted in the exit data, housing subsidies play a crucial role in helping families move out of shelter but vary considerably in their availability. Additionally, the lack of federal housing resources, such as public housing and Section 8 are glaring inadequacies in the shelter exit data. Increases in state investments and advocacy for greater federal investments are both key strategies for increasing affordable housing resources.

Hand-in-hand with affordable housing is the larger issue of poverty in the state. The most recent census data show that one in six children in the state are living in poverty (Johnston, 2014). The combination of low wages, expensive housing and childcare, and eroding economic supports have all contributed to increases in poverty across the state (Citizens' Housing and Planning Association, 2015). Multiple providers mentioned the importance of addressing poverty in the quest to solve homelessness, particularly the generational impacts of poverty on children. Additionally, providers also expressed frustration at the cliff effects families routinely encounter as they work to increase their incomes. For example, as families gain employment and incrementally increase their incomes, they often lose critical benefits for maintaining self-sufficiency, including healthcare and childcare benefits. Addressing cliff effects and creating programs that allow families to build their way out of poverty is a crucial part of any effective anti-poverty agenda.

Although shelter providers are generally not involved in the process of shelter applications and eligibility decisions, many are keenly aware of the barriers for homeless families in gaining access to shelter. Multiple shelter programs noted they get multiple calls per day or per week from families that were found ineligible for shelter and have no alternative options. Yet, they are unable to assist these families and as a result, providers expressed real concerns about the eligibility process and a desire for a more compassionate and realistic application process for homeless families. Several providers also noted the importance of prevention and described current efforts as inadequate. As noted above, diversion assistance offered at the front door of the shelter system has become more common, but family outcomes remain unknown. Providers identified a need for prevention that kept families in their current homes as opposed to shelter diversion after families have already lost their homes.

Lastly, shelter providers often rely on the availability of community resources and services to meet the myriad needs of families. Major gaps in community-based services pose a challenge to providing holistic services and keeping families linked with their home communities. These gaps include limited availability of transportation (particularly outside of Boston), a lack of mental health and substance abuse services, a lack of employment and immigration services, and a lack of affordable childcare.

All in all, these systemic challenges are critical to addressing family homelessness and must be linked with more specific programmatic changes in order to begin to address the endemic problem of family homelessness in Massachusetts. Aside from providing a detailed picture of the family shelter system in Massachusetts, this report has highlighted some other important lessons.

First, the provider community in the state is extensive, experienced, and possesses a key range of knowledge from working intensively with homeless families. The provider community at large should be a key partner in determining changes and improvements to the current service system and establishing recommendations for truly addressing family homelessness.

Second, this report highlights and acknowledges opportunities for further research, including more detailed analyses of training practices, a deeper examination of variations in eligibility across the state, and more in depth analyses of outcomes by program model. Additionally, while this report focused mainly on service provision and needs of homeless adults in families, a focus on child assessments, needs, and interventions is one that deserves more attention, specifically because most homeless children are either pre-school or school aged. Finally, an examination of the needs and recommendations from the perspective of homeless families is a crucial next step. This is currently being undertaken by the second phase of the Homes for Families project and will be an important addition to the mission to end family homelessness.

Note on Data Sources and Qualitative Analysis

Many data sources were used in this project. Historical census and numerical data were obtained from DHCD and archived data at Homes for Families. Data on the background and workings of the shelter system were compiled from conversations with DHCD contract managers, conversations with Homes For Families staff, conversations with service providers, and from government documents. Qualitative data from site visits were coded for themes and analyzed using ATLAS.ti software.

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