An Interim Evaluation of the Massachusetts Homelessness Prevention and Rapid Re-Housing Program
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Abstract

In 2009, the Massachusetts Department of Housing and Community Development (DHCD) received $18.4 million from the federal Department of Housing and Urban Development (HUD) to begin implementation of the Homelessness Prevention and Rapid Re-Housing Program (HPRP) under the American Recovery and Reinvestment Act. This program is targeted to provide assistance to families and individuals who are currently experiencing homelessness, or who are on the brink of homelessness.

After completing the HPRP’s first year of implementation, DHCD sought to perform an interim evaluation of the program. This report details the results from the evaluation, including detailed analyses from interviews with grantee agency providers, and a cost effectiveness analysis. Additionally, the report provides recommendations for improvement for the remainder of the program, and for future prevention-based programs. We recognize that some wide-spread policy changes are not likely to be within the power of DHCD or other state agencies, but rather reflect the larger political climate and funding scarcity.

The need to provide a range of social services (such as housing assistance, health care, mental health services, childcare, transportation assistance, education, and job training) in addition to financial assistance emerged as the primary theme of this interim evaluation. Our findings conclude that such wrap-around services are critical to ensuring housing stability for families. The interagency collaboration that will thus be required to break down current disciplinary silos may be formidable, but is paramount to ultimately eliminating homelessness in Massachusetts.
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Executive Summary

Policies aimed at eliminating homelessness have recently experienced a sea change in the United States. Federal and state governments have shifted from focusing exclusively on an emergency shelter system, to including a broader range of prevention-based services. The Housing First model is one approach that prioritizes housing stabilization for families and individuals that are at risk of becoming homeless. It is designed to help homeless individuals, and individuals at-risk of homelessness, transition more rapidly out of the shelter system or prevent them from entering shelters in the first place.

In 2009, the state of Massachusetts Department of Housing and Community Development (DHCD) received $18.4 million from the federal Department of Housing and Urban Development (HUD) to begin implementation of the Homelessness Prevention and Rapid Re-Housing Program (HPRP) under the American Recovery and Reinvestment Act. This program is targeted to provide assistance to families and individuals who are currently experiencing homelessness, or who are on the brink of homelessness. This is particularly relevant for Massachusetts, as approximately 27% of all Commonwealth households are considered “shelter poor,” or that the household cannot meet a minimum standard of non-housing requirements—such as food, medical care, transportation, and clothing—after covering housing costs (Stone 2006).

After completing the HPRP’s first year of implementation, DHCD sought to perform an interim evaluation of the program. This report details the results from the evaluation, including detailed analyses from interviews with grantee agency providers, and a cost
effectiveness analysis. Additionally, the report provides recommendations for improvement for the remainder of the program, and for future prevention-based programs.

Evaluation Findings

Activity

Twenty agencies have been contracted by DHCD to provide homeless prevention and rapid re-housing services (Figure 1). Twelve of these agencies specifically provide eviction prevention and diversion services to families, which is the focus of our evaluation. In total, 633 families have received services in the first year (Table 6). Of all financial assistance provided to families, rental assistance and rental and utility arrearages are provided most frequently (Figure 2). Families also receive housing relocation and stabilization services, primarily consisting of case management and outreach services (Figure 3).

Capacity

Participation in the HPRP has allowed many grantee agencies to expand their client caseload, or increase staff size. Additionally, some agencies have improved internal administration from adopting streamlined client eligibility standards set by the program. Conversely, client income eligibility requirements established by HUD have limited provider ability to serve a range of client populations. Almost unanimously, all providers cited a need for more funding and increased staffing.

Impact

The HPRP’s greatest impact is seen by tracking client outcomes. Of the families that received prevention and diversion services and exited the program, 76% exited into permanent housing (Figure 4). Two percent exited into an emergency shelter. Despite these encouraging statistics, a general sentiment among providers was that providing financial assistance alone was not enough to
ensure housing stability. Successful client outcomes relies on a combination of financial assistance, health care, mental health services, transportation assistance, childcare, education, and job training.

**Recommendations**

The following recommendations are based on the research team’s findings, including the quantitative and qualitative data analyses presented throughout this report. These recommendations represent course corrections that may be implemented in the short term, as well as longer-term adjustments that may be more useful to future programming implemented by DHCD through grantee agencies around the state. The recommendations may also provide guidance for other states that are considering adoption of a homelessness prevention program model.

1. Measure the frequency of client repetition
2. Expand client eligibility criteria
3. Increase funding flexibility
4. Increase support for administrative requirements
5. Plan for increased demand.

The need to provide a range of social services in addition to financial assistance emerged as the primary theme of this interim evaluation. Our findings conclude that such wrap-around services are critical to ensuring housing stability for families. The interagency collaboration that will thus be required to break down current disciplinary silos may be formidable, but is paramount to ultimately eliminating homelessness in Massachusetts.
Federal and state governments have employed various approaches to ending homelessness in the past several decades, ranging from emergency shelters to mental health interventions to housing subsidies. Programs have experienced a widely varying degree of success, though opinions vary broadly and relatively few data exist to paint an accurate picture of the long-term impacts of anti-homelessness efforts.

Housing First is an approach to ending homelessness that was pioneered in New York City in the early 1990s, and has since been implemented in a variety of ways by a number of community-based organizations and other entities around the country. Housing First programs share the common goal of rapidly re-housing homeless individuals and families into permanent housing. Most Housing First programs provide home-based case management services after families have been re-housed to help them maintain their housing and become better connected to mainstream services that can help to stabilize and sustain them. Over the past decade, Housing First has gained ground as an advantageous approach in Massachusetts and around the country.

In 2009, the Commonwealth of Massachusetts received funding from the federal Homelessness Prevention and Rapid Re-housing Program (HPRP) to combat homelessness statewide. The Commonwealth was already employing the Housing First approach with state-run prevention-
based, housing pilot programs, in partnership with local housing authorities and other social service agencies. HPRP funding further encourages this approach as well as expands and changes services available to both homeless individuals and families.

Evaluation of the program at its mid-point provides an opportunity to learn and share the most successful program components as well as implement any necessary and possible course corrections. Program monitoring and evaluation are essential tools for learning, improving programs, and developing better policies, hopefully resulting in more robust and effective program design and implementation.

The Massachusetts Department of Housing and Community Development (DHCD), which manages the Commonwealth’s HPRP funding, requested this interim evaluation of its family eviction prevention and homelessness diversion programs. DHCD’s goal is to better understand program execution and impacts at the local agency level while there is still opportunity for improvement, as well as enhance learning that may improve future funding and programming decisions. The following report outlines our findings based on a review of the literature regarding homelessness prevention policies and programs nationally and statewide, a financial review and cost analysis of such programs, and conversations with case managers and other agency staff. We employ a three-part evaluation framework to examine the activities, capacity and impacts of the Commonwealth’s HPRP programs based on those interviews and other data sources. We hypothesize that the financial cost to the state is lower for prevention-based programs such as HPRP that allow clients to remain in stabilized housing than for shelter services to families that have been evicted or lost housing. This hypothesis is based on previous financial studies of homelessness prevention programs and on studies of the additional costs (health care, mental health services, etc.) associated with maintaining a responsible emergency shelter system. Finally, we offer recommendations based on our findings, which we hope will be useful to DHCD, its grantee agencies and other interested parties during the second half of this HPRP funding period and into the future as they engage with the great challenges of ending homelessness in the Commonwealth.
Chapter 2: Methodology

This report provides a comprehensive overview of the current status of HPRP in Massachusetts, including program outcomes and the degree of its implementation success. An evaluation framework was adopted to assess three components of the program: activity, capacity, and impact, guiding the creation of our evaluation criteria. An overview of the report’s data sources and analysis are discussed, as well as the study’s limitations and scope.

The current evaluation covers the first 14 months of HPRP implementation in the Commonwealth, from October 2009 through December 2010. Of the 20 agencies across the state contracted by DHCD for HPRP programming, 12 provide eviction prevention and diversion services to families, and eight provide eviction prevention and diversion services to individuals, or provide rapid re-housing services (Figure 1). We focus specifically on the agencies that have been contracted by DHCD to provide homelessness prevention and diversion services to families. We believe an evaluation of other homeless prevention and diversion programs, such as those aimed at individuals, to be equally important; such programs, however, were beyond the scope of this study.
Evaluation Framework

Our evaluation of the HPRP program is based on an analytic framework developed by Sawhill and Williamson (2001), titled the “Family of Measures Models.” We used this framework as a foundation for our investigation and developed evaluation criteria based on its three program components: activity, capacity, and impact, described in more detail in Box 2. The model provides a clear description of how success can be defined for each

Figure 1. Twenty agencies are contracted under the Massachusetts Homelessness Prevention and Rapid Re-Housing Program to serve families and individuals at-risk of homelessness. This evaluation focuses exclusively on the 12 agencies that provide eviction prevention and diversion services to families (highlighted in red). Stars represent agency locations, but provider agencies often serve families outside the city limits. Cartographer: Blake Roberts 2011, data from MassGIS and DHCD.
program component, and emphasizes that each aspect of
the program should not be analyzed individually, but in
relation to the broader unifying goal—in this case, the goal
of preventing homelessness. It thereby “reinforces the
essential linkage between mission, goals, strategies, and
programs” (p. 375).

This model was suited particularly well to our
evaluation because it emphasizes process and does not
exclusively assess outcomes. This is exceptionally
important for an interim program evaluation, which
creates the opportunity to concurrently modify and
improve the program’s implementation. While long-term
outcomes and impact are still important considerations,
the framework also evaluates processes, resources and
strategies.

**HPRP Evaluation Criteria**

This three-pronged approach led us to defining
evaluation criteria for program activity, capacity, and
impact (Table 1). Each criterion aims to inform the
overarching question of program accomplishment by
identifying specific and measureable aspects of HPRP
programming. This framework provided a roadmap for the
study’s design by connecting data collection and research
to the three evaluation components. Data gathering was
based primarily on open-ended interviews with DHCD
grantee agencies, based on the following set of questions
in each category:

**Activity**

◊ What services are provided to program clients and how
  often?

◊ What services are in greatest demand?

◊ How many families are served each month?
<table>
<thead>
<tr>
<th>Program Activity</th>
<th>Program Capacity</th>
<th>Program Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identifies the processes that occur. It paints a picture of what actually transpires under the program design. An evaluation of activity provides an overview of what the program looks like, who is involved, and what role key actors play.</td>
<td>Explores the degree to which agencies are able to implement program activity. It identifies the resources and strategies that are needed for successful implementation, challenges to carrying out goals and tactics to reach goals.</td>
<td>Identifies the program’s outcomes. It determines whether goals are being met, and the degree to which the original mission has been accomplished.</td>
</tr>
</tbody>
</table>

**Table 1. Overview of the evaluation framework’s three components.**

◊ How long do case managers spend with each family?

◊ How many times do they meet with families each month?

◊ How does agency staff reach out to, or recruit program clients?

◊ What resources are needed to meet goals?

◊ How cost effective is the program?

◊ What challenges have grantee agencies faced in program implementation?
  Is the agency able to meet client demand?

◊ What types of referrals are made to other agencies and how often?

**Capacity**

◊ How do agency staff reach out to or recruit program clients?

◊ What resources are needed to meet goals?
◊ What challenges have grantee agencies faced in program implementation?

◊ Is the agency able to meet client demand?

**Impact**

◊ How many families have successfully avoided eviction under HPRP?

◊ What services are most essential to successful prevention?

◊ Is the HPRP program meeting its established goals?

◊ What can be changed to make the program more successful?

◊ How has HPRP funding changed agency programming?

**Data Sources and Analysis**

With our evaluation criteria established for each component of HPRP, we used both quantitative and qualitative data sources to develop our assessment. The main data sources include:

**HPRP contracts between DHCD and grantee agencies**

Agency contracts outline the benchmarks each agency hopes to meet for each year of the program. This includes the number of clients they intend to serve, what services they will provide to clients, and what funds are allocated to meet these goals. Agency contracts were used to guide our understanding of programmatic variation between providers and to compare provider goals to
provider outcomes.

Quarterly and annual progress reports for each agency for the first grant year

Both quarterly and annual progress reports are compiled by DHCD, as required by the federal Department of Housing and Urban Development (HUD). The most recent quarterly report included in this study covered July 1 – September 30, 2010. The annual report spans October 1, 2009 – September 30, 2010. Each agency reports specific categories, such as how often each service is provided, how many clients they have served, how many have exited the program, and whether clients are able to remain in stable housing after exiting the program. Annual reports also include the total funds that have been spent for each reporting period. Specific information for each agency was gleaned from reports, and used to provide an overview of the program to date, answer questions from the evaluation criteria, and used to verify information reported by interview participants. Additionally, we utilized progress report data to analyze the financial effectiveness of a prevention-based program in comparison to a shelter-based system.

Semi-structured interviews with agency staff

Semi-structured interviews were conducted in March and April 2011 by the research team. Each interview was conducted by one team member, either in-person or via telephone. Questions were formulated to gain a deeper understanding of program success at each level of program design: activity, capacity, and impact, as described above. Questions focused on how each agency has implemented the HPRP, difficulties they have encountered, successful aspects of the program and potential recommendations for improvement. See Appendix A for a complete list of interview questions.
Interview subject selection

One interview subject was chosen from each agency, based on a list of primary program contacts supplied by the client. Each subject was chosen based on his or her intimate knowledge of HPRP implementation, and an in-depth understanding of how the program operates. Subjects’ work titles include program managers, lead case managers, director of client services and other comparable positions. A total of nine subjects were interviewed, as we were not able to reach three of the twelve agencies providing homeless prevention services to families. Appendix B lists the nine agencies represented in our interviews. Interview methodology was approved by the Tufts University Institutional Review Board (IRB) (Appendix C).

Interview Analysis

Interview responses were grouped and coded based on response theme. Themes are categorized into the three components of the evaluation framework (activity, capacity, impact). Interview data were also compared to quarterly and annual progress report data. Crosscutting themes were identified under each evaluation component to reveal comparable and contrasting strategies for and challenges to homelessness prevention and diversion.

Literature review

We also reviewed numerous sources to gain an understanding of similar homelessness prevention programs, the status and impact of Housing First in the United States, the severity of homelessness in Massachusetts, and the costs incurred by various approaches to homelessness prevention and diversion. Literature reviewed includes:

◊ Primary research literature

◊ Government publications
Limitations

A number of limitations arose related to data gathering and analysis. Accurately calculating the social costs associated with homelessness is complicated, and much research has already been done to estimate such costs. As such, our study used previously established social costs in our financial analysis. Although this saved time and resources, social costs are estimates, and may not be an accurate representation of the actual costs under HPRP in Massachusetts. Assessing monetary costs was also challenging, as annual progress report data for families and individuals are not disaggregated, so we were unable to calculate the costs of prevention services solely for families.

Political and power dynamics must be taken into account in any evaluation process. It is notable that we are doing this evaluation in response to a request from DHCD, and that our introduction to the agencies interviewed took place through DHCD staff, which may have given the appearance—despite our best efforts to the contrary—that this research team works for DHCD. It is possible that interview subjects withheld information from the research team, or framed their comments according to their perceptions of their own best interest, despite guaranteed anonymity. This may have impacted our interviews and resulting analysis. It is also worthwhile to note that interviewees were not directly asked if they thought HPRP should be continued. Any such recommendations included here are based on this research team’s analysis of data, taking all sources into consideration.

Finally, results and findings from this study may not be applicable to other states or local agencies.

Scope of Study

Client Interviews

Due to time constraints, this study was not able to include HPRP clients in its scope. We strongly recommend that future evaluations of HPRP programming include the
perspectives of clients who had received, or who are currently receiving, prevention services. Also, only one staff member from each agency was interviewed. Although each subject was chosen based on his or her intimate knowledge of HPRP implementation, their views are individual, and should not be understood to represent the agency as a whole. In addition, interview subjects have a large investment in HPRP success, and the recommendation that future funds be provided for similar services is likely in their best interest.

Agency Contracts

A common central component of program evaluation is the comparison of goals established at the program’s onset to actual outcomes. As part of our evaluation of HPRP, we reviewed individual contracts between each provider agency and DHCD as a method to assess agency successes. Each agency was required to provide specific goals for four performance measures of the program, and were provided template tables with the following categories: outputs, outcomes, efficiency, and effectiveness.

We reviewed the contract terms of each of the 12 grantee agencies, which supply information about each provider’s homelessness prevention and diversion goals for the first and second years of the program. Upon further investigation, however, we found that the performance measurement templates were utilized inconsistently between agencies. Different output measures were used; some agencies set goals for each year, while some agencies set goals for the total number of clients to be served. Different outcome measures were used; some agencies measured performance in terms of the percentage of clients whose tenancies were re-established, while others measured the percent of clients that remained in housing for 18 months. Moreover, many agencies did not provide any goals at all for certain categories.

Although these disparities make comparing agency goals and outcomes across the agencies difficult, if not
impossible, it should also be noted that such variation in performance measurement can provide many beneficial aspects. Certain measures may not be appropriate, or useful, for all agencies, and allowing for flexibility can lead to more suitable measures that fill specific needs for each agency.

Although we had originally intended to compare agency goals to actual achievements, time and resource constraints on the part of both the research teams and DHCD grantee agencies limited our ability to collect data on the latter. Our results are therefore limited to analysis of information gathered from reports and interviews. Any conjecture regarding the reasons behind agencies’ particular successes and challenges is beyond the scope of our study.

**Client Case Files**

Reviewing case files proved impractical for the scope of this study. An effective review of client files would require a significant sample size of files to be reviewed, which in itself could make up the bulk of an evaluation study. Moreover, this study’s goals did not seek to evaluate case management skills, but rather the overall implementation of the HPRP program. Finally, information regarding client population background, level of need, and outcomes was compiled and available in DHCD quarterly progress reports.
Background and the Response to Homelessness

Homelessness in America mushroomed and became newly visible on streets across the country starting in the late 1970s and into the early 1980s. At that time, according to Nee (2010) and Beyond Shelter (n.d.), housing prices were rising, job opportunities for those with low education levels were shrinking, federal funding for affordable housing and employment training was decreasing, mental institutions were closing, and the gap between housing costs and household income was widening. Many people were forced out of housing and onto the street due to a lack of sufficient housing funds, mental illness or substance abuse. The supply of affordable housing in the United States did not—and still does not—meet the level of demand (Friedman et al, 2007), while rates of poverty in the United States keep climbing (U.S. Census Bureau, 2010).

Among the first responders to the homeless epidemic were mental health programs. Since many of the first street homeless experienced high rates of
psychological problems, mental health programs mobilized to help curb the increasing homeless population (Tsemberis, 2010). In addition, the federal government responded by providing funding for the establishment and development of the country’s emergency shelter system. Many homelessness activists utilized such funding to open emergency shelters across the nation (Nee, 2010, p. 121). Tsemberis (2010) describes the emergency shelter programs as providing a linear residential treatment continuum, which is seen as the dominant program model today (p. 39).

The linear residential treatment continuum model hypothesizes that, prior to housing placement, homeless individuals need an assortment of support services that will help them develop the skills necessary to obtain and maintain a permanent living situation. Clients are usually required to participate in training workshops and other activities related to their individual needs. Bassuk and Geller (2006) note that to reach permanent housing placement in theory, clients must first proceed through an emergency shelter and then on to transitional housing. However, they also reveal that in reality, “housing options may be primarily related to availability and lengthy waits for housing subsidies instead of actual need” (p. 783). Federal funding promotes this linear residential treatment model through its Continuum of Care (CoC) process. According to the U.S. Department of Housing and Urban Development (HUD) (n.d.), a CoC is “a community plan to organize and deliver housing and services to meet the specific needs of people who are homeless as they move to stable housing and maximize self-sufficiency” (p. 7).

The linear residential program model is similar to “Treatment First” models for homeless individuals with substance abuse problems. Treatment First programs require detoxification and sobriety or mental health treatment before the provision of independent housing. Program participants must be deemed ready for independent living—they must be “housing ready”—before transitioning into a permanent housing situation (Padgett, Gulcur, and Tsemberis, 2006, p. 74-75). This

One of the fastest-growing subgroups of homeless people in the nation consists of families with children.
model is based on the premise that individuals must confront and eliminate personal barriers to housing stability before housing services are provided.

In recent years, rising poverty levels among families have spurred changes in mainstream approaches to homelessness that have traditionally focused on individuals. Stereotypes of homeless Americans conjure up a single adult male living on the street. However, one of the fastest-growing subgroups of homeless people in the nation consists of families with children. According to HUD (2010), approximately 170,000 families were in homeless shelter facilities nationally in 2009, roughly a 30% increase since 2007. One-third of the people who used an emergency shelter in 2009 were members of homeless families, three-fifths of those were children, and more than half of the children are under six-years of age (HUD, 2010, p. iii).

Approximately 8% of families in Massachusetts—defined as at least one adult and one minor child under 18-years of age—live below the federal poverty level (Friedman et al, 2007). Those numbers are likely to have increased given the economic downturn in the U.S. over the past several years. Stone’s (2006) poverty assessment methodology adds several layers of complexity to poverty labels in an effort to determine whether a family is “shelter poor,” that is, whether the household cannot meet a minimum standard of non-housing requirements (including food, medical care, transportation, and clothing) after covering housing costs. Through this lens, the percentage of families living in poverty rises to roughly 27% of all Commonwealth households, approximately 650,000 families. The statistics for minority households are even more staggering, with 55% of Latino, 42% of Black, and 39% of Asian households being shelter poor in the state (Stone, 2006). As an alarming number of families cannot afford housing in addition to other basic necessities, more families are finding themselves without a home, and turning towards the emergency shelter system.

In 1982, Massachusetts funded only two shelters specifically for homeless families; in 2005, the state
financed more than 80 of these shelters, at an expenditure of $73 million for family shelter services (One Family, Inc., 2006). According to the DHCD 3rd Quarter Legislative Report (2010), the Massachusetts shelter system housed 2,209 families in June 2008; one year later that number had jumped to 3,000 (as cited in Davis, 2010). Massachusetts is the only state in the U.S. with a "right to shelter." There is no cap on the number of eligible people who can access the state’s emergency shelter program, meaning that in times of excessive demand on shelter space, the state is obligated to house the homeless elsewhere. Such shelter has most often been provided in hotels and motels. Due to the increase in families needing shelter, the Commonwealth resumed housing families in motels and hotels in 2008. In addition, families are staying in the emergency shelter system for longer periods. Nationwide, homeless families resided longer in shelters in 2009 than the previous year, with the median number of nights increasing by six to 36. Not only has family homelessness continued to expand, it also seems to have become more acute, since it takes the average family longer to leave shelter placements (HUD, 2010).

**Children and Families in Shelters**

There are positive and negative aspects to life in an emergency shelter. It provides a roof and some sense of security for homeless individuals and families, but simultaneously places restrictions on residents. Seltser and Miller (1993) find that "shelter life [begins] to represent disappointments and threats to [residents’] dignity at the same time as the shelters provide a needed haven and social support" (p. 51). Shelters provide more amenities and comfort than living in a car or on the street, although residents have to adjust to living with new rules, a lack of privacy, and sharing living quarters with strangers.

Research has investigated the impacts of shelter living and homelessness on children. Bassuk, Rubin, and Lauriat (1986) found that half of children living in 14 of
Massachusetts’ shelters were experiencing developmental lags, anxiety, depression, and learning difficulties. Another report on children residing in Massachusetts shelters discovered 50% were failing academically, 43% had repeated a grade and 25% were in special education classes (Bassuk and Rubin, 1987). Findings are similar to other reports exploring academic achievement as well developmental, psychological, and behavioral problems of sheltered children (Rescorla, Parker and Stolley, 1991; Zima, Wells, and Freeman, 1994 as cited in Yamaguchi, Strawser and Higgins, 1997).

Furthermore, in comparison to stably housed poor children, children in shelters were reported to have more behavioral problems and school failure, along with higher rates of developmental delay and overweight issues (Wood et al, 1990). One study conducted in Massachusetts found homeless children had higher rates of acute illness, including fever, ear infection, diarrhea, and asthma, as well as emergency department use than did low-income housed children (Weinreb et al, 1998). An increase in behavioral and health problems, and higher rates of child abuse and neglect were also discovered in additional research comparing sheltered children to housed youth of similar low socioeconomic status (Alperstein, Rappaport, and Flanigan, 1988; Bassuk and Rosenberg, 1990; Masten et al, 1993; Rafferty and Shinn, 1991 as cited in Yamaguchi, Strawser and Higgins, 1997). These studies illustrate that even with controlling for poverty, children residing in emergency shelters experience higher rates of educational, psychological and health problems.

Many advocates have begun to feel that emergency shelters are unable to provide the long-term support required to truly stabilize homeless families (Beyond Shelter, n.d.) or provide for the unique needs of children. Others oppose the “Shelter First” model on the grounds that housing is a human right and that people should not have to be judged “housing ready” before being able to access permanent housing. Culhane’s (2004) research suggests that the provision of social services (e.g. financial management education, healthcare, and counseling) in a
shelter does not positively impact a family's ability to remain stably housed in the future. According to One Family, Inc. (2006), “even in the best shelters, families often exit less stable than before they entered shelter” (p. 2). The organization further notes that within a four-month period in 2005, “53% of [Massachusetts] families leaving shelter were either terminated (asked to leave without a home to go to) or disappeared” (ibid). Commonwealth emergency shelters have been shown as unable to provide future housing stability for over half of sheltered families. As a result of similar unfavorable views of and findings on the traditional Shelter First approach to homelessness, a new model evolved: Housing First.

**Paradigm Shift to Housing First**

Housing First is an approach to combating homelessness that prioritizes assisting individuals and families to both quickly access and stably maintain housing. It expedites the placement of homeless families into permanent rental housing, with the services traditionally provided in shelters and transitional housing provided after relocation. It is built on the idea that those at risk of homelessness are more responsive to housing interventions and social services assistance when they are living in their own housing, as opposed to living in short-term or transitional accommodations (Beyond Shelter, n.d.). Basic housing needs must therefore be met, according to the Housing First approach, before other social services or treatments are offered or provided. It is designed to help homeless individuals, and individuals at-risk of homelessness, transition more rapidly out of the shelter system or prevent them from entering shelters in the first place. Services offered can include crisis intervention of various kinds, rapid re-housing, continual case management, and housing support services (ibid). This approach attempts to empower independent living and strengthen self-reliance through crisis intervention and individualized social services linking people and families to community resources.
In 1992, Pathways to Housing, a New York City-based non-profit organization, developed the first Housing First model, specifically targeting chronically homeless individuals and mentally unstable. This program continues to provide immediate access to housing for participants in conjunction with treatment, case management and support services (Tsemberis, 2010, p. 43). Around the country, homelessness prevention agencies began to test the Housing First approach and Pathways to Housing’s strategies in their own work and were pleased with the outcomes. With the success of the Housing First approach in achieving housing stability, the traditional aim of targeting the chronically homeless and those most at risk of homelessness thus expanded to include families.

**Governmental Shifts to Housing First Funding**

Federal and state policies have also begun to shift in recent years to update housing models. Federal policy initiatives have particularly accelerated the implementation of Housing First models focused on chronically homeless adults with a physical disability, mental illness or substance abuse problems (Bassuk and Geller, 2006, p. 782). Minnesota, for example, was an early leader in the field when in 1993 it passed the Family Homelessness Prevention Act, which was intended to curb homelessness, cut shelter stays, and reduce shelter reentry based on a rapid re-housing model. It also provided for eviction and mediation services, financial assistance and case management (One Family, Inc., 2006).

Federal funding continues to encourage states and communities across the country to implement or continue Housing First programs. The American Recovery and Reinvestment Act of 2009 created the Homelessness Prevention and Rapid Re-housing Program, which provided $1.5 billion in grants to states and communities to combat homelessness. HPRP funds initiatives that focus on the prevention and diversion from homelessness for at-risk individuals and families as well as rapid re-housing into permanent and stable homes.
Evaluation of the Housing First Approach

Most attempts to evaluate the success of Housing First have focused on models that target chronic homelessness. Several of those studies conclude that Housing First is quite successful in keeping people in stable housing, limiting drug and alcohol use, and improving overall physical and mental health among program participants (Tsemberis and Eisenberg, 2000; Meschede, 2006; Culhane, Metraux, and Hadley, 2002). Massachusetts’ first statewide pilot of a Housing First program for chronically homeless individuals, Home and Healthy for Good, recently reported a residential stability rate of 84%, with participants either being continually housed in the program or residing in other permanent housing (Massachusetts Housing and Shelter Alliance, 2010). Studies also have compared success rates of Housing First against Continuum of Care programs for homeless individuals with mental illness; and the Housing First approach has been found to have more success in housing tenure (Tsemberis and Eisenberg, 2000; Padgett, Gulcur, and Tsemberis, 2006).

Advocates have illustrated the significance of Housing First approaches in supporting the health aspects of at-risk children as it decreases the length of homelessness. Burt, Pearson and Montgomery (2005, p. xi) note research showing well-built connections between moving three or more times and escalated behavioral, emotional, and academic problems in children, even with an absence of poverty (Shinn and Weitzman, 1996). They indicate that “even if families receiving prevention assistance would not become literally homeless without assistance, reducing the number of times they move may be worth the investment of paying rent, mortgage, or utility arrearages” (Burt, Pearson and Montgomery, 2005, p. xi). In a study conducted in Massachusetts by Buckner et al (1999), children living in emergency shelters and transitional housing facilities had increased internalizing behavior problems the longer the period of residence. They further surmise “it is possible that school-age children internalize [the homelessness] experience by
becoming more depressed and self-critical and feel that living in a shelter is a negative reflection of their self-worth” (p. 254). Preventing homeless or rapidly moving homeless families out of temporary situations has shown to lessen the negative mental impacts on children.

Other research has shown that the Housing First method is better able to foster housing stability than Shelter First approaches. One Massachusetts initiative, the Shelter to Housing pilot program, provided one-year subsidies to families to move out of shelters. Two years later, 80% of families had remained housed (One Family, Inc., 2006). In Minnesota, after the passing of a homeless prevention bill focused on Housing First, no new shelters were built in the following 10 years and the average shelter stay for families decreased from three months to less than 30 days (One Family, Inc., 2006). Also in Minnesota, Burt, Pearson, and Montgomery (2005) noted that a rapid re-housing program reduced the average length of shelter stay from 60 to 30 days and attained an 88% success rate in preventing formerly homeless families from returning to the shelter system within the following 12 months (p. xviii). In addition, a Schwab Foundation report documented the success of a Housing First program with providing housing faster for homeless families; and at a 6-month follow-up of exited households 96% of families maintained permanent housing, 64% had improved their financial situation and 50% had saved money (2005).

The Housing First model is additionally more cost effective than sheltering families. Reviewing three homeless prevention initiatives in the Massachusetts, One Family, Inc. (2006) found that in one year these programs maintained housing for 1,119 families at the same expense as providing emergency shelter to 63 families. The Commonwealth’s Shelter to Housing pilot program provided services to families at a cost of $6,000 per family per year covering rent and all supportive services—significantly more economical than an estimated $47,000 annual shelter stay per family (One Family, Inc., 2006). Another report by Culhane and Byrne (2010) noted the
costs of housing stabilization service provision as $9,000 per family, as compared with the tens of thousands it would have cost to house them in emergency shelters (p. 4).

The combination of housing subsidies and rapid re-housing of the Housing First approach also decreases the probability of families reentering homelessness. Shinn and Bauohl (1998) investigated homelessness prevention and reported on studies indicating that family homelessness could be reduced through subsidized housing. Research conducted in New York City found that families who exited shelters into subsidized housing had lower shelter readmission rates than those exiting to private housing or unknown arrangements. Another study showed that subsidized housing provisions lessened the likelihood of families entering shelters in the first place, compared with households in private accommodations receiving other forms of public assistance such as welfare payments (Shinn et al, 1998; Wong, Culhane, and Kuhn, 1997). The same study found that the provision of subsidized housing was the most significant factor in the housing stability of families receiving public assistance at the time of follow-up research (Shinn and Bauohl, 1998). The only consistent predictor of permanent housing stability for families, argued by One Family, Inc., is the availability of a housing subsidy (2006). Housing First is an important centerpiece for homeless prevention, but it must include the financial assistance necessary in order to truly keep families housed.

Combining Housing First with Prevention and Diversion

The National Alliance to End Homelessness (2006) has identified additional “promising strategies to end family homelessness,” including: prevention activities; housing-specific financial support; specific services targeted at the unique needs of each family; and enhanced integration of data and policymaking. These are similar to
the strategies endorsed by Burt, Pearson, and Montgomery (2005) in their HUD study of homelessness prevention approaches, which include: housing subsidies; supportive services coupled with permanent housing; mediation in housing courts; cash assistance for rent or mortgage arrears; and rapid exit from shelter.

Anti-homelessness advocates widely argue that prevention efforts cannot be one-size-fits-all. Some families require more social services support; others, more financial assistance. Bassuk and Geller’s (2006) research indicates that “many families are successfully re-housed without the aid of services and that it may not be necessary to expend costly resources on services since many families exit homelessness and remain housed without them” (p. 783). Other studies have, as previously indicated, highlighted subsidized housing as the most significant predictor of housing stability after shelter, thereby minimizing the importance of other barriers to stability such as substance abuse and bad rental history (Wong, Culhane, and Kuhn, 1997; Shinn et al, 1998).

Certain emergency prevention strategies, including short-term financial assistance for the sake of eviction prevention, and subsidies toward rapid re-housing, have proven particularly successful in promoting stable housing situations for families. Friedman et al (2007) evaluated three Commonwealth homeless prevention programs and discovered that 75 to 91% of families who received short-term financial assistance reported being stably housed 12 months later. Burt, Pearson, and Montgomery (2005) researched a Massachusetts eviction prevention program for tenants with serious mental illness and found that it preserved housing for 85% of participants (p. xvii).

While the research referenced above paints an encouraging picture, some researchers and advocates caution that the short-term subsidies are not enough to truly provide for housing stabilization. In 2009, the Massachusetts Department of Housing and Community Development conducted an interim evaluation of at-risk families receiving emergency housing assistance who were given a short-term subsidy. The findings indicated
that at the end of a one-year lease the majority of families required additional assistance after the subsidies expired, while fund administrators noted that many families even needed assistance during the subsidy period since they were required to pay a portion of the rent themselves (as cited in Massachusetts Law Reform Institute, 2010, p. 12). Furthermore, an evaluation of rapid re-housing initiatives in New York City discovered a dramatic increase in family recidivism rate—from 22% in 2002 to 40% in 2009—with the expiration of housing subsidies postulated to be the main driver (Institute for Children, Poverty and Homelessness, 2010, p. 3). Families that have already exited shelters to “permanent housing” are returning to shelters due to expiring subsidies and their inability to meet housing costs. This research illustrates that some at-risk families need longer-term financial assistance and ongoing case management services than solely rapid re-housing and short-term subsidies. Such findings do not discredit the Housing First approach, but do raise questions about how to best incorporate this method with other social and financial services in order to meet the long-term needs of at-risk families. Stability and funding of holistic anti-homelessness approaches over the longer term must be provided, particularly as stronger economic and social forces continue to generate the conditions that leave individuals and families at risk of homelessness in the first place.

The Housing First approach in combination with short-term subsidies only briefly resolve a symptom, and not the main causes of homelessness. In other words, they are, at best, a temporary solution, but are still on-track to keeping at-risk families permanently stabilized in their own housing.
Housing and homelessness policy in the Commonwealth of Massachusetts has undergone numerous shifts and different iterations within the past decade. As of 2007, when the state undertook a major study and subsequent overhaul of its approach to homelessness, 5,000 families—including 10,000 children—were experiencing homelessness annually (Massachusetts Homelessness Commission Report, 2007).

At that time, most of the state’s homeless and at-risk [of homelessness] population was receiving assistance from the Massachusetts’ Department of Transitional Assistance’s (DTA) Emergency Assistance (EA) program, which oversaw the operations of all state-funded emergency shelters and offered shelter and re-housing support. That year, Governor Deval Patrick’s Special Commission Relative to Ending Homelessness in the Commonwealth, chaired by Representative Byron Rushing and DHCD Undersecretary Tina Brooks, issued its final report. The report contained a five-year plan to eliminate homelessness in Massachusetts, with the important caveat that the success of the plan would depend on it being “implemented and funded appropriately” (Massachusetts
Homelessness Commission Report, 2009). It also noted the potential for cost savings to the state that would result from lower shelter needs, pointing out that “[e]nding homelessness, therefore, is a rare opportunity where doing the right thing is also the most cost-effective solution” (p. viii).

The Commission’s report brought into focus a number of the challenges facing the Commonwealth’s homelessness programs. It noted that not only were 5,000 families with 10,000 children placed in the shelter system in 2007, but that 30,000 more families were at risk of homelessness in that year. Perhaps even more disturbing, the Commission reported that approximately 650,000 families—or 27% of Massachusetts households—were “shelter poor” (Massachusetts Homelessness Commission Report, 2009). Particularly given the economic climate of the late 2000s, such precariousness in the housing situation of so many Massachusetts families was a cause for alarm. Indeed, the cost of sheltering families also presented significant challenges to the state’s economy. The Commission focused on the need to provide “the right resources to the right people at the right time,” providing properly targeted funding and interventions rather than simply more funding and interventions that the state could not afford, and which were, in any event, unlikely to notably improve the situation of at-risk families (ibid).

The political will behind the Commission and the momentum created by its report allowed several other factors to align in such a way that the state was well-positioned to make significant changes in homelessness policy (Culhane, 2009). Three other key state-based factors came into play, as well as concurrent shifts on the national policy level.

First, also in 2007, Gov. Patrick signed an Executive Order reconstituting the Interagency Council on Housing and Homelessness (ICHH). The Commission, upon release of its report, charged the ICHH with implementation of its recommendations. One of the ICHH’s first major steps toward that goal was the allotment, in 2008, of $8.25 million for the development and launch of a pilot program
of Regional Networks to End Homelessness. The Regional Networks project was based on a core belief that regional programming could more effectively engage a broad variety of stakeholders and respond to the specific challenges of each region than could statewide programming (2009). A significant amount of local and regional programming was already happening around the state, with widely varying degrees of success (DHCD HPRP RFR, 2009). The ICHH initiative allowed for a greater focus and increased funding for such approaches. It also mandated an evaluative component that would allow an expanded analysis of the benefits and challenges of regional networks and help capture best practices not just for a statewide audience but also for similar organizations attempting such work nationally (Culhane, 2009).

A second major development in state policy came about partly as a result of the Homelessness Commission’s Report in 2007, which recognized homelessness as primarily a housing problem. That is, it took a Housing First approach: requiring long-term solutions integrating stable housing support. This recognition led the Legislature to conclude that the Commonwealth’s attempts to combat homelessness had to be directed by the state housing agency, DHCD, and in 2009 it adopted Article 87, which mandated the transfer of all EA programs from DTA to DHCD (Culhane, 2009). This shift gave operational control over all housing intervention programs and shelter operations to DHCD, while DTA continued to administer employment, food and cash assistance programs for individuals and families. Such programs, of course, are often integral to successful homelessness prevention and intervention, since shelter poverty does not occur in isolation from employment, nutritional and health challenges.

Another development that allowed Massachusetts to shift its homelessness policy approach was the renegotiation of all of its contracts with shelter providers, with new contracts taking effect in February 2009. The goal of this “reprocurement” of shelter contracts was to facilitate the transition of then-current homelessness
policy approaches toward less shelter-dependent programming and to place more emphasis on Housing First programming, highlighting prevention, diversion and rapid re-housing. The rewritten contracts also separated accommodation costs from service costs, and based payment of the latter on an agency’s efficiency and effectiveness in placing families in permanent housing (Culhane, 2009). This approach allowed for more accuracy in determining families’ needs, and provided greater flexibility in meeting them.

Federal Homelessness Prevention and Rapid Re-housing Programming

At the same time that these changes were happening in Massachusetts, HUD launched the Homelessness Prevention and Rapid Re-housing Program (HPRP). HUD awarded Massachusetts $45 million in HPRP funds as part of the American Recovery and Reinvestment Act of 2009, $18.4 million—or approx. 40%—of which was awarded to the state government, with the rest awarded directly to 20 Massachusetts cities and towns. DHCD is responsible for the administration, coordination and allocation of state HPRP funds.

DHCD acquired responsibility for EA programming and HPRP funding at a time when the number of homeless families in Massachusetts was on the rise. Family shelters had been at capacity since 2007, leading to a situation in which EA-eligible families had to be placed in hotels and motels across the state. Due to the disparate and disconnected locations of hotel and motel shelter, as well as other constraints in the DTA system, families in such situations received neither housing search support nor stabilization services, which only further exacerbated their housing challenges. Their inability to secure stable housing, in turn, exacerbated the hotels and motels crisis, as families continually returned to the shelter system seeking services.

In mid-2009, approximately 900 families were in
hotels and motels in addition to the 2,000 families in shelters. At several points in that year there were more than 1,000 families in hotels and motels on a given night, an unprecedented demand on the shelter system (DHCD, 2009). These family hotel and motel shelter demands alone cost the state approximately $2 million per month. Furthermore, the EA system, as it operated at the time of its transition to DHCD, created several perverse incentives for families to stay in the system, including no limits on hotel and motel stays and no cost-sharing demand on families whose income exceeded the EA eligibility limit (Culhane, 2009).

The combination of these developments at the state and national levels led to a rethinking of Massachusetts’ approach to homelessness and the creation of its new “Architecture” policy framework for responding to the needs of homeless and at-risk families throughout the state. This formed the basis of DHCD’s approach to utilizing and disseminating HPRP funding across the state, with two main goals (DHCD HPRP RFR, 2009): 1) short- and long-term reduction in reliance on hotels and motels, to be achieved by a new emphasis on programming designed to keep families in stable housing and avoid their entrance into the shelter system; and 2) support regional network-building in order to expand the use of the Architecture to ultimately include all EA regions in the state, while emphasizing support for the five Transitional Assistance offices with the largest caseloads (DHCD HPRP RFR, 2009).

DHCD funded the Architecture from two primary sources: HPRP funding, and an expected surplus in the EA budget resulting from reductions in hotel and motel and other emergency shelter costs, which the state expected would save it a significant amount of money (DHCD HPRP RFR, 2009). The effectiveness of such funding would increase as well, as those funds would proceed to the actual housing of families, as opposed to shelter costs that dealt with the short-term symptom—lack of a roof for the night—but not necessarily the long-term overarching problem of shelter poverty itself, and the conditions of
each family that led them to need emergency shelter in the first place.

**The Architecture**

The Architecture comprises a “four-door” approach, with its field office Homeless Coordinators (formerly the DTA’s EA field staff) at the center of a network of actors working on homelessness prevention, diversion, supported shelter and stabilized re-housing. Prevention comprises the foundation of the approach, and encompasses a variety of services and support to keep families from needing to enter EA shelter. According to DHCD’s HPRP Request For Responses (RFR), the elements of the “four doors” approach include:

**Diversion** – the “front screen door.” Diversion—closely related to prevention—serves EA-eligible families who come to EA offices seeking assistance, meaning they are at immediate risk of homelessness. Rather than entering the shelter system, resources in the community are offered to support the family to stay in or find stable housing, as well as other assistance, such as that offered by DTA and its associated agencies, to help resolve the family's broader shelter poverty challenges.

**Family Emergency Shelter** – the “front door.” Families go through this “front door” when they have “exhausted all reasonable and sensible” (DHCD HPRP RFR 2009) prevention and diversion strategies. Once inside the front door, the family is sheltered in the most appropriate place and way according to their situation and the available shelter options in the community.

**Re-housing** – the “back door.” Once a family is in the EA shelter system, the emphasis is on helping them transition successfully out of shelters in the most efficient and stability-enhancing manner possible.
Stabilization – the “back screen door.” The goal of stabilization is to support families once they have been re-housed, so that they remain in stable housing and do not need to re-enter the shelter system. Such support may include advice and assistance on lease compliance, income and asset development, and access to a “Housing 911” emergency support system for families and landlords.

The Architecture’s inherent complexity and multi-layered approach involves numerous actors with many types and combinations of funding. With 22 offices in the state having DHCD Homeless Coordinators, there are many unique local situations that DHCD must understand, and significant coordination challenges it must confront. Homeless Coordinators are responsible for mobilizing numerous elements and actors in each location, from social service agencies, regional housing authorities and agencies, community action organizations, private property developers and managers, and shelter operators. In this report, we focus on the agencies forming the foundation and front screen door that stand between families and the shelter system; that is, providers of prevention and diversion programming.

Disbursement of HPRP Funds in Massachusetts

The 20 agencies that received HPRP funding through DHCD beginning in 2009 first had to respond with an application to the state’s RFR, which detailed the funding guidelines including HUD’s HPRP requirements and some conditions specific to DHCD’s administration of the federal funds (DHCD HPRP RFR, 2009). According to the RFR, households must meet the following criteria in order to be eligible for HPRP-funded services:

- The household income must be at or below 50% of Area Median Income (AMI) at the time of application and at every subsequent 3 month interval;

- The head of household must participate in an initial face
to face consultation with a case manager or other qualified professional using a pre-approved assessment tool;

◊ The applicant lacks the financial resources and support networks needed to obtain immediate housing or remain in the existing housing but for HPRP assistance;

◊ No appropriate subsequent housing options have been identified for the applicant;

◊ The participant lacks the financial resources and support networks needed to obtain immediate housing or remain in its existing housing but for HPRP assistance.

◊ The household must agree to participate in case management stabilization services as required (DHCD HPRP RFR, 2009, p.8).

The agencies being evaluated in this report offer prevention and/or diversion programming, in addition to other services they may provide with direct HPRP funding or other sources of support. Such programming operates within the following DHCD guidelines:

**Prevention**

Using HPRP funding, DHCD’s grantee agencies may offer eviction prevention. This targeted programming demands strong relationships between prevention services providers and public and private subsidized housing providers, as the latter are responsible for all referrals of families to the program. Services may include direct financial assistance and case management, among others, for up to 18 months.

**Diversion**

Diversion programming entails many of the same services offered in prevention programs, with an added
factor of urgency. These programs assist families who come to the attention of DHCD’s grantee agencies when they come into an EA office in immediate need of shelter. The agencies attempt to find immediate alternatives providing shelter beds or hotel and motel space. DHCD’s program prioritizes staff support for diversion programming and offers flexible funding for a wide variety of services with the goal of minimizing the time frame of support necessary to ensure stabilized housing.

These services are intended to provide support that can help families recognize and disrupt the processes that would otherwise let them slide into homelessness, as well as provide skills and training that will ideally improve their ability to handle similar challenges in the long-term. They illustrate the evolution of homelessness policy over the past several decades to its current preventative approach that seeks to intervene at critical moments before families and individuals become homeless, in addition to providing shelter and housing support to those who are in that situation. This report seeks to illuminate the outcomes of this approach in the Commonwealth in the first two years of its existence; its impacts over the long term will remain to be seen.
Our investigation of cost effectiveness reviews the contracts established between DHCD and 12 grantee agencies providing prevention and diversion services. The purpose of this analysis is twofold: 1) to determine the costs of providing effective eviction prevention services; and 2) compare prevention costs to those associated with services provided within the shelter system. Because DHCD’s financial reports do not distinguish between the costs of individual and family prevention programs, this analysis includes financial information for both client groups combined.

Prevention costs, or inputs, are defined as the total amount spent by DHCD grantee agencies on homelessness prevention interventions during the initial operating year. These expenses include the costs of data collection, evaluation and administration, as well as actual financial support to families. Outputs are the total number of participants exiting HPRP-sponsored homelessness prevention programs into permanent housing. “Permanent housing,” as defined by the DHCD, encompasses:
◊ rental by client (with/without housing subsidy)
◊ housing owned by client (with/without housing subsidy)
◊ living (long-term) with family/friend

The data on prevention costs is extracted from the HUD Annual Performance Report (APR) for the program’s initial operating period (October 1, 2009 to September 30, 2010). Data on shelter costs come from the Boston Foundation’s preliminary assessment of the rapid re-housing of hotel- and motel-sheltered families (Friedman, 2007).

**Challenges to determining cost effectiveness**

Our approach, like previous studies of prevention programs, assumes that without HPRP assistance, participants in the prevention program will inevitably become homeless. For example, HPRP prevention pre-assessments designate participants in one of two categories: “imminently losing their housing” or “unstably housed and at-risk of losing their housing.” However, according to Friedman et al (2007), receiving an eviction notice or facing other indicators of imminent eviction resulted in actual homelessness for only 20% of families, while other predictors—very low incomes, presence of mental health problem, substance abuse or chronic illness, incarceration or placement in a foster home during childhood—contribute to homelessness, but to a lesser known degree. Unfortunately, we do not know how many people categorized as on the verge of homelessness actually would have become homeless without HPRP services.

Also, while DHCD grantees offer the same range of homelessness prevention interventions to a similar target population, there is significant variation in the content of these services from one provider to another. The intent of this analysis is to assess the overall performance of DHCD-
and HPRP-supported prevention and diversion initiatives, not to rate individual service providers; therefore, variations in provider outcomes are not included in the overall cost effectiveness of the HPRP program.

Lastly, reliance on the DHCD APR as a primary data source brings various limitations to our analysis. Because the DHCD APR aggregates the costs of serving families and serving individuals together, the comparison to data on shelter services, which do report separate costs for families and individuals becomes difficult. Additionally, we cannot state with certainty that expenditures reported to DHCD reflect the full extent of the inputs utilized to produce the reported outputs. In other words, agencies operate from a variety of funding sources and typically utilize non-HPRP funds to carry out their work. However, these costs would be documented in the grantee reports delivered to DHCD and thus lay outside the scope of our analysis. While we believe that HPRP reporting reflects a best-faith effort to accurately organize and account for agency funding, we also understand that the actual expenditures necessary may not be fully reflected in these reports.

Analysis and Findings

Exiting the Program

DHCD reports that 1,764 people participated in the first year of the homelessness prevention program: 552 of these clients lived in households without children, 1212 in households with children and adults. Upon entry into the program, 544 clients were unstably housed and 1220 clients were in imminent danger of losing housing. Of the 1764 participants, 642 (36.4%) had exited the prevention program by the end of the reporting period. While only slightly more than a third of participants were ready to leave the program after the first year, a high proportion of those who did exit did so into permanent housing ( 568 out of the 642, or 88.5%).

We note that 64.3% of exited program participants
were in the program for fewer than 90 days, and that this cohort had a slightly higher success rate than their counterparts who utilized HPRP services for 90 days or more (90.3% and 85.2% respectively) (Table 2). The destination of some graduates is unaccounted for. Information is unavailable for 27 participants in the program for more than 90 days, and for ten participants of fewer than 90 days.

Table 3 further differentiates between subsidized and non-subsidized housing outcomes and reveals similar patterns for the two cohorts. More than half of those receiving services for more than 90 days exited into non-subsidized permanent housing, and 42.6% exited into subsidized permanent housing. For those exiting after fewer than 90 days, 67.3% exited into non-subsidized permanent housing and 32.7% exited into subsidized permanent housing. Of all successful exits, 63.9% exited into non-subsidized and 36.1% exited into subsidized housing.

<table>
<thead>
<tr>
<th>Length of program</th>
<th>Exited into permanent</th>
<th>Total exits</th>
<th>Percent exiting to permanent</th>
</tr>
</thead>
<tbody>
<tr>
<td>More than 90 days</td>
<td>195 (34%)</td>
<td>229 (35.7%)</td>
<td>85.2</td>
</tr>
<tr>
<td>Less than 90 days</td>
<td>373 (66%)</td>
<td>413 (64.3%)</td>
<td>90.3</td>
</tr>
<tr>
<td>Total</td>
<td>568 (100%)</td>
<td>642 (100%)</td>
<td>88.5</td>
</tr>
</tbody>
</table>

Source: HUD HPRP Annual Performance Report, 2010
### Table 3: Number of program participants exiting into non-subsidized and subsidized permanent housing.

<table>
<thead>
<tr>
<th>Destination</th>
<th>Time spent in HPRP</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Greater than 90 days</td>
<td>Less than 90 days</td>
<td></td>
</tr>
<tr>
<td>Without subsidy</td>
<td>112 (57.4%)</td>
<td>0 (0%)</td>
<td>251 (67.3%)</td>
</tr>
<tr>
<td>Owned</td>
<td>0 (0%)</td>
<td>112 (57.4%)</td>
<td>191 (51.2%)</td>
</tr>
<tr>
<td>Rental</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
<td>60 (16.1%)</td>
</tr>
<tr>
<td>Friends/family</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>With subsidy</td>
<td>83 (42.6%)</td>
<td>112 (22.7%)</td>
<td></td>
</tr>
<tr>
<td>Owned</td>
<td>1 (0.5%)</td>
<td>0 (0%)</td>
<td>121 (32.4%)</td>
</tr>
<tr>
<td>Rental</td>
<td>82 (42.1%)</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Friends/family</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
<td>1 (0.3%)</td>
</tr>
<tr>
<td>Permanent Supportive</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
<td></td>
</tr>
<tr>
<td>Housing (PSH)</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>195 (100%)</strong></td>
<td><strong>373 (100%)</strong></td>
<td></td>
</tr>
</tbody>
</table>

*Source: HUD HPRP Annual Performance Report, 2010*

### Table 4: Total expenditures of HPRP (Year 1).

<table>
<thead>
<tr>
<th>Costs</th>
<th># of Successful Outcomes</th>
<th>Cost per Successful Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial assistance to program participants</td>
<td>$1,416,742</td>
<td></td>
</tr>
<tr>
<td>Housing relocation &amp; stabilization services</td>
<td>$441,911</td>
<td></td>
</tr>
<tr>
<td>Data collection &amp; analysis</td>
<td>$138,360</td>
<td></td>
</tr>
<tr>
<td>Administration</td>
<td>$203,368</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$2,200,381</strong></td>
<td><strong>$3,874</strong></td>
</tr>
</tbody>
</table>

*Source: HUD HPRP Annual Performance Report, 2010*
The Price of Success

We calculated the cost of prevention services per client by dividing the total funds spent on prevention services including financial assistance, administration, data collection and analysis costs ($2,200,381) for all 17 agencies involved in the HPRP program (DHCD HPRP APR, 2010). We divide that cost by the total number of program participants exiting into permanent housing (568) and determine cost per successful outcome to be $3,874 over the course of the initial operating year. Table 4 shows the total expenses of the homelessness prevention program—financial assistance to program participants, housing relocation and stabilization services, data collection, and analysis and administration.

It is difficult to draw conclusions about cost savings of prevention programming compared to shelters, because anecdotal and research evidence both suggest that all individuals at risk of homelessness do not necessarily end up in the shelter system. However, that assumption is a basic premise of a comparative analysis of this type. Thus, for the purpose of this calculation, we arrive at $3,874 (Table 4). However, this figure is not very useful in comparing the costs of shelter outcomes and HPRP outcomes.

Our sources for shelter costs report separate figures for families and individuals; HUD’s APR does not. Since HUD does not report separate figures for individual and household expenses and client outcomes, we would be comparing cost per person against cost per family. It would be inaccurate to draw conclusions based on differing units of measurement. Furthermore, depending on the proportion of the 568 exited persons that were served as a family, the figure in Table 4 is likely an underestimate because households are more expensive to serve. Nonetheless, we believe that the savings are promising enough to warrant attention from the Commonwealth and others interested in the cost-effectiveness of various responses to family homelessness.
A complete evaluation of DHCD’s HPRP programs cannot be based on financial numbers alone. A critical indicator of success would be a causal link between the content of homelessness prevention programs and the successful reduction in homelessness populations. While developing a quantitatively significant causal relationship is beyond the scope of this study, the following presents an evaluation of the program’s activities, capacities, and impacts, based on semi-structured interviews with provider agency staff. Nine out of 12 agencies contracted for family homeless prevention and diversion services were interviewed (Appendix B). Therefore, we refer to agency contracts with DHCD and quarterly progress reports to supplement where possible. Adapting the same Family of Measures model (Sawhill and Williamson, 2001) as our evaluation framework to design interview questions, we sought to:

◊ explore the various activities and implementation strategies utilized by providers towards achieving this impact;

◊ measure the effect of HPRP funding and DHCD
guidelines on providers’ capacities to achieve this impact; and

diamond gauge the impact providers have on achieving the HPRP overall mission, and whether that impact is being felt by the true target population.

**AGENCIES OVERVIEW**

In total, 12 agencies have established contracts with DHCD, and have been providing either homelessness prevention services, diversion services, or both to families since HPRP’s start date on October 1, 2009 (Table 5). In the first operational year of the program (October 1, 2009 through September 30, 2010), these 12 agencies have collectively provided homelessness prevention services to 633 family clients. Table 6 shows the number of clients served by each of the 12 agencies.

**Table 5. DHCD grantee agencies providing family eviction prevention and diversion services.**

<table>
<thead>
<tr>
<th>Agency</th>
<th>Family Prevention</th>
<th>Family Diversion</th>
</tr>
</thead>
<tbody>
<tr>
<td>BAMSI Helpline</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>City of Worcester</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Community Action Committee of Cape Code &amp; Islands, Inc.</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Community Care Services, Inc.</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Community Teamwork, Inc.</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>HapHousing</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Metro Boston Housing Partnership</td>
<td></td>
<td>✔</td>
</tr>
<tr>
<td>New England Farm Workers Council</td>
<td></td>
<td>✔</td>
</tr>
<tr>
<td>North Shore Community Action Programs</td>
<td></td>
<td>✔</td>
</tr>
<tr>
<td>South Middlesex Opportunity Council</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Springfield Housing Authority</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Worcester Housing Authority</td>
<td>✔</td>
<td></td>
</tr>
</tbody>
</table>
### Table 6. Number of families served in first year of program.

<table>
<thead>
<tr>
<th>Agency</th>
<th>Total # of families served in first year</th>
</tr>
</thead>
<tbody>
<tr>
<td>BAMSI Helpline</td>
<td>27</td>
</tr>
<tr>
<td>City of Worcester</td>
<td>57</td>
</tr>
<tr>
<td>Community Action Committee of Cape Code &amp; Islands, Inc.</td>
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<tr>
<td>Community Care Services, Inc.</td>
<td>14</td>
</tr>
<tr>
<td>Community Teamwork, Inc.</td>
<td>41</td>
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<tr>
<td>HapHousing</td>
<td>39</td>
</tr>
<tr>
<td>Metro Boston Housing Partnership</td>
<td>85</td>
</tr>
<tr>
<td>New England Farm Workers Council</td>
<td>54</td>
</tr>
<tr>
<td>North Shore Community Action Programs</td>
<td>66</td>
</tr>
<tr>
<td>South Middlesex Opportunity Council</td>
<td>81</td>
</tr>
<tr>
<td>Springfield Housing Authority</td>
<td>94</td>
</tr>
<tr>
<td>Worcester Housing Authority</td>
<td>55</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>633</strong></td>
</tr>
</tbody>
</table>

### ACTIVITY

Activity measures focus on implementation to achieve goals. We are concerned here with determining: (1) what services are providers offering; and (2) what strategies have been developed to address provider implementation challenges. Conversations with provider agencies in this area were based on the following questions:

- What services do agencies provide under HPRP? Which services are in greatest demand?
- How many families are served each month?
How do agencies collaborate with other organizations? What types of referrals are made to other agencies, and how often?

What are the major implementation challenges, and what actions have been taken to overcome them?

Agency Services

The Housing First approach endorses a holistic approach to homelessness prevention and response. While most provider agencies offer both housing and non-housing services, all providers are cognizant of the dynamic situations that bring households to the brink of homelessness. Because HPRP’s policy language offers a relatively high degree of flexibility to implementation, providers have the potential to be creative, or myopic, or anywhere in between in their approach to homelessness.

DHCD reporting requirements include the collection of data on activities divided into the following two categories: 1) financial assistance; and 2) housing relocation and stabilization services. Financial assistance activities minimally vary between agencies. However, our interviews revealed that DHCD grantee agencies varied most in their interpretation and execution of housing relocation and stabilization services. The following section details the types and nature of support services agencies offer to families in the context of their HPRP-funded programs.

Financial Assistance

The majority of HPRP clients are behind on their rent, utility payments, or both. Financial services offered by DHCD grantee agencies generally focus on assisting families with rental assistance, and payment of rent and utility arrearages for specified periods of time, depending on the contract between DHCD and the agency (Figure 2). HUD guidelines limit the agency to providing six-months of back payments, although actual client need may total as
Agency staff reports that financial support for utility payments is often highly demanded; one provider noted client households average $1,500 in unpaid utility bills, making it nearly impossible to retain utility services. Financial support may be made available to families, and case workers may provide assistance to establish positive relationships between clients and utility companies, while negotiating payment of overdue bills.

Financial assistance may also go toward move-in costs including security deposits, first and last month’s rent, and moving expenses. It may also provide a short-term subsidy to pay a portion of a client’s rent for a specified period of time. In our interview sample, the longest period of time for such a subsidy was 12 months. One provider mentioned that clients may receive social support services on an ongoing basis, but require financial assistance only once per year, on average. Other agencies
report that short-term subsidies are available to families on a monthly basis depending on the client’s level of participation in the program. If a client is non-responsive to correspondence from case managers or fails to comply with an agreement or work plan, financial assistance is terminated. The agency staff interviewed reported minimal trouble with “non-responsive” families.

**Housing Relocation and Stabilization Services**

Case management services was provided most often (69%) of all relocation and stabilization services (Figure 3). The specific services included in this category varied across the nine agencies interviewed. Depending on the contract between DHCD and the grantee agency, active case management is available to families for a period of 6- to 18-months, including follow-up services after a family has been stably housed. “Housing stability” is defined as a household that is actively abiding by all lease agreements and is in no immediate danger of eviction.

![Figure 3. Housing relocation and stabilization services provided to HPRP families (Year 1). Data source: DHCD HPRP Quarterly Progress Reports, 2010-2011.](image-url)
Interactions between clients and case managers varied across agencies, in part due to varying staff capacity. In the early stages of assistance, case managers meet with clients once to several times a week for a period of two- to six-weeks. Case managers work with clients to identify needs and priorities, and then may provide referrals for additional social services accordingly. After devising a service plan, visits become less frequent as clients begin to execute the plan. DHCD guidelines require clients to visit case managers every three months to verify their incomes and program eligibility. We found that many agencies, however, require families to interact more frequently with their case managers and encourage open communication outside of scheduled meetings. Smaller organizations tend not to have the staffing resources to maintain high levels of client interaction and support; four of the nine agencies interviewed expressed a desire for additional funding in order to expand such efforts.

Only one of the nine providers interviewed noted participation in outreach and engagement, or reported making any effort to advertise their programs to the community at large. They generally use presentations and have a presence at local housing authorities and community centers as the primary method of outreach. The other eight agencies do not conduct significant outreach for family HPRP because, according to one agency, “[we] don’t have to market the program, they find us.” The majority of agencies receive referrals directly from local housing agencies, DHCD, DTA offices, and through partnerships with local social service providers. Four agencies (MOC, HAP, NEFWC, and NSCAP), in fact, work exclusively with clients who have been referred through those local partnerships and networks. For the rest, word of mouth and a physical presence at a nearby DTA office suffices. In general, as one agency staff member stated, providers “do not have to market the program, [clients] find us.” All nine of the agencies participating in this evaluation report have established a presence and a reputation in the communities they serve. One staff member at NEFWC asserted that people had been turning to her agency for help well-before HPRP funding.
Housing search and placement support is typically provided to families receiving homelessness diversion services. Somewhat surprisingly, we found that families receiving eviction prevention services may also benefit from these services. One agency staff member interviewed noted that families have to choose between maintaining current tenancy or securing new housing; perhaps in a different location or with lower associated costs (rent, subsidies, transportation costs, etc.), and agency staff play a role in assisting in this process.

Case managers often reach out on behalf of clients to their established housing networks, including area housing authorities, real estate agents, and private homeowners, to locate available rental apartments and explore potential housing options. If case managers are unable to make an initial connection between clients and potential housing providers, families are directed toward housing resources they can contact on their own, with varying levels of involvement from agency staff. Some families need more active case management during the housing search due to language or cultural barriers and other challenges. Five out of the nine agencies interviewed report that they are able to provide a significant amount of such support “in-house;” if providers do not have this capacity, they connect clients to other support services in the area.

Once housing options are identified, case managers may negotiate lease terms with landlords on behalf of the clients, particularly for those clients with eviction histories and low incomes. Case managers also assist families in securing a spot on waitlists for fair market and subsidized housing. Once families are placed in housing, case managers may conduct home visits to ensure families are in lease compliance, and to identify potential barriers to lease maintenance. A staff member at BAMSI reported that families often utilize its landlord mediation services for lease issues arising between the client and the landlord. In other situations, case managers may intervene to ensure that landlords follow through on work orders. This extension of case management services depends upon
staff and resource availability. The interview data suggest that larger agencies are more likely to be able to provide extended and personalized services, as they often have more resources at their disposal.

Legal services provided under HPRP-funded homeless prevention and diversion programs address legal housing issues, such as eviction, but cannot be related to mortgages. However, some providers offer legal services or advice on debt collection issues, Criminal Offender Record Information checks, and IRS and other tax issues. One agency mentioned it sometimes provides legal services addressing client rights in the event of foreclosure on a rental property. Another agency reported using legal services to educate families on their housing services options or to serve as a mediator between clients and banks when difficult situations arise.

NEFWC and NSCAP have trained staff within their organization to assist families with credit repair, including how to obtain, read, and dispute financial claims listed on their credit reports as well as how to budget finances. Other agencies refer families to a credit-counseling center for such services. Depending on the agreement between the agency and the family, clients may be required to attend financial education sessions in order to receive other support services. The BAMSI Helpline and NEFWC reported that clients commonly lack knowledge and skills pertaining to acquiring, reading, and understanding credit reports and other critical financial documents.

For one agency offering in-house financial counseling, staff members meet with clients to determine household income and the necessary expenses required to maintain the household. Case managers try to maximize the household’s income and determining what additional financial aid or public assistance the family may qualify to receive. One agency mentioned that “[t]here are single mothers who have full custody of their children but are not receiving child support. We refer them to our subcontractor, who provides legal services for our clients, so they can begin the process of obtaining child support or increasing their child support payments. This additional

*Clients do not take advantage of credit repair services because they are overwhelmed by everything else.*
household income can help with the expenses.” Case workers may work with families to track spending habits and establish a monthly budget that will help ensure they can fulfill larger monthly financial obligations, such as rent and utilities.

Staff at all nine agencies agree that a lack of financial education and budgeting contribute to client inability to maintain tenancy. All providers encourage financial literacy and budgeting services as part of case management services. A staff member at BAMSI stated that among the barriers to families’ financial stability there is a dearth of skills, as well as an inability to prioritize learning them, particularly when household members have little previous experience or knowledge of personal financial management. Faith Frazier, from BAMSI, explains that clients do not take advantage of credit repair services because they are overwhelmed by everything else. The multiple challenges that bring a family to the brink of eviction—which may include employment, physical and mental health, and domestic issues—often create a self-sustaining cycle of crisis that stands in the way of the ability to pursue practical changes that could significantly lead to maintaining permanent tenancy. MOC, NEFWC, NSCAP, and BAMSI report that the main reason many families participate in prevention and diversion programming is their lack of financial management skills and knowledge.

High Demand for Housing and Stabilization Services

Staff members in our interview sample agreed there is a significant need for more affordable housing in Massachusetts. Additionally, they offered a lengthy list of other social services essential to effectively stabilizing households. These services include: financial literacy programs, education, jobs training, welfare-to-work programs, housekeeping, mental health support, improved public transportation (particularly for cities and towns outside the Boston metropolitan area) and affordable
childcare. The demand for such services heavily outweighs supply. The statement heard most often from case managers and other agency staff interviewed was that even with housing assistance, a household cannot be fully stabilized without additional social supports.

Agency staff members often noted the faults in many programs designed to support needy families. A single mother, for example, is required to work 30 hours per week or participate in job training in order to secure a childcare voucher from the Transitional Aid to Families with Dependent Children program. However, without childcare (or a family to watch her children), she will not be able to fulfill the required 30 hours. One agency staff member reported, “the lack of affordable childcare prevents a lot of people from working. Childcare costs can be a minimum of $400 per month with a childcare subsidy.”

**Implementation Challenges**

While every agency faces a unique set of circumstances and obstacles to program implementation, several common themes emerged from our sample. We recognize that addressing these issues are not necessarily within the purview of agencies or DHCD to change. However, we believe that bringing such challenges to light is a useful exercise, as it may allow the actors involved to more effectively share their successful management strategies. We hope it may also be useful for future discussions on successful implementation of HPRP and the Housing First approach.

First, caseworkers have found it challenging to efficiently and effectively verify and document clients’ eligibility. Staff members reported finding the process frustrating and time consuming and could be better spent on relationship-building and assessment. To help overcome this challenge, providers have encouraged referring agencies to perform preliminary eligibility assessments in order to speed up this process.

Second, agency staff from all participating agencies found HPRP reporting requirements to be confusing and
unduly cumbersome. Federal and state HPRP guidelines for eligibility, implementation and reporting requirements differ, and some agencies receive HPRP funding from both DCHD and HUD. In addition, the technology and documentation infrastructure required for HPRP reporting was not always in place in agencies at the initiation of the funding period and has been a challenge to adopt afterwards.

Similarly, case managers have found it difficult in many circumstances to conduct effective exit interviews with families leaving the program. In some cases, such interviews are actually impossible because families may be unreachable—they may have abandoned their accommodations, lost or changed phone numbers, and ceased to contact their case manager. In response, agencies have collaborated with DTA offices to find families and track their status after they exit the program, but the success of such efforts has varied.

**CAPACITY**

Capacity measures gauge the degree to which an agency is able to mobilize the resources necessary to fulfill its mission. We aim to determine: (1) the effects of HPRP funds and policy on program implementation; and (2) the resources which might be augmented. We asked the respondents the following questions related to program capacity:

- How has HPRP funding affected client volume and/or programming?
- What DHCD or HPRP policies have specifically supported or hindered agency processes?
- What challenges seem insurmountable? What additional resources do agencies need to carry out their work?
Benefits of HPRP on Program Implementation

Improved Services

HPRP funding has increased provider capacity to carry a greater caseload for most agencies, although it does not seem to have significantly affected the kinds of services and programming offered. One agency staff member summed up a sentiment heard from many others: “[HPRP] didn’t change the way we do business, but helped what we do.” That agency was able to hire a new case manager, expand its family services, and also extend services to at-risk individuals, a group previously unattended to by the agency.

Six out of the nine interviewees indicated that HPRP funding has not fundamentally changed the nature of their organization’s programming, but has improved program execution. This is especially true for agencies that previously offered homelessness prevention services prior to HPRP, because the infrastructure and processes for such programming were already in place. Various providers stated that services similar to HPRP family diversion and eviction prevention were provided to families prior to the existence of HPRP, but under a different name. Prior to HPRP, for example, one agency offered eviction prevention services to families using a system called Toolbox. The provider stated, “the same services we are providing under HPRP funding just has a different language compared to the prevention services we did prior to HPRP. Prevention has always been around.”

HPRP funding has also allowed grantee agencies to increase staff size. One provider stated “not only has the HPRP program allowed us to stabilize families, it has also created jobs. We were able to hire a new staff member under the HPRP program.”

Administration

One noticeable effect of the HPRP is its ability to help set standards for program requirements. Specifically,
structured requirements for client eligibility, established by HPRP policy, has translated to formal adoption of these standards by agencies. This standardization has allowed agencies to more easily establish a basic point of reference from which to determine program eligibility. Moreover, although providers previously had data collection and eligibility systems and procedures in place, HPRP has helped to raise the bar for data collection and documentation. The establishment of such standards has made requirements clear for both caseworkers and clients, which ultimately can lead to a more efficient use of time.

HPRP funding has additionally allowed agencies the freedom to allocate time and resources in order to spend more time engaged in preventative rather than punitive activity. For example, one agency we interviewed reported that a significant portion of its resources and staff time were devoted to tenant eviction litigation, a lengthy and expensive process that cost the housing authority approximately $10,000 per case. Staff from that agency reported, however, that HPRP funding has allowed them to help clients stave off eviction through financial assistance for rent and utility arrearages—leading to an 80% reduction in home eviction cases. At the same time, the agency has been able to connect clients with a range of other services focused on helping families improve their ability to build and maintain housing stability over the long term.

Program Limitations

The HPRP provides an opportunity for increased funding and implementation improvements for grantee agencies. HPRP policy design, however, includes several stipulations and requirements for the use of program funds. One of the goals for this report was to determine whether program requirements had limiting effects on agency capacities, and to identify specific aspects of the program design that had the greatest impact on capacity.
Client Eligibility

The primary limitation cited by agency staff centers on restrictive client eligibility requirements and assistance limitations, even though it does help with clarity. For example, two providers reported that the requirement for families to meet DHCD’s EA eligibility standards limited their ability to serve a range of client populations. According to the agency staff, this was particularly frustrating given that HUD’s issued HPRP funds came with no such restriction. Many staff members pointed to the need to serve a wider range of clients, beyond the 50% AMI eligibility limit. Families are being turned away from the program in some circumstances for having too high an income, yet agency staff noted that such families are almost always equally at risk of homelessness as those earning less.

One provider estimates that their program denies approximately 10% of requests for service because family income exceeds the income benchmark set by HPRP, but these are certainly still in need of some assistance. The benchmark is additionally adjusted for family size, so smaller families, such as a single mother and one child, have even lower cutoff points for income eligibility. Incomes are thought to be too high for HPRP assistance. Another provider has noticed a decrease in the number of households in their diversion program, and speculates that this may be caused by households not meeting HPRP criteria for diversion assistance. They question whether these criteria are still relevant in the present
economic environment since an increasing portion of their clientele are reporting low- to no-income.

One provider goes beyond questioning the specific income requirements and questions the applicability of the verification process itself, which requires clients to provide specific documentation and complete paperwork from governmental agencies. When asked about the requirements for income certification, one provider replied: “What works for Boston doesn’t work for western Massachusetts.” If clients cannot make their verification appointments, they may be tagged as “nonresponsive” and services may be canceled, although this problem may be particularly challenging in areas with limited public transportation.

Although most agency staff reported that HPRP funding allowed them to increase caseload, one case proves an interesting exception to this trend. One provider reports that DHCD contracts have restricted them to exclusively serving the two housing authorities in their region. This limitation prevents them from maximizing their caseload capacity, although this may be related to the specific contract signed between the agency and DHCD, and therefore not experienced by other grantees.

**Services Funded under Program**

The variety of services included in the program design is another limitation noted by agency staff. For the providers agencies focused on providing financial assistance, only being allowed to cover specific types of payments under the prevention component of HPRP has been especially limiting, as there is demonstrated need for assistance with a much larger range of financial costs. Agency staff also noted a need to pay for arrearages beyond six months, as most clients owe eight or more months of back rent.

**Need for Additional Resources**

Almost unanimously, all providers cited a need for
more funding (or at least more flexible money) and increased staffing. Providers agreed that with increased funding and staff, comes increased accomplishments and improved abilities. For example, BAMSI staff noted that some clients need more than the 12 to 18 months of assistance the agency currently offers in order to achieve housing stability. Another provider noted that the agency’s two staff members (a case manager and a diversion specialist) are overloaded by needing to work with current clients, while simultaneously screening potential program participants. The agency’s caseload is therefore constantly increasing and it becomes impossible to keep up with all program families.

Some providers report that funding for program administration is limited, which presents a hardship for agencies. Faith Frazier, from BAMSI, explained that her agency covers a large percentage of their own administrative needs because HPRP funds do not meet the full costs of administering the program. To do this, BAMSI strategically funds HPRP administration costs by folding it into the administration of other in-house services provided (WIC, family services, information referral program).

**IMPACT**

Evaluation of a program’s impact assesses the overall degree of mission success, and the outcomes that result. We therefore seek to determine: (1) whether providers are meeting the projections put forward in their initial contracts with DHCD; and (2) whether HPRP funds are reaching the intended target population—families at imminent risk of homelessness. To that end, we asked respondents the following questions:

◊ What goals have been set towards meeting program expectations?

◊ Is the HPRP program meeting its established goals?
What is the process for assessing need?

In what ways has the program been successful? In what ways has it been problematic or disappointing?

What services are most essential to successful homelessness prevention?

Agency Outcomes

We used DHCD contracts with grantee agencies as indicators of the agencies’ program goals, and used DHCD quarterly progress reports of number of households served and participant destinations as indicators of actual outcomes. An overview of these data sources points to an overarching pattern among agencies. Of the eight grantees that included specific numerical outcomes in their contracts, we found that five had exceeded their service expectations, two were below and one was on par.

While most agencies are meeting and surpassing their service volume expectations, they have been less successful in meeting their anticipated prevention and diversion outcomes. In fact, none of the agencies have met their first year projections for the number of clients to successfully house, and none seem to be on pace to meet their longer-term (15+ months) expectations. We expect that contracts were written using anticipated exit rates to calculate their prevention and diversion projections. Generally the language follows, “we will serve X number of clients and Y% of them will be diverted/stabilized within some time period.” We found anticipated exit rates ranging from 75 to 100%. However, only 642 of the 1,764 participants (36.4%) have exited the homelessness prevention program (DHCD APR, 2010). This disparity suggests that the process for successful prevention and diversion is longer than originally expected. We highly recommend following up on agency outcomes after the completion of the program’s two years, as the initial learning curve may have leveled out for many providers, allowing them to more efficiently serve clients.
All agencies are also required to monitor the housing situation of clients that have exited the program, or those who have received a course of services. This measure tracks whether exited families are in permanent housing (rental by client with or without housing subsidy, or stably living with family or friends) or temporary housing (emergency shelter, temporarily staying with family or friends, or a place not meant for human habitation) (Figure 4). Based on the DHCD annual progress report, we found that 76% exited the program into permanent housing (47% subsidized, 17% non-subsidized, 12% permanently staying with a family member or friend). Six percent exited into temporary housing (either in an emergency shelter or temporarily staying with family or friends), and none of the clients has exited the program into institutional housing, such as prisons and mental health facilities. A small number of clients have deceased, or have unknown housing situation (18%).

The Target Population

For the sake of comparison, we assume that the population targeted by HPRP would enter the emergency shelter system without prevention-based intervention. The validity of this assumption varied across our interview sample. Some contracts outline more specific efforts than others to target hard-to-reach populations. Some agencies explicitly target families with behavioral challenges (such as mental health and/or drug abuse, domestic violence, landlord and tenant conflicts, hoarding, non-compliance with inspection requirements), and/or financial problems (including rent and utility arrearages, budgeting, credit and payment repair, financial literacy). Other agencies cast a somewhat broader net and have no such specific criteria for their target populations. For example, the City of Worcester is contracted to serve families based on the likelihood that assessments and economic development and stabilization plans will lead to success.

Individual client recruitment and assessments are conducted through formal and informal mechanisms.
Many agencies rely on referring organizations to screen clients, while others provide screening on their own. For example, Massachusetts Opportunity Council—a subcontractor for the City of Worcester, uses a system called Community Action Access Point (CAAP) to initially determine client need. CAAP looks at the client’s needs, such as housing, childcare, transportation, and healthcare. Based on the answers provided by the client, he or she is linked to in-house services that will help meet the needs identified during the screening process.
The following recommendations are based on the research team’s findings, including the quantitative and qualitative data analyses presented throughout this report. These recommendations represent course corrections that may be implemented in the short term, as well as longer-term adjustments that may be more useful to future programming implemented by DHCD through grantee agencies around the state. The recommendations may also provide guidance for other states that are considering adoption of a homelessness prevention program model. The generally positive relationship we observed between DHCD and its partner agencies will be considerably helpful in any efforts the Commonwealth is able to make now to improve HPRP implementation, and of course such decisions must be made with respect to programmatic best practices and the current environment of significant fiscal constraint.

1. **Measure the frequency of client repetition.**
   Currently, reporting requirements include the average length of time clients spend in the program, and whether clients who have exited the program are in stabilized
housing. Current reporting does not, however, measure whether the same clients who have exited the program return again at a later date. Such data would indicate the degree of sustainability achieved, offering the opportunity to quantify correlation between long-term stability and program activities. This data collection may not be feasible for short-term programs like HPRP, but is essential for truly understanding the impacts of prevention-based programming.

2. **Expand client eligibility criteria.**

Many providers reported having significant client populations that were in need of prevention and diversion services but were unable to receive HPRP services due to program eligibility requirements. The current program guidelines are designed to target the most needy populations, but prevention-based services are needed by a much wider population. We recognize that such expansion is not likely to be within the power of DHCD or other state agencies, but rather reflects the larger political climate and funding scarcity.

3. **Increase funding flexibility.**

A common theme among providers is the desire for more flexibility regarding the use of prevention programming funds. Many other needed services that relate to housing stability should be incorporated into future prevention-based programs, including: funding for childcare, education and GED programs, mental and general health services, and welfare-to-work services. Although these do not represent housing costs per se, many providers felt that increasing the capacity of available funds to meet such needs would positively contribute to more sustainable housing outcomes for
clients. Such interagency collaboration will require breaking down of current disciplinary silos, and can ultimately lead to improved client outcomes.

4. **Increase support for administrative requirements.**

The current level of provider autonomy has allowed for grantee agencies to successfully capitalize on their existing infrastructures and resources while integrating their programming into the overarching HPRP model. To help fit into the larger HPRP model, however, we believe it would be a worthy investment for future programs to provide grantee agencies with initial training for reporting requirements, all necessary administration requirements, and client eligibility requirements. This training should be provided for both administrative personnel and case managers.

5. **Plan for increased demand.**

HPRP funding has increased provider capacity and allowed agencies to expand services to a larger number of clients. The success of this program has been so great, however, that demand for services in some cases has ultimately led to overwhelming caseloads. It may be useful in the future for DHCD or grantee agencies to develop a plan for how to manage caseloads when demand exceeds agency capacity.
As the only state in the country with a right to shelter, Massachusetts has incentivized a significant challenge and opportunity for itself to implement progressive programming that maximizes both cost-effectiveness and, more importantly, positive impacts on homeless individuals and families. Housing First programs present a persuasive alternative to shelter living. Emergency shelters will continue to be a crucial component of the safety net for families facing a housing crisis, but transitioning individuals and families out of shelters should take top priority.

This evaluation of the Commonwealth’s HPRP-funded family eviction prevention and homelessness diversion programming has addressed the first year of program implementation on three levels: activities, capacity and impacts. One year into the program, DHCD’s grantee agencies have made some significant strides in terms of quickly adjusting to the new funding and the shifts in programmatic structure and capacity it necessitated. It is too early to see the initiative’s ultimate impact on the rate of family homelessness in Massachusetts, but the enthusiasm of DHCD’s grantee
agencies for the program indicates that HPRP may indeed provide an impetus for important changes in Massachusetts’ approach to preventing homelessness and keeping families from having to enter the shelter system.

Massachusetts’ housing and social service providers continue to work creatively and tirelessly to meet the needs of the populations they serve. While HPRP funding has temporarily increased the capacity of these agencies to provide services to families at risk of homelessness, it is clear that demand for such support continues to significantly outstrip supply. With the launch of HPRP, agencies have made rapid shifts to new policies, procedures and reporting requirements in order to utilize HPRP funding to reach the greatest possible number of families. They have clearly been overstretched at times, and have presumably faced significant organizational challenges in integrating these new priorities into their existing--and already burdensome--operations. Yet the consistently positive attitudes we encountered among agency staff demonstrate their passion and commitment to doing whatever they can to decrease homelessness and improve the lives of their clients, and belied the burnout that is so common and understandable among social service providers. DHCD is somewhat constrained by federal restrictions on HPRP funding, but there are a number of steps it can take to better facilitate the hard work of its grantee agencies.

A number of challenges were identified, some of which can be addressed immediately, while others will require long-term policy change on a larger scale than any one state or federal agency can generate. In the short term, the Commonwealth’s HPRP programming would benefit from agency capacity-building to clarify expectations, support more efficient program administration and reduce paperwork. Greater flexibility in funding usage and program eligibility would allow grantee agencies greater opportunity to realize their missions and reach more families with the available funding. That said, further expansion should be approached with caution, as it is
unclear that agency staff would continue to be able to offer services of the necessary quality as they stretch limited funding—and themselves—ever thinner. Ultimately, despite the implication of placing another reporting burden on service providers, better long-term data collection and analysis are needed to understand the true impacts of HPRP programming families, and how they fare in the months and years following their exit from the program. Successful implementation of family HPRP and other Housing First programming will require that policymakers and service providers address these barriers collaboratively, while recognizing their own limitations.

An interim evaluation allows for modifications and improvements partway through implementation. We commend DHCD for undertaking this important and often overlooked step and endeavoring to make what improvements it can at this time, and we particularly appreciate its emphasis on qualitative analysis that expands the definition of success beyond financial calculations. We also strongly recommend that a final evaluation be executed at the end of the program’s two years to account for any changes that may occur in the second half of the program’s lifespan, and ensure that lessons from the HPRP program may guide future policymaking and programming as much as possible.

In the long term, agencies’ experiences clearly suggest that HPRP is not enough. While immediate housing and stability support are critical to ending family homelessness, families’ long-term ability to maintain stable homes is the ultimate measure of success. For this to happen, policymakers and providers must think beyond “Housing First” to “Housing Always” with a clear commitment to preventing initial episodes of family homelessness risk as well as repeat episodes. Reducing the number of families enduring eviction and seeking emergency shelter is a notable accomplishment; stabilizing families so that they do not continuously find themselves in the stressful and precarious position of being at risk of homelessness would be a much greater accomplishment yet.
References


Massachusetts Department of Housing and Community Development (2010) Legislative Report 3rd Quarter.


Appendix A

List of Interview Questions

1. DHCD has contracted **PROVIDERNAME** to provide **SERVICE**. Please explain what this entails.

2. **SUBGRANTEE** ONLY: Why did **PROVIDERNAME** decide to contract out to **SUBGRANTEE**?

3. How often does a case manager meet with a family ( # of Days/wk & hrs/meeting)? In your opinion, is this amount of time sufficient to fully meet the family’s needs?

4. When referring families for outside services, does a staff member contact that agency on the family’s behalf? Why or why not?

5. What goals have **PROVIDERNAME** set towards meeting HPRP expectations?

6. How does **PROVIDERNAME** reach out to the target population informing them about services **PROVIDERNAME** provide?

7. On a monthly basis, how often do requests come into the organization for these services? Out of that number of requests, how many are addressed & completed?

8. What services are in the greatest demand from families?

9. How many families seeking services are turned away from your program each month and why (for ineligibility, etc.)?

10. Are specific eligibility requirements preventing families from receiving assistance? In your opinion, are certain HPRP requirements unreasonable for the population **PROVIDERNAME** serves?

11. What do you see as the most significant factors limiting your ability to meet family’s needs in HPRP-related programs?

12. In an ideal situation, what additional resources do you feel would help you best serve families? What are the barriers to obtaining such resources?

13. Have you experienced situations in which specific DHCD/HPRP policies particularly supported or prevented your ability to meet family’s needs? Please describe.
14. How has DHCD/HPRP funding impacted your client or service volume? How has it impacted programming?

15. In what ways do you feel the program has been successful?

16. In what ways has the program been problematic or disappointing?

17. Are there other services at PROVIDERNAME provided to HPRP family's that are not funded by DHCD/HPRP funds?

18. Has receiving DHCD/HPRP funding changed the way you handle clients’ cases? How?

19. Does PROVIDERNAME collaborate with other organizations/institutions, within the area being serviced, on housing/homelessness-related programming? Who? What is the nature of collaboration? If collaboration is not present, please explain why not.
Agencies included in evaluation

*Note: agencies in bold were included in the interview analysis

BAMSI Helpline
City of Worcester
Community Action Committee of Cape Cod and Islands, Inc. (CACCI)
Community Care Services, Inc (CCS)
Community Teamwork, Inc (CTI)
HAPHousing (HAP)
Metro Boston Housing Partnership (MBHP)
New England Farm Workers Council (NEFWC)
North Shore Community Action Programs (NSCAP)
South Middlesex Opportunity Council (SMOC)
Springfield Housing Authority
Worcester Housing Authority
Appendix C

Tufts University IRB Protocol Approval

OFFICE OF THE VICE PROVOST
Social, Behavioral, and Educational Research
Institutional Review Board
FWA00002963

Re: IRB Study # 1102042
Title: Evaluation of MA Homelessness Prevention and Rapid Rehousing Program. Provider Interviews.
PI: Rachel Gordon
Department: Urban and Environmental Policy and Planning
Co-Investigator(s): Carl Onubogu, Blake Roberts, Samantha Sandoval, Sophia Burks
Faculty Advisor: Rachel Bratt
IRB Review Date: 2/24/2011

February 24, 2011

Dear Rachel,

This is the official notification that your project, Evaluation of MA Homelessness Prevention and Rapid Rehousing Program. Provider Interviews, protocol # 1102042 does not meet the definition of human subject research under the Code of Federal Regulations Title 45 Part 46.102(f); therefore is not subject to review by the Institutional Review Board.

Please bear in mind that this exclusion only applies to the interviews you plan to conduct with the Providers. You still need to submit a revised application for Expedited Review under Category 7 to cover interviews with both Participants and Staff.

Please be sure to file this notification.

Sincerely,

Yvonne Wakeford, Ph.D.
IRB Administrator
Appendix D

Memorandum of Understanding
between
Tufts University Field Projects Team No. 5
and
Massachusetts Department of Housing and Community Development

I. Introduction

Project number: Team #5
Project title: An Interim Evaluation of the Commonwealth’s Homelessness Prevention Initiatives under the American Recovery and Reinvestment Act
Client: Massachusetts Department of Housing and Community Development

This Memorandum of Understanding (the “MOU”) summarizes the scope of work, work product(s) and deliverables, timeline, work processes and methods, and lines of authority, supervision and communication relating to the Field Project identified above (the “Project”), as agreed to between (i) the UEP graduate students enrolled in the Field Projects and Planning course (UEP-255) (the “Course”) offered by the Tufts University Department of Urban and Environmental Policy and Planning (“UEP”) who are identified in Paragraph II(1) below (the “Field Projects Team”); (ii) DHCD, further identified in Paragraph II(2) below (the “Client”); and (iii) UEP, as represented by a Tufts faculty member directly involved in teaching the Course during the spring 2011 semester.

II. Specific Provisions

(1) The Field Projects Team working on the Project consists of the following individuals:

1. Samantha Sandoval  
   email address: 
2. Carl Onubogu  
   email address: 
3. Blake Roberts  
   email address: 
4. Rachel Gordon  
   email address: 
5. Sophia Burks  
   email address: 

Tufts Field Projects MOU Spring 2011 Page 1
(2) The Client’s contact information is as follows:

Client name: MA Department of Housing and Community Development
Key contact/supervisor: Brendan Goodwin
Email address: [redacted]
Telephone number: [redacted]
FAX number: [redacted]
Address: 100 Cambridge Street, Suite 300, Boston, MA 02114
Web site: www.mass.gov/dhcd

(3) The goals of the Project are:

☐ Review and evaluate the services aimed at stabilizing families being provided by a representative sample of DHCD’s HPRP grantees. These services include:
  • Case management;
  • Referral services and;
  • Financial assistance.
☐ Study the cost-effectiveness of the family homelessness prevention (eviction prevention and diversion) components of DHCD’s Homelessness Prevention and Rapid Re-housing Program (HPRP) (contingent upon available time and resources)

(4) The methods and processes through which the Field Projects Team intends to achieve these goals are:

☐ Conduct interviews with case managers, program managers, other key informants and possibly with program clients (pending IRB approval)
☐ Review case management files and/or reports (pending IRB approval)
☐ Analyze data from client service plans and outcomes collected by DHCD
☐ Conduct a literature review that includes comparative research and analysis of similar programs

(5) The work products and deliverables of the Project are:

☐ An interim progress presentation mid-way through the project
☐ A final written report to include:
  • Executive summary of report’s major findings and recommendations
  • An analysis of the available data (numbers, demographic information, outcomes, costs) of households that have been diverted from shelters or who have not become homeless due to HPRP assistance; this will be based on either a full sample or a sub-sample of the six Family Eviction Prevention contracts and the eight Family Diversion contracts that DHCD has with grantees across the state;

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- An overview of the types of prevention interventions being conducted by DHCD HPRP subgrantees;
- An analysis of the cost-effectiveness of prevention vs. shelter (shelter costs, hospital costs, eviction costs, and so forth) for families based on already-established metrics of previously conducted research (contingent upon available time and resources);
- Recommendations for best practices, as demonstrated by individual HPRP providers in Massachusetts; and
- Review of the literature on shelter diversion and homelessness prevention initiatives, along with available discussions of assessments that have been performed.

(6) The anticipated Project timeline (with dates anticipated for key deliverables) is:

- February 18, 2011 – Proposed list of interview subjects submitted to DHCD for review.
- Week of March 14, 2011 - Interim presentation to DHCD staff
- April 13, 2011 – Draft final report submitted to DHCD for review
- April 20, 2011 – May 3, 2011 - Final presentation (to be determined)
- May 6, 2011- Final deliverables/report due

(7) The lines of authority, supervision and communication between the Client and the Field Projects Team are (or will be determined as follows):

Brendan Goodwin is the Team’s main supervisor and contact person at DHCD. The faculty team is Rachael Bratt and Pete Kane. Blake Roberts will be mainly contacting Mr. Goodwin regarding logistics, while other team members may be contacting Mr. Goodwin and DHCD staff regarding project content. Contact will be primarily via email, with phone calls being made as needed.

In addition, informal updates on project progress and developments will be given to DHCD on a biweekly basis via telephone or email and are intended to present interesting findings and to help address unanticipated course changes or need for access to additional information.

(8) The understanding with regard to payment/reimbursement by the client to the Field Projects Team of any Project-related expenses is:

There will be no payment/reimbursement by DHCD to the Team for any project-related expenses.
III. Additional Representations and Understandings

A. The Field Projects Team is undertaking the Course and the Project for academic credit and therefore compensation (other than reimbursement of Project-related expenses) may not be provided to team members.

B. Because the Course and the Project itself are part of an academic program, it is understood that the final work product and deliverables of the Project (the “Work Product”) – either in whole or in part – may and most likely will be shared with others inside and beyond the Tufts community. This may include, without limitation, the distribution of the Work Product to other students, faculty and staff, release to community groups or public agencies, general publication, and posting on the Web. Tufts University and the Field Projects Team may seek and secure grant funds or similar payment to defray the cost of any such distribution or publication. It is expected that any issues involving Client confidentiality or proprietary information that may arise in connection with a Project will be narrow ones that can be resolved as early in the semester as possible by discussion among the Client, the Field Projects Team and a Tufts instructor directly responsible for the Course (or his or her designee).

C. DHCD can access and review all research data and notes, except in regards to those materials that contain confidential information and identification, per IRB regulations. DHCD cannot alter any content of the final report. If DHCD chooses to summarize or selectively cite the final report, a disclaimer in reference to the original report and its access should be included. DHCD may distribute the final report in its entirety as it deems fit.

D. It is understood that this Project requires the expedited review and approval of the Tufts University Institutional Review Board (IRB). This process is not expected to interfere with timely completion of the project.
IV. Signatures

Signature: [Signature]
Representative of the client
By: (printed name) Brendan Goodwin
Date: February 15, 2011

Signature: [Signature]
Representative of the Field Projects Team
By: (printed name) Sophia Burks
Date: Feb. 16, 2011

[Signature]
Tufts UEP Faculty Representative
By: [Signature]
Date: 2/16, 2011