

**DHCD - EA Listening Sessions Summary**

*Below is a summary of the 5 Regional Listening Sessions with EA Leadership; items in bold are issues that were raised in 3 or more of the sessions. The summary also includes relative input from additional sessions with direct service staff, advocates, and parents.*

**Common Themes**

1. **Funding**
   * **Need to pay staff a living wage**
   * **Rates/staffing ratios must reflect family size**
   * Establish regular rates reviews - need to factor in cost of living and rent increases, impact of comfort animals, insurance and other costs, such as transportation, maintenance
   * Need for 12 month contracts for agency stability and to prevent delays in payment
   * Funding should cover full scope of services

* *The issue of low wages was also raised in the sessions with direct service staff and advocates. The impact on law wages for their own stability and morale was highlighted*

1. **Intake and Assessment**
   * **More thorough assessments at the front door and triaging for placements**
   * **Sharing of information at intake and transfers** so families don’t need to re-tell their stories and resubmit documents and so shelters are better prepared to provide appropriate services and supports; especially around issues of domestic violence; ensure quality control of data collected at application
   * More regional/program coordination around placement could ease the pressure on the department?
   * More use of congregates as entry points for ongoing assessment and transferring to scattered sites or co-shelter
   * Clinical support for assessments, especially during crisis
   * Use of assessment tools to link families with appropriate services
   * Can allow more targeted services and supports
   * Work experience/employment must be a consideration for placement and a focus of assessment
   * Assessments should also happen when families exit, to determine stabilization services, risk level, etc

* *Direct service staff also highlighted the need to include children in assessment and emphasized the impact that child trauma has on parents’ ability to engage in activities to advance their housing stability and economic mobility*
* *Legal advocates talked about assessment in terms of medical and employment needs*
* *Parents reinforced that it would be helpful if staff knew they basics of their situation so they don’t have to tell their story over and over*

1. **The Shelter Workforce**
   * **Training**
   * Lower caseloads/increased staffing
   * Need funded staffing requirements around key issues: domestic violence, substance abuse, mental health
   * DHCD should provide more resources and supports regarding housing search, communication of new developments, lotteries, etc.

* *Direct service staff stressed the need for training and shared that DMH trainings have been helpful; they shared that staffing shortages and turnover make it hard for self care. “It is hard to engage and empower when we are demoralized”*
* *Advocates reinforced the need for training; acknowledging that there is a wide variance in skills and support, and that a lot of staff are overworked and would benefit from more training; they pointed to the DPH procurement for DV programs relative to addressing racial diversity and cultural competency in the workforce*
* *Parents**also recognized the range in staff capacity and how the pace of a staff person can set them back or help them engage*

1. **Integration of services**
   * Need **for clinical support** for staff supervision and direct work with families
   * **Services should include employment services/career development**
   * **More focus on children**
   * Some agencies subcontract with behavioral health specialists for staff supervision, crisis intervention, and other challenges
   * Should prioritize continuity of care with community based supports
   * Can require on-site care or MOU’s
   * Pendulum swings from service focus to housing focus; need both
   * Relationship to Family Resource Centers, parent resources

* *Direct service staff suggested more formalized partnerships between DHCD and service programs, especially job training, so that there could be an accredited program list, accountability, and a common understanding about family homelessness*
* *Parents* highlighted the importance of getting linked to appropriate community resources and supports – for their children and their own health/mental health, ESL classes, and education programs

1. **Capacity Issues**
   * Need for capital funding
   * Demand in Boston impacts entire system; what city/state owned stock could be available in Boston?

* *Advocates raised need to operate system below capacity to allow for more triaging, local placements, and faster responses to safety issues; they suggested data be used to determine where units are needed*
* *Parents shared their negative experiences being placed far away from their community of choice and in motels in poor conditions*

1. **HomeBASE**
   * **If HomeBASE continues as a primary tool for re-housing, it has to be re-structured and be tied to much deeper stabilization, more time, and more targeted**
   * Services should extend beyond the subsidy
   * Families in HomeBASE should retain homelessness status

* *Advocates stated that HomeBASE does not make sense for all families, and is especially risky for single parents and persons with disabilities. Evictions after HomeBASE create additional barriers and trauma*
* *Parents shared their fear about taking HomeBASE and the economic challenge of being able to afford rent after the assistance ends. “As mothers, the most important thing we want for our children is stability. Shelter feels more stable than HomeBASE. Taking HomeBASE is like choosing crisis.”*

1. **Stabilization**
   * Need better assessment and tracking
   * Mechanisms for extending stabilization services
   * Stabilization should include in person meetings and home visits
   * Discretionary/flexible funding
   * Utilize assessments and tiered service provisions
   * Stabilization services should follow the family if they move out of the region, but need support to build the relationship between families and the new provider

* *Direct service staff agreed that stabilization should be a focus of the procurement and services should be ramped up; they mentioned that families that returned to the system after HomeBASE are afraid to use it again and that there needs to be an increase in stabilization services for families in HomeBASE; they also highlighted that the transition from not paying rent for a long stay to suddenly being responsible for rent and bills is a big adjustment*
* *Parents* *were supportive of the concept of stabilization, primarily interested in assistance as they transition out of shelter into their homes, rather than long term assistance. In person visits were the preferred format, depending on work and other variables. The inconsistency of stabilization services was highlighted*

1. Program Components
   * Fully fund and implemented prevention and diversion
   * **Employment services**
   * **Child-centered services**
   * **Clinical services**
   * Flexible funding for incentives, addressing barriers, and stabilization
2. Program Outcomes
   * Need a mix of quantitative and qualitative measures
   * More tracking of employment, income, education, custody, housing stability, school
   * Outcomes should be looked at by model
   * Have more realistic placement goals
   * **Need a longer term look at outcomes/stabilization**
   * Individualized goals

* *Direct service staff also mentioned the need for realistic placement goals*

1. **DHCD Oversight/Provider Authority**

* DTA staff used to come on site to manage components of the self sufficiency plan, some presence of DHCD would help to have same messaging
* There is less autonomy for providers; providers have a decreased authority to keep their program’s safe
* The Intensive Case Management model with motels can be helpful. It was helpful when there were resources/MRVP, otherwise it can feel duplicative and time consuming
* More involvement of DHCD in the role of “the heavy” while providers can focus on being more collaborative
* The role of Contract Managers is seen as a positive
* Some of the rules should be reviewed and revised, including around overnights
* *Direct service staff also mentioned feeling that shelters’ hands are tied and the need for improved and augmented relationships with DHCD and the need respond quickly to violent and risky behavior in a congregate shelter*
* *Advocates suggested that shelters have more discretion to give TESI (temporary shelter interruptions)*

1. **Challenges with Landlords**

* **Landlords no longer want to take HomeBASE**
* The short term nature of HomeBASE has burned a lot of landlords
* Landlords can get more money in the rental market than to lease with a voucher or as a scattered site

1. Other Needs/Barriers:
   * **Transportation**
   * **Child Care**
   * English classes
2. Program Models
   * There is a need for a variety of models and an ability to transfer
   * Some co-shelter can work, but needs appropriate staffing and should be triaged and not placing strangers together
   * Owning works better than leasing

* *Direct service staff raised the issue of the quality of unit*
* *Advocates raised concerns about triggers to PTSD in congregate settings, especially around domestic violence*

**Other System and Policy Issues**

* Need for liaisons at other state agencies (especially DCF)
* **Housing Stock – the coordination and implementation of a true housing response needs to come from DHCD**
  + Need housing development for 4 and 5 bedroom units
  + Increase the stock of supportive housing
  + More targeted us of MRVP vouchers
  + Landlord relationships and accountability
  + Capital funding for shelter space, converting to permanent housing
  + Assistance in identifying and rehabbing buildings such as old nursing homes, city/state owned properties
  + General leadership on: public education about the issue, zoning laws, court data base issues, common applications
* *Advocates highlighted the need for centralized systems of application, reduced barriers to access public housing, and the augmented role of DHCD to support housing search*
* Changes to eligibility criteria and consideration of different criterion for diversion, shelter, and stabilization
* Economic mobility initiatives to support people to move out of public housing and return subsidies
* More coordination with MassHealth and for medical providers to accept MassHealth; support from the behavioral health community for supports for families without legal status
* DMH should have a lower threshold for families and have family housing programs
* Change should be gradual and build on things that work
* More coordination and communication with the legal community

**Practice Issues**

* Development of more differential responses and expertise, especially with young parents
* Look at models of service and re-housing used in natural disasters

**Ideas for Pilots/New Initiatives/Bringing Back Old Initiatives**

* Rolling stock
* Improved data systems – universal intakes, drop downs for details and referrals
* More peer to peer learning across shelter programs
* Workforce development programming
* Vouchers targeted to working families

**Areas of difference**

* Assessment Centers vs. 10/30/60/90 day Assessment Periods within programs
* Family acuity – some regions/providers reported an increase in mental health issues, substance use and increased barriers; others reported less of a shift in the population but a reflection of the lack of resources, the longer lengths of stay, a more challenging economic climate and the political climate that can exacerbate fears and augment trauma
* EOHHS Role– some groups pushed that the focus should be on the connecting the EA system with DHCD programs so a true housing response and less integrated with EOHHS. Suggestions for EOHHS involvement included homelessness liaisons at the distinct agencies, in stabilization, for staff training, and increased accountability for EOHHS clients facing housing instability. Other groups suggested EOHHS integration should include: more case coordination, DMH/DCF/DPH services in shelters