



LONG-TERM PUBLIC HEALTH STRATEGIC OUTLOOK

*Serving the Mass & Cass area and
unsheltered individuals in Boston*

*Updates and Strategic Direction
May 2022*

CONTEXT

Under Mayor Wu's leadership, the City carried out a public health-led emergency response to the encampment near Massachusetts Avenue & Melnea Cass Boulevard in January 2022. This effort included a housing surge that transitioned over 145 individuals into shelter and housing from November 2021 to January 2022. These immediate actions were only the start of the City's work to transform how Boston cares for unsheltered residents. This report outlines the City's strategic direction to strengthen the continuum of services for unsheltered individuals impacted by substance use disorder.

The strategic initiatives outlined in this guide aim to:

- Make experiences of unsheltered homelessness rare, brief, and non-recurring
- Ensure unsheltered individuals impacted by substance use have a path to a stable recovery and home
- Promote safe and healthy streets in our neighborhoods

I. THE INTERSECTING CHALLENGES OF UNSHELTERED HOMELESSNESS AND SUBSTANCE USE DISORDER

How many individuals are living unsheltered?

During the annual homeless census in January 2021, 170 individuals slept unsheltered in Boston in the depths of winter. This count was up from 135 unsheltered individuals in January 2020. The increase reflects that the COVID-19 pandemic not only increased the number of individuals at risk of homelessness, but also shut down many services. Though no formal census takes place later in the year, service providers also report that more individuals sleep unsheltered during warmer months. However, after the housing surge of January 2022, the unsheltered homeless count during the February 2022 count was down to 119 individuals.

Throughout a full year, the total number of individuals who experience unsheltered homelessness is larger than on any single night. The City's Engagement Center, which focuses on serving individuals experiencing homelessness and people who use drugs, served 14,368 unique individuals from May 2021 through March 2022.

Why are unsheltered homelessness and substance use disorder intersecting challenges?

Many of the individuals who sleep unsheltered are impacted by substance use. In December 2021, over half of the 145 individuals living unsheltered near Massachusetts Avenue & Melnea Cass Boulevard reported use of at least one substance.

The opioid epidemic exposed that individuals with substance use disorder face distinct barriers to accessing the continuum of care for unhoused individuals, including shelter and housing. As the opioid epidemic evolves, the drug supply has increasingly shifted to stronger opioids, including fentanyl. The potent and short-acting effects of fentanyl have made it more difficult for people who use opioids to stay in traditional shelters. This is a major factor that pushes more individuals to sleep outside.

Because unsheltered homelessness intersects with the statewide opioid epidemic, this Strategic Outlook prioritizes two approaches:

- *Improve services:* Ensure outreach, shelter, recovery, and housing systems are well-equipped to support individuals navigating addiction

- *Expand availability of services across Boston and Massachusetts:* Ensure unsheltered individuals and people who use drugs can access services no matter where they live

While this Strategic Outlook focuses on initiatives for unsheltered individuals with substance use disorder, it is just one slice of the City’s broader efforts to improve access to shelter, housing, and recovery services in Boston. In addition to the public health and housing strategies described in this Strategic Outlook, the City will also continue to promote public safety and quality of life strategies that ensure the well-being of unsheltered individuals and their surrounding communities through the Warm Weather Plan.

METHODS

I. DESIGNING THE STRATEGIC OUTLOOK

To shape this Strategic Outlook, the City:

- Conducted over 20 stakeholder meetings, meeting with over 250 individuals. Stakeholders included: community members with lived experience, clinical partners, neighborhood associations, community health centers, shelter and housing partners, faith-based organizations, outreach teams, Boston’s State delegation, Boston City Council, outreach teams, and justice partners.
- Reviewed best practices with colleagues and cities around the country.
- Evaluated equity data to target initiatives toward neighborhoods facing disproportionate impact from substance use disorder and racial/ethnic disparities in health care access.
- Gathered input from City departments, including the Office of Housing, Boston Public Health Commission (BPHC), and the cross-departmental Coordinated Response Team. The CRT is made up of over 10 City departments involved in responding to the needs of unsheltered individuals and the communities in which they live, including the BPHC Bureau of Recovery Services, BPHC Bureau of Homeless Services, Office of Housing, Public Works Department, Boston Police Department, and Inspectional Services Department.

II. EQUITY FRAMEWORK

Health equity is a guiding principle for this Strategic Outlook. To promote health equity, policies and practices must ensure all people have the opportunities and resources they need to thrive. Health equity requires addressing disparities in health outcomes, including those across race, ethnicity, gender, language, neighborhood, and income.

This outlook centers health equity by:

- Using data to identify communities experiencing disparate impact
 - *Appendix A* reports the demographics of individuals who were living unsheltered in the encampment near Massachusetts Avenue & Melnea Cass Boulevard in December 2021
 - *Appendix B* displays map data representing neighborhoods that experience disproportionate impact from substance use disorder, housing instability, and racial/ethnic barriers to healthcare access
- Tailoring strategies to address disparities
 - *Mid-term example:* Under “Outreach,” the expansion of community-led engagement teams will start in three neighborhoods experiencing high

- impact from substance use disorder, and racial/ethnic barriers to healthcare access.
- *Long-term example:* Under “Workforce,” the City will launch an initiative to support and grow a diverse behavioral health workforce in Boston.
- Evaluating outcomes to assess for equitable impact
 - The City will stratify outcomes by race, ethnicity, gender, age, and geography when evaluating Boston’s progress with reducing unsheltered homelessness and with promoting pathways to stable housing and recovery.
 - For example, *Appendix C* reports the Boston Public Health Commission’s equity analysis of placements in low-threshold shelter and housing during the housing surge from November 2021 to January 2022.
 - Whenever an evaluation reveals disparities in outcomes, the City will seek to adapt practices, policies, and programs in order to achieve equitable impacts.

1. OUTREACH

MID-TERM STRATEGIC INITIATIVES

I. EXPAND PUBLIC HEALTH OUTREACH TO BE PROACTIVE, 24/7, AND EQUITABLE CITY-WIDE

The City will increase both homeless services outreach and harm reduction outreach. Expanding outreach will help ensure that individuals who are living unsheltered connect with services, like housing and treatment. This initiative will enhance multiple aspects of outreach, including hours (bolstering 24/7 coverage), geography (bringing outreach to more parts of the city), equity (improving reach in Boston’s communities of color), service offerings (increasing mobile harm reduction services), and collaboration across outreach disciplines.

II. LAUNCH CITYWIDE ENCAMPMENT RESPONSE AND SERVICE ENGAGEMENT (CERVE) TEAM

The CERVE team will ensure timely outreach and resolution for any encampments in the City of Boston. The goal of this team is to promote clean and safe streets in Boston’s neighborhoods while outreach teams work with our unsheltered neighbors. CERVE team members will be overseen by the City’s Coordinated Response Team, which is made up of over 10 City departments involved in responding to needs related to unsheltered individuals and the communities in which they live.

III. CREATE COMMUNITY-LED ENGAGEMENT TEAMS

The City will support community-led engagement teams in three Boston neighborhoods whose communities have been disproportionately impacted by substance use and racial/ethnic disparities in health care access. This investment builds off the Nubian Square Neighborhood Engagement Team pilot. In this model, engagement team outreach workers are nominated members of the community. They not only conduct outreach to unsheltered individuals, but they also work with community stakeholders to identify the neighborhood’s specific needs and to design solutions that leverage the neighborhood’s distinct resources.

LONG-TERM STRATEGIC INITIATIVES

IV. COORDINATE ACROSS STREET OUTREACH TEAMS TO MAXIMIZE IMPACT

Several public and private outreach teams conduct street outreach in Boston. The City will increase coordination and convening between outreach teams to ensure equitable coverage across neighborhoods and to promote best practices for outreach to people who use drugs. As described in “Permanent Housing - Action II,” the City will formalize a systematic pathway that connects chronically unsheltered individuals with housing. This work will include expanding street outreach documentation in the Coordinated Access System, which prioritizes individuals for housing – a step that will be essential to a centralized, fair, and data-driven system.

2. SERVICE NAVIGATION

MID-TERM STRATEGIC INITIATIVES

I. EXPAND DROP-IN PROBLEM-SOLVING FOR UNSHELTERED INDIVIDUALS

The largest shelters in Boston conduct front-door triage with new guests. Through front-door triage, providers work with an individual on the edge of entering shelter to problem-solve for a safe and supportive place to stay other than shelter. If an alternative place to stay is identified, triage assists individuals with pursuing that alternative and addressing barriers. If an alternative is not identified, triage assists individuals with referrals to services. The City will expand access to this service for unsheltered individuals by opening more drop-in hours at locations throughout Boston. In the long-term, the City will advocate that towns and cities across Massachusetts increase the provision of housing instability problem-solving services.

II. CREATE ACCESS TO WEB-BASED RESOURCE MAP

Building awareness of the resources available in Boston for shelter, housing and recovery is critical for promoting access to care. The City will update a map of services across Boston to give providers and community members a tool that can be used to connect people to services.

III. INCREASE ACCESS TO LOW-THRESHOLD DAYTIME SPACES

Low-threshold daytime spaces provide a place for individuals navigating homelessness and addiction to spend time off the street and connect with services. The City’s Engagement Center in the Mass/Cass neighborhood pioneered this model in Boston. By summer 2022, the City will expand low-threshold daytime spaces in at least two additional neighborhoods in Boston. In the long-term, the City will continue to expand this model in Boston and to advocate for more low-threshold daytime spaces across the Commonwealth.

LONG-TERM STRATEGIC INITIATIVES

IV. POLICY AGENDA: ALL TREATMENT & CORRECTIONS SYSTEMS SHOULD ENSURE INDIVIDUALS LEAVE WITH A PLAN FOR SHELTER OR HOUSING AND WITH APPROPRIATE IDENTIFICATION

Too often people leave treatment facilities, hospitals, and corrections settings without a viable plan for where to stay, resulting in homelessness in shelters or on the street. More resources and coordination are needed to assist these systems with ensuring individuals leave with a stable discharge plan. In addition, individuals often leave without identification (“ID”); identification is a critical resource for many social services, including health care, housing, and employment. The City will advocate to improve regulations and programs that help ensure individuals leave all treatment and corrections systems with a plan for shelter or housing and with appropriate identification.

V. CONTINUE EFFORTS ACROSS BOSTON TO EXPAND ACCESS TO ESSENTIAL RECOVERY AND HOMELESS SERVICES

Increasing recovery, shelter, and housing services throughout the City is critical to ensure that services are accessible to all community members, no matter where they live in Boston. The City will work to expand access to essential services for individuals navigating homelessness and substance use across the city, including low-threshold day-time space, syringe services, medications for opioid use disorder, shelter, and housing navigation.

3. LOW-THRESHOLD SHELTER + HOUSING

MID-TERM STRATEGIC INITIATIVES

I. PROVIDE NEW MODEL OF LOW-THRESHOLD TRANSITIONAL SHELTER + HOUSING AT SIX SITES IN BOSTON THROUGH FY23

Since November 2021, six new low-threshold transitional shelter + housing sites have come online in Boston. These new sites have lower barriers to entry than traditional shelter and have wrap-around supports tailored to individuals impacted by substance use disorder. This new model has enabled over 200 individuals to transition off the street and into these low-threshold beds. Thanks to collaboration between the City and the State, these six sites will continue providing low-threshold shelter + housing through June 2023. Over the next year, we will work with the providers operating these sites to evaluate and strengthen the low-threshold model, including ensuring that the programs connect all guests with medical care, mental health services, substance use services, and housing navigation.

II. LAUNCH SHELTER TRANSFORMATION - PHASE 1: LOW-THRESHOLD PILOTS

Adapting shelters can help more individuals stay in shelter rather than on the street, contributing to the goal of making unsheltered homelessness brief, rare, and non-recurring. The City led a comprehensive planning process in the fall of 2021 for

shelter transformation. Phase 1 of Shelter Transformation will consist of the low-threshold pilots at three shelters. This phase includes providing a service mix to serve guests who are unsheltered and have a substance use disorder (examples include low-threshold spaces and on-site nursing), modifying the physical environment (examples include single beds, designated storage/lockers), and implementing low-barrier and housing-focused shelter policies (examples include ability to come and go, amnesty lockers).

LONG-TERM STRATEGIC INITIATIVES

III. IDENTIFY AND SUSTAIN LOCATIONS FOR LOW-THRESHOLD TRANSITIONAL SHELTER + HOUSING IN BOSTON

The low-threshold transitional shelter and housing beds are critical resources in Boston's continuum for serving previously unsheltered individuals impacted by substance use disorder. The City will identify locations where the pilot programs can continue long-term in Boston.

IV. LAUNCH SHELTER TRANSFORMATION - PHASE 2: SYSTEM EVALUATION

Phase 2 involves conducting space analysis to evaluate opportunities for physical modifications to shelter; data analysis to identify opportunities for scaling services for populations with specific needs; policy analysis to strengthen harm reduction policies and services within shelter; and workforce analysis to determine needs for additional training and development.

The City will then lead implementation of the recommendations that emerge from Phase 2 of Shelter Transformation, advancing the following priority strategies:

1. Modify physical spaces (examples include increasing bed privacy and setting aside spaces for sub-populations, like youth, individuals navigating addiction, individuals in recovery, and individuals with medical conditions that are incompatible with congregate shelter)
2. Lower barriers to starting service pathways (examples include making information more available and leveraging peer support specialists)
3. Enhance service mix and partnerships (examples include increasing on-site recovery and behavioral health services)
4. Review policies (examples include lowering barriers to entering shelter for people who use drugs and addressing inequities in outcomes for shelter guests)
5. Build capacity (examples include increasing Housing First and racial equity training for staff)
6. Assess staffing model (examples include integrating operations staff into service connection work and increasing clinical social worker staffing)

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The City will then lead implementation of the recommendations that emerge from Phase 2 of Shelter Transformation, advancing the following priority strategies:

7. Modify physical spaces (examples include increasing bed privacy and setting aside spaces for sub-populations, like youth, individuals navigating addiction,

- individuals in recovery, and individuals with medical conditions that are incompatible with congregate shelter)
8. Lower barriers to starting service pathways (examples include making information more available and leveraging peer support specialists)
 9. Enhance service mix and partnerships (examples include increasing on-site recovery and behavioral health services)
 10. Review policies (examples include lowering barriers to entering shelter for people who use drugs and addressing inequities in outcomes for shelter guests)
 11. Build capacity (examples include increasing Housing First and racial equity training for staff)
 12. Assess staffing model (examples include integrating operations staff into service connection work and increasing clinical social worker staffing)

4. PERMANENT HOUSING

MID-TERM STRATEGIC INITIATIVES

I. INCREASE ACCESS TO RAPID RE-HOUSING

Rapid re-housing is a form of housing assistance that provides up to two years of support with rent and with transitioning into housing. In FY23, the City will set aside additional rapid re-housing resources for the Street 2 Home initiative (described in “Permanent Housing - Action 2”) and for residents of the new low-threshold transitional shelter and housing programs. These rapid re-housing resources will include tailored supports to help individuals stay in housing.

LONG-TERM STRATEGIC INITIATIVES

II. MAKE STREET 2 HOME A PERMANENT PATHWAY FOR CHRONICALLY UNSHELTERED INDIVIDUALS

Boston’s work to end chronic homelessness made significant strides by prioritizing long-term shelter stayers for housing. There remained a need, however, to strengthen housing pathways for long-term unsheltered individuals. In 2021, the Mayor’s Office of Housing launched the Street 2 Home initiative (S2H) to house 250 long-term unsheltered homeless individuals with high substance use, behavioral health, medical and disability needs. The City will strengthen Boston’s housing system by embedding a permanent, coordinated approach for matching chronically unsheltered individuals with housing resources.

III. INCREASE PERMANENT SUPPORTIVE HOUSING IN BOSTON FOR INDIVIDUALS WITH SUBSTANCE USE DISORDER

Unsheltered individuals impacted by substance use disorder often also face acute medical and mental health challenges. The City will develop new permanent supportive housing dedicated to individuals with histories of homelessness and substance use disorder. This model of permanent supportive housing will have on-site wrap-around supports to help individuals find stability in housing and in recovery.

IV. POLICY AGENDA: WORK WITH THE STATE TO INCREASE PERMANENT SUPPORTIVE HOUSING ACROSS MASSACHUSETTS FOR INDIVIDUALS WITH SUBSTANCE USE DISORDER

The City will work with our State partners and city counterparts to promote access to permanent housing across the Commonwealth that is tailored to the needs of individuals navigating addiction. The City will advocate to expand this housing resource - such as the Bureau of Substance Addiction Services' low-threshold housing model - to more units and more towns.

V. PARTNER TREATMENT PROGRAMS AND HOUSING SEARCH AGENCIES

Historically, it has been difficult for individuals to enter the inpatient treatment system while maintaining their prioritization for and progress toward housing. The City will work to strengthen partnerships between treatment programs in Boston and housing search providers. This transformation will ensure that unsheltered individuals who enter inpatient treatment can progress toward two pillars of recovery at the same time: housing and health.

5. HARM REDUCTION + TREATMENT

MID-TERM STRATEGIC INITIATIVES

I. EXPAND ACCESS TO MEDICATIONS FOR OPIOID USE DISORDER AT LOW-THRESHOLD SHELTER + HOUSING SITES

Medications for opioid use disorder (MOUDs) - which include methadone, buprenorphine, and vivitrol - reduce opioid use and prevent overdose.¹ In FY23, the City will partner with the low-threshold shelter and housing providers to ensure every site offers guests pathways to starting MOUD.

II. LAUNCH LONG ISLAND FACILITIES PRESERVATION PROJECT AND EXPLORE EXPANDING ACCESS TO TREATMENT CONTINUUM THROUGH RECOVERY CAMPUSES

In Massachusetts, access to inpatient and outpatient substance use treatment falls short of meeting the need. Of the over 500,000 Massachusetts residents facing a substance use disorder, only 10% access substance use treatment at a specialty facility annually.²

To begin to tackle this issue, the Boston Public Facilities Department will oversee a construction project to stabilize and repair existing buildings on Boston's Long Island. Stabilizing these buildings is a critical step toward making a Long Island Recovery Campus possible.

Then the City will expand access to recovery campuses by:

- Partnering with the State on the Lemuel Shattuck Hospital campus, with a focus on acute treatment services and low-threshold transitional shelter and housing

¹ Substance Abuse and Mental Health Services Administration. *Medications for Opioid Use Disorder. Treatment Improvement Protocol (TIP) Series 63.* 2021.

https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP21-02-01-002.pdf

² Substance Abuse and Mental Health Services Administration. *2018-2019 National Surveys on Drug Use and Health.* 2020.

<https://www.samhsa.gov/data/sites/default/files/reports/rpt32879/NSDUHsaeTotal2019/2019NSDUHsaeTotal.pdf>

- Evaluating plans to move forward the Long Island Recovery Campus, with a focus on longer-term treatment services and job training to support individuals with returning to community

LONG-TERM STRATEGIC INITIATIVES

III. ROLL OUT MOBILE METHADONE IN BOSTON

Specialized opioid treatment programs are the only health care providers that can provide long-term methadone, a regulation that has presented a long-standing barrier to methadone access. In 2021, the federal government allowed opioid treatment programs to expand their mobile van programs. The City will collaborate with State partners and methadone providers to bring mobile methadone to Boston's neighborhoods.

IV. COLLABORATE WITH COMMUNITY HEALTH CENTERS TO EXPAND OPPORTUNITIES FOR HARM REDUCTION SERVICES AND MOVE TOWARDS INTEGRATING HARM REDUCTION INTO ALL HEALTH CARE SETTINGS

Harm reduction is an evidence-based practice for reducing health harms of drug use and for promoting engagement in care among people with a substance use disorder.³ The City will engage Boston's range of healthcare providers - from hospitals to community clinics - and social service providers to unlock harm reduction access for patients across the city.

Furthermore, the City will partner with community health centers to increase the harm reduction services they offer their patients, in order to meet the needs of the communities they serve. These services include overdose prevention training, naloxone access, and syringe services. Providing these services at the community health centers - where our residents already access care - will help Boston achieve the goal of creating harm reduction access in every neighborhood.

V. POLICY AGENDA: WORK WITH THE STATE TO PROMOTE CONTINUITY THROUGH TREATMENT SYSTEM FOR UNSHELTERED INDIVIDUALS WITH SUBSTANCE USE DISORDER

Unsheltered individuals face heightened barriers to progressing through the treatment system. The barriers to inpatient treatment (like a lack of options for individuals who are still actively using) and outpatient treatment (like limited hours and locations for methadone clinics) discourage individuals from beginning or continuing recovery pathways. The City will advocate to work with the State to assess the barriers in the treatment continuum across the Commonwealth, in order to improve access to and utilization of evidence-based care for individuals experiencing homelessness, a population that has been disproportionately impacted by the opioid epidemic.

³ City of Boston Office of Recovery Services. Boston Harm Reduction Toolkit. 2021. <https://www.boston.gov/sites/default/files/file/2021/09/CoB%20Harm%20Reduction%20Toolkit.pdf>

6. RECOVERY SUPPORTS

MID-TERM STRATEGIC INITIATIVES

I. CONTINUE WRAP-AROUND TEAMS ON THE STREET

The City, along with community-based partners like Boston Health Care for the Homeless Program, has engaged an integrated and collaborative team of community providers to meet the complex needs of unsheltered individuals in the Mass & Cass area. Alongside the BPHC Recovery Services street team, the wrap-around support on the street includes nurses, mental health clinicians, and recovery professionals. This collaborative model meets individuals where they are to care for their medical and behavioral health needs, with an emphasis on coordinated care plans.

LONG-TERM STRATEGIC INITIATIVES

II. BRING WRAP-AROUND TEAMS FROM THE STREET TO SUPPORT NEWLY HOUSED AND ADVOCATE WITH THE STATE TO EXPAND THESE TEAMS ACROSS MASSACHUSETTS (POLICY AGENDA)

When individuals transition from the street into a shelter or housing placement, wrap-around support is critical for ensuring they are safe and stable in their new home. Boston's 2022 housing surge highlighted that outreach teams have trusting relationships, knowledge of care plans, and skills for keeping people who use drugs safe. The City will add capacity to outreach organizations to operate in a "follow-the-person" model, so that an organization can transition from supporting their clients on the street into stabilizing their clients in shelter or housing, complimenting any services already available on-site.

The City also seeks to work with the State to scale mobile support teams that provide individualized, wrap-around, and flexible supports for individuals with SUD across Massachusetts to help them stay in housing. The State currently funds a similar model for individuals with mental illness through Programs of Assertive Community Treatment, from which a parallel model for individuals with SUD could be developed.

III. CREATE LOW-THRESHOLD WORK OPPORTUNITIES

Low-threshold work lowers the barriers for unsheltered individuals impacted by substance use disorder to earn income and increase job readiness. For example, the Newmarket Business Association peer work crew hires individuals navigating homelessness and addiction in the neighborhood to support street cleaning. The program has provided participants with pathways to longer-term employment. The City will expand the peer work crew model in FY23 to provide more individuals with this stepping stone into recovery.

V. CREATE JOB + LIFE SKILLS TRAINING FOR NEWLY HOUSED

Transitioning into permanent housing is an intense time for unsheltered individuals impacted by substance use disorder. Many have to re-learn day to day activities, ranging from cooking to cleaning to doing laundry, all while managing recovery from a substance use disorder. The City aims to create job and life skills training to newly housed individuals to provide long term support, keep individuals housed, and ensure they have the tools they need to transition successfully.

7. BEHAVIORAL HEALTH WORKFORCE

LONG-TERM STRATEGIC INITIATIVES

I. LAUNCH INITIATIVE TO SUPPORT AND GROW DIVERSE BEHAVIORAL HEALTH WORKFORCE

The City's 2022 housing surge highlighted that one of the greatest challenges to expanding services for unsheltered individuals with substance use disorder is the national behavioral health workforce shortage. Supporting and growing a diverse behavioral health workforce is essential to expanding access to care and to promoting equity in outcomes across race, ethnicity, and gender. Across Massachusetts, the State is investing in the Behavioral Health Roadmap to grow the workforce and improve access to care. In Boston, the City will launch an initiative focused on recruiting and sustaining diverse Boston residents in the behavioral health field.

II. BUILD THE HARM REDUCTION SKILLS OF THE WORKFORCE

Harm reduction is an evidence-based approach for caring for individuals with a substance use disorder. Harm reduction strategies recognize substance use as a reality in our communities and focus on reducing harms and promoting engagement in care for people who use drugs. Training our shelter, recovery, and housing workforce in harm reduction is critical to improving care quality and health outcomes for individuals with substance use disorder. This initiative would equip providers across the City with tools and skills for better serving individuals navigating addiction.

III. POLICY AGENDA: PARTNER WITH FEDERAL AND STATE GOVERNMENT TO INCREASE REIMBURSEMENT FOR BEHAVIORAL HEALTH SERVICES

Public and private insurers continue to reimburse behavioral health services at rates that limit the ability of providers across the Commonwealth to compensate behavioral health professionals at rates that (1) support existing staff and (2) attract new, diverse talent. The State's Behavioral Health Roadmap will take steps to increase reimbursement rates. The City will partner at the federal and state levels to continue improving behavioral health reimbursement rates.

8. ADDITIONAL DELIVERABLES

MID-TERM STRATEGIC INITIATIVES

I. UPDATE DATA DASHBOARD

To keep the community updated on the work the City is conducting and to maximize transparency, the City is updating the data dashboard on Boston.gov/Mass-Cass in the near future. This data dashboard will contain up to date information on treatment placements through the Office of Recovery Services, number of EMS Squad 80 incidents, number of closed 311 requests, number of individuals housed from shelter, and the syringe return rate. It also will contain information related to attendance at the 6 low threshold transitional shelter and housing sites.

II. USE CITYWIDE AUDIT TO IDENTIFY SITES FOR HOUSING + RECOVERY SERVICES

Mayor Wu directed the Boston Planning and Development Agency to conduct a citywide audit of underutilized City-owned property that can be leveraged for increasing housing and recovery services. The City will evaluate whether properties identified in this audit can contribute to expanding services across Boston's neighborhoods.

III. ENGAGE COMMUNITY AROUND STRATEGIC OUTLOOK

Community feedback was critical for informing the Long-Term Public Health Strategic Outlook. The City will share the Long-Term Public Health Strategic Outlook with community members and civic associations and engage in ongoing conversation about the plan's progress.

LONG-TERM STRATEGIC INITIATIVES

IV. LAUNCH ANTI-STIGMA CAMPAIGN

Reducing stigma toward people who use drugs is key to improving access to care for unsheltered individuals impacted by substance use disorder. Not only does reducing stigma encourage individuals struggling with substance use to reach out for support, it also leads more providers and communities to partner to offer these supports. The City will prioritize partnering with community members to combat stigma, with a focus on promoting access to care among communities of color facing a rising overdose crisis.

V. ASSESS AND IMPROVE EQUITY IN ACCESS AND OUTCOMES

To ensure that everyone has equitable access to outreach, recovery, and housing services, the City aims to assess and improve how well the service continuum promotes (1) language and communications access; (2) service design that is responsive to diverse communities and identities; and (3) equity in outcomes across diverse communities and identities.

VI. DEVELOP PRIVATE-PUBLIC PARTNERSHIP WITH THE BUSINESS COMMUNITY

Boston's businesses have been important partners for innovating solutions that support our vulnerable residents and that promote healthy and safe communities. The City will collaborate with Boston's business community to promote the health of residents and neighborhoods impacted by homelessness and addiction.

VII. COLLABORATE TO CREATE REGIONAL AGENDA FOR HARM REDUCTION + RECOVERY SUPPORTS

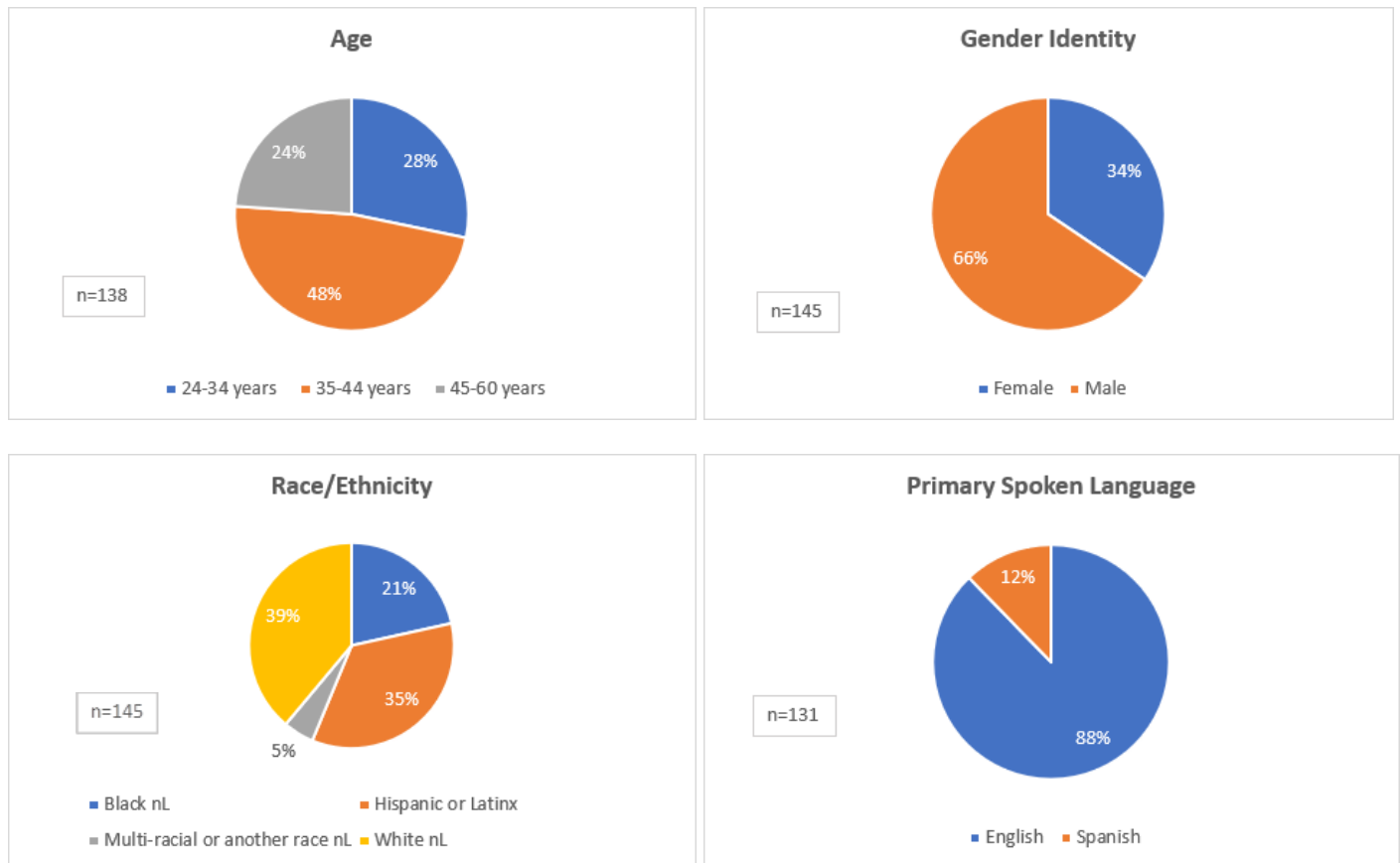
This Strategic Outlook is a first step toward identifying regional priorities. To make a true regional approach possible, the City under Mayor Wu's leadership will partner with the State and mayoral counterparts on ensuring that Massachusetts residents can access harm reduction and recovery services no matter where they live.

APPENDIX: CONTEXTUAL DATA

APPENDIX A

From December 6 to December 9, 2021, the City surveyed all individuals living in tents in the area near Massachusetts Avenue and Melnea Cass Boulevard. The survey identified 145 individuals. The charts below display the distribution of age, gender identity, race/ethnicity, and primary language among the individuals surveyed.

Between December 15, 2021, and January 12, 2022, the City offered low-threshold transitional shelter and housing to individuals who were living in tents at the time of the survey.



APPENDIX B

The Boston Public Health Commission created separate maps for four different variables that measure substance use disorder or social inequity in each Boston zip code (Maps A - D). The final map overlays all four variables together to identify the Boston zip codes experiencing the greatest impact from substance use disorder and inequitable access to care (Map E). In all the maps, the highest numbers are represented by darkest shading.

Map A shows the number of opioid-related deaths occurring among residents grouped by quintile. Zip codes in the quintile with highest number of deaths are:

- Dorchester 02124 (incl. Codman Sq.), 02121 (incl. Grove Hall), and 02125 (incl. Upham's Corner)
- South End 02118 (incl. Massachusetts Ave. and Melnea Cass Blvd. intersection)
- Roxbury 02119 (incl. Nubian Square)
- South Boston 02117

Map B presents Boston EMS Narcan administrations among those who have overdosed based on the incident location zip code. This map shows the highest number of Narcan administrations occurring among the same six zip codes as for opioid mortality (map A).

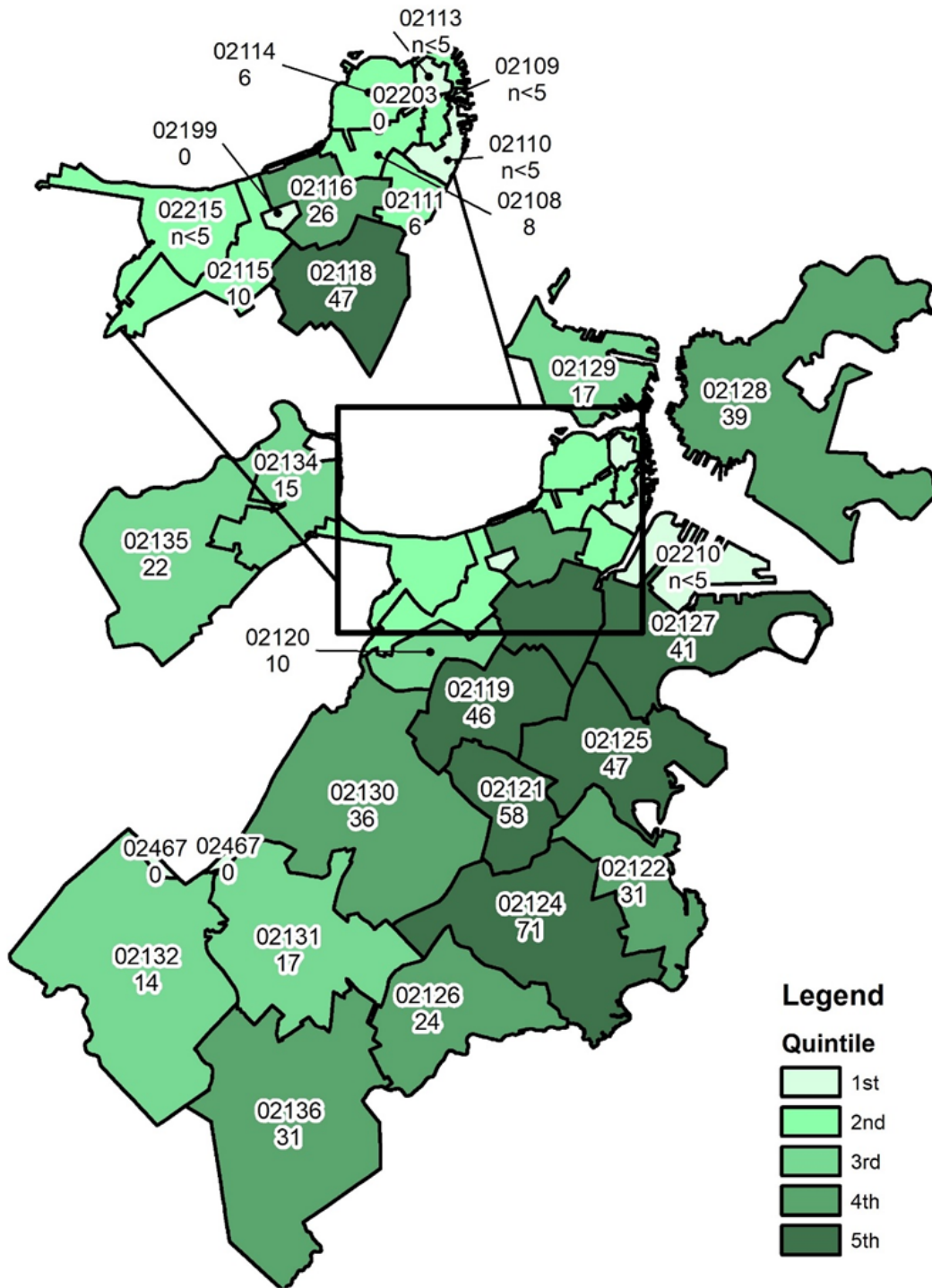
Map C presents the percentage of residents identifying with race/ethnicity other than White non-Latinx. This map shows that four of the six zip codes with highest opioid burden also have highest percentages of residents not identifying as White non-Latinx: Dorchester 02124, Dorchester 02121, Dorchester 02125, and Roxbury 02119. In addition, Mattapan 02126 and Hyde Park 02136 are among zip codes with the highest percentage of residents not identifying as White non-Latinx, but not among those with the highest opioid burden as indicated by maps A and B.

Map D presents zip code quintiles for the percentage of residents ages 25+ with less than a college education (a social determinant of health). Three of the zip codes with the highest percentage of residents with less than college education were also among those with highest opioid burden (maps 1 and 2): Dorchester 02124, Dorchester 02121, and Roxbury 02119.

Map E presents indices calculated to reflect the combination of the variables in Maps A - D. Zip codes in the quintile with the highest opioid burden with demographic consideration are:

- Dorchester 02124 (incl. Codman Sq.), 02121 (incl. Grove Hall), and 02125 (incl. Upham's Corner)
- South End 02118 (incl. Massachusetts Ave. and Melnea Cass Blvd. intersection)
- Roxbury 02119 (incl. Nubian Square)
- East Boston 02128

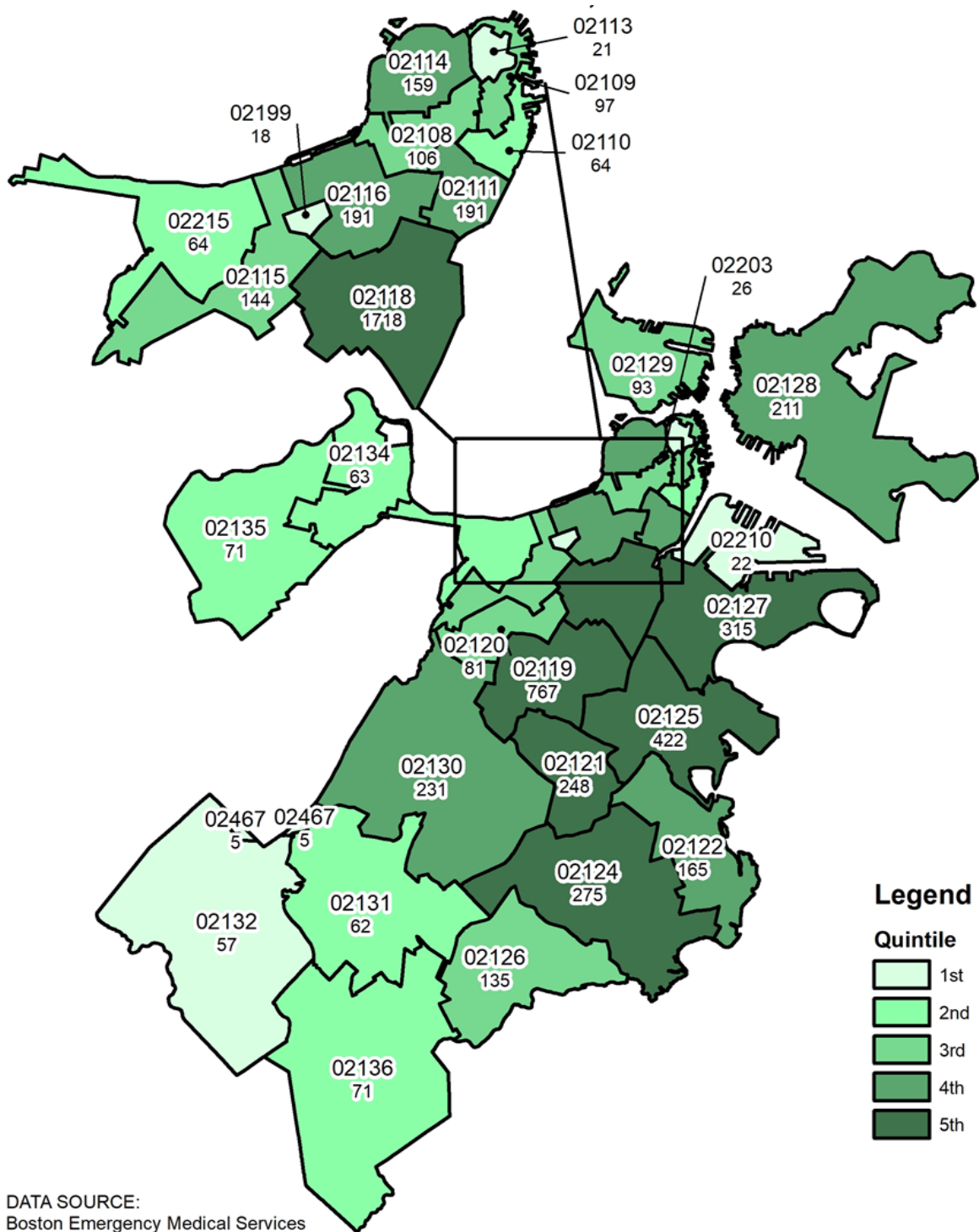
MAP A - NUMBER OF OPIOID DEATHS BY RESIDENTIAL ZIP, 2019-2021*



*Please be advised that 2020-2021 data are preliminary and subject to change. Raw preliminary data may be incomplete or inaccurate, have not been fully verified, and revisions are likely to occur following the production of these data. The Department of Public Health strongly cautions users regarding the accuracy of statistical analyses based on preliminary data and particularly with regard to small numbers of events.

Data Sources: Boston Resident Deaths, Massachusetts Department of Public Health
 Prepared by: Research and Evaluation Office, Boston Public Health Commission

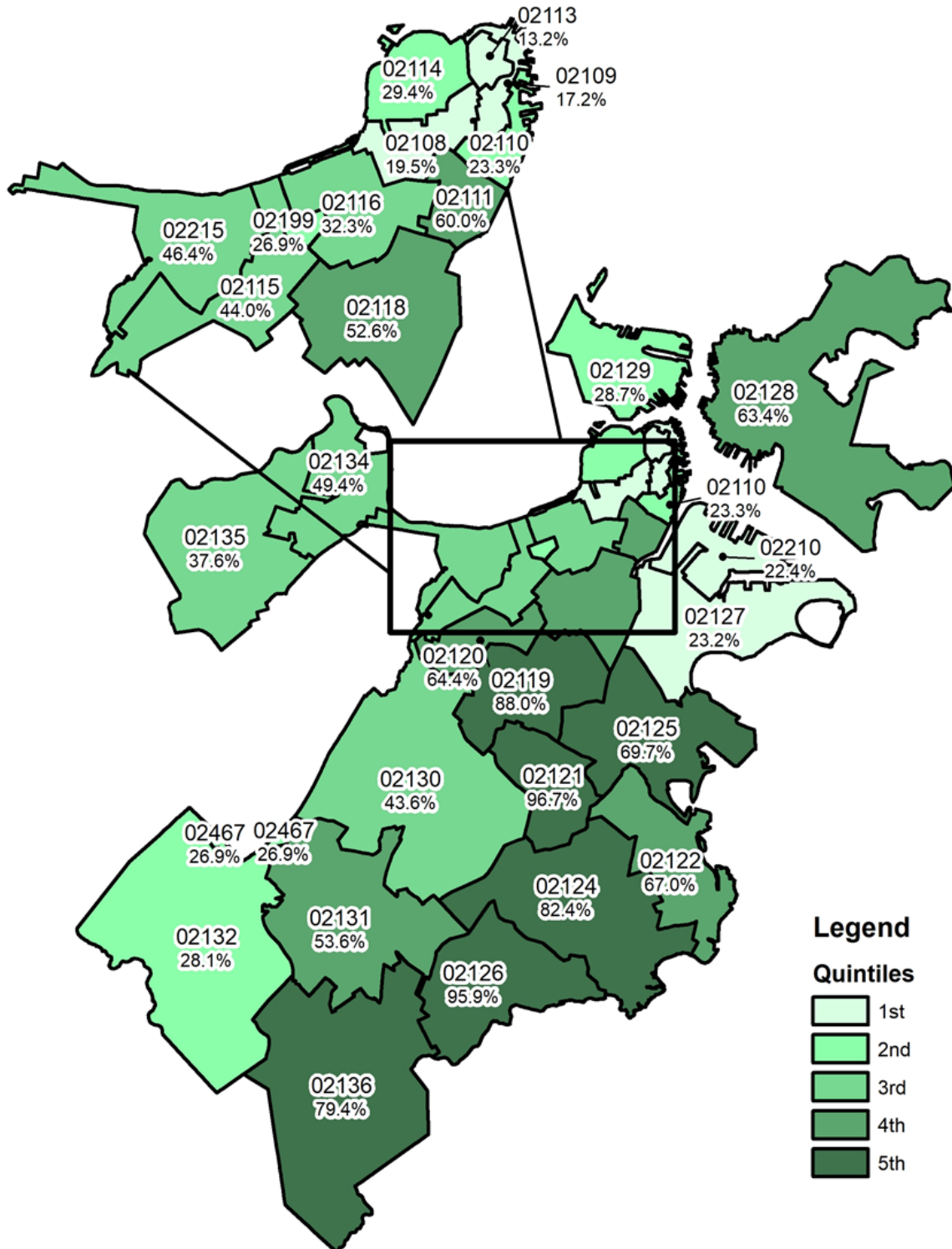
MAP B - NUMBER OF NARCAN ADMINISTRATIONS AMONG BOSTON EMS NRI* INCIDENTS, 2019-2021



DATA SOURCE:
 Boston Emergency Medical Services
 *Narcotic Related Illness (NRI): A Boston EMS clinical incident identified as suspected to be related to narcotic use (including opiates and opioids) after review. Potential NRI cases are identified based on information entered in patient care reports by on scene EMTs or Paramedics, with confirmation of pinpoint pupils and altered mental status.
 Prepared by Research and Evaluation Office, Boston Public Health Commission

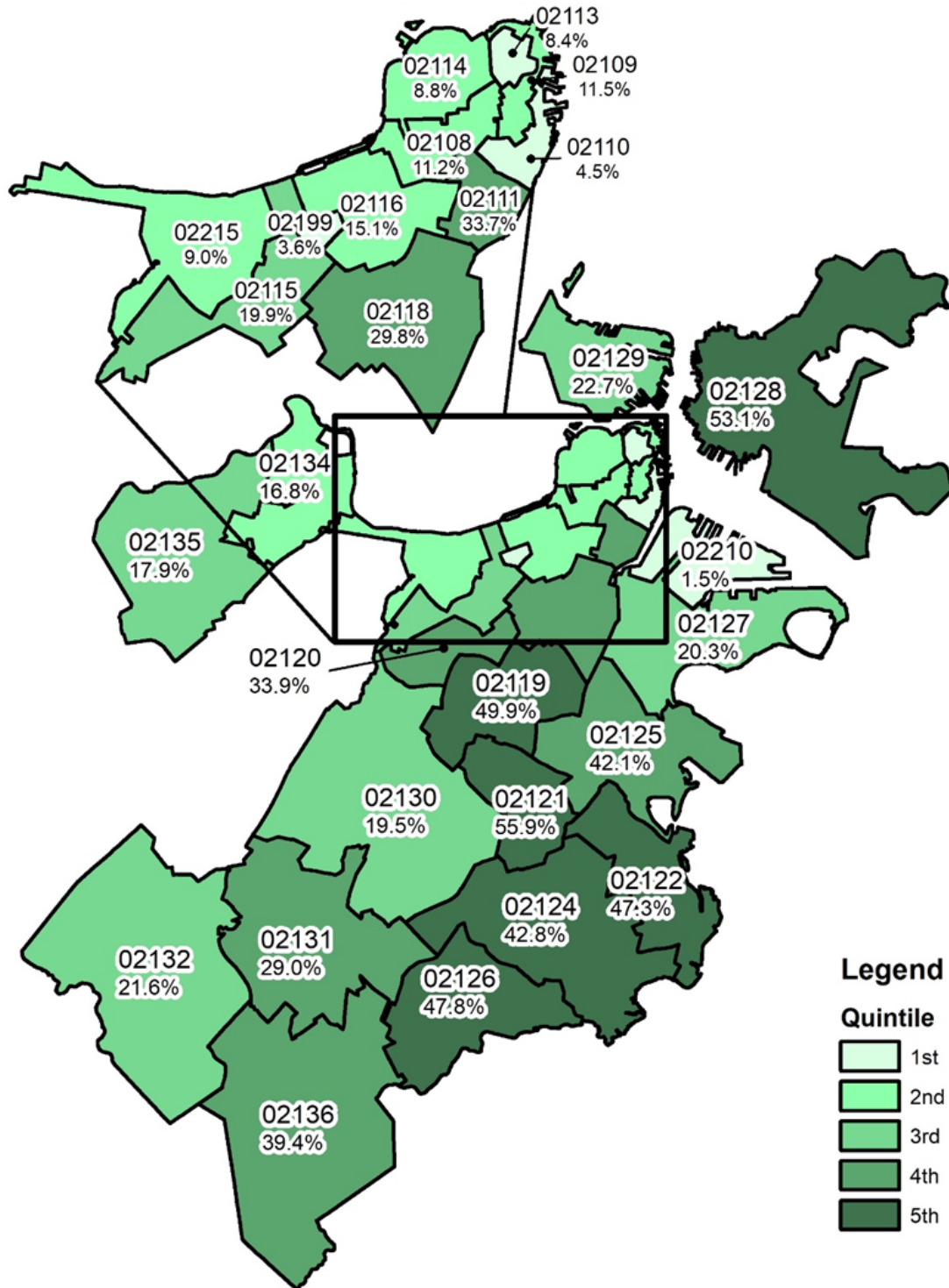


MAP C - BOSTON RESIDENTS IDENTIFYING AS OTHER THAN WHITE NON-LATINX



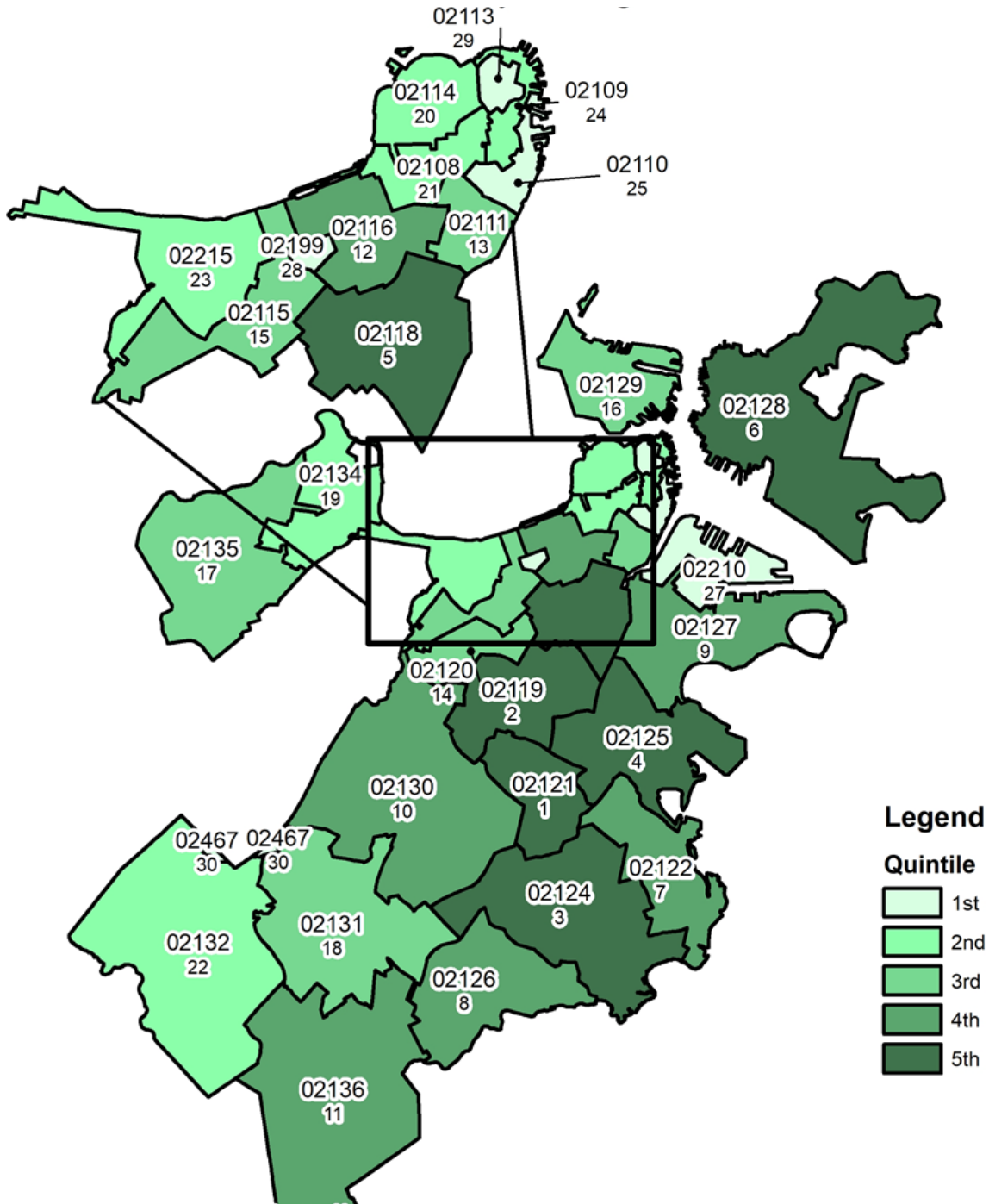
Data Sources: 2020 United States Census, United States Census Bureau
 Prepared by: Research and Evaluation Office, Boston Public Health Commission

MAP D - BOSTON RESIDENTS AGES 25+ WITH LESS THAN ANY COLLEGE EDUCATION



*Data for ZIP codes 02203 (Boston City Hall) and 02467 have been omitted from the quintile distribution
 Data Source: American Community Survey, 2020 5-Year Estimates (2016-2020); United States Census Bureau
 Prepared by: Research and Evaluation Office, Boston Public Health Commission

MAP E - INDEX: OPIOID MORTALITY + NARCAN NRIs + RESIDENTS IDENTIFYING AS OTHER THAN WHITE NON-LATINX + RESIDENTS WITH LESS THAN ANY COLLEGE EDUCATION



*Index specifies rank order (range 1-30) with lower ranking generally expressing a combination of higher opioid burden, higher percentages of other than White non-Latinx consideration (non-White nL) and higher percentages of less than college education consideration. Underlying index value used for index rank (data not shown) calculated by summing weighted component ranks as follows: $.335 \times \text{component 1 (mortality rank)} + .335 \times \text{component 2 (Narcan rank)} + .22 \times \text{component 3 (other than White non-Latinx rank)} + .11 \times \text{component 4 (less than any college education rank)}$. In this manner opioid mortality contributes 33.5%, Narcan administration contributes 33.5%, racial ethnic consideration contributes 22% and education consideration contributes 11% to final index rank (i.e., 3 parts opioid mortality, 3 parts Narcan administration, 2 parts race/ethnicity, 1 part education).

Prepared by: Research and Evaluation Office, Boston Public Health Commission

APPENDIX C

Preliminary findings from an equity analysis of the Mass. and Cass Tent to Shelter/Housing Initiative

December 12, 2021 to January 12, 2022

In November of 2021 as part of the City crisis response related to tent encampments in the Mass. and Cass area of Boston, Mayor Michelle Wu ordered existing tent encampments be dismantled and tent occupants be housed or sheltered by January 12, 2022. This is a preliminary summary of the subsequent effort to equitably transition 145 unsheltered individuals, most acknowledging having a substance use disorder (SUD), from these tent encampments to shelter and housing options between December 12, 2021 and January 12, 2022.

The Tent to Shelter/Housing (T2SH) Initiative primarily sought to provide a fair and equitable distribution of low-threshold shelter (LTS), transitional housing (TH), and permanent housing (PH) placements among those living in the tent encampment by demographic factors, including racial/ethnic identity, gender identity, and age. To assess for any demographic differences in placement, an analysis was completed comparing those placed in a low-threshold shelter, transitional housing, or permanent housing with those who were placed in traditional emergency homeless shelter (EHS) or who had left the area (LA) and were considered lost to follow-up.

The process of providing shelter and housing options included consideration of their interest in entering low-threshold housing or shelter and additional factors including gender identity, wheelchair accessibility, and whether individuals were part of a couple.

Baseline data for the 145 individuals show 22% identified as Black, 35% Hispanic/Latinx, 39% White and 4% as other (i.e., multi) race who were excluded from the comparative analysis due to their small number (n=7). By gender, 34% identified as female and 65% male (two identified as transgender). By age, 28% were 24-34, 48% were 35-44, and 24% were 45-60 years.

As of January 13, 2022, 70% of individuals had been successfully placed in one of the three low-threshold placement types: 12% in low-threshold shelter (LTS), 49% in transitional housing (TH), and 10% in permanent housing (PH). Those not placed in low-threshold sites include 4% who ended up accessing traditional emergency homeless shelters (EHS) and 26% who had left the area (LA) for unknown reasons/destinations (one individual who entered residential SUD treatment was excluded from the comparative analysis). The percentage achieving placement (either LTS, TH, or PH) was slightly higher for White non-Latinx persons than for Black non-Latinx and Latinx persons (73% vs. 68% and 66%, respectively). These differences were based on small numbers and were not statistically significant ($p=0.59$ and 0.51 , respectively). There was, however, a significant difference by gender with 82% of females compared with 60% of males achieving successful placement ($p=0.03$). Across age groups, 77% of aged 24-34, 70% of aged 35-44 and 75% of aged 45-60 achieved successful placement (LTS, TH, or PH). None of the age group comparisons were statistically significant ($p= 0.42$, 0.85 , and 0.59 , respectively).

Aside from a higher percentage of placement for females compared with males, these data provide qualified evidence that equitable placement across race/ethnicity and age groups was approximated (i.e., as evidenced by statistically significant differences not being observed). While

very small numbers and not statistically significant, these findings highlight the need for continued monitoring and ongoing equity analysis as future low-threshold shelter, transitional housing, and permanent housing resources are deployed.

