Homelessness in New Bedford

Assessing the MA-505 Continuum of Care's Response to Homelessness

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Executive Summary

Like many communities across the nation, New Bedford, MA has seen increasing rents and home prices. An estimated 68% of New Bedford renters pay more than one third of their monthly income on housing, making it more likely that one health crisis, loss of income, or sale of the rental property can make previously affordable housing unaffordable and even result in an experience of homelessness. The City of New Bedford is concerned with ensuring that all City residents have a safe and affordable place to call home. They have commissioned this report to analyze the New Bedford homelessness response system and provide recommendations for system improvement, including the feasibility of a regional center approach and considerations for a merger of Continuums of Care (CoCs), the US Department of Housing and Urban Development's designated body to address homelessness in a given region.

New Bedford's strongest asset in its efforts to prevent and end homelessness is the Office of Housing and Community Development (OHCD), which was consistently recognized as an anchor in this work. People with lived experience of homelessness also lifted up a network of dedicated service providers where they were able to get their basic survival and stability needs met. The City has a dedicated group of community advocates and volunteers who provide time and material resources to supplement formal grant funded programs to address homelessness. When New Bedford's CoC, MA-505, merged with the Greater Bristol County/ Attleboro/ Taunton Coalition to End Homelessness (CoC MA-519), OHCD agreed to assume the collaborative applicant role, bringing experienced leadership, a robust fundraising committee, and a solid coordinated entry system (used to efficiently assess, prioritize and match people with available housing) to the newly formed Bristol County Continuum of Care (BCCC). The city also received a one-time allocation of HOME-ARP funds, which offers an opportunity to build the infrastructure needed to expand system capacity.

These system strengths provide a solid foundation to address system gaps and barriers. The emergency shelter system meant to support people through a crisis is overwhelmed, under-resourced, and lacking support services like housing navigation. New Bedford has almost twice as many subsidized units of housing as neighboring towns, but the current portfolio of targeted permanent supportive housing (PSH) is disproportionately focused on serving people with substance use disorder, leaving out people with other severe service needs. More low-barrier PSH for single adults is greatly needed. Rapid rehousing and homelessness prevention are underutilized in the existing system. Best practice frameworks in Housing First, trauma-informed care and harm reduction are inconsistently applied by service providers. Leadership in the workforce is aging, and staff turnover is high, affecting continuity of care and depth of skill. There is unrealized partnership potential with hospitals, law enforcement, and the private housing market.

This report is presented to assist the City of New Bedford and OHCD in their strategic planning and implementation of best practice models so that they might quickly rehouse people experiencing homelessness, keep them housed, and ultimately prevent people from entering homelessness in the first place. As OHCD has been named the collaborative applicant for BCCC, data from former CoC MA-519 is included in the gaps analysis where appropriate, and recommendations include actions that OCHD can apply both within the City and beyond its borders.

Summary of Recommendations

Diversify Housing and Services

1. **Expand permanent supportive housing** supply for individuals with high service needs.
2. **Leverage Medicaid, medical respite, and hospital partnerships.**
3. **Expand rapid rehousing and transitional care models** to meet a wider range of housing needs.
4. **Shift shelter and emergency service models** to non-congregate, service-rich programming.
5. **Provide flexible financial assistance** to prevent homelessness or quickly resolve a housing crisis.

Use Policy Levers to Maximize Housing Resources

1. **Enforce landlord requirements** and implement incentives.
2. **Leverage the Violence Against Women Act (VAWA)** for housing retention among survivors.
3. **Partner with the Housing Authorities** to set homeless preferences.
4. **Target affordable housing development** at all income levels, with set-asides for people exiting homelessness and a pipeline of targeted permanent supportive housing.

Regionalize the Provision of Services

1. **Invest in communication for better coordination** both within the CoC and in external messaging.
2. **Make adjustments to the Coordinated Entry process** to improve match with housing opportunities.
3. **Offer more one-stop programming** in existing providers and **Establish a Regional Center** with smaller satellite centers in each municipality.
4. **Standardize trauma-informed response** in law enforcement.

Invest in the Service Provider Workforce

1. **Provide the existing workforce** with best practice training and tools.
2. **Diversify and build leadership capacity** among youth, people with lived experience, and agency partners.
3. **Shift success measures** to center actions within staff control.

Strengthen CoC Governance

1. **Deepen partnership** with people who are now experiencing or have formerly experienced homelessness.
2. **Use data** to help inform decision-making and drive resources.
3. **Develop and dedicate resources** to CoC leadership and initiatives.

Methods

Over a period of six months, beginning in November 2023 and continuing into April 2024, the Technical Assistance Collaborative (TAC) conducted a review and analysis of the City of New Bedford's current response to preventing and ending homelessness. A document review included the following key strategic planning documents, data sources, and a review of media articles related to housing and homelessness in the region.

- New Bedford's five-year Consolidated Plan
- Analysis of Impediments Plan
- Building New Bedford Plan
- FY22/FY24 Action Plans
- HOME ARP Allocation Plan
- US census data
- Real estate data
- HUD's Longitudinal Systems Analysis
- Point in Time Count
- Housing Inventory Count and Systems Performance Measures for New Bedford and GBCATCH CoCs
- MA-505 and MA-519 CoC governance documents
- Newly formed BCCC governance documents
- 2023 CoC applications for MA-505 and MA-519
- FY2023 award distributions for MA-505 and MA-519 CoC, and New Bedford Emergency Solutions grants
- 2024 Racial Equity Assessment and Action Plan
- HEART Outreach protocol

TAC created and distributed a survey to service providers in New Bedford and Bristol County, and 49 people responded. We held focus groups with people experiencing homelessness in the region, service providers in the region, and Housing Service Provider Network (HSPN; CoC MA-505) Executive Committee members. Twenty-six people experiencing homelessness participated in focus groups held in-person in New Bedford, and eight people experiencing homelessness participated in a Taunton-based focus group for broader regional perspective. Participants were recruited by trusted staff members at outreach sites, and were provided a meal and a financial stipend for their time. Two virtual service provider focus groups were held with seven service providers recruited from the system-wide survey. A special meeting of the HSPN Executive Committee (nine attending members) was called to engage CoC Board Leadership. Finally, key informants were identified for longer one-on-one interviews with questions tailored to their unique areas of expertise. These interviews consisted of four system leaders from both CoCs, two regional business leaders, two local community advocates, one government representative of New Bedford, and three service providers. Survey and focus group questions are located in Appendix C.

Two interim summary report-out meetings were held in January and March 2024 with New Bedford leadership, and feedback provided at these meetings was incorporated into subsequent work and steps. Several models were created to project the numbers of people expected to experience unsheltered homelessness over the next 10 years, using three different scenarios to show how investments would affect this measure (see Projection of Need section). The team researched best practice examples of communities and projects that have the potential to enhance the work currently being done to address homelessness in the region.

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Community Background

Located south of Boston and east of Rhode Island, a significant portion of southeastern Massachusetts is occupied by Bristol County, including the entire municipal boundary of the City of New Bedford.[1] The region is partially connected by fixed-route and paratransit service with limited schedules. Taunton, New Bedford, and Fall River are currently the only major cities in Massachusetts within 50 miles of Boston without Massachusetts Bay Transportation Authority (MBTA) Commuter Rail access to Boston. However, it is anticipated that the South Coast Rail project scheduled for opening in 2025 will reconnect the region to Boston, impacting job opportunities and economic development for residents.

U.S. Census data from 2020 provides a high-level overview of the area's demographic composition. The largest cities in Bristol County each have primarily White and non-Hispanic/Latina/e/o populations, with New Bedford standing out as having the lowest population of White and non-Hispanic/Latina/e/o residents. New Bedford also has a significantly higher population of Hispanic/Latina/e/o residents (23.1%) compared to the other largest cities in the region.[2] Historically, the region's industries - including whaling, textiles, and cranberry production - drew Portuguese, Azorean, and Cape Verdean migrants to the area in the 19th and 20th centuries. Today, the area is home to one of the largest Portuguese-American populations in the U.S. In 2014, over 25% of the foreign-born Portuguese speaking population in the U.S. lived in Massachusetts, and some of the largest foreign-born Portuguese-speaking populations in the Commonwealth resided in New Bedford and other parts of Bristol County.[3] At the time, 42% of foreign-born Portuguese speakers in Massachusetts were Brazilians, followed by Portuguese (28%), Cape Verdeans (18%), and Azoreans (12%).

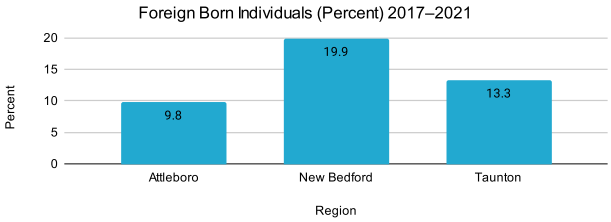
Figures 1–2 offer high-level U.S. Census data on the percent of the population that was foreign-born and the percent of residents five years old and above who speak non-English languages at home for Attleboro, New Bedford, and Taunton. New Bedford appears to have more culturally and linguistically diverse populations.

[1] Former MA-519's jurisdiction consisted of Acushnet, Attleboro, Berkley, Dartmouth, Dighton, Easton, Fairhaven, Freetown, Mansfield, Norton, North Attleboro, Raynham, Rehoboth, Seekonk, Somerset, Swansea, Taunton and Westport.

[2] *U.S. Census Bureau QuickFacts*. U.S. Census Bureau. http://www.census.gov/quickfacts/fact/table/US/PST045223. Accessed 5 January 2024.

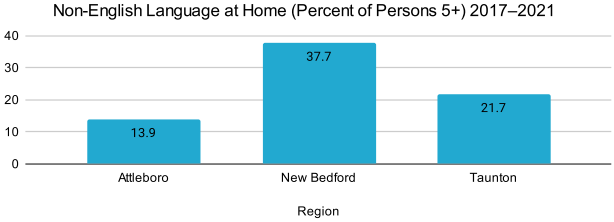
[3] Golden, Brian P. *Portuguese Speakers in Massachusetts*. Boston Redevelopment Authority, 2016, www.immigrationresearch.org/system/files/Portuguese_speakers.pdf. Accessed 5 January 2024.

Figure 1: The graph summarizes data collected from the U.S. Census on the percent of foreign-born individuals in Attleboro, New Bedford, and Taunton.[4]



Source: *U.S. Census Bureau Quick Facts*

Figure 2: The graph draws from the U.S. Census data on the percent of individuals aged 5 years old and above that speak a language other than English at home in Attleboro, New Bedford, and Taunton.[5]



Source: *U.S. Census Bureau Quick Facts*

People Experiencing Homelessness

In 2024, the Greater Bristol County/Attleboro/Taunton Coalition to End Homelessness CoC (formerly recognized by HUD as MA-519 and locally known as GBCATCH) merged into the New Bedford CoC (formerly recognized by HUD as MA-505 and known locally as the Homeless Service Provider Network or "HSPN") to form the Bristol County Continuum of Care (BCCC). Like many communities across the nation, the two former CoCs that now make up the BCCC have recently experienced a rising trend in the number of people experiencing unsheltered homelessness, though the increase has been starker and more linear in New Bedford. HUD's Stella Performance (Stella P) tool offers a way to look at the Longitudinal System Analysis (LSA) data captured through each CoC's Homeless Management Information System (HMIS) and gain an understanding of the demographics and flow of people experiencing homelessness in a CoC. HUD's System Performance Measures (SPM) help communities gauge their progress in preventing and ending homelessness and provide a more complete picture of how well a community is achieving these goals. The data and narratives that follow rely heavily on the most recent LSA data available (October 2022 - September 2023) and trend data from SPM for both the New Bedford and GBCATCH CoCs. Some additional data sources are noted where appropriate.

Demographics

Communities across the country are grappling with how to ensure that access to housing and services is equitable and racially just. New Bedford recently commissioned the New Bedford CoC Racial Equity Assessment and Action Plan (2024), to provide a comprehensive assessment of racial equity in the homeless system and recommendations for action. Based on a survey conducted as part of that assessment, a higher proportion of individuals and families identifying as Black, Indigenous, Cape Verdean; LGBTQI+ populations; older adults; subgroups of people identifying as Asian; and people identifying as Latina/e/o (including recent migrants) were found to be at risk of homelessness within the New Bedford population as a whole.[6]

[4] *U.S. Census Bureau QuickFacts*. U.S. Census Bureau. Accessed 5 January 2024.

[5] *U.S. Census Bureau QuickFacts*. U.S. Census Bureau. Accessed 5 January 2024.

[6] Edwards, Earl, Richard, Molly, and Antelo-Ovando, Mayte. "Racial Equity Assessment and Action Plan." Feb. 2024. City of

In New Bedford, adult-only households are more likely to be male, while adults in family households with minor children are much more likely to be female. Very few adults identify as or disclose their identity as transgender. Table 1 provides a summary comparison of age characteristics for the former New Bedford and GBCATCH CoCs.

Table 1: Key Age-Related Takeaways[7]

New Bedford (MA-505)	GBCATCH (MA-519)	Comparison/Takeaway
31% of single adults are 55 years or older	18% of single adults are 55 years old or older	New Bedford has a greater proportion of older adults compared with the County
34% of people in families are children ages 0-5 and 24% are 6-17	25% of people in families are children ages 0-5 and 39% are 6-17	Children constitute more than half of all people experiencing homelessness in families
Unaccompanied youth (18-24) make up 13% of the single adult homeless population	Unaccompanied youth (18-24) make up 10% of the single adult homeless population	Unaccompanied youth (18-24) are a small but not insignificant portion of the adult homeless population in both New Bedford and Bristol County

Pathways In and Out of Homelessness

According to the most recent LSA data, more than half of adult-only households in MA-505 and MA-519 are leaving shelters and transitional housing to temporary destinations, with the largest group exiting to the street. Families are much more likely to exit to permanent destinations (over 50% in both CoCs), mostly to rent with or without a subsidy.[8] It should be noted that Massachusetts has a right to shelter law for families. As a result, the majority of family shelters and efforts to rehouse families are funded through state resources, not the local CoCs.

Table 2 compares length of time homeless (in emergency shelter, safe haven, or transitional housing) in each of the two newly merged CoCs.

New Bedford Homeless Services Provider Network, New Bedford, MA.

[7] Longitudinal Systems Analysis data from October 2022 – September 2023 viewed via Stella P. Accessed May 2024.

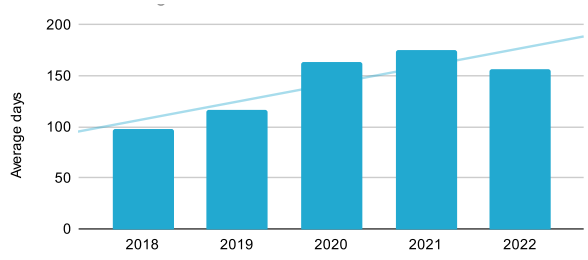
[8] Longitudinal Systems Analysis data from October 2022 – September 2023 viewed via Stella P. Accessed May 2024.

Table 2: Length of Time Homeless Key Takeaways[9]

New Bedford (MA-505)	GBCATCH (MA-519)	Comparison/ Takeaway
50% of adult only households leave within 60 days	44% of adult only households leave within 60 days	Many short stayers among adult only households
13% of adult only households are homeless longer than one year	26% of adult only households are homeless longer than one year	New Bedford has a smaller percent of adult only households experiencing homelessness longer than one year
24% of families are homeless longer than one year	47% of families are homeless longer than one year	New Bedford has a smaller percent of families experiencing homelessness longer than one year

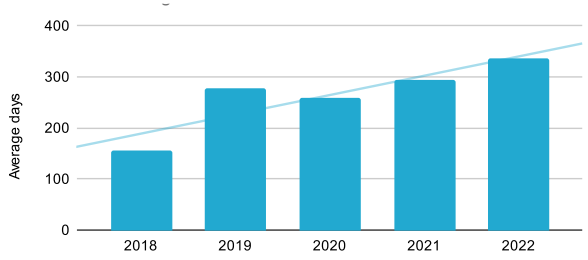
Figures 3–4 show length of time homeless for all households measured over time for each CoC. Both New Bedford and GBCATCH data show an increasing trend in average length of time homeless. The graphs use the mean length of time people spent in shelter (in days) across all populations.

Figure 3: Length of Time Homeless – New Bedford[10]



Source: Longitudinal Systems Analysis data, viewed via Stella P.

Figure 4: Length of Time Homeless - GBCATCH[11]



Source: Longitudinal Systems Analysis data, viewed via Stella P.

The New Bedford CoC and the former GBCATCH CoC both have relatively low rates of returns to homelessness compared to national rates. In the most recent LSA data, fewer than 10% returned to homelessness within 2 years for all types of housing in both CoCs except in one category: In New Bedford, 15% of people exiting transitional housing within six months returned to homelessness.[12]

[9] Longitudinal Systems Analysis data from October 2022 – September 2023 viewed via Stella P. Accessed May 2024.

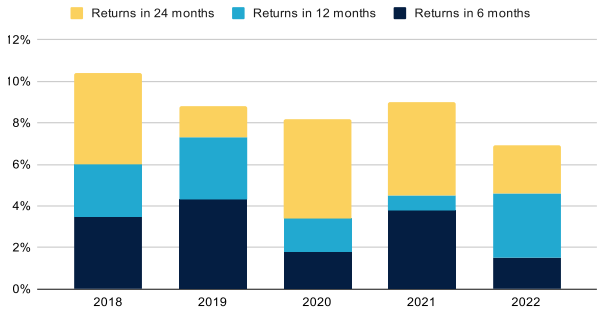
[10] Longitudinal Systems Analysis data from October 2022 – September 2023 viewed via Stella P. Accessed May 2024.

[11] Longitudinal Systems Analysis data from October 2022 – September 2023 viewed via Stella P. Accessed May 2024.

[12] Longitudinal Systems Analysis data from October 2022 – September 2023 viewed via Stella P. Accessed May 2024.

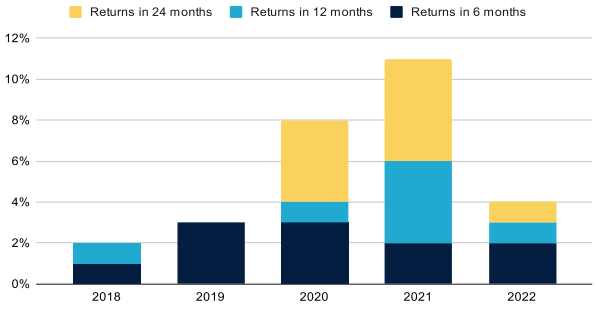
Figures 5–7 show returns to homelessness over time for each CoC, comparing local and national trends.

Figure 5: Returns to Homelessness Over Time – New Bedford[13]



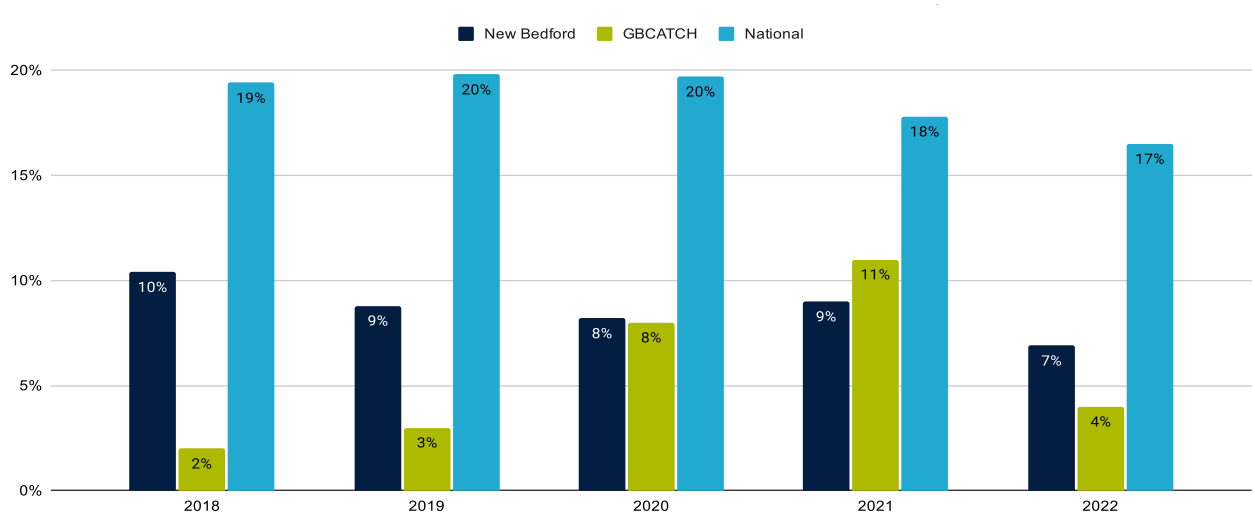
Source: CoC System Performance Measures Data Since FY2015

Figure 6: Returns to Homelessness Over Time – GBCATCH[14]



Source: CoC System Performance Measures Data Since FY2015

Figure 7: Total Returns to Homelessness in 24 Months – National Comparison[15]



Source: CoC System Performance Measures Data Since FY2015

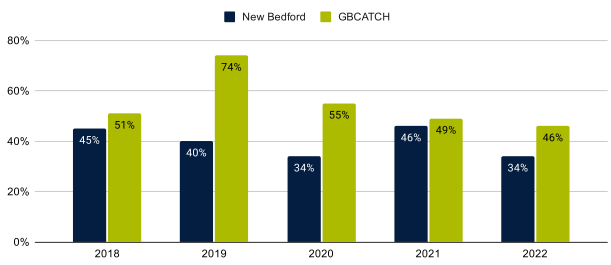
[13] *CoC System Performance Measures Data Since FY2015*. HUD Exchange, May 2023. Accessed Dec 2023.

[14] *CoC System Performance Measures Data Since FY2015*. HUD Exchange, May 2023. Accessed Dec 2023.

[15] *CoC System Performance Measures Data Since FY2015*. HUD Exchange, May 2023. Accessed Dec 2023.

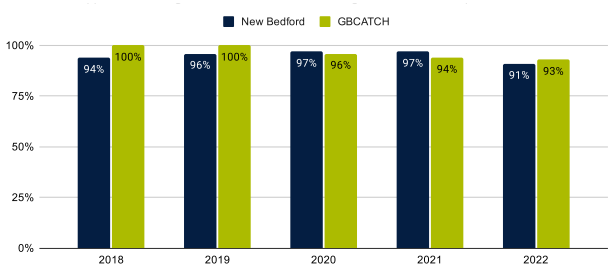
Figure 8 shows the rates of successful exits to permanent housing, while Figure 9 shows the rate of retention or successful exits once people are housed in PSH or other permanent housing over time. Both communities have retention rates over 90%, which is considered excellent by standards for the Housing First model when serving the most vulnerable households.

Figure 8: Exits to Permanent Housing – Successful exits from emergency shelter, safe haven, transitional housing and rapid rehousing.[16]



Source: *Systems Performance Measures (SPM), HUD Exchange*

Figure 9: Successful Permanent Housing Retention or Exit – Permanent Supportive Housing and Other Permanent Housing client retention or positive exit rate.[17]



Source: *Systems Performance Measures (SPM), HUD Exchange*

[16] *Systems Performance Measures (SPM)*. HUD Exchange. Accessed Dec. 2023.

[17] *Systems Performance Measures (SPM)*. HUD Exchange. Accessed Dec. 2023.

Projection of Need

Current Analysis of Unsheltered Homelessness

This analysis was developed to aid the City of New Bedford and the BCCC in data-informed decision-making to address a growing trend in unsheltered homelessness. The trend analysis uses data from New Bedford from 2014 to estimate the rate of increase in unsheltered homelessness. For greater understanding of those unsheltered, we also present the rate of chronic homelessness among people experiencing homelessness, as well as age distribution.

Methods and Limitations

At the time of writing this report, the former New Bedford and GBCATCH CoCs had not merged their data. For some measures (e.g. age of unsheltered homeless, housing resources available through Coordinated Entry, etc.), only New Bedford CoC data was available. Modeling is based on New Bedford CoC data and resources only.

Current Data Trends

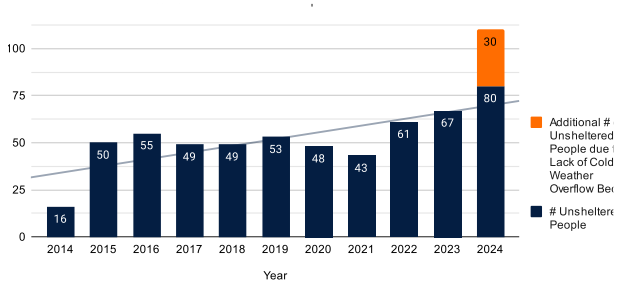
Figures 10–11 show an analysis of unsheltered homelessness in the New Bedford and GBCATCH CoCs over the last 10 years. It should be noted that fair weather on the night of the 2024 Count meant the cold weather overflow shelter was closed, unlike in previous years. Since the overflow shelter has the capacity to house 30 people, one way to interpret the 110 people counted in 2024 is as a combination of 80 people living unsheltered and 30 who would have been counted as sheltered if the overflow shelter were open.[18] With or without the addition of the cold weather shelter, the overall trend since 2014 is an increase in people experiencing unsheltered homelessness, with a sharper rise reported in New Bedford than in GBCATCH.[19, 20] Both communities show a decrease during the COVID-19 pandemic, likely due to the additional pandemic funding that increased non-congregate shelter options. Those temporary shelter options have now closed, along with other shelter reductions such as Killian's unaccompanied youth shelter, and a reduction in family shelter beds. Thus, we see an increase in unsheltered homelessness while the overall number of households experiencing homelessness in New Bedford has gone down.

[18] Clarke, Jennifer. Personal communication. 18 June 2024.

[19] *PIT and HIC data for MA-505 and MA-519 from 2014–2023*. HUD Exchange.

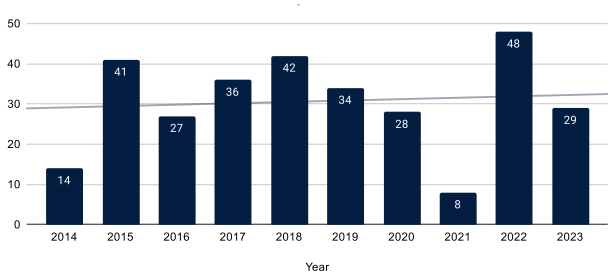
[20] Maia, Jose. Personal communication. 22 May 2024.

Figure 10: Number of Unsheltered People in New Bedford[21]



Source: *PIT and HIC data for MA-505 and MA-519 from 2014-2023*

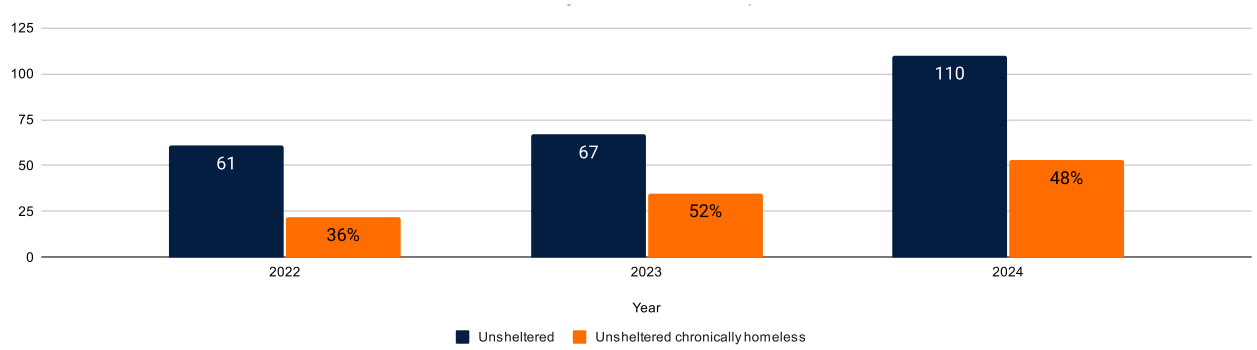
Figure 11: Number of Unsheltered People in GBCATCH[22]



Source: *PIT and HIC data for MA-505 and MA-519 from 2014-2023*

Chronic homelessness is defined by HUD as experiencing more than one year of continuous homelessness or four separate instances of homelessness within the last three years that add up to 12 months of homelessness along with a diagnosis of a disabling condition.[23] Experiencing chronic homelessness, especially unsheltered chronic homelessness, is often associated with more severe health and service needs than shorter episodes of homelessness.[24] There are notable trends when it comes to experiencing chronic homelessness and the age distribution for those experiencing unsheltered homelessness. As seen in Figure 12 below, the proportion of people experiencing chronic homelessness among the unsheltered population increased between 2022 and 2024 from 36% to 48%.[25]

Figure 12: Percentage of Unsheltered People in New Bedford who are also Chronically Unsheltered[26]



Source: *PIT and HIC data for MA-505 and MA-519 from 2014–2023*

[21] *PIT and HIC data for MA-505 and MA-519 from 2014–2023*. HUD Exchange.

[22] *PIT and HIC data for MA-505 and MA-519 from 2014–2023*. HUD Exchange.

[23] Definition of Chronic Homelessness. HUD Exchange. Accessed 25 June 2024.

[24] Serving unsheltered people with severe service needs. HUD Exchange. Accessed 25 June 2024.

[25] *PIT and HIC data for MA-505 and MA-519 from 2014–2023*. HUD Exchange. Accessed April 2024.

[26] *PIT and HIC data for MA-505 and MA-519 from 2014–2023*. HUD Exchange. Accessed April 2024.

Projections of Unsheltered Homelessness

Methods and Limitations

There are many factors that affect homelessness, and models are useful in understanding the potential effect of new resources on the status quo *if* current trends hold steady. The model used to create the scenarios below is based on simple trends and assumptions. It was adapted from a model created by Dr. Tom Byrne in 2016 for Father Bill's and MainSpring.[27] As such, this model does not take into account changes in the housing market that may arise due to economic factors (see Community Background section), changes in housing stock or prices, or other macro factors that could have an impact on housing and homelessness in New Bedford and the region.

HUD also provides Stella M as an interactive web-based tool to model projections of homelessness based on resource allocation. Stella M calculates required inventory for an ideal homelessness response system based on data the community puts in on homelessness, current inventory, costs, and target goals. While Stella M could be used to compare New Bedford with other communities that have used this publicly available tool, it relies on more complex assumptions, and is only as good as the completeness and quality of data that is entered into the modeling software.[28] It is designed to be used by a group of stakeholders who understand local priorities, opportunities, resources, and vision for an ideal system.

The simplified Byrne model was selected for two reasons. First, the model is easy to modify, making it a tool that can be used in real time as resources and trends emerge over time. Second, the data produced is more transparent, making it easier to understand and to explain to community partners. The use of the model for this report is focused on addressing unsheltered homelessness, but it could be used to model the need for permanent supportive housing (PSH) and other housing resources for other populations, including families, sheltered individuals, and youth.

Projected Homelessness

The model uses assumptions based on local data, when available, and conservative estimates grounded in knowledge about the field. The assumptions can be updated and changed as additional data becomes available. The model incorporates the following assumptions:

- The number of people experiencing unsheltered homelessness will continue to increase linearly every year. This trend is calculated based on the last three years of unsheltered point-in-time count data and adjusted for availability of cold-weather shelter overflow beds. Assuming that winter overflow shelter is available when needed, this calculation shows an average annual increase of 6 people.
- Within the homeless population, the proportion of people experiencing chronic unsheltered homelessness will remain at the 2024 level (48%) in future years.
- Turnover of existing PSH units is estimated at 7% per year. In Scenario 3, an additional 3% is estimated based on a conservative estimate of the impact of initiating of a move-on preference at local housing authorities.

[27] Byrne, Tom. Personal interview. 13 May 2024

[28] "Stella and System Modelling." *HUD Exchange*. Accessed 28 June 2024.

- In Scenario 2 and Scenario 3, 80% of housing resources will be targeted to people experiencing unsheltered homelessness.
- The reduction in average length of stay due to introduction of new rapid rehousing (RRH) resources will be 30 days.
- The reduction in average length of stay due to introduction of new diversion resources will be 25 days.
- The reduction in average length of stay due to new PSH will be 120 days.
- The distribution of length of stay in shelter is based on extrapolations from LSA data.

Scenario 1

The projection for Scenario 1 assumes no changes or targeting in resources. It anticipates a linear increase in unsheltered homelessness, with chronic unsheltered homelessness remaining at 48% of total unsheltered individuals (as it was in 2024) through the year 2030.

Figure S1: Projection for Unsheltered People in New Bedford — no new housing resources, just existing shelter beds

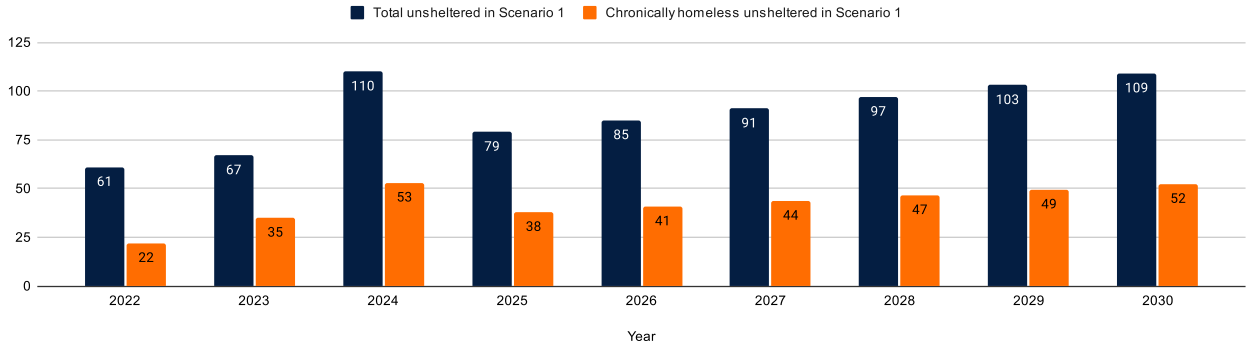


Table S1: Table of Projected Changes in Unsheltered vs. Overall Homelessness

Scenario 1 Projections (2022–2030)	Estimated Change
Overall Point in Time Count	0
Unsheltered Point in Time Count	0

Scenario 2

In Scenario 2, New Bedford introduces 50 targeted shelter beds for long-term homeless individuals who have been unsheltered in the community. Though in Scenario 2 the unsheltered point in time count is significantly reduced, the overall point in time count remains the same. In contrast, the addition of permanent housing in Scenario 3 reduces both the unsheltered point in time count and the overall point in time count.

Figure S2: Projection for Unsheltered People in New Bedford — 50 new targeted shelter beds

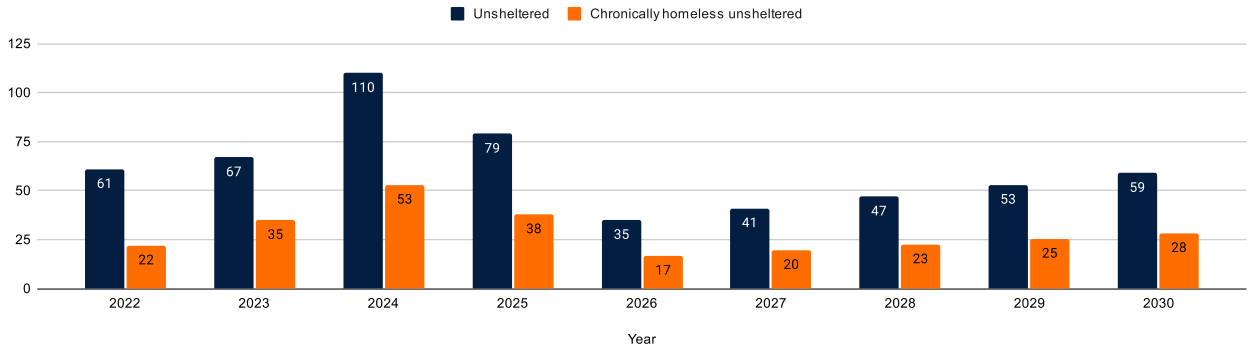


Table S2: Table of Projected Changes in Unsheltered vs. Overall Homelessness

Scenario 2 Projections (2022–2030)	Estimated Change
Overall Point in Time Count	0
Unsheltered Point in Time Count	-50

Scenario 3

In Scenario 3, New Bedford introduces 50 targeted shelter beds for long-term unsheltered homeless individuals in the community, just like in Scenario 2. However, in this scenario, New Bedford also targets 80% of each of the following housing resources to unsheltered people:

- 76 PSH units dedicated to chronically homeless individuals (existing PSH that is not restricted to a subpopulation like HIV or Veterans)[29] that become available due to turnover. This is based on an estimate of 7% current annual turnover rate in PSH units and an additional 3% turnover due to the initiation of a move-on preference at local housing authorities.
- 30 units of PSH for chronically homeless individuals introduced in 2026 via partnerships with housing authorities to target units to this population and leverage services (new PSH).
- 125 annual slots of rapid rehousing for individuals introduced in 2026 (new and existing RRH)
- 100 annual slots of diversion for individuals introduced in 2026 (new diversion).
- 60 new units of PSH for chronically homeless individuals introduced in 2030 due to investments in new developments.

As more resources are secured and become available, they can be included in this model to show their impact. To bend the curve backwards on the projected unsheltered Point-in-Time count against a growing trend, the community will need to continue to increase the amount of dedicated permanent housing available to transition people from unsheltered homelessness.

[29] Maia, Jose. Personal communication. 22 May 2024.

Figure S3: Introduction of 50 new targeted shelter beds, housing turnover, new housing resources and assumed impact of resources

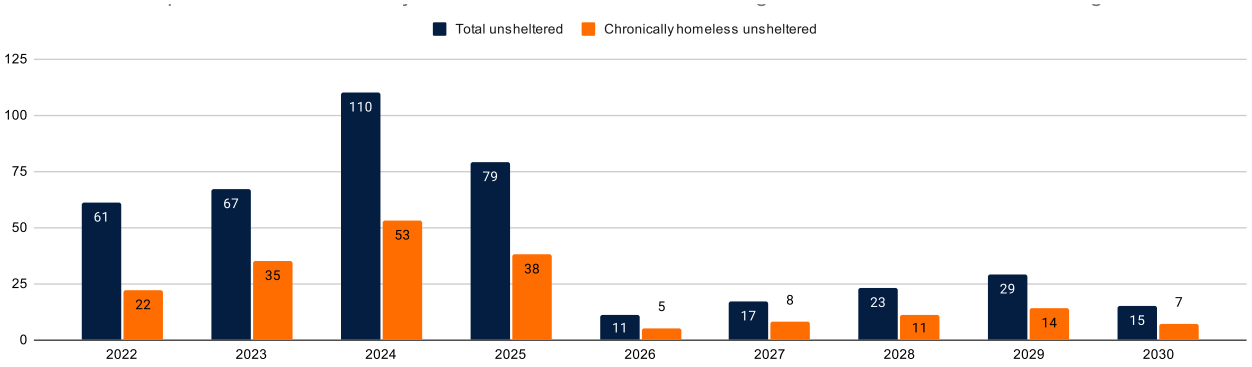
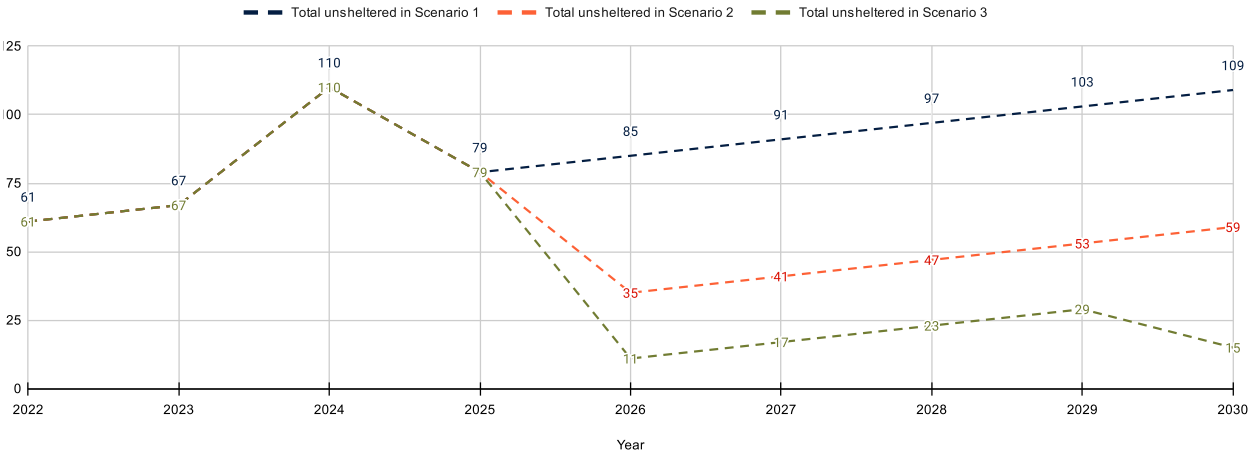


Table S3: Table of Projected Changes in Unsheltered vs. Overall Homelessness

Scenario 3 Projections (2022–2030)	Estimated Change
Overall Point in Time Count in 2026	-29
Unsheltered Point in Time Count in 2026	-74
Estimated Additional Change in Overall Point in Time Count in 2030	-25
Estimated Additional Change in Unsheltered Point in Time Count in 2030	-20

Figure 13 shows projections for the Point in Time count of the total number of people experiencing unsheltered homelessness in Scenarios 1, 2, and 3.

Figure 13: Unsheltered Projections – Scenarios 1, 2, and 3



Communitywide Strengths

New Bedford is asset-rich when it comes to efforts to address homelessness. As the collaborative applicant for the former MA-505 CoC, OCHD brings years of experience and commitment in engaging a set of diverse providers, community leaders, people with lived experience of homelessness, funders, and city residents in preventing and ending homelessness. Leaders emphasized the power of using data to drive provider and system performance, to understand the ramifications of not investing more in housing and ending homelessness, and to make progress across systems and siloes.

A combination of private and publicly funded service providers works in the region, offering street outreach, mobile food and clothing services, homelessness prevention, emergency shelter, a network of recovery houses, substance abuse and mental health treatment and support, workforce development, elder services, a non-profit hospital and health care services, specialized services for veterans and people experiencing domestic violence, and subsidies for permanent housing. New Bedford has created a tool known as the Street Sheet that consolidates these resources on one short document for ease of access on paper and online. Local providers are actively piloting and running initiatives to maximize funding. Examples include the Interchurch Council's pilot with hospitals and PAACA to set up 2-6 temporary beds for medically fragile homeless persons, and the partnership between Southcoast Health and Community Counseling of Bristol County (CCBC) to allow for housing related social needs such as first and last month's rent, security deposits and moving costs to be paid for through Medicaid waivers. Multiple focus group participants with lived experience of homelessness cited the winter shelter model used during the COVID-19 pandemic as one they would like to see replicated. In particular, the shelter was low-threshold and the staff engaged guests using a relationship-oriented and person-centered approach. Services were provided on site in addition to shelter, and there was no mandatory exit at 6 am. The consensus among guests was that this model was humane, fair, and helped provide a stable shelter that was greatly needed and appreciated.

Like other communities across the country, people experiencing homelessness in New Bedford have formed a network of mutual support. Many help each other informally, offering resources, supporting one another in navigating services and systems, and in some cases forming chosen families that provide ongoing care for one another. In one such act of generosity, a focus group member who was stably housed shared his phone number with others in the group and offered to cook a traditional Portuguese meal for anyone in need.

In addition to the mutual aid and compassion people with lived experience offer one another, their insights into the homelessness response system's challenges and strengths are unmatched. The combined expertise and humanity of people with lived experience are major assets that communities across the country are harnessing to improve their homelessness response systems. The newly adopted

by-laws for the BCCC include the establishment of a Lived Experience Leadership Council with a minimum of five persons who have experienced homelessness.[30]

Tangibly, the merger of MA-505 and MA-519 into BCCC broadens the geography in which CoC vouchers can be located, offering more choice to clients and a greater network of potential landlord partners. It also offers an opportunity to regionalize services and create one or multiple one-stop sites to serve people in the region with comprehensive housing and services in a single location, a move which both service providers and people with lived experience of homelessness support. There are sites throughout the region that could be potential locations for such a center, including Our Daily Bread in Taunton, the Dartmouth Community Services Outreach Team office, and/or the City-owned building on Coggeshall Street where Positive Action Against Chemical Addiction (PAACA), Inc. operates.

CCBC acts as the Coordinated Entry system for both New Bedford and GBCATCH CoCs and will continue on in this role for the BCCC. The fact that New Bedford uses a prioritized by-name list to ensure the most vulnerable people are housed and stabilized is a strength. CCBC also brings expertise in behavioral health services, including engaging vulnerable people, enrolling and billing Medicaid (MassHealth) for services, streamlining health care enrollment, and maximizing services within the Coordinated Entry process. Over the past year, New Bedford established a Medical Respite Committee on the CoC, which allowed them to grow their partnership with the Southcoast Hospitals Group to serve the medically fragile population.

In 2023, New Bedford released "Building New Bedford,"[31] a comprehensive set of strategies to create a range of housing for people at all income levels. The final HOME ARP allocation plan[32] was also released in 2023 and proposes to make strategic infrastructure developments while also addressing the immediate needs of people experiencing homelessness in New Bedford. To ensure equitable access to CoC resources available to prevent and end homelessness, the CoC completed a Racial Equity Assessment and Action Plan in 2024.[33] Rise Up for Homes, the CoC committee dedicated to private fundraising for the community's initiatives to address homelessness, has a strong history of community fundraising, hosting annual one-stop service events, *Community Dinners*, and it has the potential for successful scope expansion. One key informant envisioned using data on the progress made toward ending homelessness for a public campaign to engage new stakeholders, funders, potential landlord/property owner partners, brokers, real estate investors, and members of the public.

[30] Bristol County Continuum of Care Governance Bylaws. February 2023. Accessed 16 April 2024.

[31] "Building New Bedford: Strategies to promote attainable housing for all in a thriving New Bedford." *New Bedford Office of Housing and Community Development*, 29 March 2023.

[32] "HOME ARP Allocation Plan." *New Bedford Office of Housing and Community Development*, 29 March 2023.

[33] Edwards, Earl, Richard, Molly, and Antelo-Ovando, Mayte. "Racial Equity Assessment and Action Plan." Feb. 2024. City of New Bedford Homeless Services Provider Network, New Bedford, MA.

Gaps, Barriers, and Opportunities

The strengths outlined in the previous section provide a solid foundation which New Bedford can build upon to address the system's gaps and to mitigate the barriers to maintaining and obtaining housing stability after experiencing homelessness.

Housing Affordability

It was universally acknowledged by people experiencing homelessness, service providers, system leaders, and community members that the core challenge in addressing homelessness in the region is a need for more available housing for people of all income levels. In order for homeownership to be considered affordable, a value to income ratio (VIR) of three or four is necessary for a typical household to avoid spending more than 30% of their income on housing costs.[34] While New Bedford is considered affordable with a VIR of 3.98, a 2024 *Housing For All* report found that 68% of New Bedford renters and 86% of New Bedford mortgage holders are paying more than one third of their monthly income on housing, suggesting that homeowners and renters are not easily finding housing within their price range.[35] Rents in New Bedford increased 27% between January 2022 and July 2023 to a median rent of $1,500 per month.[36] Current estimates taken from three major realtor sites show that the median rent continues to rise and is now averaging $1600 per month, an additional 7% increase from July 2023 and April 2024.[37] While all Bristol County communities can still be considered affordable to rent or to own at the median area income, New Bedford's rental vacancy rate in 2022 was just 3.2 percent, which means that landlords can be more selective about who they rent to.[38] In addition, the rising rents are rapidly reaching a tipping point where the lowest income residents will soon be (if not already) priced out of the rental market. For example, a New Bedford resident earning the MA minimum wage of $15 per hour will spend 62% of their income on rent. A two-person minimum wage household can barely afford housing, spending 31% of their combined income on rent. A senior receiving the average 2024 Social Security benefit of $1907 per month[39] would spend a staggering 79% of their income on rent. Table 3 shows a comparison of home affordability and rental affordability for Bristol County in April 2024.

[34] Schuetz, Jenny. "How can State governments influence local zoning to support healthier housing markets?" *Cityscape: A Journal of Policy Development and Research*. vol.25, no.3, 2023 pp.73–98.

[35] "Housing for All: Forward looking strategies for a growing New Bedford." *NBEDC The Regeneration Project*. January 2024.

[36] "Housing for All: Forward looking strategies for a growing New Bedford." *NBEDC The Regeneration Project*. January 2024.

[37] Median home value and rents were calculated using an average of data reported on three realtor sites in April 2024: zillow.com, realtor.com, and redfin.com. Accessed 15 April 2024.

[38] "Housing for All: Forward looking strategies for a growing New Bedford." *NBEDC The Regeneration Project* (p.26). January 2024.

[39] Social Security Administration https://www.ssa.gov/cola Accessed 28 June 2024.

Table 3: Housing Affordability in Bristol County, MA

Metrics	New Bedford	Attleboro	Taunton	Dartmouth
Area Median Income (2024)[40]	$91,300	$112,400	$134,600	$91,300
Median Home Value (2024)[41]	$364,000	$459,000	$477,000	$585,000
Value-Income Ratio[42]	3.98	4.08	3.54	6.4
Median rent (2024)[43]	$1,600	$1,975	$1,900	$2,500
Percent of income needed to rent[44]	21%	21%	17%	33%
Percent of income needed to rent for two adults working at MA minimum wage of $15/ hour	31%	38%	37%	48%
Percent of subsidized units[45]	11.63%	6.12%	6.92%	7.81%

Service providers and people experiencing homelessness alike advocated for more affordable, subsidized housing opportunities in New Bedford and the surrounding County, with an emphasis on more PSH and the return or development of some bridge housing similar to past Transitional Housing (TH) options.[46] Table 3 shows that New Bedford currently has the highest number of subsidized units in the region.[47] However, data modeling conducted by TAC corroborated the need for additional PSH for individuals experiencing homelessness in both New Bedford and the surrounding County. People experiencing homelessness in greater Bristol County confirmed that they would prefer to remain in their hometown, but are unable to access the PSH and subsidized housing needed to exit homelessness and remain housed.

[40] Median income: gathered from HUD USER FY2024 Income Limits Documentation System. Accessed 28 June 2024.

[41] Median home values: data averaged from three realtor sites: zillow.com, realtor.com, and redfin.com. April 2024

[42] Value-to-income ratio: median home value divided by median income.

[43] Median rents: data averaged from three realtor sites: zillow.com, realtor.com, and redfin.com. April 2024

[44] Percent income to rent: monthly median rent divided by monthly median income.

[45] "Chapter 40B Subsidized Housing Inventory." *Executive Office of Housing and Livable Communities*, 29 June 2023.

[46] Since the mid-2010s, HUD prioritizes permanent housing options in the annual CoC funding competition, actively encouraging communities to reallocate transitional housing funding to these models. In 2017, HUD introduced a transitional housing - rapid rehousing model, discussed more in the Diversifying Housing and Services section.

[47] "Chapter 40B Subsidized Housing Inventory." *Executive Office of Housing and Livable Communities*, 29 June 2023.

Gaps in Service Delivery and Housing Choice

Sixty-seven percent of service providers surveyed from New Bedford's former MA-505 CoC[48] believe that people experiencing unsheltered homelessness are not making use of existing resources because the services they want or need are inaccessible for varying reasons. People currently experiencing homelessness in the region agreed, with one focus group participant noting that it felt like one must first "get worse to get better" to obtain housing assistance. Both service providers and people with lived experience of homelessness expressed frustration with insufficient elderly and disabled housing, as well as a lack of housing for people with a past criminal record or a history of evictions. Service providers wanted to see more specialized housing options for people with mental health and/or substance use conditions. In contrast, some people currently experiencing homelessness noted that opportunities for supportive housing without a substance use treatment component were lacking in both New Bedford and greater Bristol County. All people interviewed expressed a desire for more supportive housing with 24-hour staffing support, and more ADA[49] compliant emergency and permanent housing options. While 32% of the State's housing was built before 1940, more than half (52%) of New Bedford's housing holds this designation.[50] Finally, people experiencing unsheltered homelessness reported a desire for more assistance in housing navigation once a voucher or approval for rental assistance is received, and many expressed a need for post-placement support to help people adjust to living in housing after many years of living unsheltered.

> *Accessibility Matters. The older housing stock where some privately run shelters are located can result in inaccessible entrances for people using wheelchairs. During the winter months, when the temperature can fall below 28 degrees Fahrenheit, this is literally a life and death issue.*
>
> – Notes from Service Provider Focus Group

Insufficient Emergency Shelter

One hundred percent of people in the lived experience focus groups (34) spent at least some time unsheltered, and 40% of participants reported living unsheltered for more than 3 years. Given the limited or non-existent supply of shelter beds in greater Bristol County, it is not surprising that no one in the Taunton-based focus group had been successful in accessing a shelter placement. In comparison, New Bedford has the most emergency shelter beds available in Bristol County, but only a handful of the New Bedford-based focus group participants had previously spent some time in a shelter. Because there

[48] The Service Provider survey was distributed through the HSPN mailing list in December 2024. A total of 49 providers responded: 69% of respondents work in New Bedford; 22% work in both New Bedford and GBCATCH.

[49] Americans with Disabilities Act.

[50] "Housing for All: Forward looking strategies for a growing New Bedford." *NBEDC The Regeneration Project*. January 2024.

are simply not enough permanent housing units that are affordable to people currently utilizing shelter beds, the number of people exiting shelter to permanent housing in fiscal year 2023 was just 28%.[51]

Some shelter models and policies further narrow access making it difficult for people who are newly experiencing homelessness to access an indoor bed. For example, shelters that allow current guests to reserve a bed for the following night limit the number of new beds that will come open in a given day. Shelters with residency requirements and shelters that only serve a single gender artificially limit who can enter a program. There is a particular dearth of shelter options for women and families, especially families composed of two or more adults; in part because the State operates the family shelters, and New Bedford has little control over their definition of eligibility. Aside from the shelter serving domestic violence survivors, there are no shelters that provide 24/7 access. Many shelters require people to exit the shelter at 6 AM daily, the earliest time allowed by State standards, creating daily stress for shelter guests and reducing access to support services like case management and housing navigation. While the region offers cold-weather shelters, this shelter option is only open on a night-by-night basis when temperatures drop below 28 degrees Fahrenheit.

Permanent Housing

Approximately half of the Service Provider Survey respondents identified additional population-specific housing needs in the region, including housing for people with disabilities or severe medical needs (28%), low-income housing for people who cannot afford market rate but don't qualify for HUD subsidies (24%), and senior housing (20%). Additional population specific housing needs identified through the survey include survivors of human trafficking, women veterans, young people aged 18–24, people identifying as transgender, non-married couples, and people with a criminal record and/or on a sex offender registry.

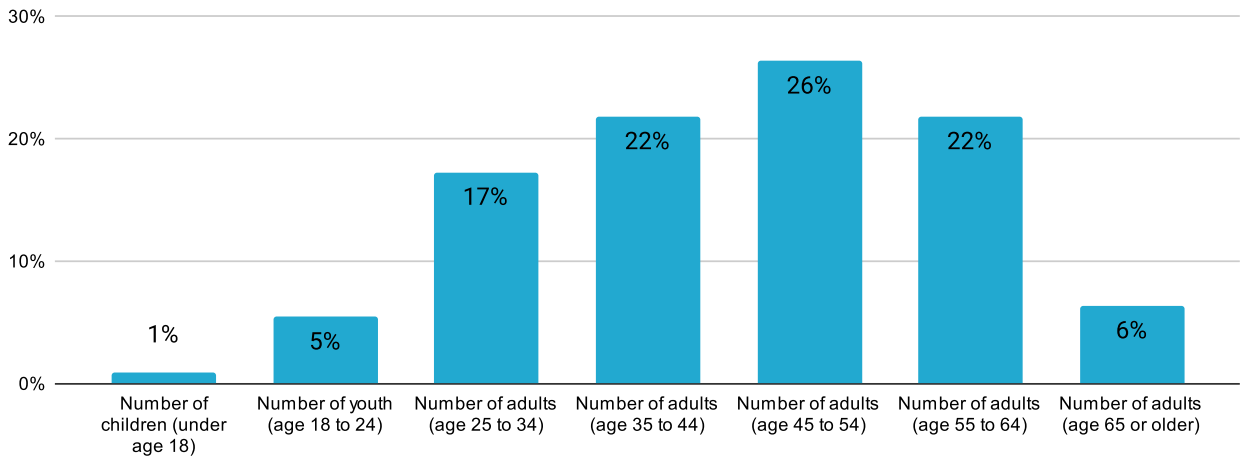
Senior Housing Needs

Current data trends in New Bedford support the need for additional senior housing in the near future. Figure 14 shows most people experiencing homelessness in New Bedford are between the ages of 25-54, however, there is also a significant cohort aged 55 and older (28%) and a smaller group of unsheltered youth and young adults (6%).[52] Older adults often have fixed incomes and cannot maintain their housing when landlords increase rents. By 2030, well over half of people experiencing homelessness in New Bedford could be seniors.

[51] New Bedford shelters receiving ESG funding reported just 28% of people exited to permanent housing destinations in the FY 2023 annual progress report. Accessed and calculated February 2024.

[52] Maia, Jose. "HUD Point in Time Report – Unsheltered." *Simtech Solutions*, 1 March 2023; 13 February 2023.

Figure 14: Age Distribution – New Bedford 2024 Unsheltered Homeless Point-in-Time



Source: "HUD Point in Time Report – Unsheltered," *Simtech Solutions*.

Street Outreach Coverage

New Bedford has a strong street outreach program funded through the Emergency Solution Grant (ESG) program. The current model includes well-organized routes and strategies designed to engage and assist people in accessing housing and services to meet basic needs. However, high staff turnover in the last few years has resulted in inadequate route coverage and higher caseloads for existing staff. People experiencing unsheltered homelessness rely on continuity of relationships to help them navigate complex housing and service systems. High turnover disrupts these trusted relationships and contributes to an overall lower skill level among outreach staff.

Outside of New Bedford, some cities and towns in Bristol County have no dedicated outreach workers, operating on an on-call basis or relying on people experiencing unsheltered homelessness to come to them at designated drop-in centers or community kitchens. One person reported that members of their encampment were issued citations for littering, but also faced consequences when they attempted to put trash in a local business dumpster.

In addition to the engagement strategies conducted by outreach staff, people experiencing unsheltered homelessness wished outreach teams would provide tents, propane, and other critical warming items in the winter. They wanted access to facilities and supplies to meet basic hygiene needs.

Transportation and Travel

Forty-nine percent of service providers and 100% of people experiencing homelessness cited the location of services and/or lack of transportation as a barrier to service.

Some people experiencing homelessness reported being offered beneficial housing opportunities or resources, but no transportation to get to those resources and no follow through assistance to access the resources. While New Bedford has several mobile services that provide donations of food and clothing, people with lived experience of homelessness noted that these programs often have long lines on the day of service. People using emergency shelters and services reported spending much of their day in transit

from one side of the City to the other to access meals and services located at multiple sites. As one focus group participant noted, a significant part of their day is spent waiting without the "opportunity to do something productive." Wait time is exacerbated in greater Bristol County, where there are fewer resources and longer distances between services. To combat this issue, the local regional bus authority, Southeastern Regional Transit Authority (SRTA) has been piloting "fair free" ridership charging nothing to ride the public transit system anytime, day or night. All bus authorities in MA are now advocating to obtain financial support from the legislature necessary to maintain fare-free service.

> *Inefficient Access. Dartmouth has several lower cost hotels that may be contracted as overflow shelters during winter months, however, in order for a Dartmouth resident to access that shelter, they must travel to the City that has the contract just to be referred back to the City they were already in. The entire process can take most of a day.*
>
> *– Notes from Service Provider Focus Group*

Service Access, Delivery, and Capacity

Service providers and people with lived experience alike expressed frustration with the level of regional coordination and partnership currently in place to prevent and end homelessness. The possibility of creating a regional center with extended hours was met with universal support, with key informants noting that few services in the region are currently available in the evening and weekends, and some service providers believing that the number of overdoses appears to increase during these underserviced hours. Doubt was expressed by those interviewed that a location for such a center could be agreed upon by the City and the other municipalities in Bristol County. One service provider likened the creation of a regional center to putting a "band-aid on a bullet wound", because the real need was more affordable housing.

Barriers to Emergency Shelter Access

Narrow Definitions of Family

Eligibility criteria emerged as a major barrier to accessing emergency shelter services meant to provide a safety net against the experience of unsheltered homelessness. Certain subpopulations are more negatively impacted, including women, families with or without dependent children, and individuals with substance use histories. As the majority of family shelters are operated by the State's Emergency Assistance (EA) system, these shelters define "family" as parents with minor children, and do not allow unrelated adults to stay together. Two adults with lived experience noted that their elderly parents were in temporary housing while they themselves were living unsheltered because they were unable to stay together as a family at the shelter. One couple described obtaining a shelter placement at a local privately run shelter "under the pretext we were sisters [and] not two lesbians, lying to provide shelter for our [disabled child]." Couples are frequently unwilling to separate when one adult is able to access space at a single gender shelter if that means leaving the other adult unsheltered and alone.

Another person living unsheltered noted that his platonic adult friend and he were denied a shared room, despite considering each other essential to their mutual support and survival. Narrow definitions of family hinder social support systems, exacerbating stress, trauma, and worry. It should be noted that during this topic of discussion, several members of the group became emotional and tearful when describing their attempts to keep their families together and safe while navigating unsheltered homelessness.

Narrow definitions of family are outdated and create a barrier to access. As one focus group participant said, "I've met people on the street that are more family than my family."

In the Commonwealth of Massachusetts, families with dependent children and pregnant people must meet separate EA shelter eligibility criteria and oftentimes face a waitlist given the shelter system's capacity constraints. While waiting for EA shelter placement, families are placed in local hotels/motels to mitigate the overflow. Once an EA shelter placement becomes available, families might be relocated to a different part of the state, which disrupts their children's schooling, poses transportation-related concerns, and removes families from their social support systems. Families experiencing homelessness also report fears and concerns related to providing safe and secure situations for their dependent children. One key informant cited Department of Children and Families (DCF) involvement and maintaining custody of children as an immense stress for adult family members.

Rules Unrelated to Health or Safety

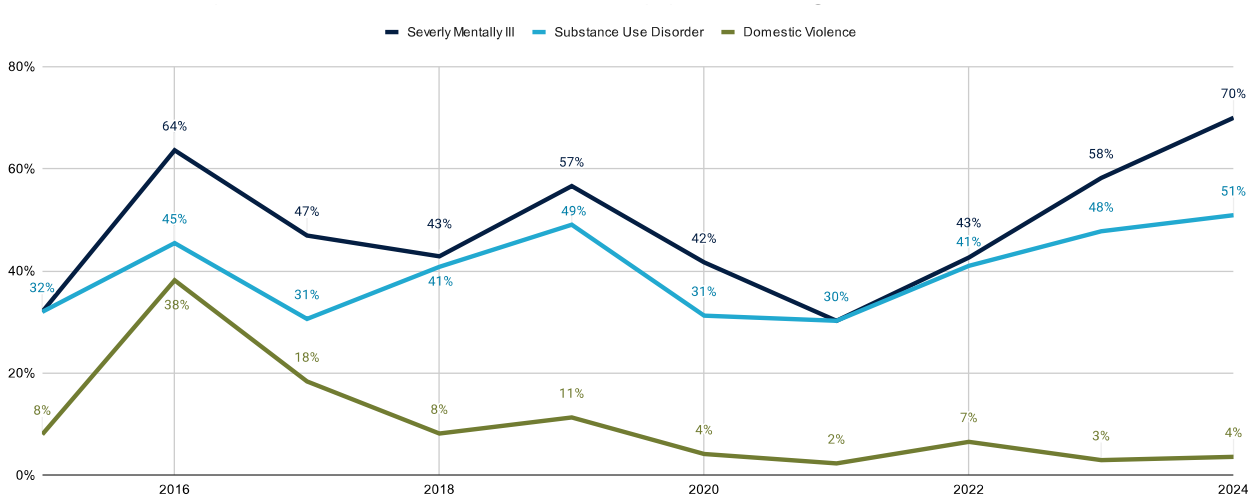
Outside of eligibility criteria, people who spent time in a shelter program (both City funded and privately operated) were often frustrated by the rules and requirements, which include, but are not limited to: prohibiting outside food/drink, inflexible smoking times, requiring 100% sobriety, turning over/locking up cell phones, and strict curfews (causing subsequent disruptions for certain jobs). Generally, rules that are not directly linked to a health or safety concern feel unreasonable and at times dehumanizing to people accessing shelters and interim housing. As one former shelter guest put it, the shelters "put rules [in place] to prove they are in charge." Service providers echoed these sentiments, with 60% of survey respondents reporting that when shelter or service requirements were too high, people experiencing homelessness would not access the service.

Focus group participants experiencing homelessness shared even more restrictive stories from the privately run shelters. One provider required participants to turn over their Social Security Income (SSI) payments for "rent," leaving them with no income and no housing at the end of their shelter stay. Another described a need to line up mid-afternoon to ensure a spot for the night.

Housing for People with Behavioral Health Needs

The 2024 Point in Time count marked the highest number of adults experiencing unsheltered homelessness who also self-identify as having severe mental illness and/or substance use disorder since such counts have been conducted. Figure 15 highlights the fact that 70% (77) of adults experiencing unsheltered homelessness self-reported as having a severe mental illness in 2024.

Figure 15: Year to Year Comparison of Most Prevalent Self-Identified Subpopulations among Unsheltered Individuals in New Bedford[53]



Source: *New Bedford Homeless Service Providers Network*

At the same time, there has been a dramatic drop in prevalence of severe mental illness and substance use disorder in the sheltered population. The percentage of people experiencing substance use disorder was above 60% at the peak in 2011, down to under 20% in 2024. Severe mental illness was above 50% at the peak in 2015, and was down to below 20% in 2024.[54] One possible explanation for this downward trend in acuity among sheltered individuals and upward trend in acuity among unsheltered individuals is a movement by New Bedford shelters to require/ enforce sobriety and other restrictive rules. Interviews with service providers and people with lived experience of homelessness support this possibility. Several people experiencing homelessness were adamant that they would never stay in a shelter because the physical set up was not conducive to supporting their mental health. For people with diagnosed mental health conditions or a history of traumatic interactions, congregate shelter settings exacerbated anxiety regarding safety, prompted hypervigilance around personal space and belongings, and triggered Post Traumatic Stress Disorder (PTSD) symptoms in some cases. Service provider staff agreed, explaining how shelters' congregate setting can be disruptive or harmful to mental and physical health conditions, in addition to posing serious safety and privacy concerns. As a result, service providers reported that individuals with serious conditions often resort to spending between $500–$600 per week from their fixed or limited income on hotel/motel stays until their funds are depleted.

Barriers to Accessing Housing

Subsidized housing in New Bedford and the newly formed BCCC is funded through HUD's CoC and ESG programs. Per regulation, these programs require that individuals and families meet HUD's definition of homelessness or chronic homelessness to qualify for referral and placement. Service providers noted that required documentation, especially for verifying disabling conditions and history of homelessness, can pose significant barriers and prolong episodes of homelessness. Institutional stays of more than 90

[53] *PIT and HIC data for MA-505 from 2007-2023*. HUD Exchange and "PIT HIC PRESENTATION.2024" *New Bedford Homeless Service Providers Network*, 21 June 2024.

[54] "PIT HIC PRESENTATION.2024" *New Bedford Homeless Service Providers Network*, 21 June 2024.

days can impact an individual's status as homeless or chronically homeless under this definition, and this can in turn affect their eligibility for housing. As a result, individuals that recurrently stay in institutional care facilities (e.g. hospitals, mental health or substance use treatment facilities, jails, etc.) lose their eligible status for housing if their stay exceeds 90 days. Similarly, people living doubled-up or couch surfing, which is more common among young people experiencing homelessness, cannot be counted toward the number of homeless nights, which can delay or inhibit eligibility or cause people to lose out on housing opportunities when they are available. Counts are further disrupted when individuals or families use their income to fund short stays in hotels/motels rather than staying in an emergency shelter or living unsheltered.

In addition to definitional barriers, there is a disconnect between the limited supply of Permanent Supportive Housing (PSH) units in the region and the capacity of service providers to accommodate individuals with disabling conditions and complex health needs. Services offered within the existing PSH programs are heavily weighted toward substance use disorders and are not equipped to address complex medical needs and needs of an aging population. In addition, case management is often light touch, but sobriety requirements are emphasized, resulting in participants being evicted for untreated mental health or behavioral health concerns. It is extremely difficult to find landlords willing to lease units to candidates with prior evictions, so evictions of program participants still working toward sobriety just compounds barriers to future housing.

Housing Navigation

A key source of frustration expressed by people experiencing homelessness with HUD's Housing Choice Voucher Program and/or other housing vouchers was the paradox of being approved for rental assistance funds or vouchers but being unable to utilize these resources because they could not find a landlord to accept the assistance before the expiration of funding. People experiencing homelessness wanted more housing navigation resources to help with locating units, and they wanted this assistance to start earlier. Aside from general case management provided in the shelter system, people who previously stayed in shelters could not identify any additional services offered by shelters to help them exit and be rehoused. Once housing is located, long delays in processing payments to landlords often results in the loss of the unit to a renter who is not dependent on a housing subsidy.

Provider Capacity and Skill

People experiencing homelessness praised workers who proactively reached out, made time to talk, and problem-solved with them. However, focus group participants with lived experience of homelessness more commonly reported that staff appeared to be doing the "bare minimum," or acted annoyed when people followed up with workers on their waitlist status for housing placement. People with lived experience of homelessness want programs and services to be more transparent about what help can and cannot be received. Many voiced frustration about provider staff giving out incorrect or incomplete information, such as unrealistic promises about how long it takes to find housing. These actions raise false hopes and repeatedly disappoint people in need of reliable help.

Service provider staff who participated in the survey are aware of these shortcomings; in fact, 62% of survey respondents cited past negative experiences with providers as a reason that people experiencing homelessness might not accept current assistance and services. Losing one's housing is traumatizing.

Staff who are not properly trained are at risk for experiencing vicarious trauma and moral injury, especially when a person expresses a willingness to be rehoused but housing resources are not immediately available or accessible. Staff working with vulnerable populations need a solid command of the current resources available to them, safety protocols to follow, and skills to effectively engage and intervene to end homelessness.

Housing First Principles

Conversations with service providers in the region revealed a lack of clarity on what it means to employ Housing First principles in practice. Service providers expressed genuine concern for people with medical, mental, and behavioral health care needs but were unsure how to actively engage these participants in addressing their health issues without mandating treatment. Some providers were frustrated when people declined housing opportunities without offering insight into the reasons for the denial. Some staff were unsure how to surface and address the barriers keeping a person from accepting help. Many of the PSH projects in the community require participants to remain sober. Failing a mandatory drug test in some of these projects can result in an eviction and return to unsheltered homelessness. People experiencing homelessness who previously engaged in subsidized housing projects reported minimal case management contact and a limited set of supportive services that did not necessarily match their needs. For example, one person without a substance use history was still required to attend a sobriety support group.

Conversely, some providers demonstrated closer alignment with Housing First, believing programs should not impose barriers or strict eligibility criteria, such as sobriety or residency requirements, to obtain housing. These providers emphasized person-centered relationships as the foundation of their work, and they advocated for providers to serve the "whole person." Providers worried about how to keep people housed and prevent eviction when program participants were still actively using substances, experienced a relapse in treatment, or were not following program requirements. These concerns indicate that more education is needed to help staff use creative problem-solving to support recently housed clients in engaging in appropriate supportive services. Staff could also benefit from more robust transition planning as people exit street outreach programs and move into subsidized housing programs.

Whole of Community Investment

Multiple system leaders expressed concern about the aging leadership at core non-profits. Some mentioned the possible disruption to fragile service systems when new agency leadership shifts the focus from a single municipality to a broader regional approach, a philanthropy shifts its funding focus, or an agency stops providing a service. There are few service providers in the region whose primary focus is serving those experiencing homelessness. It is much more common for housing services to be part of a larger mission like addressing substance use, mental health conditions, or as part of a service ministry. At the direct service level, staff turnover is high, with few staff staying longer than 2 years or moving into open leadership roles. The community does not have a Youth Action Board, and has only recently created a Lived Experience Council as part of the new BCCC governance structure.[55] Though the

[55] A Youth Action Board is an authentic collaboration with youth and young adults who have lived experience of homelessness for the purposes of providing strategic direction to prevent and intervene in youth homelessness. See YHDP (homelesshouston.org) for more information.

region has strong participation from local business leaders, it is unclear how new community leaders are cultivated and engaged in the CoC's efforts.

System Barriers

People experiencing homelessness expressed frustration at community-level policy and funding decisions that prevented them from accessing housing. They wanted to see more transparency around resource allocation and program monitoring to ensure monies are going to their intended purposes, for example, how to ensure that donations intended to aid people experiencing homelessness are properly distributed. Two additional examples for community-wide clarity emerged. First, people with lived experience of homelessness wanted more clarity on how the money dedicated to cold weather shelter nights is used when the shelter is closed. Second, there is a lack of understanding about the distinction between Federal funding to assist refugees, migrants, and/or immigrants and Federal, State and local funding to prevent and end homelessness, resulting in some cases as anti-immigrant sentiment when services were not available for U.S.-born people experiencing homelessness. Addressing transparency and correcting misinformation is critical to gathering support for implementation of systemwide initiatives.

Municipal Response and Police

People currently living unsheltered in New Bedford and Bristol County towns reported a stark shift in the municipal response in the last few years, moving from a neutral to a more hostile approach, with a more noticeable negative shift reported outside of the City. Multiple New Bedford residents described instances of police harassment while resting in parking garages out of the elements, sleeping in their own car, or trying to put their trash in a dumpster or receptacle. As one participant put it, "the City weaponizes the police to terrorize homeless people." Some County residents cited the destruction of tents by police. A New Bedford resident noted that if you are wearing a backpack or carrying a trash bag with belongings, you are more likely to be stopped and frisked. Yet, focus group participants felt they had little choice but to live their lives in public as emergency shelter beds were scarce or non-existent, especially outside of New Bedford. People experiencing homelessness observed the dichotomy of upgraded police vehicles, while municipalities cannot afford to provide emergency shelter beds.

Hospitals and Health Care

Service providers, key informants, and people with lived experience noted that medical care quality in local hospitals can be shaped by staff's assumptions about individuals experiencing homelessness. Service providers noted that the lack of shelter beds in the region contributed to the local non-profit hospital's choice to bifurcate the waiting room into two sections - one for people experiencing homelessness who are sheltering from the elements, and another section for people who have housing and are seeking emergent medical care. As a result, when people are unable to provide a fixed mailing address, hospital staff are more likely to assume that they do not have a real medical complaint and to redirect people to the waiting area section used for "monitoring." People with lived experience related stories of being issued a "no trespass" if and when they attempted to advocate for themselves. On the other hand, they shared situations where the level of care shifted when a service provider advocate accompanied the person seeking medical help.

Transitioning from Institutions of Care

Intentional and effective discharge planning can help reduce institution readmissions and improve overall outcomes for people experiencing homelessness. Institutions' discharge policies and guidelines often do not account for individuals without fixed addresses and traditional support networks. This can, in turn, result in inappropriate discharges and health and social inequities for people experiencing homelessness. One focus group participant described exiting from foster care as a particularly vulnerable time where young people are "forced into terrible situations because no one helped [them to] transition from being a child taken care of…into an adult." Focus group participants also described the risks and harms of being released from inpatient surgery or hospitalization directly to the street. New Bedford's CoC committee on discharge planning has lapsed and is currently inactive, leaving the City without a centralized way to address gaps and barriers in planning.

People exiting jail or prison similarly faced immense challenges without support, such as navigating housing barriers, difficulties gaining legal income, and stigma that persisted long past the initial crime. Multiple participants noted that they were denied housing for criminal charges that happened over 7 years ago. For some people experiencing homelessness, an initial instance of incarceration or hospitalization began a cycle of homelessness and institutionalization as discharged individuals found themselves unsheltered and unable to support themselves. Criminal justice reform legislation signed into law in Massachusetts in 2018 has resulted in a rapid decrease in the levels of incarceration for people identifying as white, but not for people identifying as Black or Latino.[56] This difference may further exacerbate racial disparities in homelessness in New Bedford.

Rising Rent and Landlord Actions

Focus group participants explained how rising rents, emergencies (e.g. fire, illness or injury), and inconsistent income from seasonal/variable work hours contributed to their current experience of homelessness. Rooming houses, which often charge less rent, were seen as dangerous, characterized by drug and gang activity. People experiencing homelessness could not identify any tangible assistance to help displaced renters swiftly find new housing within their budgets. While New Bedford operates the only homelessness prevention and rapid rehousing programs in the new BCCC, these programs serve a very limited number of people and offer only short-term rental assistance (4 months or less). In addition, available apartments are few and landlords usually have many tenants to choose from. Though landlords cannot legally discriminate against voucher holders, they do screen for credit and assess current income as proxies. Service providers in New Bedford noted that landlords require high credit scores and three times the rent to move in, which is prohibitively expensive to people with limited income. People currently experiencing homelessness described paying application and background check fees, without securing a single housing offer. These conditions are exacerbating an environment where "livable housing [is] shrinking and [the] homeless population growing."

[56] "Five years after landmark criminal justice reform, prison racial disparities widen in Mass." WGBH. 24 January 2024.

Allocation of Funds to Address Homelessness

The single biggest expense in effectively addressing homelessness in New Bedford is the development of more housing that is affordable and accessible. The City has embarked on several initiatives toward this goal, including allocating $900,000 of its HOME-ARP award toward the development of affordable housing and the creation of a comprehensive *Building New Bedford: Strategies to promote attainable housing for all in a thriving New Bedford* Plan, addressing the housing shortage in a number of key ways.

In addition to housing initiatives, the City of New Bedford has allocated $700,000 of its HOME-ARP award for the acquisition and development of non-congregate shelters; $500,000 for tenant-based rental assistance; and $299,090 for supportive services. In fiscal year 2023, the City of New Bedford received $2,093,066 in Continuum of Care (CoC) funds and $240,516 in Emergency Solutions Grant (ESG) funds. The GBCATCH CoC, which is now merged with the New Bedford CoC, received $1,017,524 in CoC funds.

The analysis of funding below shows areas of strength and opportunity based on the most recent annual performance reports.

Coordinated Entry

Prior to merging, the New Bedford CoC and GBCATCH CoC used the same provider and infrastructure for their Coordinated Entry systems (CES), with a total of $218,674 invested across both CoCs.[57] This includes a recent infusion of HOME-ARP funds to enhance the connection of people seeking assistance with necessary resources and support. The shared CES is an asset to the community, as the existing infrastructure will allow the newly merged CoC to continue with prioritization and matching with minor adjustments. The BCCC Continuum has the opportunity to determine if all funds are needed for this purpose, or if there was duplication of effort that can be reduced with the recent merger.

Homelessness Prevention

New Bedford funds two homelessness prevention (HP) programs with $43,570 in ESG dollars. Pairing HP funds with supportive services provided by local agencies can produce positive outcomes, as evidenced by last fiscal year's ESG outcomes; 92% of 102 households served were able to remain housed with HP assistance. The State also provides Rental Assistance to Families in Transition (RAFT) for individuals and families at or below 50% of area median income.[58] Widely advertising this service and having CES workers make a direct connect with RAFT programs can help stretch local HP funding and serve more

[57] MA-505 SSO grant $43,745.63, MA-505 planning grant funds $24,762.92, New Bedford HOME-ARP funding $73,591.63, and MA-519 CoC SSO grant $76,574.

[58] Rental Assistance to Families in Transition. NeighborWorks Housing Solutions. Accessed 30 June 2024.

people. As BCCC looks to more strongly engage Bristol County municipalities, HP may be an area that City and Town Councils and/or local philanthropy are willing to support, as it is generally seen as a good investment in housing stability and helps current community members to remain housed. Expansion of HP assistance could have real impact, preventing renters from entering housing crises and homelessness due to fluctuations in income, rising rent costs, and/or displacement due to disaster. Some models to consider include:

- Columbus, OH: Homelessness Prevention Network Community Shelter Board (csb.org)
- Cape Cod: Homeless Prevention Council | Housing and Financial Help | Orleans, Cape Cod (hpccapecod.org)

Street Outreach

With $29,875 of ESG funds allocated to Street Outreach, New Bedford was able to serve 198 people in FY2022. These funds are effectively reaching people experiencing unsheltered homelessness and connecting them with housing and services. Of the 103 participants who exited the Street Outreach program in FY2022, 91% exited to a permanent or temporary housing destination, and 76% were able to increase their income from enrollment to exit. New Bedford has allocated $40,000 to street outreach efforts in FY2024.

Emergency Shelter

A total of $102,652 in ESG funds supported three emergency shelters serving individuals, families, and survivors of domestic violence in FY 2023.[59] An analysis of program performance showed that all three shelters exceeded their program target for the number of people served - a total of 289 households in FY 2022. On the other hand, exits to permanent housing fell short of desired targets. Across programs, only 28% of shelter residents exited to permanent housing destinations. The project faring the poorest reported only 20% of exits to positive housing destinations and reported 32% of people exited returned to unsheltered homelessness in FY2022. In this project, 89% of guests exited before 180 days, and 39% of guests exited within two weeks of entry. In contrast, the shelter with the best outcomes reported that 59% of guests exited to permanent housing in FY2022, with no exits to unsheltered homelessness. This project reported that 50% of residents stayed longer than 180 days in shelter, with only 2% of residents exiting within the first two weeks of entry.

> *"[Giving people private space can] make you feel like a human being, not like you are in a zoo"*
>
> *– Focus Group Participant with Lived Experience of Unsheltered Homelessness*

[59] A total of $60,300 of ESG funding is being allocated to emergency shelter in FY 2024. No application from the domestic violence shelter provider was submitted (personal communication, Jennifer Clarke. 24 June 2024).

The City of New Bedford is preparing to invest $700,000 in HOME-ARP funding for the acquisition and development of non-congregate shelters. It is not possible from performance data alone to draw a causal inference about why people are exiting shelters to unsheltered homelessness. However, the current data points to somewhat longer lengths of stay being related to positive housing outcomes for people experiencing homelessness. A deeper analysis of exit data over the past several years is warranted to determine the range for optimal housing outcomes. For people staying longer than 180 days, more intensive services and supports may be needed to help them transition to housing.

For people who exit early, an examination of reasons for leaving before housing placement may point to engagement and intervention strategies. For example, focus group participants, service provider staff and people with lived experience alike, highlighted the need for non-congregate shelter options, fewer rules/restrictions (with the exception of those related to health/safety), and the importance of effective shelter staff-client engagement as areas of opportunity and improvement.

Rapid Rehousing

Thirty-two units of rapid rehousing (RRH) are provided by two providers in New Bedford. An ESG grant of $44,311 supports the units' rental assistance, and it is structured as short-term support of less than four months' worth of rental assistance. An average of 98% of people participating in RRH programs exit to permanent housing, with 71% of participants also reporting an increase in income at the time of program exit. This funding award will be increased to $65,000 in FY 2024. In addition, of the $500,000 currently allocated in HOME-ARP for rental assistance, a total of $70,000 has been awarded to date to expand one of the existing programs. Focus group participants explained how rising rents, emergencies (e.g. fire, illness or injury), and inconsistent income from seasonal/variable work hours contributed to their current experience of homelessness. While New Bedford does operate the new BCCC's only homelessness prevention (HP) and RRH programs, these programs serve a very limited number of people and offer only short-term rental assistance (4 months or less).

Permanent Supportive Housing (PSH)

In FY2023, a combined $2,635,489 of CoC funding was allocated to 6 Permanent Supportive Housing (PSH) projects serving approximately 248 persons (or 151 households) across both CoCs. The New Bedford PSH utilization rate averaged 84% of beds filled relative to the projected targets.

The two family PSH projects reported excellent outcomes during the FY 2021 program year (running calendar year 2022). In projects focused on serving families, the utilization rate was 95% on average (It should be noted that because family size is not always predictable, it may not be possible to reach 100% of project beds in a project serving families. Further, PSH is offered as permanent housing with no time limit for services). During the FY 2021 program year, 46 families exited the two projects, with 94% of families leaving for another permanent housing destination. On average, 73% of participants reported receiving some form of income at exit, with almost half (47%) reporting earned income.

Performance data for PSH projects serving individuals could not be fully assessed, as two PSH projects reported zero exits and one project reported that 100% of participants were without a source of income. It is

unclear if these data points were accurate, omitted during data entry, or unreported by program participants. Overall, utilization rates for projects serving individuals were low, with only 77% of beds in the FY 2021 program year reported as occupied. In the most recent CoC competition, a 6-unit PSH project was not renewed, resulting in a loss of 12 PSH beds for individuals experiencing homelessness in New Bedford.

Modeling data suggests the need for PSH among vulnerable individuals is much greater than the supply of PSH units available each year (primarily through turnover). CoC funding for PSH is insufficient to meet the full need for single adults in New Bedford and additional resources will need to be utilized and targeted to the most vulnerable. Further, there is an imbalance between PSH for families and PSH for individuals especially when the distribution of household types is considered. While the 2024 Point in Time count revealed 3 single households for every family household, New Bedford has more units of PSH dedicated to families (167) than units of PSH dedicated to households without children (131).[60, 61] Some of those units of PSH are dedicated to a subpopulation, such as the VASH program for Veterans.

[60] 2024 HIC REPORT for the BRISTOL CONTINUUM OF CARE. *New Bedford Homeless Service Providers Network*, 21 June 2024.

[61] PIT HIC 2024 INFOGRAPHIC. *New Bedford Homeless Service Providers Network*, 21 June 2024.

Recommendations

The City of New Bedford has many components of an effective response to homelessness. With a thorough understanding of the gaps and barriers in the system, TAC offers this set of recommendations toward a more comprehensive and efficient homelessness response system.

Diversifying Housing and Services

BCCC has a good mix of emergency and permanent housing solutions. As mentioned in the Allocation of Funds to Address Homelessness section, investing in homelessness prevention is one strategy that can slow the number of people who experience homelessness each year. Additional strategies include expanding permanent supportive housing (PSH), expanding rapid rehousing (RRH) and transitional care models, expanding and adjusting shelter models, increasing flexible financial assistance, and leveraging Medicaid, medical respite and hospital partnerships.

Expansion of Permanent Supportive Housing for Vulnerable Individuals

PSH is the most effective intervention for people experiencing chronic homelessness. However, because it is resource-intensive, it is also one of the largest gaps in homelessness response systems across the country, including in New Bedford. Some existing PSH in New Bedford is restricted for subpopulations (like Veterans or People Living with HIV/AIDS) or operates as zero-tolerance sober environments, which do not meet the needs of many highly vulnerable people.

As shown in the Projections of Unsheltered Homelessness section, there is a significant need for more low-barrier, Housing First-oriented PSH for individuals experiencing unsheltered homelessness. Scenario 3 projects the current PSH need to include creation of 30 new units through housing authority partnerships in 2026, increased turnover in existing PSH through Moving On partnerships with housing authorities, and the development of 60 new units of PSH through new construction, affordable housing set asides, or tenant-based PSH vouchers via Continuum of Care (CoC) bonus projects or other funding to be operational by 2030. Further modeling with the provided tools can be used to project the larger need for PSH across other populations.

Developing new Permanent Supportive Housing

Developing PSH in Massachusetts is challenging, resulting in a limited number of non-profits with the capacity to undertake such projects. New Bedford has two Community Development Corporations (CDCs), but although CDCs can develop affordable housing, the local CDCs do not currently prioritize affordable or permanent supportive housing development. To increase PSH production in New Bedford, more local developers need to build the pipeline. Technical assistance could increase the capacity of mission-driven non-profits dedicated to ending homelessness and the Housing First approach, even if they have not previously developed PSH. Alternatively, providers experienced in stabilizing people experiencing homelessness could partner with each other or with developers that have experience creating PSH in other parts of the state or country to play distinct roles in PSH development and operation.

Because developing permanent supportive housing is complicated, costly, and difficult to site, it is more likely to succeed with a sustained community campaign championed by local political leaders and clearly connected to the mission of ending homelessness. Research supports the value of PSH in its positive impact on residents, neighborhoods, and community-wide outcomes, but neighborhoods and businesses often need to be educated about these benefits.[62, 63] Communities often establish multi-year target goals for PSH expansion based on community need and available resources. The broader geography of BCCC offers an opportunity for a regional approach to creating a robust PSH pipeline. PSH development can be achieved by creating set-aside units in affordable or mixed-income buildings or by developing single sites dedicated to people exiting long-term homelessness.

Targeting existing Permanent Supportive Housing to the most vulnerable

The current stock of PSH in New Bedford is primarily funded through the CoC and many of the PSH programs for single adults are dedicated to subpopulations (such as people living with HIV/AIDS, Veterans). Furthermore, the majority of PSH providers have a sobriety-oriented mission and approach, which can conflict with the Housing First approach, a requirement of CoC funding. Although HUD does allow for sober living models in PSH, the current mix in New Bedford is not serving people with other severe service needs well, including people who are not ready to commit to a sober lifestyle. This leads to frustration on the part of the service providers and people experiencing homelessness, and contributes to low utilization, poor retention outcomes, and unnecessary evictions. It is important to instead target CoC PSH to the most vulnerable individuals, which includes people who are not currently interested in recovery. New Bedford OHCD can start by working with existing providers to adapt their current model, and can consider reallocation of some projects to new providers willing to operate a lower-barrier model. For this reason, providers that take a harm reduction approach are better suited to operating PSH.

Leveraging Medicaid, Medical Respite, and Hospital Partnerships

Massachusetts Medicaid (MassHealth) has unique services available to help people who are stabilizing while transitioning from homelessness. The 1115 waiver offers a billable housing search and stabilization service known as Community Support Program for Homeless Individuals (CSP-HI). This service is built to help people experiencing homelessness with an identified housing pathway search for housing and then stabilize them in housing. There are many other types of services, some more intensive, that can also be used to stabilize people once they are housed, including but not limited to recovery coaches, home health aides, Senior Care Options, Program of All-Inclusive Care for the Elderly (PACE), and OneCare. Since many of these services are not easily accessible until individuals are stably housed, and considering that people age in place, the capacity to match people to Medicaid billable supportive services will need to be revisited once people are housed. Pairing these long-term services with subsidized housing expands the pool of PSH beyond what the CoC can fund.

In April 2024, MassHealth received federal approval for an 1115 waiver amendment that includes funding for medical respite beds for people experiencing homelessness who are being discharged from inpatient care. The amendment permits MassHealth to cover up to six months of short-term post-hospitalization/pre-procedure housing (also known as medical respite) as a health-related, social needs

[62] Furman Center for Real Estate and Urban Policy at New York University (2008) Impact of Supportive Housing on Surrounding Neighborhoods: New York City Evidence. Retrieved online July 2024:

[63] National Low Income Housing Coalition. Housing First Research. Accessed July 2024.

service.[64] The Commonwealth currently has about 40 beds of medical respite and seeks to double this number. The model includes enrolling people in the Community Support Program for Homeless Individuals (CSP-HI), a housing search and stabilization service funded by MassHealth, while they recuperate in a medical respite setting. The medical respite program is required not to discharge people back to shelter or the street. Instead, providers actively engage the client in searching for a permanent housing solution that will work for them, including reuniting with family or finding subsidized housing, and, when possible, finding employment or other ways to increase income to pay rent. Though medical respite does not fill the gap of PSH, this model meets the needs of people exiting hospitals who cannot receive the care they need on the street but do not yet have permanent housing and can act as a bridge to permanent supportive housing or other permanent housing.

Fortunately, the CoC has an established Medical Respite Housing Committee and is actively partnering with SouthCoast Hospitals. This committee is ideally situated to explore initiatives that have the potential to bring together hospitals, medical providers, and housing providers, building stronger relationships and cross-sector knowledge about how to address homelessness through a housing focused and person-centered approach.

Expansion of Rapid Rehousing and Transitional Care Models

BCCC is overly reliant on PSH to meet the community's subsidized housing needs, with few options available for people who do not need the higher level of services and support that PSH offers. Rapid rehousing (RRH) is a promising strategy to increase subsidized housing for multiple underserved populations. For example, six months to two years of rental support with supportive case management can provide youth experiencing homelessness with a smoother transition from foster care, help build job and credit history, and position youth well for independence on exit from the rental assistance portion of the program.[65] RRH can also provide support for families with very young children, for low-income individuals and adults who became homeless when landlord raise rents, for people displaced due to disaster, and for people experiencing domestic violence, dating violence, sexual assault or stalking.[66]

> *Homelessness is a housing problem. You can have the best case managers in the world but you need housing to place [people] in."*
>
> – HSPN Executive Committee Member

With the expansion of the CoC and the current allocation of HOME-ARP funding to rental assistance, New Bedford has an opportunity to recruit new providers in Bristol County who may be willing to pilot a longer-term rapid rehousing project in the City. HOME ARP funds can also be used as part of a longer-term rapid rehousing program in the CoC, perhaps by working with youth serving programs and victim service providers to begin a specialized housing program tailored to these populations. Pilot programs

[64] "Press Release: MassHealth Receives Federal Authority to Expand Eligibility for Individuals and Lower Insurance Costs for Massachusetts Families." *Mass. Gov*. 19 April 2024.

[65] "Homeless Prevention and Rapid Re-Housing Program (HPRP): Year 2 Summary." *HUD Exchange*. February 2013.

[66] "Evidence From Demonstration Evaluation." *Washington State Coalition Against Domestic Violence*. June 2023.

offer an opportunity to work directly with people experiencing homelessness to ensure the program meets their needs and work out what support services will be most effective. Pilot projects can also help programs to gain experience and demonstrate effectiveness, which can then be leveraged to compete effectively for CoC Bonus and DV Bonus projects.

One of the barriers to accessing HUD funding for RRH is the 25% match requirement for RRH programs. There are different strategies communities use to support organizations in meeting this requirement. These include:

- Using private philanthropy and donations as a cash match. This funding could support staff time or support services for participants or could support rental assistance, extending the number of months a participant can receive support.
- Adding funded partners into the application and requiring those partners to match their portion of funding. For example, a workforce development program receives $10,000 of a RRH project grant to support participants in the program with job training and placement skills. As part of the MOU, the program agrees to serve an additional number of participants pro bono and document that as in-kind match.
- Helping organizations think through sources of in-kind match, including volunteer and intern hours, value of donations (ongoing and holiday specific), value of a discounted or donated space that the organization uses to provide services to program participants, etc.

In 2017 HUD recognized that some populations experiencing homelessness would benefit from a housing model that combines transitional housing with RRH. This TH-RRH model focuses on providing "a safe place for people to stay – crisis housing – with financial assistance and wraparound supportive services determined by program participants to help them move to permanent housing as quickly as possible. Stays in the crisis housing portion of these projects should be brief and without preconditions, and participants should quickly move to permanent housing."[67] This project component is approved for projects serving people experiencing unsheltered homelessness, youth experiencing homelessness and survivors of domestic violence, dating violence, sexual assault and stalking. As multiple service providers expressed a desire for more transitional care models, this project type might be a good option to build new programming.

Shared Housing

In the private rental market, shared housing is a widely accepted practice to make rental housing affordable, particularly in communities where the rental market exceeds affordability based on area median income. Many young people use shared housing as an early independence strategy, relying on a roommate to share costs and decrease loneliness before moving into housing on their own or with a partner. Similarly, older adults with a reduced income find that shared housing allows them to retain independence while also reducing isolation. Shared housing can also be used with HUD and VA funded housing including CoC, ESG, HOME, HCV, SSVF, and HUD-VASH funding streams.[68] By building a more robust shared housing program, BCCC can make use of larger unit sizes, and even match tenants such

[67] "SNAPS In Focus: The New Joint Transitional Housing and Rapid Re-Housing Component." *HUD Exchange*. 13 July 2017.

[68] Shared housing is prohibited both in project-based voucher programs and in all multifamily housing units.

that income subsidy may not be needed at all or only for the first few months. There are many resources available to assist communities with thinking about shared housing:

- The Shared Housing Institute has a multitude of resources to help communities build capacity, think through roommate matching, and engage landlords.
- The SSVF Shared Housing Toolkit offers a great example of how communities can offer shared housing to elderly and veteran populations.
- Videos on Shared Housing and Behavioral Health Supports and Palm Beach's Youth Housing offer guidance on how to provide shared housing with high acuity and youth populations.[69]

Additional Specialized Housing Programs

Outside of the annual CoC competition, BCCC may consider applying for or partnering with local eligibility entities to apply for the following funding opportunities to expand housing for underserved populations within Bristol County.

- The Administration for Children and Families offers grants to establish a Maternity Care Home for pregnant and parenting youth.[70] One example to review is Night Ministry's 8-bed residential program, Parenting with a Purpose for parenting youth aged 16 and older and their companion Interim Housing Program for youth as young as 14.[71]
- The Department of Justice, Office on Violence Against Women, offers a three year Transitional Housing Assistance Grant for Survivors of Sexual Assault, Domestic Violence, Dating Violence and Stalking that will support victim service providers in both on-site and in community transitional housing.[72] The Kentucky Coalition Against Domestic Violence established a rural focused rapid rehousing model specifically for "difficult to serve" survivors that provides a possible model.[73]
- To better serve the aging population in the region, HUD's Section 202 program provides interest-free capital advances to private, nonprofit sponsors to finance the development of supportive housing for the elderly. Rental assistance funds can cover the difference between the HUD approved operating cost for the project and tenants' contribution towards rent.[74]
- Building on the success of New Bedford CoC's Youth Homelessness Demonstration Program (YHDP) award from HUD, the newly merged communities could apply for new Family Unification Program (FUP) vouchers for youth transitioning from foster care.

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[69] "Expanding System Capacities for Shared Housing." *Shared Housing Institute.* Accessed June 2024

[70] Administration for Children and Families and Family & Youth Services Bureau. "Maternity Group Homes Program" *Runaway and Homeless Youth Program*. September 2023.

[71] HUD USER Office on Policy Development and Research. "Programs Addressing Youth Homelessness". *Evidence Matters*. Spring 2022.

[72] "Transitional Housing Program." *US Department of Justice Office on Violence Against Women*. Accessed June 2024.

[73] "Kentucky Coalition Against Domestic Violence Rapid Re-Housing Program." *Safe Housing Partnerships*. Accessed June 2024.

[74] Section 202 Supportive Housing for the Elderly Program. HUD Office Multifamily Housing. Accessed June 2024.

Shelter and Emergency Services

Focus groups with people with lived experience and with service providers identified barriers to engaging in emergency services. Shelters are not available in every community, and some shelters have residency requirements to access them. Eligibility emerged as a major barrier to accessing shelter for a variety of reasons, and shelter policies can be revisited and amended to reduce exits for rule violations and increase services designed to help people leave shelter for permanent housing. As discussed in the Allocation of Funds section, the current permanent housing outcomes for New Bedford shelters are poor. Demand for beds far exceeds current capacity; there are issues with shelter guests leaving before a permanent housing option is obtained, and with shelter guests exceeding 180 days in shelter. There are a number of strategies that New Bedford can take to right size the shelter system and increase positive housing outcomes for guests.

Minimizing Barriers to Shelter Access

As mentioned in the Service Access, Delivery and Capacity section, there are a number of barriers to shelter access centered on definitions of family and shelter rules that are not strictly related to health or safety. These policies are not conducive to supporting diverse social support systems, can jeopardize safety, and often result in exits from shelter programs before permanent housing is achieved. The CoC can adopt a definition of family that allows people to define family for themselves, without a legal or biological determination. The CoC can also use contract language and/or Standard Operating Procedures for the CoC to require shelters that serve families to accept all family types and/or create a shelter for adult-only households.

For non-funded programs, a collaborative effort to agree on a set of shared operating values and principles can help create consistency across programs and improve the experience of people experiencing homelessness in access and shelter stay. In exchange for agreeing to abide by this shared contract, staff in non-funded programs could be offered access to the CoC membership platform, training and resources.

Non-Congregate Options with On-Site Services

Traditional congregate shelter settings lack privacy and can be harmful to safety and health. As one person experiencing homelessness put it, providing people with more private space can "make you feel like a human being, not like you are in a zoo." Utilizing HOME-ARP funding to develop and run a non-congregate shelter option and/or non-congregate shelter connected to the Regional Center can improve feelings of safety and potentially increase uptake of /or belonging and engagement.

A number of the municipalities within BCCC would benefit from at least one 24-hour shelter, or co-located night shelter and day service center with open office hours (no appointment needed). Accommodating later arrivals would allow people to attend to their employment and appointments without having to bring their belongings and return in time for bed assignment. The U.S. Interagency Council on Homelessness reports that extending shelter hours and offering predictable access helps people in crisis attain stability, and this was reflected in focus group responses.[75] When services were

[75] "Key Considerations for Implementing Emergency Shelter within an Effective Crisis Response System." *USICH*. August 2017.

provided as needed and in one place, participants felt more able to focus on tasks that could advance their housing and stability goals.

Shelters in the region can adopt a reservation system wherein people can confirm if they need a bed space for the evening. Hiring Peer Navigators to staff early morning, late night, or weekend hours would help expand operations, among many other benefits that come from employing people with their own lived experience and expertise.

Community Highlight: The Greater Worcester Housing Connection (Worcester, MA)[76]

The South Middlesex Opportunity Council (SMOC) operates the Greater Worcester Housing Connection, which provides emergency shelter and individualized housing planning. Dedicated shelter staff work with guests to develop a housing plan and work towards housing opportunities.

In addition, OHCD can work with emergency shelter programs to ensure that there are trained staff on-site that can provide some level of diversion, exit planning, and housing navigation services to guests. With the scarcity of affordable housing in the area, people experiencing homelessness need quality housing navigation services to secure housing and exit shelter programs in a timely manner. Housing navigation services in emergency shelters can encompass on-site access to the Coordinated Entry process, case management to assist individuals seeking subsidized and market rate permanent housing, and/or strong workflows that support referrals to external housing navigation services. Ideally, this assistance should be provided to new guests immediately upon or soon after entry, with the guests directing their own housing and stability goals.

Resource Highlight: Housing Navigation Considerations & Tools

HUD Exchange Homeless System Response: Housing Navigation

HUD Exchange Housing Search Assistance Toolkit

U.S. Interagency Council on Homelessness's Considerations for Implementing Emergency Shelter Within an Effective Crisis Response System

Although CoC funding does not support emergency shelters, creating a committee within the CoC focused on supporting best practices in sheltering can help reduce length of time homeless metrics that CoC System Performance Measures are required to track and report on.

Low-Barrier Shelter

Substance-related harms are particularly high among people experiencing unsheltered homelessness. To address community reported restrictions on substance use and mandatory substance testing for

[76] "Greater Worcester Housing Connection." *South Middlesex Opportunity Council*. Accessed May 2024.

program participants, there is a need for a lower-threshold shelter with staff who are highly skilled in harm reduction and can serve people at different points in their path towards recovery. For instance, some local shelters can adopt policies that allow possession of and/or access to harm reduction supplies and/or engagement with guests regardless of intoxication. Some low-barrier shelters allow residents to leave their belongings, regardless of what they may be, in an amnesty locker before entering shelter.

Resource Highlight:

Manual: Harm Reduction Framework for Housing & Homelessness Services[77]

Webinar: Low-Barrier Shelter Models for People Who Use Drugs | HHRC (hhrctraining.org)[78]

All shelters can think about how to minimize logistical barriers to entering and remaining in shelter. BCCC has an opportunity to establish best practices for low-barrier shelter. Though the state is a major funder of shelter, the CoC can play a role in holding shelters accountable to standards that align with their funding by monitoring issues through an Emergency Shelter committee, establishing best practice Standard Operating Procedures for shelters, educating private providers on fair housing laws, and advocating for entry when people are wrongly denied. When local funding is established to expand shelter, contracts can require low-barrier admission and other practices that ensure universal access. Joint monitoring with state agencies that fund shelters could support alignment and accountability to low-barrier practices. Furthermore, BCCC might consider exploring and replicating the non-congregate winter shelter model provided by Steppingstone during the pandemic. This project was repeatedly brought up by people with lived experience as a more trauma-informed and effective model of service, citing the 24/7 nature of the service stay, non-congregate living space, and support services offered on site as helpful to their housing and stability goals.

Once barriers to shelter have been lowered, the CoC could explore how to best target the resource to the most vulnerable people. Existing policies in some individual shelters that reserve beds for the same people every night may hinder extremely vulnerable people from accessing shelter. In contrast, some CoCs use Coordinated Entry for entry into emergency shelter to ensure it is available for the most vulnerable people each night. Other communities develop specialized shelter for particularly vulnerable populations, such as unsheltered individuals who are actively using substances and are at a high risk of overdose. Increasing access to shelter may involve a mix of such policy changes and adding to the supply of shelter beds to meet the needs of the community.

Street Outreach

New Bedford has a robust street outreach program that includes non-facility-based activities meant to address the needs of people experiencing homelessness in unsheltered locations (including spaces not meant for human habitation) and connecting people with shelter, housing, and critical services. With the

[77] "Harm reduction framework: fostering dignity for people who use substances across housing and homelessness services." *Shelter, Support and Housing Administration*. 2017 April.

[78] "Low Barrier Shelter Models for People who Use Drugs." *HHRC.* 14 November 2023.

expansion of the CoC, BCCC would do well to survey how street outreach is currently performed across the region and identify opportunities to improve the service for those experiencing unsheltered homelessness. Preliminary information gathering includes identifying (a) the providers that deliver street outreach in the region, (b) any pre-existing communication or partnerships between those providers, if any, (c) the services and/or specialties performed (e.g. staff specializing in harm reduction, housing navigation, etc.), and (d) the locations or routes covered and vehicle access. Street outreach routes and vehicle/transportation access require particular attention, as transportation was a commonly listed barrier for people experiencing homelessness. Consulting both people with lived experience of homelessness and program data can help BCCC to understand the current state of street outreach, areas for improvement, and any disparities in access and outcomes.

Integrating medically supported street outreach into the homelessness response can remove obstacles to accessing health care. People experiencing unsheltered homelessness, in particular, are more vulnerable to health risks and have higher rates of physical and mental health conditions. One approach to address these needs is to engage providers that have healthcare for the homeless programs, like the Greater New Bedford Community Health Center, Inc., and incorporate staff trained in street medicine into the regional street outreach efforts.

Finally, under the CoC funding stream, supportive services are allowed to be provided to recently housed individuals for up to six months post placement. Employing a case conferencing meeting for recently housed individuals can help effectively transition services from street outreach staff to housing staff, coordinating services to avoid unnecessary duplication and ensuring that new tenants have the skills and supports they need to remain housed. Some communities have also invested in occupational or peer support staff to assist newly housed persons in the transition and adjustment to living indoors. In L.A., Occupational Therapists Help People Stay Housed - California Health Care Foundation (chcf.org)

Flexible Financial Assistance

Service providers can utilize flexible financial assistance to reduce housing barriers. Many sources of emergency assistance have eligibility criteria, stipulations, and processes that can be restrictive and difficult to access, especially for individuals in crisis. Flexible funding can be a low-barrier, expedited alternative to fill gaps left by existing funding sources. This can include funding to repair a vehicle needed to maintain employment, pay for professional licensing, or rental arrears to clear someone to re-enter public housing. Small amounts of support have shown excellent outcomes for increasing housing stability and safety.[79] The CoC can support embedding flexible funding in programs, which would allow people experiencing homelessness with limited and/or fixed incomes to keep more of their income and support housing-related goals.

Transportation was repeatedly mentioned by people experiencing homelessness in both New Bedford and Bristol County, citing both the geographic layout of the region and the associated costs of transportation as barriers. Some participants with lived experience shared that at times they were offered resources, but there was no transportation assistance to ensure they could actually access those resources. Flexible funding can be used to provide transportation to housing viewings and job training

[79] Sullivan, Chris O; Simmons, Cortney; Guerrero, Mayra; Farero, Adam; López-Zerón, Gabriela; Oluwafunmilayo Ayeni, Oyesola; Chiaramonte, Danielle; Sprecher, Mackenzie; Fernandez, Aileen. "Domestic Violence Housing First Model and Association With Survivors' Housing Stability, Safety, and Well-being Over 2 Years." *JAMA Network Open*. (2023) vol.6, no.6.

programs to name a few examples. It can also be used to help people experiencing unsheltered homelessness to mitigate the financial burden associated with personal care/hygiene, and tasks related to achieving housing and other stability-related goals.

Community Highlight: The LGBTQ+ Center of Central Pennsylvania's Flexible Funding Program (Harrisburg, PA)

There are many programs with flexible, short-term assistance components that have yielded promising outcomes. The LGBTQ+ Center of Central Pennsylvania's Flexible Funding Program is an intervention that focuses on addressing survivors' immediate financial needs. Twenty-six percent of program participants moved from homelessness to temporary or permanent housing situations, among other promising results. In 2022, assistance fell into some of the following categories: Rental assistance, move in costs and security deposits, transportation, basic needs.

Some of the guiding principles for the program include:

- Low-barrier access;
- Supporting multiple needs without predetermined limitations; and
- Prompt disbursement of funds (i.e. available within 24-48 hours).

Policy Levers to Maximize Housing Resources

Policy levers can help align resources and streamline access for people experiencing homelessness in Bristol County. By engaging multiple sectors in preventing and ending homelessness, the system becomes less fragmented and more unified in the strategy envisioned by New Bedford and BCCC.

Enforce Landlord Requirements and Implement Incentives

Accessing landlords was identified as a significant challenge for people experiencing homelessness who have secured a voucher or have recently enrolled in a rental assistance program. Housing search workers should be encouraged to report any suspected discrimination to the City, to enforce compliance. However, workers and prospective tenants may also File a Complaint with HUD's Office of Fair Housing and Equal Opportunity.[80]

Building in monetary incentives and liaison support to landlords who choose to house people exiting homelessness can help with recruiting and retaining more private landlords, especially in competitive housing markets. In exchange for accessing the incentive fund, landlords agree to accept referrals from the by-name list for a period of three to five years. CoCs can recruit landlords to participate in a shared application site that only requires potential renters to "apply and pay once" to be considered for multiple open units —this fee could be paid by a flexible funding pool (see Diversifying Housing and Services section) to further reduce barriers to housing. Additional monetary incentives can include, but are not limited to, the following approaches:

[80] Report Housing Discrimination. HUD's Office on Fair Housing and Equal Opportunity. Accessed 3 July 2024.

- **Signing bonuses** – Payments offered when the landlord completes the program agreement and/or executes the lease
- **Situational financial assistance** – Funds that can support rent arrears, damage fees, etc.

Boston's Landlord Incentive Program can be referenced as a strong example of such a project.

Key informants and participants in focus groups suggested several additional strategies to improve access to rental housing, including introducing rent control laws and creating or enforcing adequate notice for evictions and lease terminations. Free legal services and advice at housing court can also protect renters who are in the process of eviction. Informants advocated for more City assistance to help displaced renters not fall into homelessness.

Leveraging VAWA for Housing Retention

The Violence Against Women Act (VAWA) requires that any landlord, property owner, or program that accepts rental assistance funding from HUD abide by a set of housing protections designed to help survivors stay safe and housed.[81] Ensuring that all landlords are distributing the VAWA Notice of Occupancy Rights at application, notice of denial of housing and notice of termination/ pending eviction can help keep survivors housed by alerting them to actions they may take to contest evictions or damages that were the result of actions an abusive partner took. As required by VAWA, New Bedford has an Emergency Transfer Policy allowing a survivor of violence the right to request an emergency transfer if violence occurred in their unit or sexual assault occurred on the premises and they fear additional violence if they remain. A review of the policy to ensure that best practices are included can help survivor families stay housed and also protect other tenants and housing project staff from collateral harm and/or violence.[82] These provisions include ensuring that survivors are prioritized for VAWA transfers, eliminating or streamlining the application process during the transfer process, and emergency hotel funds to act as temporary safe housing for survivors if a transfer isn't immediately available.

- One possible source of funding for temporary shelter for survivors is the Victims of Crime Act grant program administered by Mass.gov.

BCCC has an opportunity to strengthen the collaborative relationship between the Victim Service Providers (VSPs) in the region, New Bedford's Women's Center and New Hope. With both of these providers under one CoC, the BCCC has an opportunity to build out a true victim coordinated entry response. The National Network to End Domestic Violence and Safe Housing Partnerships both offer excellent guidance on how CoC's can serve survivors of violence effectively without compromising confidentiality.

Housing Authority Preferences and Partnerships

Local Housing Authorities are critical partners in the effort to end homelessness in any community. The impact that Housing Authority preferences, priorities, and supportive housing partnerships can make are unmatchable. Currently, there are foundational relationships with the New Bedford Housing Authority

[81] "Notice of Occupancy Rights Under VAWA". *HUD Violence Against Women Act webpage*. Accessed May 2024.

[82] "Model Emergency Transfer Plan". *Safe Housing Partnerships*. (2018). Accessed May 2024.

(NBHA) and the Taunton Housing Authority (THA), both of which have a homeless admission preference. It is recommended that New Bedford OHCD work to engage other Public Housing Authorities (PHAs) in the BCCC catchment area, and the strategic approach can be informed by the successful relationships with the NBHA and the THA.

Housing authorities often struggle with housing highly vulnerable people from their waitlist, whether or not they were previously homeless. Housing authorities are typically more willing to - and often welcome - creating a preference for chronically homeless households if supportive services are provided and the CoC organizes regular case conferences for tenants who struggle to stabilize in housing. This can be a win-win for both housing authorities and the CoC to keep formerly homeless tenants housed. As mentioned in the Leveraging Medicaid, Medical Respite and Housing Partnerships section, some such partnerships have focused on subpopulations, like chronically homeless older adults who can be stabilized in housing with Medicaid-funded and other services.

Conversely, CoCs often have stable tenants in their PSH portfolio who cannot exit because they need subsidized housing, but they no longer need supportive services. Housing authorities can serve as next step housing through a "Moving On" partnership for people who are in PSH, no longer need stabilization support, and are ready to move to more independent housing. This connects housing authorities with stable tenants who can move quickly, and the PSH units that become available as a result can be targeted for vulnerable people currently experiencing chronic homelessness. Housing authorities, such as the Boston Housing Authority, can amend their Administrative Plan to accommodate this type of housing. (For more details, see the Boston Housing Authority Housing Choice Voucher Administrative Plan, page 24.)

Furthermore, PHAs can help solve some bottlenecks in emergency shelters if they create a policy to keep formerly homeless tenants on their waitlists. Some local housing authorities still consider people in RRH or even PSH as active on their waitlists, removing a disincentive for some people who would otherwise wait rather than accepting RRH or PSH. This also offers people time to stabilize in CoC-funded housing before moving to public housing or mobile vouchers administered through the housing authority.

Lastly, actively involving PHAs in case conferencing of people experiencing homelessness can help improve outcomes. Several focus group participants mentioned losing vouchers because they ran out of time while looking for housing. Extensions can be given at the discretion of a housing authority, so case conferencing people can prevent those types of significant losses. Similarly, outcomes can improve by designating a dedicated, solution-oriented point person at the housing authority for CoC providers to contact when issues arise.

Target Housing Affordability

New Bedford has already committed to increasing affordable housing through their Building New Bedford plan. As the CoC expands to include Bristol County, BCCC can consider working with other local municipalities to advocate that new housing developments "set aside" a percentage of income-restricted units for people exiting homelessness. For example, in Boston, there is a 10% homeless set-aside requirement for all developments that receive City subsidies for capital development. This requirement is paired with support from a staff person at a non-profit to help people exiting homelessness navigate the application process and offer on-call stabilization services as needed. Pairing this type of policy targets for affordable rental housing units distributed across neighborhoods and the

region would significantly increase access to housing for people experiencing homelessness.[83] Vacant businesses, nursing homes and schools may offer communities an opportunity to expand the overall affordable housing stock through renovation. The Fall 2023 edition of Evidence Matters offers examples of how communities are repurposing office buildings into affordable housing.[84]

Regionalization of Service Provision

The BCCC Continuum covers a significant portion of southeastern Massachusetts. Appendix A delves into demographic data for the region, primarily drawing from the 2020 U.S. Census data, as well as the 2020 and 2023 Point-in-Time counts. New Bedford and the new BCCC are strongly recommended to examine the expanded population and evaluate necessary changes to service and housing needs to ensure equitable service delivery across the CoC. Data points of interest include a focus on income/ socioeconomic status, immigration and migrant status, and household composition.

Invest in Communication for Better Coordination

Systemwide coordination and communication was a recurring theme throughout the Service Provider Survey responses, focus groups, and key informant interviews. Service providers want to better understand one another's roles and services, streamline service delivery, minimize duplicative efforts, effectively manage expectations, and hold one another accountable. Ultimately, this would improve experiences and outcomes for people experiencing homelessness in New Bedford and Bristol County.

Data and Information Sharing

Service providers identified a need for access to real time, systemwide data, information, and networking opportunities. The current system of securing required releases of information could be streamlined without compromising client choice and confidentiality requirements. This could result in more efficient referrals, coordinated services, unduplicated intakes, and enhanced service access. Some CoCs have developed a universal release of information that allows partners to share information across the network of providers, facilitating case conferencing, collaboration, and coordination between multiple agencies necessary to get people housed and stabilized. For example, the Boston CoC has used this type of data sharing system and can serve as a model.

Community Highlight: South Shore Continuum of Care (CoC)

According to the South Shore Continuum of Care (CoC) Policies and Procedures Manual,[85] subrecipients are required to collect and keep records of releases of information, supporting more efficient communication, less duplication of data collection, and the maintenance of a regional data warehouse.

[83] "Establishing Goals and Monitoring Progress." *Local Housing Solutions.* Accessed May 2024.

[84] HUD USER Office of Policy Research and Development. "Office to Residential Conversations." *Evidence Matters*. Fall 2023.

[85] "South Shore Network CoC Policies and Procedures Manual." *South Shore Network Continuum of Care*. (2021)

Technology can support effective and sustained coordination. Through an interagency membership productivity platform, partners across the CoC network can communicate in real-time and organize, delegate, and collaboratively conduct CoC committee work, among other helpful features. A platform shared by CoC members, such as Member365 | Purpose Built Membership Management, would allow everyone to share updates and knowledge, readily access information, streamline decision-making, and advance work in one place. Such a platform can also facilitate greater awareness and understanding about other agencies' expertise, services, and capacity.

Responses from community members also revealed opportunities to improve collaboration across broader systems (e.g. homeless services, healthcare and hospital systems, law enforcement, etc.), especially to best support individuals with multiple barriers and/or health-related complexities. To increase access, BCCC can build relationships between major community systems designed to serve and protect all and implement shared Standard Operating Procedures (SOPs).

- BoardEffect offers this resource to locate Technology Grants for Nonprofits.
- Verizon foundation grants support digital inclusion for non-profits and some government entities.

Messaging Matters

A strong messaging campaign can unify both New Bedford and Bristol County around a focus on inclusion and opportunity, supporting our neighbors in crisis, and economic growth through housing stability. By recentering the person when discussing solutions to homelessness, local communities may be more motivated to support funding initiatives such as homelessness prevention, multifamily affordable housing projects, and a modest percentage of subsidized housing in the form of RRH and PSH. Strategies to unify messaging include:

- Holding an educational forum for neighborhood associations and landlords.
- Scheduling a meeting with newly elected leaders to answer questions and dispel myths.
- Disseminating a brief 1–2 page policy document that combines personal experience with facts, solutions, and comparison funding (e.g. the cost of housing someone with a disabling condition through PSH versus the cost of long-term hospitalization for the same person).
- Engaging the local media in a series of articles/news stories focused on the severe housing shortage, the impact on people currently housed but struggling or mid-crisis, and the systemic barriers that prevent rapid resolution out of homelessness. Op-ed pieces following negative news coverage can help to offer a counter-narrative and surface real solutions to preventing and ending homelessness in the community.

There are several resources to assist communities with crafting their messaging. A brief video resource from Johns Hopkins University gives clear and concise guidance on How to Deliver Effective Testimony. The Network for Public Health Law also offers a free Micro Toolkit to assess legislation for equity, and tools to help counter potentially harmful initiatives.

Adjustments to the Coordinated Entry Process

With the expansion of the CoC, New Bedford has an opportunity to conduct a community-wide review of how people experiencing homelessness are prioritized for housing. Including people with lived experience

and service providers in this process can ensure a shared understanding of who is most at risk for adverse outcomes. Using CoC data and the experiences of people who have tried to navigate the Coordinated Entry system, the assessment process can be updated to increase clarity in questions, reduce and minimize potential bias, and tailor questions to the factors identified in the prioritization discussion.

Resource Highlight: HUD Resources for Customizing Coordinated Entry Systems (CES)

HUD provides many resources and examples to help CoCs create a CE system that works for their communities.

- Many communities start with a Coordinated Entry Self-Assessment to identify gaps and create a set of action steps for improvement.
- The Coordinated Entry Community Samples Catalogue is structured around CES Components, system design, and special populations.
- The Connecticut Balance of State CES offers a strong example of how a CoC can effectively operate a CES across multiple counties.

The BCCC's Coordinated Entry system (CES) is unique in that it is administered by a behavioral health agency that bills Medicaid services. This is a significant strength for the CoC, as it allows the CES process to maximize Medicaid billable services at the point of assessment.

Although the BCCC promotes a Housing First approach, the dominant PSH model in the CoC is a sober living environment. While CES can accommodate matching individuals who prefer a sober service model, outcomes can be poor if people are matched to this approach without their approval. It is crucial to determine how many people prefer a sober service model over harm reduction to understand the demand for such programming. If the demand for sober living options among those prioritized through Coordinated Entry is lower than the available supply, the CoC can seek more harm reduction-oriented providers to offer services. Once demand and supply are balanced, preferences for sobriety or harm reduction service models can be integrated into Coordinated Entry assessments and matching. In addition, because HUD requires programs to follow Housing First principles, all service models must permit relapse and respect program participant choice. For instance, if a tenant uses substances while still upholding the terms of their lease, Housing First practices would ensure the tenant is supported to remain in housing, regardless of the provider's philosophy. It is recommended that all providers be retrained in harm reduction and Housing First approaches to ensure compliance with HUD and CoC funding requirements.

Offer More One-Stop Shop Programming

Ensuring that the maximum amount of information and services can be offered in one place will reduce the amount of time people experiencing homelessness spend in travel to multiple agencies, offer opportunities for immediate connection to services, and maximize limited staffing resources. The BCCC can adopt a "No Wrong Door" approach to housing access and ensure the methodology is adopted by all service providers. This person-centered approach means each door is a gateway to all the resources people need to become stably housed. There are many strategies that communities use to share resources and expertise. A few low cost strategies include:

- Training specific point people at each agency to be Coordinated Entry (CE) assessors and ensuring the CE assessment tool is comprehensive for all the services and supports people need to end their homelessness. New Bedford already has an existing online 2-page resource called CHAT that staff can and should use with every shelter guest. Shelters can also add (or partner with other agencies to embed) a Diversion/Exit Planning Specialist trained in exit pathways, housing navigation, and general case management, engaging new guests immediately upon entry. River Valleys CoC in Minnesota created this resource that outlines how a CE Housing Navigator can enhance Coordinated Entry work.[86]
- Several New Bedford organizations host events popular among people experiencing homelessness (e.g. food pantries, mobile laundry, etc.). Using these events to host information sessions with external partners can improve both staff and client knowledge about available services and resources. Expansion opportunities that enhance stability goals include the addition of document replacement assistance, haircuts, housing navigation, job search, public benefit applications, and access to harm reduction and health services. Adding peer navigators can help build trust and facilitate warm handoffs while also providing a source of income for people who once experienced homelessness.
- Agencies with capacity can deepen partnerships by co-locating staff in one or more central locations to offer office hours, with a focus on housing pathways planning. This would result in bringing a wider range of services and resources to those most impacted and/or underserved. Co-located staff might have specialties in: housing navigation, homelessness prevention of diversion, substance use, mental and/or physical health care, job search/workforce development, public benefits and income maximization, and/or general referrals.

Opportunity Spotlight: Dartmouth's Community Services Outreach Team

The Town of Dartmouth's Community Services Outreach Team presents an opportunity to expand their pre-existing offerings in a co-location model. Currently, an Intake Worker from CCBC visits the Dartmouth site two times per month and transportation is provided to the appointment. By expanding this model to include housing search and navigation resources, the site can provide an efficient and effective way to engage people experiencing homelessness and advance their goals of housing and stability. In the new BCCC, this service has expanded throughout the County.

- Lastly, the CoC can organize a one-day or multi-day housing resource event (sometimes called a "housing surge" or "accelerated moving event") with targeted housing resources and a specific group of people experiencing homelessness - for example, people living in a large encampment, a rotating quarterly schedule for each town, etc. Depending on the population's needs,

[86] "Understanding the Coordinated Entry Housing Navigator Role." *Rivers Valley Continuum of Care MN-502*. September 2019.

communities can consider hosting the event in one place versus engaging street outreach workers to connect with people in the field.[87] Once invitees arrive or are transported, they can be paired with someone to help them navigate the process. These would ideally be peers who are now stably housed. Setting realistic expectations and coordinated messaging is critical. The goal of a housing resource event is to connect participants with housing and services on the spot. These events require a sizable number of housing vacancies (CoC, public housing, or other vacancies that are targeted to CES), and are sometimes planned around the start date of new CoC Bonus projects or other funded projects. The convener can bring all relevant parties needed to process and approve someone's housing application or housing resource and services package in real time at the event. New Bedford hosts an annual New Bedford Connect event focused on services and housing resources. This infrastructure could be adapted to support an accelerated moving event that centers housing placement with specific housing targets.

Establishing a Regional Center

There was consensus across community members that a regional or multi-service center would greatly benefit the region. Service providers suggested that one or more centralized hubs could help address current gaps in the community and mitigate some transportation barriers for individuals navigating homelessness. People experiencing homelessness saw the potential for a regional center to help address some of these challenges, while providing a place to rest out of the elements, charge their phone, attend to basic hygiene needs and gain information about housing and services available. While there was resounding support for a regional center, there was less consensus on the most effective and accessible location. People experiencing homelessness expressed a desire for shelter and housing in their own local community where they have established support networks and resources. To address these competing needs, the BCCC can implement a hub and spoke model with a centrally located main center, and satellite locations throughout the Continuum. The smaller locations can coordinate local resources and provide warm handoffs. Satellite locations are likely to be existing facilities already offering at least one relevant service, such as soup kitchens or health centers.

Flexibility in access and hours can greatly benefit people's safety, well-being, and the advancement of housing and stability goals. Regional Center hours of operation should factor in these considerations and ideally would be open for some portion of the day seven days a week and/or open 24 hours a day, year-round. The ability to access the site without a pre-set appointment would increase the likelihood that people experiencing homelessness will take advantage of the offerings. The center can also hire peer navigators to help staff on holidays and during early morning, late night, or weekend hours.

Strategic partnerships can expand regional center services, resources, and/or impact. Informed by the vision, purpose, and scope of the center(s), it is highly encouraged to consider establishing trusting partnerships that are included in the process early and throughout each step thereafter. Instrumental partners in the region include the local police departments/law enforcement, the hospitals, and the Public Housing Authorities (PHAs). It is best practice to develop Standard Operating Procedures (SOPs), which includes a Memorandum of Understanding (MOU) for each partner, and to implement comprehensive releases across involved partners to enable streamline service coordination.

[87] Homeless Response System: Planning a Housing Surge to Accelerate Rehousing Efforts in Response to COVID 19. HUD Exchange. Accessed May 2024.

Community Models

Three existing community models located in Quincy, MA, Hackensack, NJ, and Oxnard, CA stood out as beneficial approaches for the BCCC Continuum to learn from. These models are summarized, respectively, in Table 4, Table 5, and Table 6 below, and in greater detail in Appendix B. It should be noted that all models also use private fundraising dollars to support ongoing operations. Those amounts were not included, as they shift annually and were not provided at the time of this report.

Located in Quincy, MA, the **Yawkey Housing Resource Center** was developed in response to a need for a new service delivery model that centers housing, streamlines services, and provides individualized interventions to prevent homelessness, divert people from shelter when possible, and reduce the length of time people experience homelessness. Construction began in 2022 and the site opened in 2023. To achieve these goals, the center provides comprehensive homeless prevention, triage, and rapid exit planning services, as well as units of PSH. These services are core components of the Center. Diversion Specialists at the Center assess individuals to identify immediate needs, help them navigate alternatives to emergency shelter, offer housing problem-solving support to identify an appropriate housing plan, and provide connections to flexible resources that can mitigate barriers. To further support clients' housing goals, these staff members assist clients with income maximization to help sustain rent and basic needs. The Center's clients are engaged and assessed as early as possible in their housing crisis. Several partner agencies are co-located at the Center, and there are clear referral processes in place to streamline service coordination and pathways out of crisis.

The Yawkey Housing Resource Center campus houses both congregate shelter and PSH. The overnight congregate shelter was created with dignity and functionality in mind, using built-in dividers to ensure some privacy for overnight guests. The campus layout, especially the proximity of the shelter and PSH, allows Center staff to easily move between spaces for different uses and functions (i.e. quiet meetings, client engagement), and it helps ensure coverage between the buildings.

Table 4: Father Bill's & Mainspring's (FBMS) Yawkey Housing Resource Center (Quincy, MA)

Description	Site Details	Financing
Congregate Shelter & Multi-Service Center	• 15,700 square feet	**Estimate** • $4.6M in public capital • Portion of $10M private fundraising (shared with PSH site) • Portion of land value donated from City of Quincy (shared with PSH site) **Sources** State, local, and fundraising
Permanent Supportive Housing (PSH)	• 20,000 square feet • 30 efficiency units	**Estimate** • $10.2M in capital • Portion of $10M private fundraising (shared with shelter and multi-service center site) • Portion of land value donated from City of Quincy (shared with shelter and multi-service center site) **Source(s)** Federal, state, local, and fundraising

The Bergen County Housing, Health, & Human Services Center in Hackensack, NJ is a 24-hour emergency shelter and "one-stop" multi-service center, with no PSH component. Construction began in 2009 and the site opened in 2010. The Housing Authority of Bergen County operates the Center, with most services provided by contracted community partner agencies. The Housing Authority of Bergen County's role emphasizes the community's conviction that housing is at the epicenter of the solution to the homelessness crisis. Center clients gain support navigating housing resources available through the Housing Authority.

The Center's services are driven by connecting individuals to permanent placements. Center staff immediately assess clients, and a shelter-based housing team engages clients to explore their housing options. Various other services are available on-site to support clients' housing goals and overall stability, such as care management, mental health and Substance Use Disorder (SUD) counseling, legal aid, job readiness programming, and more. Perhaps more uniquely, the Center offers both congregate, dormitory-style shelter space and non-congregate settings.

Table 5: Bergen County Housing, Health, & Human Services Center (Hackensack, NJ)

Description	Site Details	Financing
Low threshold emergency shelter, with a mix of dormitory style and non-congregate spaces. Daytime multi-service center with comprehensive services. Managed by the Housing Authority of Bergen County.	• 25,516 square feet • 90 shelter beds	**Estimate** • $11.5M in capital • $4M for operating **Source(s)** • County • Federal, state, and local

Casa de Carmen and the Oxnard Navigation Center is located in Oxnard, CA, Ventura County's most populous city. Construction began in 2024 and the site is partially completed. It incorporates congregate, 24-hour emergency shelter and PSH. Similarly to the models previously mentioned, the Center implements a housing-centered case management approach with clients and aims to support transitions out of shelter. Housing Navigators assist clients with finding housing, the application and screening process, move in, and support. Dedicated Leasing Department staff search for available units and liaise with local landlords and property managers.

Table 6: Casa de Carmen and the Oxnard Navigation Center (Oxnard, CA)

Description	Site Details	Financing
Congregate Shelter/ Housing Navigation Center	• 22,000 square feet (full center; includes PSH units) • 110 shelter beds	**Estimate** • $42.6M in capital (incl. PSH) • $3M for operating • $300,000 for services **Source(s)** Federal, state, and local (primarily local funds)
Permanent Supportive Housing (PSH)	• 56 units	**Estimate** • $504,000 for operating, incl. services **Source(s)** Federal, state, and local (primarily local funds)

There are some commonalities across all of the aforementioned models. Gradually building political will and gaining community support over time was key to their successful development and eventual implementation. In the early days of the Casa de Carmen/Oxnard Navigation Center, team members proactively introduced themselves to community neighbors and identified facility points of contact. Since opening, dedicated staff trained in de-escalation have been responsible for conducting regular outreach around the facility's perimeter with both neighbors and the Center's clients to help ensure positive community relations.

Strategic partnerships are also a key tenet of each of the models. In many cases, it was beneficial to engage government, nonprofit community-based organizations, and private partners early on in the process. The three centers forged relationships that drew on each partner's strengths and adopted practices to enhance service coordination and accountability, such as comprehensive releases of information and partner agreements or MOUs. Programmatically, individualized exit planning, housing problem-solving, and housing navigation are at the forefront of the three models' efforts, with the overarching goal of supporting pathways out of homelessness.

Standardizing Trauma-Informed Response in Law Enforcement

Outside of housing-focused programs, working with local law enforcement to establish a shared set of Standard Operating Procedures (SOPs) can improve the current atmosphere of animosity that people experiencing homelessness reported, decrease trauma, and increase the likelihood that people will accept help. Both New Bedford and Taunton have active Community Crisis Intervention Teams in place that may provide a starting point for this work. At a minimum, SOPs should include a set of shared engagement strategies, a warm handoff procedure to Street Outreach or Regional Center staff, and guidelines on the preservation of dignity and personal property during encampment removal. One resource to review is Chicago's Community Encampment Report, which categorizes the response to encampments into levels based on size and intensity, outlines a specific notification timeline, and designates specific steps that governmental and non-governmental entities can take to reduce harm.[88]

BCCC can also consider advocating for a County-wide agreement with local law enforcement and courts to forgo arrests and convictions for survival crimes (i.e. crimes or infractions committed to secure basic survival or safety) in favor of diversion into housing and services.

Investing in the Service Provider Workforce

An undercurrent of all community conversations in New Bedford and Bristol County was the difficulty in hiring and retaining well-qualified staff. Between July and September 2023, the National Alliance to End Homelessness conducted a survey with people working to end homelessness in the United States. Seventy-two percent of survey respondents indicated that they entered this field because of their desire to do work that is meaningful or helpful, and 87% felt that they were doing work that was worthwhile. However, the survey also revealed that 74% of respondents felt there were insufficient staff in their agency to do the work properly, 90% of respondents reported increased stress, and 64% reported feeling overworked.[89] In much of the work done to prevent and end homelessness, the primary intervention is the staff. To retain and support staff working with vulnerable populations, the following strategies are recommended.

[88] Sierks, Cara; Burnett, Kimberly; Dunton, Lauren; Sitler, Aubrey; Khadduri, Jill. "Chicago, Illinois Community Encampment Report." HUDUSER Office of Policy Development and Research. February 2020. pp 9–11.

[89] Working In Homeless Services: A Survey of the Field. National Alliance to End Homelessness. 5 December 2023.

Resource the Existing Workforce

First and foremost, BCCC can leverage CoC and ESG funding to encourage organizations to pay direct service workers a living wage for the region, with access to health benefits and paid time off. Some organizations are actively supporting employees in using their sick leave to also address their mental health and wellbeing, building in planned wellbeing days.

Community Spotlight: Building Resiliency Project

The Building Resiliency Project is a collaboration of North Dakota Victim Serving Agencies that came together out of their commitment to the health and wellness of their staff and team members. The model begins with a recognition that all staff are impacted by secondary traumatic stress and includes an on-going organizational assessment and evaluation aimed at improving retention rates, supporting healthy staff, providing ongoing training, and building reflective supervision and supports to process impactful events. They have also pooled resources across the community to support free access to Emergency Assistance Program therapy and resiliency supports for staff members in the collaboration's agencies.

Standards of Practice

The quality of the relationships that staff develop with people experiencing homelessness, the depth of staff members' knowledge of resources, and their ability to tailor solutions to each individual are valuable skills that must be cultivated and supported to do this work effectively. The cornerstone of people-focused intervention is case management. At a minimum, BCCC can review project proposals and require that funded projects follow best practice guidelines for caseload standards, with more intensive case management models calling for a ratio of 1 staff person per 10 clients, and less intensive models implementing a 1 to 35 ratio.[90]

BCCC can also engage the CoC in a set of collective standards of practice. Required training can be incorporated into agency contracts. HUD Exchange offers a wide range of best practice on-demand training for people working in the field of addressing homelessness. One strategy is to create a web page and/or a PDF document with easy-to-access links for key training on housing focused outreach, motivational interviewing, and other best practice skills needed to work effectively. Creation of a training manual, like the Florida Housing Coalition's Case Management Guidebook, or the San Antonio/ Bexar County Street Outreach Standards can support staff across the CoC in best practice methods and foundational principles.[91]

Diversify and Build Leadership Capacity

The newly expanded CoC offers an opportunity to build capacity among smaller private non-profits and emerging leaders across Bristol County.

[90] "Vital Role of Case Management for Individuals Experiencing Homelessness." *National HCH Council In Focus Newsletter* (April 2016) vol. 4, no.1.

[91] "Case Management Guidebook." *The Florida Housing Coalition*. (June 2018).

- Support newly formed agencies with an established mentor agency, or connection to a fiscal agent to help new leaders meet the requirements of government funding sources and laws. Forming a peer network for collective learning can also support agencies and promote stronger partnerships.
- Establish a leadership academy cohort to help direct service staff move into leadership roles and create capacity for succession planning in established agencies.
- Invest in the capacity of people with lived experience of homelessness to fill leadership and direct service roles. This could look like a leadership academy or business incubator focused on people with lived experience of homelessness, and/or establishing a Youth Advisory Board with youth experiencing homelessness in the community.

Shift Success Measures

In addition to outcomes-based metrics, establishing a small set of quality improvement metrics can both support programs and reduce staff turnover. In a system with too few resources and increasing need, the opportunity for vicarious trauma and burnout is high, resulting in increased turnover of positions, and/or disrupted and damaged relationships with clients.[92] Aligning success measures with actions within individual worker control can reduce negative impacts on staff, and improve client outcomes by increasing the likelihood that clients will achieve their housing and service goals.

Some examples of worker-centered outcomes include:

- Number of barriers to housing or services that a worker is able to address or remove.
- Number of new or updated resources that a worker shares with their program team.
- Number of new people or agencies to which a worker is able to connect their client.
- Number of clients brought forward for intensive or group problem solving (to move a client from contact to engaged, from engaged to housed, etc.).

Finally, help programs shift their case conferencing format from discussions about actions that clients have taken to a focus on actions that outreach and housing staff are taking to support clients and advance their goals.

Strengthen CoC Governance

New Bedford has a strong history of leading the MA-505 CoC with an intentional focus on building inclusive representation on the Executive Board. As they take on the role of Collaborative Applicant for the new BCCC, New Bedford OHCD has an opportunity to expand this membership to the broader County. The full report on CoC merger considerations can be found in Appendix A. This section highlights three areas of governance that TAC believes will maximize leadership's effectiveness in homelessness response.

Dedicate Resources to CoC Leadership and Capacity

To effect the recommendations in this report, sufficient staff resources must be dedicated by OHCD, and these staff must have homelessness response as their primary role. Currently the CoC collaborative

[92] Working In Homeless Services: A Survey of the Field. National Alliance to End Homelessness. 5 Dec. 2023.

applicant and lead functions are held by OHCD staff, and are executed as part of their other responsibilities. The duties of the CoC Lead Agency are vast and varied. The New Bedford CoC has the equivalent of 1 FTE paid time, spread across three staff who hold positions with many other responsibilities. This does not afford the time or focus needed to accomplish the basic requirements of a CoC Lead Agency, let alone the initiatives leaders seek to move forward to improve system outcomes. The scarcity of dedicated staffing to convene, build relationships, monitor programs, analyze data, and create regional initiatives will be further exacerbated by the merger.

Recommendations for more adequate staffing include the addition of one dedicated FTE to manage reporting, monitoring, and to use data to drive performance and the addition of one dedicated FTE to convene partners and drive strategic initiatives, including supporting the Lived Experience Advisory Council. Dedicated positions can work together to identify and support new programs in their readiness to execute a federal grant, help programs shift from transitional housing to rapid rehousing models, and help programs to implement Housing First projects to fidelity. Adequate staffing will allow the BCCC to further encourage and support community members to get involved, help existing programs to identify possible solutions for piloting, and facilitate partnerships to enhance the work done by both organizations. In addition to these two new positions, keeping a portion of time of leadership roles to provide supervision and guidance to full time staff, interface with Mayor's office, state and other high-level officials, and to participate on executive committee and working groups.

Expansion of Funding Sources

To support the staff and full spectrum of initiatives needed to prevent and end homelessness, funding must expand beyond federal sources. The Continuum of Care and Emergency Solution Grant funding streams are insufficient to fund the best practice programming required to sustain housing and stability outcomes. The CoC and OHCD would benefit from a diversified funding strategy that includes private philanthropy, other government funding streams, and fundraising. The BCCC is well positioned with the Rise Up committee to expand their collective fundraising power. The addition of dedicated CoC staff positions can help the committee and individual programs to identify and pursue relevant public and private grant sources and cultivate regular individual donors:

- Dedicating part of the combined CoC planning grant dollars for BCCC to supporting one position or part of both full-time positions.
- Funders Together to End Homelessness is a national network of funders supporting strategic, innovative and effective solutions to homelessness. A request for a one- or two-year startup grant to support salary costs, giving new leadership time to get established and develop a fundraising strategy to sustain ongoing costs.

Deepening Partnerships with People with Lived Experience of Homelessness

People with lived experience of homelessness often have a deep understanding of the services, interventions, and most effective possible solutions to help prevent and end homelessness. HUD recognizes the critical need to authentically and meaningfully include people with lived experience in decision-making at all levels throughout the homeless response system to achieve transformational change. While CoCs must follow the regulatory requirement to include a minimum of one person with

lived experience on the Board, it is a best practice to engage and integrate people with lived experience at *all* levels of CoC membership.[93]

The BCCC Governance Bylaws reflect the importance of engaging people with lived experience in the combined CoC membership, stating: "[The] BCCC…invites individuals who are either currently, or have previously experienced homelessness, to participate as members…." BCCC has also increased the number of Executive Board seats and established a Lived Experience Leadership Council,[94] which will allow BCCC to gain valuable insight on topics such as the frequency of outreach to people with lived experience throughout the geographic area, who leads the outreach and engagement, and how to employ input from people with lived experience.

To proactively encourage and support the participation of people with lived experience of homelessness in the CoC, BCCC can designate a point of contact to support capacity and skill building. As when any new team member joins an organization, people with lived experience might need onboarding and training at the beginning of their participation to understand the CoC and their roles and responsibilities, but they may also need ongoing support to ensure equitable and effective participation.[95] Many CoCs train their entire membership on how to identify and address biases that may result in the exclusion, diminishment, or harm of people with lived experience. In depth training and capacity-building on how to maintain a facilitator (not a leader) role, supporting conflict resolution, and how to support and advocate for initiatives led by people with lived experience are important for people tasked with the point of contact role. Points of contact can also provide options to customize participation depending on people's interests and capacity, meet with people in advance of meetings to support preparation, or after meetings to answer questions and/or debrief in a comfortable environment.

Further, as part of the designated functions outlined in the Governance Bylaws, the CoC Board of Directors can develop an intentional plan to recruit, onboard, and retain people with lived experience as members of the CoC. Recruitment strategies might involve targeted outreach, which can be initiated by engaging community partners and peer support networks to identify workplaces, groups, and/or job/employment programs that hire or work with people with lived experience.

Community Highlight: Austin Homeless Advisory Council (AHAC)

- Originally a pilot, the AHAC is now focused on ensuring that "individuals experiencing homelessness have a voice in every process, program, and practice impacting and serving individuals experiencing homelessness"
- Some goals include, but are not limited to: Educate and inform policymakers on the realities of homelessness; inform the improvement of services and outreach.

[93] HUD. (2020, January 15). *SNAPS In Focus: Integrating Persons with Lived Experiences in our Efforts to Prevent and End Homelessness* HUD Exchange.

[94] Bristol County Continuum of Care Governance Bylaws. February 2023. Accessed 16 April 2024.

[95] For more information and guidance on meaningfully engaging PLE, see Engaging Individuals with Lived Expertise on the HUD Exchange.

- The AHAC meets regularly to provide input on processes, programs, and practices, such as recommendations related to coordinated case management system recommendations and storage services for individuals experiencing homelessness.
- The Downtown Austin Community Court facilitates and provides administrative support to AHAC.

It is critically important to appropriately and fairly compensate people with lived experience for their time and valuable expertise as any other staff person. Doing so affirms their contributions, addresses inequalities, and diminishes barriers to participation. In addition, service providers and community leaders often participate in CoC activities as part of their paid employment, whereas people with lived experience do not. Compensation should be provided for people with lived experience's participation in CoC membership activities, as well as any participation-related costs (e.g. transportation, childcare costs, etc.), training, orientation, and capacity-building needed to fully engage. Research on best practices and focus group findings point to direct payment methods as preferable for people with lived experience.

- CoC planning grant dollars or private philanthropy are good sources to dedicate a budget to people with lived experience compensation.
- The Annie E. Casey Foundation (aecf.org) supports youth led initiatives and may provide support for youth members with lived experience to participate in the CoC.

Data-Driven Decisions and Resource Allocation

The newly formed BCCC has an opportunity to establish a framework for utilizing existing data, even if imperfect, to assess provider and system performance. When using data to evaluate performance, data quality typically improves, and transparency about expectations and performance standards leads to better system outcomes, either through improved performance or reallocation. Data to evaluate racial equity within the system also improves system performance, as it highlights where the CoC can make an impact in improving equitable outcomes.

New Bedford's OHCD is already working with Simtech Solutions to strengthen its ability to use data to drive decisions and allocate resources. In addition to system performance measures focused on housing and income outcomes, the BCCC can include performance measures focused on data quality, such as completeness and timeliness of data entry intakes and exits, and the percentage of housing programs responding to Coordinated Entry matches within the expected timeframe. The Coordinated Entry system can monitor the length of time it takes from initial contact to intake or placement on the by-name list, as well as the attrition rate from initial contact to assessment and from assessment to housing referral. Data from Coordinated Entry rejections (from projects and clients) can be analyzed quarterly to reveal possible improvements to the match process, including improving the information given to program participants about a project to make an informed decision, training for projects on how to operate within Housing First principles, and identifying unmet need based on program participant preferences and needs.

OHCD can encourage high-quality data entry and participation through a combination of incentives and compliance. Participation incentives may include grants for providers to establish technology for data entry, bonus points in funding competitions for high data quality, or highlighting programs in newsletters, using their data to help tell the story of their success. Creating a dashboard for data quality

allows the CoC Data and Performance Committee to monitor and identify projects that struggle with data entry and recommend them for technical assistance and coaching support. For programs that are not currently funded by the CoC, establishing a consortium with a shared MOU can help encourage programs to voluntarily enter their data. The CoC can offer letters of support to these programs for their private funding initiatives if they agree to abide by CoC standards and share their data.

- BoardEffect offers this resource to locate Technology Grants for Nonprofits.

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Conclusion

The new Bristol County Continuum of Care has an excellent opportunity to leverage the strengths of the existing MA-505 homeless services system, the passion of dedicated leaders, unique funding opportunities in the form of one-time HOME-ARP funds, and the advantages that derive from consolidation of CoC competition grants through the merger. The recommendations in this report address the gaps and barriers surfaced by community leaders, service providers, and people currently experiencing homelessness in the region, signaling a strong likelihood of community support. Through a combination of policy, program, and governance changes, New Bedford and Bristol County can move closer to achieving their vision of making homelessness rare, brief, and non-recurring.

Acknowledgments

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We would also like to thank TAC's Communications Designer Jeff Nguyen for his work to design this report and make it accessible.

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Appendices A–C

Appendix A: Continuum of Care (CoC) Merger Considerations

Background

A Continuum of Care (CoC) merger is a process where two or more CoCs voluntarily agree to merge the entire geographic areas of both or all CoCs into one larger area under a single CoC.[96] In 2023, the leadership and members of the New Bedford CoC (recognized by HUD as MA-505) and the Greater Bristol County/Attleboro/Taunton Coalition to End Homelessness CoC (recognized by HUD as MA-519) expressed shared interest in integrating as a unified CoC given various mutual benefits. The CoCs independently convened their respective membership bodies and voted in support of a merger. In 2024, MA-505 and MA-519 merged to form the Bristol County Continuum of Care (BCCC).

The City of New Bedford's Office of Housing and Community Development engaged the Technical Assistance Collaborative (TAC), a non-profit consulting organization and nationally recognized expert in homelessness and the CoC program, to conduct a homeless system assessment and support in its evaluation and implementation of merging MA-505 and MA-519. This appendix offers a brief orientation to some important considerations for the early stages of implementing the CoC merger.

Governance and Organizational Considerations

The U.S. Department of Housing and Urban Development's (HUD) CoC Interim Rule[97] requires CoC Boards to be representative of the organizations and programs serving populations experiencing homelessness within the CoC's designated geographic area. The recent formation of the BCCC presents an opportunity to survey current membership, identify any current representation gaps, and adjust to ensure pertinent parties are represented at each level. As the BCCC works to establish a unified approach to preventing and ending homelessness, it will be important to ensure that each municipality within the County has representation on the Executive Board. Cultivating participation among key system leaders, such as from hospitals and aging and disability services, can present opportunities to identify people or agencies that are ready to expand service provision to these special populations. Additionally, the BCCC can also consider establishing a Youth Advisory Board (YAB) and including the Chair of that Board on the BCCC Executive Committee.

Across the U.S., including in the BCCC's jurisdiction, Black, Indigenous, and people of color (BIPOC) groups experience disparate rates of homelessness. Before the merger, New Bedford's CoC established a Racial Equity Committee to explore ways of advancing racial equity in the response to homelessness and recently completed publication of a Racial Equity Assessment & Action Plan. This work is extremely

[96] "U.S. Department of Housing and Urban Development Office of Community Planning and Development Notice CPD-18-03." Hud.Gov, U.S. Department of Housing and Urban Development (HUD), 9 Apr. 2018,

[97] CoC Program Interim Rule. HUD Exchange. July 2012.

valuable, and it would be beneficial to continue the Committee's efforts and progress aligned with the Racial Equity Plan within the merged CoC.

CoCs also play a critical role in coordinating efforts across their jurisdiction's geographic area and ensuring service providers have the opportunity to meaningfully participate. The creation of the BCCC presents ample opportunities to enhance systemwide coordination and collaboration.

One of the CoC's responsibilities is designating and operating a Homeless Management Information System (HMIS) for the geographic area. While the BCCC shares a single HMIS vendor and lead, there are a number of relevant considerations and next steps to keep in mind, such as:

- Revisions and future maintenance of the HMIS policies and procedures
- Financial resources needed to support the CoC's users
- Review and resolution of data collection and/or reporting concerns related to the merger
- Add one dedicated full-time employee, or FTE, to manage reporting, monitoring, and use data to drive performance

Community Coordination & Resource Allocation

HUD encourages CoCs to collaborate with various system partners that offer different perspectives and expertise necessary to comprehensively address homelessness and expand housing access. CoCs play a critical role in coordinating efforts across their jurisdiction's geographic area and ensuring service providers have the opportunity to meaningfully participate.

Enhancing partnerships and increasing coordination can support CoCs with leveraging resources and funding. Merging CoCs typically realign resources over the combined geographic area and establish how to apply new funds. CoCs must also determine if there is value in joining grants across the previously separate CoCs, such as in instances when the same agency administers the same grant. This can be a means of reducing administrative burden and supporting communities in a more strategic, coordinated way. The CoCs must bear in mind that CoC Planning Grants are awarded to the CoC's Collaborative Applicant or Unified Funded Agency. Following a merger, the Planning Grant is awarded to the joined CoC, and existing Planning Grants must be amended to the newly designated Collaborative Applicant. Merging CoCs are encouraged to engage in dialogue about the best uses of the CoC Planning Grant. For example, CoC Planning Grants can be utilized to compensate people with lived experience who are actively participating in CoC planning activities. This can be a helpful option to explore, especially as CoCs work on revising their people with lived experience engagement. Such payments must be consistent with the Collaborative Applicant's internal financial management policies and procedures and meet HUD-issued guidance.

Community Coordination for the BCCC

Prior to the merging of MA-505 and MA-519, the Technical Assistance Collaborative (TAC) sought to understand the community partnerships in each jurisdiction and their understanding of systemwide services. To do so, TAC conducted a Service Provider Survey that reached a wide range of organizations within the MA-505 and MA-519 catchment areas. Respondents of the Service Provider Survey included direct service workers, supervisors of direct service workers, and administrators. The survey yielded

several key findings that are relevant to the potential merger between MA-505 and MA-519 and the future of communitywide coordination.

Among the survey responses, there was a common theme related to improving coordination across service providers and sectors. Multiple respondents cited systemic challenges in interagency coordination and expressed a strong interest in increasing interagency communication and collaboration to better address unsheltered homelessness. Specifically, Service Provider Survey respondents referenced the need for streamlined coordination, de-duplication of services, and resource sharing. CoC mergers can act as a natural catalyst for discussions on current and future community partnerships and coordination. These survey findings indicate that the BCCC can reimagine how to best coordinate the system-wide local homelessness response and facilitate a more integrated effort, particularly if the CoCs merge. Doing so will allow partners to more efficiently determine and address service needs and strategize around resource allocation.

One recommendation to tackle this would be adopting an interagency membership productivity platform wherein partners across the CoC network can communicate in real-time and organize, delegate, and collaboratively conduct CoC committee work, among other helpful features. A consolidated platform shared by CoC members would allow everyone to share updates and knowledge, readily access information, streamline decision-making, and advance work in one place.

Additionally, there may be benefits to centralizing service providers' data entry and case management systems into a single shared system in the future. Previously, MA-505 and MA-519 both utilized CaseWorthy, a case management software with reporting and data tracking capabilities. However, member agencies across the combined CoC use and rely on multiple other systems for their daily workflow that can isolate efforts, hinder coordination, and result in duplicative work.

Another recurring insight from the Service Provider Survey responses was that multiple providers in the geographic area conduct some form of street outreach, including Steppingstone. However, it is unknown what level of cross-agency communication and coordination presently exists for street outreach, if any. It is recommended that the combined CoC survey how street outreach is currently performed and evaluate if it can be better synchronized across the region to equitably serve the target population. To start, the BCCC can determine (a) the providers that deliver street outreach in the combined geographic area, (b) the methods of and reasons for communication between those providers, if any, (c) the services and/or specialties performed (e.g. staff specializing in harm reduction, housing navigation, etc.), and (d) the locations or routes covered and vehicle access. Street outreach routes and vehicle/transportation access require particular attention, as a number of Service Provider Service responses reported transportation concerns as a barrier to client engagement and the target population reaching shelter and services.[98]

Among the various partnerships CoCs foster, those with the Public Housing Authorities (PHAs) and state and local housing organizations are critical in the effort to maximize housing opportunities for people experiencing homelessness. Given the recent merger, the CoC can review existing relationships with PHAs in their respective geographic areas. Former MA-505 shared a strong relationship with the New Bedford Housing Authority (NBHA), and former MA-519 similarly worked closely with the Taunton

[98] These coordination efforts can be enveloped into the CoC's exploration of a regional center and its possible functions.

Housing Authority (THA), one of 7 other PHAs[99] in the CoC's geographic area. Both the NBHA and THA have a homeless admission preference. The two PHAs should be encouraged to remain active CoC members, and the BCCC can continue to coordinate across the local PHAs to determine how the homeless admission preference will work given the recent merger, implement new targeted programs for people experiencing homelessness, and consider ways to forge new partnerships between PHAs and/or between PHAs and other community-based entities.

Another critical relationship to consider is the one shared between the CoCs and the local service providers for survivors and victims of domestic and sexual violence, or Victim Service Provider (VSP). Given MA-505 and MA-519 past CoC Applications, the CoCs each reported relationships with a primary provider that serves survivors and victims of domestic and sexual violence (i.e. New Bedford's Women's Center and New Hope, respectively). Given the merger, there is a valuable chance to foster and/or strengthen a collaborative relationship between New Bedford's Women's Center and New Hope. Even more, the CoC can support the providers with a Coordinated Entry system and streamlined process that serves survivors and victims effectively and reduces duplication without compromising confidentiality.

Target Population & Geographic Factors

A CoC merger involves two or more CoCs that voluntarily agree to merge the entire geographic areas of all CoCs into one larger CoC. Generally, the involved CoCs should weigh any geographically defined characteristics, such as varying local levels of government, infrastructure, transit or transportation access, socioeconomic statuses, economic development, and more. These factors can shape the target population's unique barriers, housing and service needs, and experiences navigating the homelessness system. Ultimately, the CoCs should aim to foster a geographically cohesive, organized CoC and a homelessness system that effectively serves those throughout the CoC's geography.

Target Population Demographics for the BCCC

Merging CoCs can prompt system and resource realignment, as the transition is a natural catalyst to revisit and evaluate the needs of those experiencing homelessness in the combined geographic region. The New Bedford CoC (formerly recognized by HUD as MA-505) comprised the entire municipal boundary of the City of New Bedford, while the Greater Bristol County/Attleboro/Taunton Coalition to End Homelessness CoC (GBCATCH, formerly recognized by HUD as MA-519) covered a more sprawling portion of Bristol County.[100] Together, the combined CoC serves a significant portion of southeastern Massachusetts. There are a number of merger considerations to weigh given the CoC's unique positioning and populations.

This next section will delve into some demographic data points for the former MA-505 and MA-519's populations, drawing from information from the 2020 U.S. Census and the 2020 and 2023 Point-in-Time

[99] The PHAs in MA-519's geographic region are Attleboro Housing Authority, Berkley Housing Authority, Dartmouth Housing Authority, Easton Housing Authority, Mansfield Housing Authority, North Attleboro Housing Authority, Swansea Housing Authority, and Taunton Housing Authority.

[100] Former MA-519's current jurisdiction includes Acushnet, Attleboro, Berkley, Dartmouth Dighton, Easton, Fairhaven, Freetown, Mansfield, Norton, North Attleboro, Raynham, Rehoboth, Seekonk, Somerset, Swansea, Taunton and Westport.

counts required by HUD. The census data focuses on some of the largest cities or towns in Bristol County, Massachusetts—Attleboro, New Bedford, and Taunton.

Reviewing economic indicators in the census data can be informative, as economic factors, poverty, and homelessness are closely linked. For these specific cities, these indicators highlight important characteristics and occasional differences. For instance, according to past census data, the median household income for Attleboro was $81,627. Taunton's median household income was $66,787. In comparison, the median household income for New Bedford was significantly lower at $50,581. The percent of persons in poverty for each city was inversely related to the median income in a predictable manner. Attleboro had the highest median household income and the lowest percent of persons in poverty at 9.1%. The median household income and percentage of households living in poverty can vary widely depending on the city. These indicators can help inform the CoCs about their combined population since those experiencing poverty are more likely to endure economic instability and are at an increased risk of becoming homeless or facing housing instability.

Moreover, the census data provides a high-level overview and fragment of the four cities' demographic composition. Table A1 below demonstrates that a large percent of each cities' population was White and non-Hispanic/Latina/e/o, but New Bedford stands out as having the lowest population of White and non-Hispanic/Latina/e/o residents. New Bedford also has a significantly higher population of Hispanic/Latina/e/o residents (23.1%) compared to the other cities. Despite the demographic data on race and ethnicity, Table A2 shows that non-White households were disproportionately represented in the population experiencing homelessness. Homelessness reaches people across all identities and backgrounds, but data reveals that some groups are disproportionately impacted by homelessness and housing instability.

Table A1: Summary of race and ethnicity data collected by the U.S. Census Bureau.[101]

Race and Ethnicity (Percent of Population)	Attleboro	New Bedford	Taunton
American Indian, Alaskan Native, Asian, Native Hawaiian, Pacific Islander alone	2.7%	1.7%	2.1%
Black or African American alone	3.7%	6.1%	6.9%
White, non-Hispanic/Latina/e/o alone	82.4%	58%	74.8%
Hispanic/Latina/e/o	7.5%	23.1%	7.7%
Two or more races	5.5%	12.5%	8.4%

Source: U.S. Census Bureau QuickFacts

[101] *U.S. Census Bureau QuickFacts*. U.S. Census Bureau. https://www.census.gov/quickfacts/. Accessed 5 January 2024.

Table A2: Demographic summary by race and ethnicity for former MA-505 and MA-519 households experiencing homelessness. This data is based on 2023 Point-in-Time information provided to HUD by CoCs.[102]

Race & Ethnicity	Emergency Shelter MA-505	Emergency Shelter MA-519	Transitional Housing MA-505	Transitional Housing MA-519	Unsheltered MA-505	Unsheltered MA-519
American Indian, Alaskan Native, Asian, Native Hawaiian, Pacific Islander	1	12	1	0	1	0
Black or African American	91	115	17	7	17	2
White	105	118	53	18	42	25
Multiple Races	30	22	8	1	7	2
Hispanic/ Latina/e/o	69	41	11	3	8	4
Non-Hispanic/ Latina/e/o	158	226	68	23	59	25

Source: HUD Exchange

It is also necessary to consider immigrant and migrant communities within the combined CoC, as immigrant and migrant households may encounter unique challenges and barriers while adapting to life in the U.S. For instance, immigrant households are disproportionately likely to experience poverty, which is a predictor of homelessness.[103] Even immigrants and migrants with extensive educational backgrounds and/or professional experience in their home countries may face barriers to establishing a stable income in the U.S. Upon arrival, households might receive lower incomes that can result in less desirable housing situations, housing instability, and/or homelessness.

Considerations on Family Homelessness for the BCCC

The BCCC, representing a merged jurisdiction, should consider how to address the evolving needs of families experiencing homelessness in the region's broader homeless shelter placement area. In August 2023, Massachusetts Governor Maura Healey declared a state of emergency over the rising numbers of migrant families arriving in the state in need of emergency shelter and services, requiring the state's shelter system to rapidly expand. The state's Executive Office of Housing and Livable Communities (EOHLC) placed a number of unhoused migrant families in various cities and towns across the state, including in the CoC's catchment area. Specifically, families were placed in Dartmouth, Fairhaven, New Bedford, Somerset, Swansea, and Taunton. Some reports indicated that Taunton absorbed the most

[102] "Coc Homeless Populations and Subpopulations Reports." HUD Exchange, HUD. Accessed 5 January 2024.

[103] "Supporting the Education of Immigrant Students Experiencing Homelessness." National Center for Homeless Education. Accessed 11 January 2024.

families within the area, with numbers reaching 162 as of October 2023.[104] The state continues to grapple with emergency shelter capacity and family placements, and in November 2023 it imposed a limit of 7,500 families in its emergency shelter system. The state is unable to expand this family shelter capacity, meaning the system may not have enough space to shelter every *eligible*[105] family immediately.[106]

Detailed data on migrant family placements is not widely available. However, the state publishes data on the number of *all* families placed in Emergency Assistance (EA) family shelters, short-term shelters, and hotels/motels.[107] In May 2024, the state reported that between 51–200 families were enrolled in the shelter system in Taunton and Raynham each. Other cities and towns within the region had between 1–50 families enrolled, including New Bedford.[108] Massachusetts funds multiple scattered-site apartments throughout New Bedford, but reports indicate that the state has not acted to expand sheltering capacity for migrant families in New Bedford as much as other nearby cities and towns. One caveat worth noting is this data represents eligible families that are placed in EA family shelter. It does not account for *in*eligible families, or eligible families that could not be placed due to the shelter capacity limit set in 2023. The merger expanded the shelter placement area for both families and individual households, and the population shift that will likely impact service needs, provider capacity, and more.

Table A3 below lists the known EA family placement sites in both MA-505 and MA-519's catchment areas, as well as the projected placement capacity.

Table A3: Directory of Known EA Family Sites

Known EA Family Site	Capacity	Former CoC Region
Family Resource Center 11 Peck Street Attleboro, MA 02703	7 families	MA-519
H.O.U.S.E. (Helping Others Until Self Empowered) Scattered sites (within the Taunton, Attleboro, Fall River, and New Bedford areas)	Undetermined	MA-505 and MA-519
Justice Resource Institute (JRI) Families Overcoming Challenges Utilizing Support (FOCUS) Program Sites in New Bedford, Attleboro, Taunton, and other surrounding communities.	Undetermined	MA-505 and MA-519

[104] Cooney, Audrey. "Nine South Coast Communities Sheltering Migrants through State of Emergency. What That Means." *The Herald News*, 11 October 2023.

[105] Households must meet specific eligibility criteria to access EA emergency family shelter.

[106] Eligible families that cannot be placed right away are put on a waitlist.

[107] "Emergency Assistance (EA) Family Shelter Resources and Data." Mass.Gov, Executive Office of Housing and Livable Communities. Accessed 5 January 2024.

[108] These cities and towns include Attleboro, New Bedford, and Norton.

Known EA Family Site	Capacity	Former CoC Region
Missionaries of Charity (or Sisters of Charity) 556 County Street New Bedford, MA 02740	10 families (women and children)	MA-505
NeighborWorks Housing Solutions (NHS) (within Brockton, Taunton, New Bedford, Fall River, Plymouth areas)	12 families	MA-505 and MA-519

Some reports indicate that former MA-519, specifically, saw a recent spike in families experiencing homelessness and EOHLC EA family placements. In the CoC Application for FY2023, former MA-519 referenced an increase in migrant and immigrant households across the state of Massachusetts and the CoC area. MA-519 documented multiple related challenges, such as emergency shelter and permanent housing scarcity, barriers to obtaining public benefits and/or employment opportunities, and supportive service needs for this population.

Another notable emerging trend involves reports by service providers conducting outreach about a rise in families living doubled up and unsheltered in cars. This trend is too early to quantify, but it is worth documenting given that escalating economic pressures (e.g. rising inflation, rising housing prices, the end of pandemic-era rental assistance) may increase this population. Data collected during the Point in Time Count will be instrumental in tracking this development. In addition, if families placed through the EOHLC EA program become ineligible for continued shelter, their resulting homelessness could increase demand on an already maximized family shelter system in the region.

Summary of Recommendations for the BCCC

This appendix has outlined important considerations related to the merger between the New Bedford CoC (recognized by HUD as MA-505) and the GBCATCH CoC (previously recognized by HUD as MA-519), forming the BCCC. Namely:

- **Recruit and maintain a CoC Board and CoC membership** that represents the combined geographic area and can help improve outcomes related to preventing and ending homelessness
  - Assess current representation in the CoC Board and general CoC membership to evaluate and address gaps
  - Consolidate committees when it increases workstream effectiveness and efficiency

- **Strengthen interagency coordination and collaboration** to facilitate a more integrated system-wide homelessness response and to more efficiently address service needs

  - Consider adopting a productivity platform for users CoC-wide and/or centralizing data entry and case management systems

  - Coordinate street outreach efforts
  - Foster or strengthen key community partnerships

- **Examine the expanded target population and evaluate changes to service and housing needs**, including within the context of the statewide EA emergency family shelter crisis
  - Strategize how to enhance equitable service delivery across the CoC's jurisdiction

Appendix B: Regional & Multi-Service Center Models

TAC gathered and reviewed information related to regional or multi-service centers, including community members' input and national best practices. As part of the information gathering process, TAC incorporated the topic of regional centers throughout the Service Provider Survey, service provider focus groups, people with lived experience focus groups, and key informant interviews. Community members' responses throughout these forums helped direct subsequent research. Responses indicated strong support for a center that incorporates emergency shelter, subsidized housing, and a range of services that support housing goals and address basic needs. Some of those expansive services include, but are not limited to:

- Housing navigation and related resources
- Showers, hygiene-related facilities, and supplies
- Laundry
- Overdose prevention, needle exchange, and/or Narcan
- Nutritious food
- Assistance with obtaining an ID and other vital documents
- Language access/translation services

TAC also conducted an online scan of pre-existing regional and/or multi-service centers across the U.S. with a primary focus on the centers' scope of services, shelter and/or housing components when applicable, and financing estimates and sources. After completing this baseline research for 25 centers, TAC contacted 10 centers located in 5 states to request key informant interviews to gain a deeper understanding of the centers' service priorities, financing, and operational budgets. Out of the 10 centers, 3 responded to TAC expressing their willingness to participate in an interview. TAC interviewed 6 informants representing 3 centers. The interview responses, supplemented by information gathered through public records and media reports, are summarized below in Tables B1–B3.

Table B1: Father Bill's & MainSpring's (FBMS) Yawkey Housing Resource Center (Quincy, MA)

Site Component & Size	Capital	Cost and Scope of Services
Congregate Shelter & Housing Resource Center • 15,700 square feet • 125 shelter beds	• $4.6M in public capital from sources including $4M from MA EOHLC and $628,612 from City of Quincy • Portion of $10M private capital campaign (shared with PSH site) • Portion of $1.8M land value donated by City of Quincy (shared with PSH site)	**Operating Costs** • Emergency shelter contract with MA EOHLC • VA emergency residential bed funding for recuperative care (5 beds) **Services** • Emergency shelter contract with MA EOHLC • Triage, engagement, assessment and clinical services in shelter for people with SUD funded by MA Department of Public Health Bureau of Substance Abuse (BSAS) • VA emergency residential bed funding for recuperative care (5 beds) • Private funding for diversion and prevention services • Leveraged services from partner agencies for behavioral health, addiction and recovery support
Permanent Supportive Housing (PSH) • 20,000 square feet • 30 efficiency units	• $10.2M in public capital from sources including $7,239,436 Low Income Housing Tax Credits (including $5 million from federal government); $2,260,128 from MA EOHLC; $621,388 from City of Quincy; and a $153,000 grant from the MA Executive Office of Health and Human Services • Portion of $10M private capital campaign (shared with Congregate Shelter & Housing Resource Center) • Portion of $1.8M land value donated by City of Quincy (shared with Congregate Shelter & Housing Resource Center)	**Operating Costs** Subsidized housing vouchers • 8 Federal housing vouchers • State housing vouchers **Services** • MassHealth – CSP-HI benefit for eligible individuals ($27.72 per diem) • MA DPH BSAS - services for people with SUD • Capital campaign raised $500,000 per year for 3 years in private service dollars for gap funding.

Table B2: Bergen County Housing, Health, & Human Services Center (Hackensack, NJ)

Site Component & Size	Capital	Costs and Scope of Services
Congregate & Non-Congregate Shelter/Multi-Service Center Low threshold emergency • 25,516 square feet • 90 shelter beds	$11.5M for development in 2009 from Bergen County, who will also cover future capital improvements.	**Operating Costs** • $4M from various sources including, but not limited to, FEMA, ESG, state, county, and local sources. • Bergen County contracts the Housing Authority of Bergen County for operations. **Services** Unspecified amount. Partners are contracted by Bergen County.

Table B3: Casa de Carmen and the Oxnard Navigation Center (Oxnard, CA)

Description	Capital	Costs and Scope of Services
Congregate Shelter/Housing Navigation Center • Full site, including the PSH units below, is 22,000 square feet	• 42.6M in capital (incl. PSH)	**Operating Costs** • $3M, primarily from county and city funding **Services** • $300,000, primarily from county and city funding. *Sources include, but are not limited to, 4% Low Income Tax Credits (LIHTC) allocation with a $17M equity investment, $7.2M from California Department of Housing and Community Development (HCD) funding, $1.5M investment from the City of Oxnard, a $1M investment from the County of Ventura.*
Permanent Supportive Housing (PSH)	See above	**Operating Costs & Services** • $504,000 for operating costs, including services, or about $9,000 per unit annually. *Sources include, but are not limited to, 56 vouchers from the Housing Authority of the City of Oxnard and 4% Low Income Tax Credits (LIHTC).*

Appendix C: Survey and Focus Group Questions

Service Provider Survey

Background on Respondents:

A total of 49 responses were received from people working in organizations providing a diverse set of housing and services designed to assist families prevent or address homelessness. 69% of providers serve New Bedford and 22% reported serving both New Bedford and the GBCATCH CoC. Responses were evenly distributed between direct services workers (40%), supervisors of direct service workers (40%) and administrators (20%). 76% of respondents reported working in the field for over 3 years, with 44.9% working in the field over 11 years.

Responses were fairly evenly distributed between Emergency Shelter (10), Transitional Housing (14), and Permanent Supportive Housing (9) with four Rapid Rehousing providers also participating. 21 respondents indicated their organization performs outreach to people experiencing homelessness. 67% of respondents indicated their organization provides some sort of Case Management. 37% (17) provide substance use treatment and 32% (15) report providing mental health treatment. Additional services provided include life skills, education, health department services, home care and meal services for seniors, SOAR assistance, homeless prevention, childcare vouchers, fuel assistance, and caregiver support for parents of young children.

Survey Questions:

Tell us a little about you and the work you do.

- What services does the organization you work for offer?
- Please list any additional services your organization offers
- What best describes your role in the organization?
- How many years have you worked in this field?
- Which CoC does your organization operate in?

Efforts to end homelessness in New Bedford (4 questions)

- Housing supports for people experiencing homelessness in our community include emergency and overflow shelter, transitional housing, permanent supportive housing, and rapid rehousing. In your opinion is this the right mix of housing?
    - Please indicate how the mix of housing supports could be better (open ended)

- Population specific services in our community include housing and support services designed specifically for survivors of domestic violence, veterans, elderly, youth, and housing with substance use and mental health treatment. In your opinion, are these housing and support services sufficient to meet the community need?
    - Please list the population that needs additional services
- In addition to the above list of current specialized housing services, are there other population specific services you would like to see developed?
- In your opinion, what services really shine? What is particularly effective?

Addressing Unsheltered Homelessness (4 questions)

- In the 2023 PIT Count, New Bedford counted 67 people experiencing unsheltered homelessness, and an additional 30 unsheltered persons were temporarily housed in overflow shelter on the night of the count. This is the highest reported number since the count started.
- In your opinion, what is causing (contributing to) unsheltered homelessness in New Bedford?
- In your opinion, what keeps people experiencing unsheltered homelessness from accessing the emergency housing and services available?
- What SYSTEM challenges need to be addressed in order to end unsheltered homelessness in our community?

CoC Governance (2 questions)

- In what ways would you like to see increased involvement by people with lived experience in the CoC's governance?
- In your opinion, are there partners or systems that you would like to see more involved in the CoC and ending homelessness? If so, please list them here:

Regional Efforts to End Homelessness (4 questions)

The pending merger of New Bedford CoC with the Greater Bristol County/ Attleboro/ Taunton CoC, has given us a unique opportunity to reimagine how we are providing housing and services to people experiencing homelessness. Some communities have created a one-stop regional center where people at risk or experiencing homelessness can access a range of housing and services all at once. This model may include day center services or may combine short and long term housing on site with other services needed to effectively address homelessness.

- How interested are you in seeing a regional center model implemented on a scale of 1 to 10 with 1 being least interested and 10 being most interested?
- In thinking about the merger of New Bedford CoC and GBCATCH CoC, what housing, services or activities would you like to see added to make ending homelessness more effective?
- If a regional center were to be created, what are the priority mix of services the center should provide?
- Where in the New Bedford region (New Bedford/ Greater Bristol County/ Attleboro/ Taunton) would a regional center be most effective?

Focus Group Questions

For People with Lived Experience of Homelessness

Background on Respondents:

A total of 34 people currently or recently (within the last six months) experiencing homelessness participated in the groups: 32 compensated participants and 2 partners of a compensated participant (uncompensated). 33 participants completed a demographic survey.

- Seventy-two percent of participants were aged 25–49, and 24% were over age 50. One youth under age 24 participated.
- All participants (100%) reported experienced unsheltered homelessness at some point in their life, with 43% of participants reporting 1–3 years of homelessness, 36% reporting over 3 years of homelessness and 21% reporting less than a year of homelessness.
- Seventy-three percent of participants were male, and 27% identified as female. There were no participants who identified as non-binary.
- The majority of participants identified as white (58%). Additional participants identified as Black, Native American, Hispanic, Azorean, Portuguese, Greek, and multi-racial. Two participants declined to answer.

Focus Group Questions:

1. In thinking about the system of services in New Bedford (greater Bristol County) that are designed to help you address your homelessness, what has been most helpful in supporting you as a whole person?
   a. What has made it harder for you to make progress on your housing and stability goals?
   b. A recent survey of service providers listed restrictive rules or service requirements as a major barrier to people engaging in services. Do you agree or disagree? What would you like to see changed?

2. When you found yourself facing homelessness, what persuaded you to accept a shelter placement?

3. Some communities trying to address homelessness have adopted a regional center approach. This might look like a one-stop-shop with shelter beds plus a day center with access to service coordination, classes, and bathrooms/showers/laundry. Would a center like this be helpful to you and why? What would you like to see included in such a center?
   a. Do you have any thoughts on where such a center would ideally be located?

4. What else do you wish leaders in New Bedford knew about homelessness and how to solve it?

For Service Providers

Background:

A total of seven staff members from service providers in the New Bedford CoC and GBCATCH CoC catchment areas participated in the two focus groups: four participants in the first focus group and three participants in the second focus group. Two participants (29%) self-identified as people with lived experience without any prompting question during the focus groups. Demographic data was not collected for these participants.

Focus Group Questions:

5. In the December survey of service providers, multiple participants reported that restrictive rules or service requirements were a major barrier to people engaging in services. Do you agree or disagree? What would you like to see changed?

6. 62% of survey respondents cited "bad past experiences" with service providers as a reason for lack of engagement. In thinking about the work that you and your colleagues do, what skills, resources and strategies are needed to help staff more effectively engage, build trust, and move folks from unhoused to housed?

7. Focus groups with people with lived experience cited inefficiencies with accessing essential services and basic needs. This creates roadblocks to moving forward with housing and stability goals. For example the separate locations for breakfast, lunch and shelters that aren't open 24/7 resulted in much of the day spent in navigating back and forth across City/ region.
   - Some communities have adopted a regional center approach. This might look like a one-stop-shop with shelter beds plus a day center with access to service coordination, classes, and bathrooms/showers/laundry. Would a center like this be helpful to you and why? What would you like to see included in such a center?
     b. Do you have any thoughts on where such a center would ideally be located?

8. As New Bedford and GBCATCH prepare to merge CoCs, there is a real opportunity to build and strengthen interagency coordination. What strategies and action steps would you like to see put in place to build communication and coordination?

9. What else would you like the leaders of New Bedford CoC to know about what works to end homelessness and support the work you do?