

Protect Human Life and Respect Human Dignity through Housing First and Public Health Policy Solutions for Mass. and Cass

Introduction and Executive Summary

In recent weeks, city and state officials, along with medical and public health experts, have acknowledged the need for a public health response to the overlapping crises facing people living unsheltered in the area of Melnea Cass Boulevard and Massachusetts Avenue. Action to address the root causes of these challenges must be bold, driven by the best available evidence, and commensurate with these complex challenges. Despite a widespread consensus that a solution cannot be achieved through prosecution, incarceration, and involuntary treatment, too many public proposals continue to focus on carceral and coercive approaches. Such plans increase the risk of harm and death, from overdose and illness, for people living unsheltered and those who use drugs. Dispersing encampments during the ongoing [HIV outbreak](#) and COVID-19 pandemic also violates guidance from the [Centers for Disease Control and Prevention](#).

There are existing ways to meet basic needs, provide housing, and promote public health that will have lasting effects. As described in greater detail below, we implore stakeholders to:

1. [Protect Civil Rights and Human Dignity in Encampments and Treatment Settings](#)
2. [Conduct An Assessment of Needs and Solutions of and by Unhoused People](#)
3. [Eliminate Systemic Barriers to Housing and Provide Dignified Non-Congregate Shelter](#)
4. [Prevent Overdose Death and HIV Transmission and Expand Harm Reduction to Keep People Alive and Safe](#)
5. [Expand Effective, Low Threshold Treatment through Immediate, Sustained Investment](#)
6. [Decriminalize Drug Possession and End the Racist Drug War](#)

Within these six policy areas, we propose three **Immediate Action Steps** to implement now:

- ❖ **Establish non-congregate shelter and low-threshold transitional housing:** Identify vacant motels, hotels, and city- and state-owned properties which could be immediately converted into non-congregate shelter and low-threshold transitional housing similar to what was done during the COVID pandemic using FEMA funds. Provide a range of housing types, including for individuals, couples, and families, that are not conditioned on sobriety and do not punish or exclude people for recurrence of use.
- ❖ **Rapidly increase targeted voluntary treatment offerings:** the State should put out a rapid cycle Request For Proposals (RFP) for healthcare and social service providers to deliver a range of voluntary treatment options for those who move into non-congregate shelter, transitional housing, and those who remain unsheltered, to enable rapid, on-demand access to proven treatment and services.
- ❖ **Improve sanitation for those residing in encampments:** While developing immediate non-congregate shelter options, the City should stop the sweeps and meet basic needs for people living in encampments in line with operative guidance from the Centers for Disease Control and Prevention until people have access to housing: trash receptacles

and trash removal, bathrooms and sanitation, access to clean water and showers through mobile units or a permanent comfort station.

Both involuntary civil commitment and incarceration threaten to dramatically increase risk of [opioid overdose death](#). Health risks of involuntary commitment are [further compounded by the COVID-19 pandemic](#), as involuntary treatment facilities have experienced a number of [severe outbreaks](#). Instead of mobilizing public funds for new jail authority and court functions within a jail, the City, the Attorney General, the Legislature, and the Governor could immediately enact the Opioid Recovery and Remediation Fund Advisory Council's evidence-backed priority areas by funding more harm reduction services, expanded access to lifesaving medication for opioid use disorder, supportive housing, and community outreach, with resources made available across neighborhoods, communities, and the region. These efforts could also be financed through [funds from the American Rescue Plan Act \(ARPA\)](#), the [Sackler settlement](#), and [sources](#) recently [earmarked](#) for the South Bay jail. We need to increase the number of voluntary long-term residential beds and dual diagnosis beds for people with co-occurring substance use disorder and mental health overlays. In the interim, contracts to convert [hotels and motels](#) into emergency non-congregate shelter would allow people to stabilize in temporary housing that offers [privacy and safety](#) without being disconnected from their regular providers, including for opioid use disorder and [HIV treatment](#).

Public health crises require public health solutions. We support a plan that treats people with dignity, that meets people's stated needs in the short- and long-term, and that relies on evidence-based practices of low-threshold housing, voluntary treatment, and harm reduction, not involuntary commitment and criminalization which risk even more death. [Many people](#) at Mass. and Cass have evaluated the limited options available to them and decided to remain in self-constructed shelter and tents because the shelter system is not actually available to them due to shelter bars and [restrictions](#), because of [personal safety concerns](#) in shelters, or due to [otherwise unmet needs](#). Any plan must create options for people that are based on the preferences, needs, and goals of the community members living in encampments.

During the height of the COVID-19 pandemic, the Commonwealth and the [City](#) quickly marshaled resources to meet an urgent public health threat. The City and State offered hundreds of people [non-congregate shelter](#) to ensure social distancing within a short timeframe while also providing complex medical care. There is no reason why we cannot now put this same bold public health leadership towards addressing the overlapping crises at Mass. and Cass, using the humane, housing- and treatment-centered, evidence-based solutions below.

Policy solutions that account for the needs and experiences of directly affected people:

1. Protect Civil Rights and Human Dignity in Encampments and Treatment Settings:

Recognize that requiring tent removal in the area will cause displacement from services, belongings, peers, medical providers, temporary shelters, and community, and will increase harm. Instead of banning tents, the City should meet basic needs for people living in encampments in line with operative guidance from the [Centers for Disease Control and Prevention](#) until people have access to housing: trash receptacles and trash removal, bathrooms and sanitation, access

to clean water and showers through mobile units or a permanent comfort station. The City should provide people with housing vouchers and case workers so they can immediately transition to supportive housing or at minimum a hotel or motel. The Commonwealth must not expand involuntary commitment or coercive “voluntary” treatment inside jails or prisons. Stop sending people to carceral settings to receive treatment (fast-track bills [H.2066/S.1285](#)).

2. Conduct An Assessment of Needs and Solutions of and by Unhoused People: The City should organize a process to provide each unhoused person an opportunity to tell policymakers what they need, what obstacles they face, what would help remove those obstacles, etc. This needs assessment should be conducted in English and Spanish and without any law enforcement involvement so as to promote trust and honesty such that stated needs and self-identified solutions will be incorporated into policy. The needs assessment should take particular note of where people are on existing waiting lists for housing vouchers and for treatment and any current barriers.

3. Eliminate Systemic Barriers to Housing and Provide Dignified Non-Congregate Shelter: Focus on housing first by removing systemic barriers at the state and city level to allow people with criminal records and/or open criminal cases (including people presently on pretrial monitoring, probation, parole, and with open warrants), those using drugs, and those receiving medication for opioid use disorder (MOUD) to become and remain housed. People who are unhoused should be offered housing vouchers or subsidies, along with supportive services in housing, for which they are eligible. State and city funds, including and beyond the [\\$10 Million allocated in line-item 4512-0200 for low-threshold housing in the Commonwealth’s FY22 budget](#) and the proposed [\\$150 Million for permanent supportive housing in line item 1599-2023 of the Massachusetts House proposal for ARPA funds](#), should be used for low-threshold transitional and permanent supportive housing, including new transitional housing on vacant City-owned land and presently unused or underutilized City properties, and where possible by converting existing structures such as shuttered schools or industrial buildings into housing. If people are presently ineligible for vouchers or subsidized housing, they should be offered hotel or motel rooms until their barriers to housing are removed. Both involuntary civil commitment and incarceration threaten an individual's ability to receive and maintain housing.

- **Short-term elements:**

- **Expand emergency non-congregate shelter options:** Develop plans to use hotels and motels to create more non-congregate shelter that offers privacy and autonomy and decreases risk of violence or theft of possessions. The City’s Executive Order suggests that people will be offered “available” shelter or treatment before being asked to move from encampments, but [people have already been displaced without an alternative in recent tent-removal actions](#) and it is unclear whether beds will actually be [available to people](#) who have been barred from shelters, people who are actively using substances, couples, etc. [FEMA funds](#) may continue to be available for [non-congregate shelter](#), mirroring the [successful response to COVID](#) which utilized vacant motels/hotels and other properties to provide non-congregate shelter to people in need.

- **Reduce barriers to existing shelter use:** Allow people to access shelter services regardless of past or current involvement in the criminal legal system, including allowing for charging of electronic monitoring devices. Require that shelters allow people to possess harm reduction supplies, allow people to come and go as needed, and remove requirements for ID or proof of residency. Allow couples to utilize shelter together. Create shelter beds that provide a sense of privacy, including by constructing internal walls and doors for shelter clients.
 - **Give people identity documents and remove legal barriers:** Make state IDs free to obtain and easily accessible. Extinguish warrants, fines, and other legal encumbrances.
 - **Integrate services:** Create [integrated service systems](#) that bundle assistance for substance use, mental and behavioral health, housing, and other health, legal, and social needs. Reduce and remove cross-silos, responsible for the current system failing to meet people's complex needs.
 - **Stop discrimination in housing:** Require state-regulated sober homes to accept transgender and nonbinary people and people treated with medication for opioid use disorder.
 - **Keep people housed:** Fast-track legislation to prevent evictions and foreclosures through the [COVID-19 Housing Equity Bill](#) (H.1434/S.891), seal records of no fault evictions via [the HOMES Act](#) (H.1808/S.921), and prohibit denying housing based on criminal records via the [Homes for All Act](#) (H.1799/S.866), all presently pending in the Legislature. Adopt [Massachusetts Senate proposals](#) to make rental assistance and rental vouchers available and easily accessible for [all those who need such support](#).
- **Longer-term elements:**
 - **Build affordable housing:** Create and provide more transitional and permanent supportive housing that fulfills the prior requirements of being low-threshold and not conditioned on sobriety. This could be funded by redirecting funds from involuntary or coercive treatment toward supportive housing infrastructure, or by the hundreds of millions of unspent ARPA funds.
 - **Diversify affordable housing:** Affordable housing should include single-room occupancy units, apartments, condominiums, houses, and group-living arrangements that are not conditioned on sobriety and do not punish or exclude people for recurrence of use.
 - **Maximize federally-subsidized public housing:** across the Commonwealth, maximize all federally supported public housing stock to [Faircloth Limits](#) under federal law. Public housing authorities across the Commonwealth can build, buy, or certify more public housing units and immediately begin receiving federal subsidies for each, and use the [Rental Assistance Demonstration](#) to make these units [financially sustainable](#) over the long-term. Estimates in Boston suggest [thousands of additional units](#) could be created through such a plan. The

Cambridge Housing Authority also has capacity for [more than 1500 additional units](#) that could be supported by this financing plan.

4. Prevent Overdose Death and HIV Transmission and Expand Harm Reduction to Keep People Alive and Safe: In the short term, fast-track legislation to pilot supervised consumption sites at the state level ([H.2088/S.1272](#)) and implement them throughout Massachusetts, to be overseen by public health organizations. Establish additional monitored centers for observation and treatment, modeled on the [SPOT program](#) operated by the Boston Health Care for the Homeless Program. Renew funding for such programs already authorized by the Legislature and better advertise existing contract opportunities with targeted outreach to harm reduction programs and public health organizations around the Commonwealth. Expand syringe service programs citywide and statewide, including with flexible hours on nights and weekends, with continuous and uninterrupted access to new syringes, free naloxone, testing strips, and other harm reduction supplies, including safer smoking supplies. Syringe access is particularly important to prevent the [continued transmission of HIV](#). Provide free drug checking at all of these locations, to prevent fatal overdose. Increase public disposal kiosks for used syringes statewide.

5. Expand Effective, Low Threshold Treatment through Immediate, Sustained Investment: Increase capacity throughout the state in low threshold, immediate access substance use disorder care, including same-day initiation of medication for opioid use disorder or other pharmacotherapy, outreach, psychosocial, and peer support services. Expand and deregulate methadone access, including mobile models and primary care based pilots. Decentralize methadone treatment, offer methadone dosing via pharmacies, and allow for more use of the three-day methadone dosing “rule” from bridge programs and hospitals while patients and hospitals work to arrange direct admission to methadone clinics. Increase the number of long-term residential beds, including dual diagnosis beds, where people can go without spending months on a waitlist after ATS or CSS/TSS. These interventions must be resourced appropriately so that people are able to access treatment rapidly, on-demand, and for the best chance at long-term recovery. Utilize funds from the Opioid Recovery and Remediation Trust Fund managed by the [Opioid Recovery and Remediation Fund Advisory Council](#).

6. Decriminalize Drug Possession and End the Racist Drug War: Substance use is a public health issue and [should not be criminalized](#). By design, the [war on drugs](#) perpetuates systemic [racial oppression](#). It has created and exacerbated public health crises, including contributing to the development of an encampment in Boston. Continuing with a criminalization response will not yield different results. In the last year, opioid overdose deaths have [particularly and sharply increased among Black men](#). Decriminalizing drug possession leads to better public health outcomes, as [Portugal has demonstrated](#). The Commonwealth has already taken steps toward decriminalization with [marijuana legalization five years ago](#) and with [public health campaigns](#) to reduce stigma and embrace a public health approach to substance use. A commitment to both public health and racial justice demands drug decriminalization. [Recent research](#) debunks claims that decriminalizing [low-level offenses](#) would increase crime. The Legislature should fast-track passage of pending bills to decriminalize simple possession ([H.2119/S.1277](#)). Longer term, we must decriminalize other low-level drug crimes and crimes of poverty related to substance use. In

the interim, dismiss such charges prior to arraignment and connect people with defense-side social workers to offer paths to housing and voluntary treatment.

Background

On October 19, 2021, the [City of Boston](#) and the [Boston Public Health Commission](#) released orders announcing that “substance use disorder, unsheltered homelessness, and related issues” constitute a public health crisis in Boston, particularly around the area of Melnea Cass Boulevard and Massachusetts Avenue. A primary pillar of the City’s plan is a [ban on tents and temporary shelters](#) under threat of criminal punishment, if people do not disperse after being offered shelter or treatment, as outlined in the [October 28th Homeless Encampment Liaison Protocol](#). The plan also adopts as a “last resort” coordination with law enforcement to arrest people who may have warrants—including for missed court appearances or unpaid fines and fees—and/or petition to civilly commit them if the police decide they are a risk to themselves or others. It appears as though operationalizing this plan will result in temporarily removing unhoused people from public space and public view through coercive action and a backstop of criminalization. This is not a public health approach.

Simultaneously, the [Massachusetts Trial Court and the Suffolk County Sheriff’s Department](#) are developing a [court session inside the South Bay House of Correction](#). Clinician evaluators and judges will appear [remotely](#) on video to assess whether people arrested from the street [by the Boston Police Department](#) are an imminent threat to themselves or others by [virtue of their mental health condition or substance use disorder](#). WBUR reports that [an estimated 135 people](#) could be arrested on warrants to accept treatment under coercion or [face criminal punishment](#).

As was true in 2019 during "[Operation Clean Sweep](#)," most people who have outstanding warrants in the area are likely charged with [low-level drug offenses related to substance use](#), and many of the warrants are from court absences or unpaid fines or fees, not new offenses. There is little evidence that this population poses a threat: according to a preliminary list of people in the area with outstanding warrants shared with the Committee for Public Counsel Services, the state public defender agency, 60% of those on the list simply missed court appearances, appointments, or have outstanding payments. Further, we know that arrests and criminal charges for low-level drug offenses [particularly target Black and Brown people](#), and as stated above we do not support the criminalization of drug use. Indeed, criminalization of drug use is a major contributor to this encampment.

This plan is being proposed on the heels of [four people dying](#) in Suffolk County Sheriff Department custody over a six-week period from July to September of this year. These deaths are still being investigated. In the Sheriff’s own characterization, all four people [“were at the jail for a short time and came there already sick.”](#) This also describes the very population this new proposal would detain. People experiencing withdrawal and infections that commonly accompany injection drug use are often seriously medically compromised and therefore urgently in need of a non-jail setting for medical care and housing. A jail is not an appropriate environment for such a high-need population.

We [do not support](#) increasing involuntary treatment in Massachusetts, given the lack of evidence for efficacy, potential harms, and erosion of patient autonomy in healthcare. The South Bay House of Correction is not approved by the state to detain people who are involuntarily committed or to serve as a voluntary treatment location, and the practice of sending men to largely [abstinence-based treatment](#) in a [jail or prison setting](#) is currently being [challenged in court](#) as unlawful and inhumane. [Ayesha Johnson died at the South Bay jail in July](#) the same day she was civilly committed on a Section 35 hold, awaiting transport to a treatment facility. While [state law](#) prohibits sending women to carceral settings to receive court-ordered substance use treatment, the same circumstances that led to Ayesha Johnson's death would remain under the proposed new treatment detention facility. Public health professionals and addiction medicine experts note that involuntary opioid use disorder treatment is [unproven](#) and unethical: it doesn't support autonomy, it [lacks an evidence base](#) proving it supports long-term recovery, and it harmfully compounds trauma and dramatically [increases](#) risk of overdose and [overdose death](#) upon release. People who undergo involuntary treatment are 2.2 times more likely to die of opioid-related overdoses, and 1.9 times more likely to die of any cause, than people who receive only voluntary treatment, according to a [2016 study from the Massachusetts Department of Health](#). To respond to the public health crises facing the population living at Mass. and Cass, we must adopt public health solutions.

This plan was developed by a coalition committed to public health and housing first approaches. Affiliations of individuals are listed for identification purposes only and do not reflect the views of their organizational affiliations.

Coalition members include: the Massachusetts Society of Addiction Medicine; the Boston Health Care for the Homeless Program; the BMC Grayken Center for Addiction Medicine; the FXB Center for Health and Human Rights at Harvard; the Health in Justice Action Lab at Northeastern University; Alice Bukhman, MD, MPH; the American Civil Liberties Union of Massachusetts; the Charles Hamilton Houston Institute for Race and Justice; the Material Aid and Advocacy Program; and Prisoners' Legal Services of Massachusetts.

This plan draws in part from existing, publicly available plans put forth by organizations including the [Boston Health Care for the Homeless Program](#) and the [Material Aid and Advocacy Program](#).

To join those endorsing this policy document, please [sign on here](#).

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First Church Shelter
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