Health, Housing & Community Services
Mental Health Commission

To: Mental Health Commissioners
From: Karen Klatt, Commission Secretary
Date: February 19, 2019

## Documents Pertaining to 02/28/19 Agenda items:



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| 5. | Mental Health Manager Update | |
| | • January Mental Health Manager Report<br>• BMH Caseload Statistics for November 2018<br>• February Mental Health Manager Report<br>• City of Berkeley Homeless Outreach and Treatment Team (HOTT) Evaluation<br>• December Mental Health Equity Committee Meeting Minutes<br>• BMH Caseload Statistics for January 2019<br>• BMH Homeless Count at Intake: Open Clients FY17/18<br>• Resolution for Contract: B-Bros Construction, Inc. For the City of Berkeley's Adult Mental Health Services center Renovations Project<br>• BMH Cost Report | **6**<br>**8**<br>**11**<br>**13**<br>**36**<br>**38**<br>**41**<br>**42**<br>**43** |
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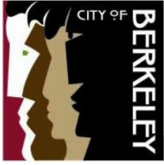


Health, Housing &
Community Services Department
**Mental Health Commission**

**Berkeley/Albany Mental Health Commission**

**Regular Meeting**
**Thursday, February 28, 2019**

**Time: 7:00 p.m. – 9:00 p.m.**

**1947 Center Street**
**Basement, Multi-Purpose Room**

# AGENDA

***All Agenda Items are for Discussion and Possible Action***

***Public Comment Policy:*** *Members of the public may speak on any items on the Agenda and items not on the Agenda during the initial Public Comment period. Members of the public may also comment on any item listed on the agenda as the item is taken up. Members of the public may not speak more than once on any given item. The Chair may limit public comment to 3 minutes or less.*

**7:00 pm** 1. **Roll Call**

2. **PRELIMINARY MATTERS**
   A. **Action Item: Agenda Approval**
   B. **Public Comment**
   C. **Action Item: Approval of the January 24, 2019 Minutes**

3. **Lifelong Presentation** – Brenda Goldstein

4. **Discussion and Action on the nomination and election of the Mental Health Commission Chair and Vice Chair**

5. **Mental Health Manager Updates for January and February** – Steve Grolnic-McClurg

6. **Discussion and Possible Action on Subcommittee Reports**
   -Site Visit Subcommittee
   -Diversity Subcommittee
   -Accountability Subcommittee
   -Membership Subcommittee

7. **Discussion and Possible Action on Mental Health Commission Annual Report**

8. **Role of Commission in Items related to BMH which appear on City Council agenda**

9. **Berkeley Mental Health Staff Announcements/Update**

10. **Prioritize Agenda Items for March Meeting**

11. **Announcements**

**9:00pm** 12. **Adjournment**

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Contact person: Karen Klatt, Mental Health Commission Secretary at 981-7644 or kklatt@ci.berkeley.ca.us.

*Communication Access Information: This meeting is being held in a wheelchair accessible location. To request a disability-related accommodation(s) to participate in the meeting, including auxiliary aids or services, please contact the Disability Services specialist at 981-6418 (V) or 981-6347 (TDD) at least three business days before the meeting date.* ***Please refrain from wearing scented products to this meeting. Attendees at trainings are reminded that other attendees may be sensitive to various scents, whether natural or manufactured, in products and materials. Please help the City respect these needs.*** *Thank you.*

**SB 343 Disclaimer**

*Any writings or documents provided to a majority of the Commission regarding any item on this agenda will be made available for public inspection in the SB 343 Communications Binder located at the Family, Youth and Children's Clinic at 3282 Adeline St, Berkeley.*

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Department of Health,
Housing & Community Services
Mental Health Commission

**Berkeley/Albany Mental Health Commission**
**Unadopted Minutes**

Regular Meeting
January 24, 2019

1947 Center Street
7:00pm
Basement, Multi-Purpose Room

Members of the Public Present: Paul Kealoha-Blake, Clara Rodas.
Staff Present: Steve Grolnic-McClurg, Karen Klatt, Conor Murphy, Leah Talley.

1. **Call to Order at 7:18pm**
   Commissioners Present: boona cheema, Cheryl Davila, Margaret Fine, Shirley Posey.
   Commissioners Absent: Erlinda Castro, Shelby Heda (arrived 7:32pm), Ben Ludke.

2. **Preliminary Matters**
   **A.** Approval of the January 24, 2019 Agenda
   **M/S/C (Davila, Fine) Approve the January 24, 2019 Mental Health Commission Meeting Agenda – PASSED**
   **Ayes:** cheema, Davila, Fine, Posey; **Noes:** None; **Abstentions:** None;
   **Absent:** Castro, Heda (arrived 7:32pm), Ludke.

   **B. Public Comment** – The members of the Public introduced themselves.

   **C. Approval of the December 13, 2018 Meeting minutes**
   **M/S/C (Fine, Posey) Approve the December 13, 2018 Meeting minutes - PASSED**
   **M/S/C (Davila, Fine) Approve the January 24, 2019 Mental Health Commission Meeting Agenda – PASSED**
   **Ayes:** cheema, Davila, Fine, Posey; **Noes:** None; **Abstentions:** None;
   **Absent:** Castro, Heda (arrived 7:32pm), Ludke.

3. **Berkeley Mental Health Fiscal Presentation** – Steve Grolnic-McClurg and Leah Talley – No action taken.

4. **Discussion and Possible Action on Subcommittee Reports** – No action taken.
   -Site Visit Subcommittee
   -Diversity Subcommittee
   -Accountability Subcommittee

5. **Discussion and Possible Motion on a Resolution on Berkeley Police Department's use of Spithoods**

   **M/S/C (Davila, Fine) Refer to the Accountability Subcommittee the Spithood Resolution, and questions we may want to ask the City of Berkeley Police Department on Mental Health and Substance use – PASSED**
   **Ayes:** cheema, Davila, Fine, Heda, Posey; **Noes:** None; **Abstentions:** None; **Absent:** Castro, Ludke.

6. **Motion to re-nominate Paul Kealoha-Blake to the Mental Health Commission**

   **M/S/C (Posey, Davila) Motion to re-nominate Paul Kealoha-Blake to the Mental Health Commission in a Berkeley General Public Interest Seat – PASSED**
   **Ayes:** cheema, Davila, Fine, Heda, Posey; **Noes:** None; **Abstentions:** None; **Absent:** Castro, Ludke.

   *At this point it was 8:53pm and a motion was made to extend the meeting.

   **M/S/C (Heda, Davila) Motion to extend the meeting to 9:15pm – PASSED**
   **Ayes:** cheema, Davila, Fine, Heda, Posey; **Noes:** None; **Abstentions:** None; **Absent:** Castro, Ludke.

7. **Discussion and Possible Action on correspondence received and attached to the MH Commission packet entitled: "Attention Mental Health Commission"** – Mental Health Manager Steve Grolnic-McClurg will forward the email to the Manager of the Housing & Community Services Division.

8. **Discussion and Possible Action on Mental Health Commission Annual Report** – Moved to February Agenda.

9. **Discussion and Possible Action on the Mental Health Commission Chair and Vice Chair elections, of which will be held during the February 28, Commission Meeting** – No action taken.

10. **Discussion and Possible Action on the City of Berkeley's Draft Local Hazard Mitigation Plan** – No action taken.

11. **Discussion and Possible action on "May is Mental Health Month", planning for community gathering hosted by the Mental Health Commission** – No action taken.

12. **Berkeley Mental Health Staff Announcements/Updates** – No action taken. Commission Secretary, Karen Klatt distributed the current Mental Health Commission membership chart.

13. **Berkeley Mental Health Manager Update** – This item was moved to the February meeting agenda.

14. **Prioritize Agenda Items for January Meeting** – Mental Health Manager Updates.

**15. Announcements** – None.

**16. Adjournment** – 9:15pm

Minutes submitted by: ______________________________
Karen Klatt, Commission Secretary

## MEMORANDUM

**To:** Mental Health Commission
**From:** Steven Grolnic-McClurg, Mental Health Manager
**Date:** January 14, 2019
**Subject:** Mental Health Manager Report

Adult Triage Grant

The Mental Health Division has released an RFP for the evaluation services for the Adult Triage Grant, and has approved requisitions for the two staff positions funded through the grant. The division is working through the logistics of incorporating the crisis line into the existing programming.

The Mental Health Division currently operates a Community Assessment and Triage (CAT) team at 1521 University Avenue at the Adult Mental Health Clinic. Community members can contact the CAT team for screening, assessment, and referral to the appropriate level of mental health treatment by either walking into the clinic at 1521 University Avenue between 8 am and 1:30 pm Monday –Thursday or calling the CAT phone line 981-5244 between the hours of 8 am and 4 pm. The funding will support the mental health division in expanding the staffing for the CAT phone line for up to three years.

With the additional funding, this phone line will be available for individuals who are in a mental health crisis to call in order to reach a mental health clinician. The exact hours the new “crisis” services on this phone will be available and the starting date of the new program are not yet set – we anticipate getting the new program up and going in March and will be publicizing this when we have clear hours and a date to start operations.

Residents of Berkeley who are having a mental health crisis can currently call Crisis Support Services of Alameda County 24 hours a day at 1-800-309-2131 to talk with a trained crisis counselor. Residents of Berkeley can also call the Berkeley Police Department (BPD) Non-Emergency number 24 hours a day at 981-5900 to request a MCT evaluation or call 911 if they or a loved one are in a life threatening mental health crisis. This grant funding will allow the Mental Health Division to create another option for individuals who are in crisis to reach help.

Children's Triage Grant

The Mental Health Division is asking City Council for approval to a children's triage grant from the MHOAC for $216,098 on 1/29/19. After getting City Council approval and entering into a contract with MHOAC, this funding will allow the division to add a dedicated crisis clinician at Berkeley High School for the academic year 19-20. Having a dedicated crisis clinician will improve crisis services at the high school and free up other staffing to spend more time doing treatment and referral.

Health Equity

The Health Equity Committee met in December. The group looked at updated demographic data connected to enrollment, medi-cal rates, and closed clients. The data showed that the percentage of African-American clients increased from 34% in FY17 to 37% in FY18. The committee hypothesized that the increase in African American open clients might correspond to increased focus on the homeless population in Berkeley, which, according to the 2017 Point In Time Count, was 50% African-American. While the distribution of closed clients very closely matched the open client distribution, the committee recommended that the division do additional quality assurance to ensure that the reason selected for discharge was uniformly being determined by clinicians. The mental health division has subsequently implemented a new process to ensure this occurs.

Wellness Center

The Mental Health Division will ask City Council on 1/29/19 to authorize the transfer of $750,000 for construction costs at Alameda County Behavioral Health Care Services (ACBHCS) for the proposed Berkeley/Albany Wellness Center. ACBHCS is also slated to get Board of Supervisor approval for the proposed contract and for $750,000 in ACBHCS construction expenses for the Wellness Center.

Adult Clinic at 2640 Reconstruction

Public Works has completed the RFP for a vendor to complete the construction work at 2640 MLK – the old Adult Clinic. The selected vendor's bid was under the most recent cost estimate, and Public Works will be requesting authority from City Council to enter into a contract with that vendor at the 1/29/19 City Council meeting.

## Berkeley Mental Health Caseload Statistics for November 2018

| Adult Services | Intended Ratio of staff to clients | Clinical Staff Positions Filled | # of clients | Monthly Cost Per Participant Per Budget* | Fiscal Year 2019 Demographics as of January, 2019 – Data Incomplete Per YellowFin |
|---|---|---|---|---|---|
| **Adult, Older Adult and TAY Full Service Partnership (FSP) (Highest level outpatient clinical case management and treatment)** | 1-10 for clinical staff. | 6 Clinicians<br>1 Team Lead | 69 | $1,767 | 71 Clients<br>American Indian: 1<br>API: 3<br>African-American: 25<br>Hispanic: 4<br>Other: 23<br>White: 15<br>Male: 44<br>Female: 27 |
| **Adult FSP Psychiatry** | 1-100 | .35 FTE | 56 | $515 | |
| **Comprehensive Community Treatment (CCT) (High level outpatient clinical case management and treatment)** | 1-20 | 9.5 Clinicians<br>.5 Lead Clinician<br>1 Non-Degreed Clinical<br>1 Manager | 163 | $865 | 176 Clients<br>API: 9<br>African-American: 63<br>Hispanic: 7<br>Other: 46<br>White: 51<br>Male: 98<br>Female: 78 |
| **CCT Psychiatry** | 1-200 | 1.0 | 127 | $319 | |
| **Focus on Independence Team (FIT) (Lower level of care, only for individuals previously on FSP or CCT)** | 1-20 Team Lead,<br>1-50 Post Masters Clinical<br>1-30 Non-Degreed Clinical | 1 Clinical Supervisor, I Licensed Clinician, 1 CHW Sp./ Non-Degreed Clinical | 98 | $359 | 101 Clients<br>API: 3<br>African American: 39<br>Hispanic: 3<br>Other: 17<br>White: 39<br>Male: 62<br>Female: 38 |
| **FIT Psychiatry** | 1-200 | .5 | 87 | $346 | |

| Family, Youth and Children's Services | Intended Ratio of staff to clients | Clinical Staff Positions Filled | # of clients | Monthly Cost Per Participant Per Budget* | Fiscal Year 2019 Demographics as of December, 2018 – Data Incomplete Per YellowFin |
|---|---|---|---|---|---|
| **Children's Full Service Partnership** | 1-8 | 2.0 Clinical | 13 | $2,037 | 17 Clients<br>API: 1<br>African-American: 8<br>Hispanic: 2<br>Other: 2<br>White: 4<br>Male: 10<br>Female: 7 |
| **Early and Periodic Screening, Diagnostic and Treatment Prevention (EPSDT) /Educationally Related Mental Health Services (ERMHS)** | 1-20 | 2.5 Clinical | 56 | $879 | 61 Clients<br>API: 4<br>African-American: 22<br>Hispanic: 9<br>Other: 15<br>White: 11<br>Male: 41<br>Female: 20 |
| **High School Health Center and Berkeley Technological Academy** | 1-6 Clinician (majority of time spent on crisis counseling) | 1 Clinical Lead,1.5 Clinical, 5 Interns | Treatment: 70<br>Groups: 12 offered, 9 conducted<br>Drop In (Crisis): 53 | N/A | N/A |

| Crisis, ACCESS, and Homeless Services | Staff Ration | Clinical Staff Positions Filled | Total # of Clients/Incidents |
|---|---|---|---|
| **Homeless Outreach and Treatment Team (HOTT)** | 1-10 Case Manager<br>1-3 Team Lead | 1 Team Lead<br>2 Case Managers | 26 enrolled clients for the month. |

| | | | |
|---|---|---|---|
| | | | 44 non-enrolled individuals received outreach. |
| **HOTT Psychiatry** | 1-100 | 0 | 0 |
| **Mobile Crisis** | N/A | 3 Clinicians, | • 105 Incidents<br>• 42 5150 Evals<br>• 23 5150 Evals leading to involuntary transport |
| **Transitional Outreach Team (TOT)** | N/A | 1 Clinician, 1 Non-Licensed Staff | 62 Incidents |

Not reflected in above chart is Early Childhood Consultation, ACCESS, Wellness and Recovery Programming, or Family Support.

*Monthly Cost To Be Determined – Budget in new format, requires additional analysis to identify treatment team costs.

**MEMORANDUM**

**To:** Mental Health Commission
**From:** Steven Grolnic-McClurg, Mental Health Manager
**Date:** February 19, 2019
**Subject:** Mental Health Manager Report

Homeless Outreach and Treatment Team

The "City of Berkeley Homeless Outreach and Treatment Team (HOTT) Evaluation" was completed by Resource Development Associates. This interim report, which includes quantitative and qualitative data about the HOTT, is included in the packet for the Mental Health Commission this month. The report demonstrates the ways in which the HOTT has become a vital and integral part of the homeless system of care, and is a testament to the compassionate and relentless work done by the staff on the HOTT.

Health Equity

The Health Equity Committee met in January. The group looked at information connected to the rate of homelessness at entry into Berkeley Mental Health and compared the demographics of the homeless population in Berkeley to the open client demographics. As intended by the creation of the HOTT, the data shows that for FY 17/18, 50% of the enrolled clients that year were homeless at intake. The homeless population in Berkeley does somewhat match to the open client demographics at Berkeley Mental Health. The data on clients opened in FY 17/18 also shows that for this fiscal year 48% of newly opened clients were female, while 52% were male. This is a higher percentage of females than in previous fiscal years, and indicates that some of the measures implemented (asking folks if they would prefer to be screened by a woman, more outreach to the Women Day Time Drop In Center) may be working. While the minutes for the committee in January are not finalized, please find attached in the packet the data around homelessness and intakes that was presented as well as the finalized minutes for the group from December.

Wellness Center

The City Council authorized the transfer of $750,000 for construction costs at Alameda County Behavioral Health Care Services (ACBHCS) for the proposed Berkeley/Albany Wellness Center. ACBHCS and the mental health division are working on the contract that will allow the actual transfer of these funds, so that construction work can begin in spring of this year.

Adult Clinic at 2640 Reconstruction

The City Council authorized a contract for the interior renovation and seismic upgrade of the Adult Mental Health Clinic at 2640 MLK. The vendor selected is B-Bros Construction Inc., and the council item authorizes the City Manager to execute a contract in an amount not to exceed $4,886,293. The renovation and upgrade work should begin in spring of this year as well.

FY18 Cost Report

As requested, please find enclosed in this month's packet is the FY18 submitted cost report. The City of Berkeley submits the cost report to ACBHCS, which in turn includes the cost report in their cost report submittal to the Department of Health Care Services. As mentioned in the fiscal presentation at the January MHC meeting, the cost report is the document utilized for final settlements on the earned revenue due to the mental health division from Medi-Cal services.

# City of Berkeley Homeless Outreach and Treatment Team (HOTT) Evaluation

## Evaluation Report

Prepared by:

Resource Development Associates

February 2019

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# Background

The following section describes the City of Berkeley's Homeless Outreach Treatment Team (HOTT) program history, service model, services provided, and the population they served during the evaluation period.

## Berkeley HOTT Program

The City of Berkeley's Homeless Outreach Treatment Team (HOTT) is a homeless outreach and engagement pilot program with the goal of engaging and connecting to homeless individuals currently living on the streets of Berkeley and Albany who have significant mental health needs to potential housing opportunities. This three-year pilot program is 60% funded by the City's Mental Health Services Act (MHSA) resources [a combination of Community Services and Supports (CSS) and Prevention Early Intervention (PEI) funds], 30% from realignment funds, and 10% from the City of Berkeley's General Fund. Given the diversification of program funds, HOTT has the ability to serve the chronically homeless population, while also providing services to individuals with severe and persistent mental illness (SPMI), services for individuals to prevent SPMI, and services to those with functional impairments due to a mental health disorder or high profile problematic behaviors on the streets.

HOTT's program was designed based on an evidence-based practice known as Critical Time Intervention (CTI). CTI provides short-term intervention services for people adjusting to a "critical time" of transition in their lives.[1] It facilitates community integration and continuity of care by ensuring that a person has enduring ties to their community and support systems during a critical period of need.[2] Rather than focusing on direct problem solving, the HOTT program focuses on building trusting relationships with participants to assist them with navigating the complex system between homelessness and long-term success.

In 2017, the HOTT program faced a number of challenges during the first year of program implementation, including limited resources and environmental changes, which led to changes to the original HOTT program's plans. Originally, the HOTT program was planned to have access to housing vouchers in the County system. However, housing vouchers were not available to the HOTT program, causing unanticipated challenges in the first year of implementation. Consequently, the HOTT program team had to think more broadly on how best to help homeless individuals outside of the County system. This situation contributed to a number of challenging circumstances, and the HOTT program staff adapted by being more flexible in their program implementation. In addition, it became apparent the initial list of agencies who can make referrals to the HOTT program excluded some important stakeholders, so the HOTT program expanded the referral sources to include any agencies as well as community stakeholders. Finally, the hiring and retention of a registered nurse proved challenging since the program had a higher demand for case management than nursing skills; thus, the program will be hiring an additional case manager instead of a nurse. In the context of limited resources and staffing shortages, the HOTT program

[1] Center for the Advancement of Critical Time Intervention, (2014). *CTI Model.* Retrieved fromhttps://www.criticaltime.org/cti-model/

[2] Ibid

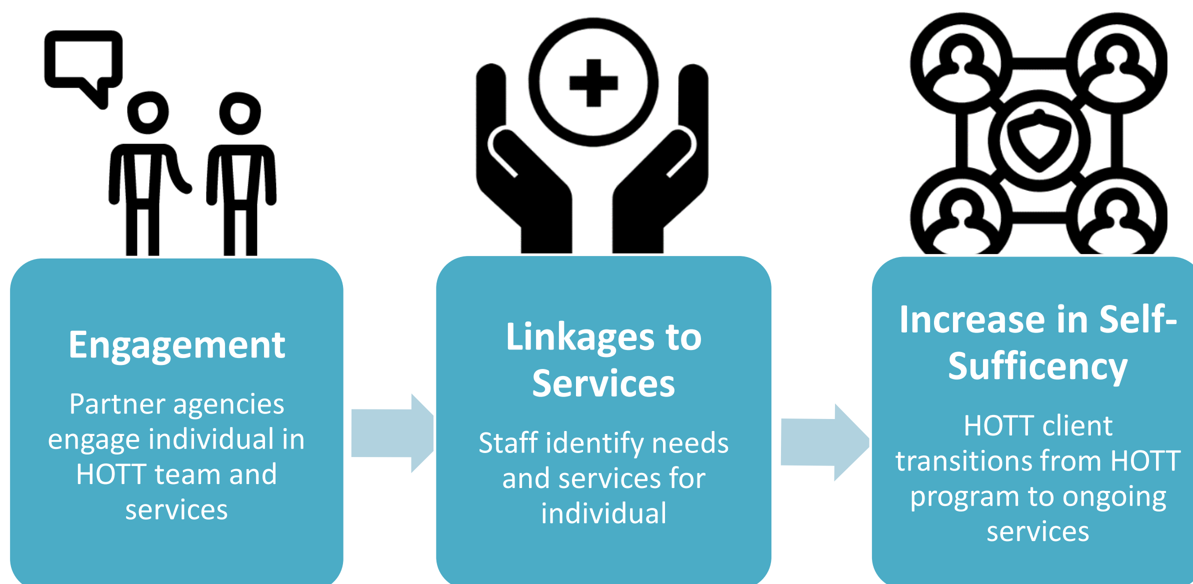
staff adapted by managing program resources and budget judiciously. Despite these challenges, the HOTT program staff have created an impactful and resilient program that effectively engages and helps homeless individuals in Berkeley and Albany.

## Program Service Model

The HOTT program model is characterized by the development of strong trusting relationships with clients; as well as the program staff's flexibility, resiliency, and commitment to adapting to emerging challenges while maintaining patient, respectful, and compassionate engagement with homeless individuals. The core value of the program is providing high quality human engagement that is centered on promoting dignity and community.

The ultimate goal of the HOTT program is to provide support for the client to successfully navigate the challenges during the transition of being homeless. The HOTT program achieves this through outreach and engagement strategies tailored for each individual to: 1) engage individuals in services, 2) link individuals to services, and 3) promote self-sufficiency (Figure 1).

**Figure 1. HOTT Program Activities**




**Engagement.** Within the engagement phase, the HOTT team conducts outreach and engagement to homeless individuals living in the cities of Berkeley and Albany and refers them to appropriate services and partner agencies. The HOTT program manager and case managers work collaboratively to engage individuals and share information about HOTT services with the hope that an individual will agree to participate. The HOTT team also responds to calls from the city to assist with providing supportive services to individuals experiencing homelessness. In addition to the street and encampment outreach efforts to refer and enroll potential participants, the HOTT program has partnered with the Berkeley Food and Housing Project (HUB) – a non-profit organization that provides housing, food, and services – to refer

individuals to HOTT's program and connect them with housing resources. During the HUB's intake process, clients are assessed to identify and prioritize housing for those experiencing chronic homelessness. The intended design was for HOTT to provide immediate short-term housing and wrap around services, while the HUB connects individuals to HUB services and provides permanent housing vouchers, when available. However, given the current shortage of housing resources, the HOTT program does not expect to receive housing vouchers to place potential participants in permanent housing units. The HOTT program still intends to place individuals in alternative housing and link individuals to appropriate services.

**Linkages to Services.** When engaging with individuals, the HOTT team provides referrals to services to address their needs. If an individual agrees to participate in the HOTT program, the HOTT team focuses on immediately connecting the individual to resources that address their current situation, including medical and mental health care, as well as a limited amount of short-term and emergency housing. The case managers assess what supports are needed, which may range from a variety of services, including benefits assistance, referrals to existing services throughout the city and county, food resources, hygiene kits, transportation vouchers, and other goods and services to help support their basic needs and self-sufficiency.

**Increase in Self-Sufficiency.** The overall goal is for HOTT to engage individuals in the program, provide access to needed resources during the program to support the transition from homelessness, and connect the individual to ongoing services likely to prevent further episodes of homelessness and promote health and mental health as well as increased self-sufficiency.

## Target Population

As previously mentioned, the HOTT program serves individuals experiencing chronic homelessness who also may be experiencing severe and persistent mental illness (SPMI) or functional impairments due to a mental health problem. There are no formal eligibility criteria; therefore, anyone that fits the characteristics of the program's target population may participate.

## HOTT Program Staff

In order to meet the needs of the HOTT program's target population, the City of Berkeley's HOTT team is composed of one program manager and four case managers. The program manager oversees and manages the daily program activities, while the case managers' primary focus is to outreach to and engage potential clients as well as provide case management support for clients who choose to work with the HOTT program. Currently there are two case managers, and the program is in the process of hiring two additional case managers. The fourth case manager will be a licensed or license-eligible clinician who will be able to conduct clinical assessments and review Medi-Cal documentation. The program also has one supervisor and one director to provide program oversight, one intern from the Master's in Social Welfare (MSW) program at University of California, Berkeley, as well as administrative staff from the City of Berkeley's Mental Health Division to provide administrative support.

## Evaluation Methodology

The City of Berkeley's Mental Health Division contracted with Resource Development Associates (RDA) to conduct an evaluation of the three-year implementation and outcomes of the HOTT program. Although the HOTT program launched in 2017, data were not yet collected until 2018. Thus, this report summarizes evaluation findings from the pilot program implementation from January 2018 through October 2018.

To effectively measure the implementation of HOTT program activities and outcomes, RDA used a mixed methods approach which utilized data from multiple sources. By utilizing mixed methods, RDA will be able to better understand the client experience and outcomes as well as identify the program strengths and challenges from the clients' perspective.

**Evaluation questions.** The evaluation study design, data collection methods, and data analysis all served to address the following key evaluation questions:

1. To what extent does HOTT identify and sustain engagement of clients with the HOTT team?
2. To what extent does the HOTT team successfully link consumers to ongoing services?
3. To what extent do clients experience a change in housing status and self-sufficiency?
4. To what extent does the HOTT program support the city and county's efforts to reduce homelessness and the impact on the community?

**Data Sources.** RDA gathered quantitative data to understand demographics of clients, goods and services provided, and referrals to HOTT program. In addition, RDA gathered qualitative data through focus groups with program staff and clients to assess staff member and HOTT participant's perspective of outreach and engagement, referrals and case management, and outcomes of clients as a result of program participation. Specific data collection tools are describes in Appendix A.

**Data Analysis.** RDA conducted descriptive statistics for client level data to 1) assess the efficacy of program implementation, 2) determine who is being referred and served, how much and in what ways, and 3) determine the success of the referral and linkage process. RDA analyzed qualitative data from focus groups to better understand quantitative data findings and describe the client and staff experiences. To analyze qualitative data, RDA transcribed responses from focus groups and thematically analyzed responses to identify reoccurring themes and key takeaways. In addition, RDA summarizes impact stories gathered during focus groups. This report presents findings from multiple data sources to tell a complete story of the HOTT program implementation and outcomes achieved throughout the program.

**Limitations.** It is important to note that any key findings that are found from RDA's analysis of process and outcome measures of the HOTT program cannot solely be attributed to the HOTT program, and there may be other factors that influence client and program outcomes. Examples of other factors that can influence client and program outcomes include the availability of permanent supportive housing and other needed resources required to support clients to transition from homelessness and increase self-sufficiency. In addition, program data collection did not start until 2018, so the quantitative data described in this evaluation report does not capture activities conducted in 2017.

## Evaluation Findings

**The HOTT program has achieved substantial accomplishments and created an impactful program approach that distinguishes it from other homeless service programs.** The evaluation data identified the following program achievements and distinctive program characteristics during the evaluation period:

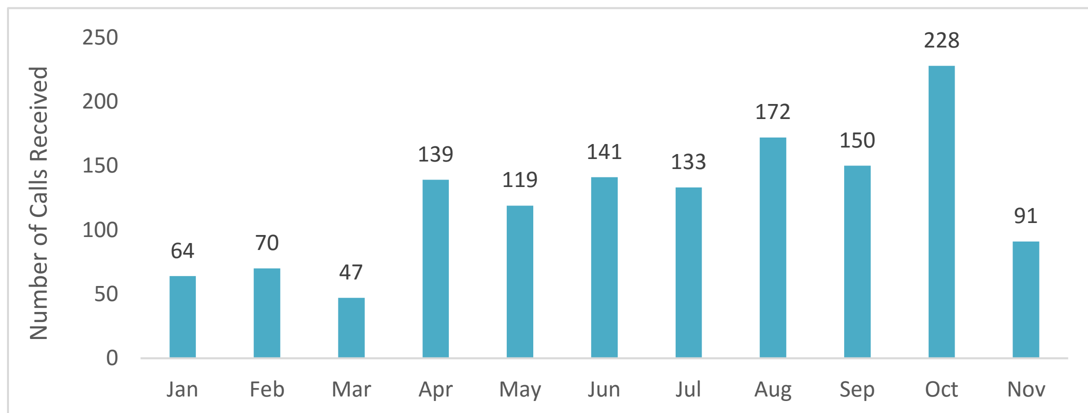
- The HOTT program serves as an important resource for the local community.
- The HOTT program works with anyone and meets them where they are.
- The HOTT Program is rooted in compassion and dignity.
- People experience immediate and tangible support.
- The HOTT program successfully engaged with chronically homeless individuals who had a history of refusing services.
- The HOTT program stays with clients throughout their experience navigating the system.
- Despite challenges in navigating housing system, the HOTT program has successfully connected homeless individuals to housing.

The following section discusses the evaluation results supporting the key findings listed above.

### The HOTT program serves as an important resource for the local community

The Berkeley HOTT program's Office of the Day (OD) responds to calls and inquiries from the community. Responses were either by phone, email, or in person. In 2018, Berkeley HOTT staff assigned to OD duty responded to 1,354 inquiries with two-thirds of inquiries (n=902) being in person and one-third of inquiries (n=450) being over the phone.[3] Many OD calls came from the community (e.g., residents, businesses) and City of Berkeley partners (e.g., mental health, crisis response, and law enforcement).

**Figure 1. Number of Calls or Inquiries Received by Berkeley HOTT Program, by month, 2018 (n=1,354)**



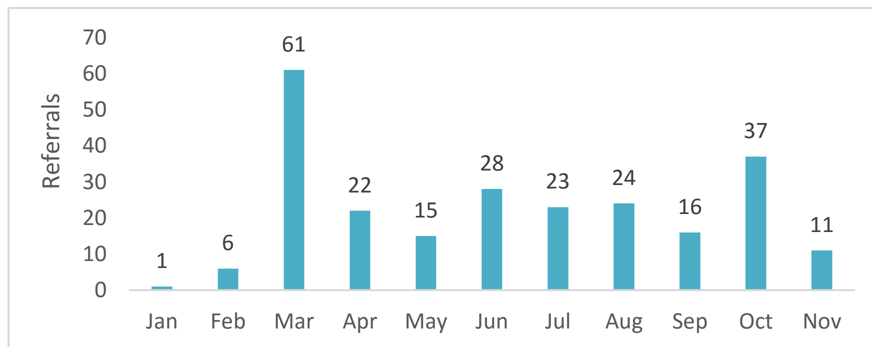

[3] The cumulative total is higher, since this estimate does not include calls in 2017.

Overall, the HOTT program is an important resource for the homeless population as well as local businesses, city programs, shelters, and all entities that are interconnected with the issue of homelessness. The majority of inquiries (67%) were made over the phone and the rest (33%) were inquiries made in person with HOTT program staff while they were in the field. Nearly half of inquiries (47%) were related to the referral of individuals in need of housing, medical or mental health services, disability services, benefits, transportation, or other basic needs. The rest of the calls were either a follow-up or check-in with existing HOTT clients (15%), referral to shelter or temporary housing (13%), referral of individuals needed for general outreach services (12%), referral to HOTT or BACS (3%), or other reasons (1%). Many OD inquiries (17%, n=227) resulted in the referral of an individual to the HOTT program.

> "We respond as soon as possible. Usually responding quickly is something that people appreciate, especially when they are calling about people."
> – Berkeley HOTT Program Staff

In 2018, there was a total of 244 referrals to the HOTT program for 205 unique individuals.[4,5] As shown in Figure 2, the Berkeley HOTT program received a large number of referrals in March 2018, likely due to heightened awareness of the program throughout the city, and then received steady referrals after this point.

**Figure 2. HOTT Program Referrals Received, 2018 (n=244)**

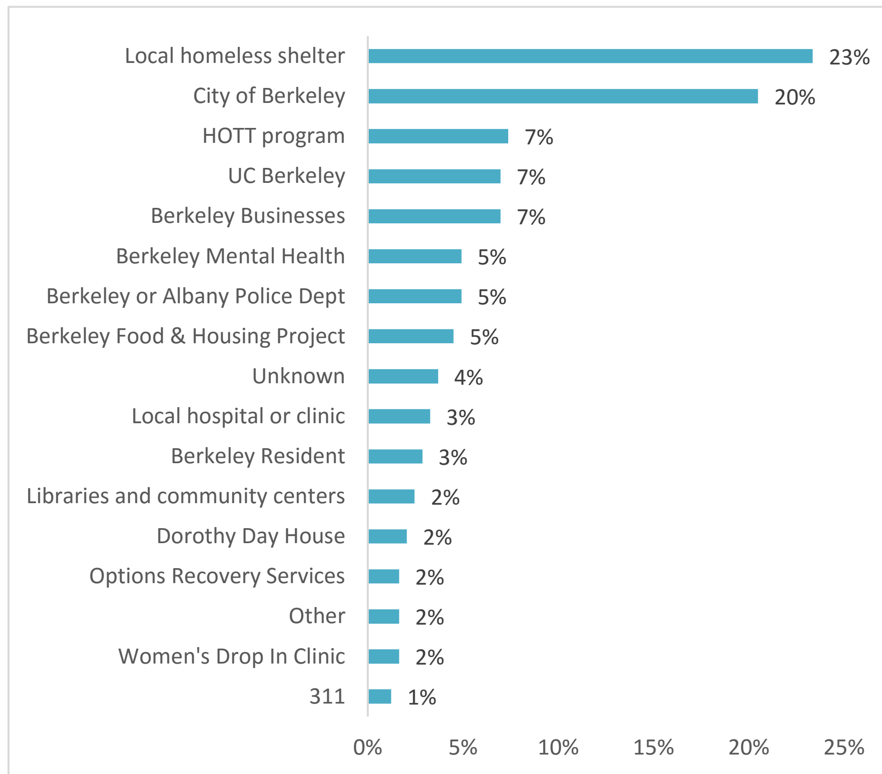



Referrals came from many different stakeholder groups, but the majority of HOTT referrals came from the following sources: local homeless shelters (23%), City of Berkeley (10%), Berkeley HOTT program staff (7%), Berkeley Food & Housing Project (7%), UC Berkeley (7%), Berkeley Mental Health (5%), and Mobile Crisis Team (5%) (Figure 3). In addition, a small number of referrals were self-referrals from the homeless community.

[4] The cumulative total is higher, since this estimate does not include referrals in 2017.

[5] Names of referred individuals was often not provided or inaccurate.

**Figure 3. HOTT Program Referral Sources, 2018 (n=244)**




Furthermore, the HOTT program has successfully collaborated with other government agencies, service providers, and homeless shelters to provide coordinated support during a homeless individual's greatest time of need. Based on client responses in focus groups and the diversity of referral sources, the HOTT program has served as a connector of gaps in the system and an important resource for the City of Berkeley.

> "We have a lot of collaboration with Alta Bates and fire department. If they know of a client that is coming out of the hospital that needs a place to stay, then we provide a motel voucher."
> – Berkeley HOTT Program Staff

The following impact story highlights how Berkeley HOTT program successfully collaborated with a local hospital and temporary housing partners to connect a family with services during a critical transition.

**Impact Story from Berkeley HOTT Program Client[6]**

Sarah and Tim are a young couple. As they were expecting a child, they struggled to pay their rent and were evicted from their home. Up until going to the hospital for the birth, they stayed in shelter homes in Berkeley. Through the coordination of the local hospital and the HOTT program, the couple and their newborn baby was able to have a safe, warm place to stay while they waited for their permanent supportive housing application to be processed.

> *"My wife and I just had a baby at the local hospital, and when we got discharged from the hospital after my wife gave birth, we had nowhere to go. The HOTT team worked with the hospital to make sure that we had a safe warm motel room to stay in while we figured out what to do. The HOTT team helped us figure out how to get into a housing program and do the housing application. They stayed with us to help with the application through every step of the way. Now, we are still staying at the hotel but waiting for our application to get approved so we can finally have a more stable home for us and the baby."*

## The HOTT program works with a diverse group of vulnerable individuals and serves people regardless of their background or circumstance

The HOTT program staff engages with individuals with diverse backgrounds and circumstance no matter where they were in the spectrum between insecurely housed and chronically homeless.

The majority of the 205 individuals referred to the HOTT program had a history of being chronically homeless (80%), having mental illness (62%), being hospitalized (35%), having alcohol or substance use issues (40%), or being incarcerated or arrested (23%). Half of referred individuals (51%) had high profile problematic behaviors in public and the majority (66%) of referred individuals were unsheltered. The HOTT program served people from diverse backgrounds, as shown in the demographic profile below:

- **Age.** The average individual was 47 years old (ranging from 21 to 81 years).
- **Language.** Most individuals (77%) spoke English.
- **Race.** Most individuals referred were Black or African American (34%), White (33%), or not reported (25%); among those with some other race (8%), Asian and American Indian or Alaska Native race were represented but exact numbers are not reported to protect client confidentiality.
- **Ethnicity.** Most individuals (67%) were not Hispanic.
- **Income.** Among the 116 individuals reported a primary income source, most individuals had supplemental security income sources (68%) or no income source (32%).

[6] Names have been changed to protect client confidentiality.

See Appendix B for a detailed table describing the demographic profile of referred individuals.[7]

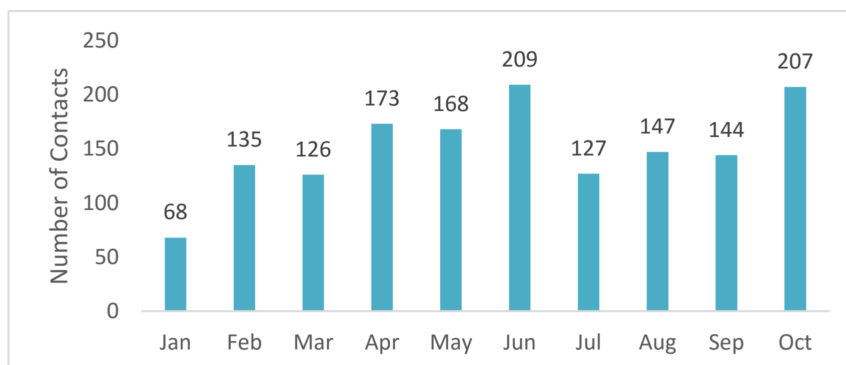
The HOTT program conducted self-sufficiency assessments with 30 individuals, the majority (57%) of whom were formally enrolled in the program. Most (90%) were chronically homeless and were assessed to be highly vulnerable (i.e., scored low on self-sufficiency assessment) when they initially made contact with the HOTT program, particularly in the domains of housing, mobility, and family and social relationships. See Appendix C for self-sufficiency matrix scores among enrolled clients.

## The HOTT program provides intensive outreach and engagement to meet clients where they are at, both literally and figuratively

HOTT program staff met with clients where they were physically located, and they also met clients figuratively in a way that valued where they were in terms of their trust in public agencies and their mental or emotional state. The majority (60%) of contacts were done in-person where the client was located or needed support (e.g., community, park, encampment, motel), while other contacts were done over the phone (34%) or at a site where client received services (e.g., DMV, clinic) (4%). Community locations included the Dorothy Day Breakfast, People's Park, local homeless shelters, Women's Drop-In Clinic, Civic Center Park, encampments, and Berkeley Public Library.

Berkeley HOTT team conducted a total of 1,506 outreach and engagement contacts for 319 unique individuals in 2018.[8] As shown in Figure 4, the Berkeley HOTT team gradually conducted more contacts over the course of the year. The HOTT team conducted outreach and engagement averaging 42 minutes per encounter (range 1 minute – 7 hours), with an average of 5 encounters per person (median 1 encounter, range 1 – 74 encounters). Although engagement periods with clients ranged broadly between one day and 16 months, most engagement periods only lasted approximately one day or less.

**Figure 4. Number of Contacts with Clients, 2018 (n=1,504)[9]**




[7] Demographic data were only collected from referred individuals and enrolled individuals; demographic data were not collected for every engaged individual since the personal inquiries may be disengaging and counterproductive towards building trust.

[8] The cumulative total is higher, since this estimate does not include contacts in 2017.

[9] Contact dates were unknown for two encounters.

The HOTT program formally enrolled 37 individuals who received longer and more intense engagement periods compared to non-enrolled individuals, with an average engagement period of 5 months (range 1 day - 16 months) and an average of 24 encounters per person (range 1 – 74 encounters) (

Table 1).

**Table 1. Engagement Period by Enrollment Status, 2018**

| | Non-Enrolled Clients (n=282) | Enrolled Clients (n=37) |
|---|---|---|
| **Encounters per person** | | |
| Average | 2 | 24 |
| Range | 1-39 | 1-74 |
| **Length of Encounter per person** | | |
| Average | 33 minutes | 49 minutes |
| Range | 0 - 420 minutes | 0 - 390 minutes |
| **Length of Engagement Period per person** | | |
| Average | 22 days | 152 days |
| Range | 1-279 days | 1-469 |

HOTT program staff also met with homeless individuals in a style that was effective and met them where they were in terms of their mental and emotional state, as well their trust in others. Through multiple attempts to engage individuals and build trust, HOTT program staff tailored their approach based on the individual's values and needs, and connected with them in a way that is effective for them.

"Sometimes, they'll take off on foot when they see us coming. We just kept coming and they noticed that we don't give up easy. We know people need things and we come back and check in."

– Berkeley HOTT Program Staff

After an initial outreach, the HOTT program staff would make multiple attempts to engage with homeless individuals and build trust. At each visit, they approached the client with an open mind and compassionate heart, and inquired how they can help him or her out. Sometimes, it would take several visits and check-ins to establish trust with the individual. Nearly half (49%) of the 37 individuals formally enrolled into the HOTT program required substantial initial outreach and engagement to build trust and rapport, which took an average of 36 days (range 1 day – 3.5 months) and 2 encounters (range 1-5 encounters). All outreach and engagement efforts were tailored to the needs and preferences of the client. Through these efforts, the HOTT program staff successfully engaged with chronically homeless individuals who had a history of refusing services.

"They kept coming for months and never gave up on me. And I eventually gave in. In other programs, after the 'soft handover', we never see them anymore and it becomes hard. But I know the HOTT team is there for me."

– Berkeley HOTT Client

## The HOTT program is rooted in compassion and dignity

The HOTT program's approach rooted in compassion and dignity helped build strong relationships and trust with the homeless community. Clients described the HOTT program staff as open-minded, honest, caring, authentic, thorough, respectful, and compassionate. They highlighted the importance of their team-based approach.

> "They are always checking in to see what we need, like meaningful stuff. They listen to people, really care, and really want to help. "
>
> – Berkeley HOTT Client

Clients expressed appreciation for the HOTT program's staff approach rooted in authentic compassion when offering services, while maintaining respect and promoting dignity. For example, HOTT program staff often provided encouragement and empowerment for clients; they will accompany clients the first time they go to a new provider, and then provide clients with a bus pass for their next appointment. This incremental approach towards building self-sufficiency has been impactful for clients.

> "Respecting people's space is the biggest part. When somebody is sleeping, you don't go there to wake them up. Approach is very important in knowing when or when not to. We're very sensitive about this. When someone says 'not today', we don't press further."
>
> – Berkeley HOTT Program Staff

Oftentimes, clients want to stay connected to HOTT program staff and continue fostering relationships even after they are housed. The HOTT program serves to encourage them to maintain secure housing and continue to promote their self-sufficiency.

The following impact story summarizes how Berkeley HOTT program was able to reconnect an individual with critical medical services and give him the support and resources to life his life with dignity.

**Impact Story from Berkeley HOTT Program Client[10]**

John has had a transient lifestyle for most of his life and had long given up on the system or asking for help. However, his harsh living conditions contributed to his failing health. The HOTT program gave him newfound hope in his worst moment, and convinced him to seek medical services at urgent care after neglecting medical attention for six years. The program gained his trust and helped him access much needed hospice care services and secure housing. Now he is stably housed in a hospice home.

> *"I would still be on the streets and probably dead if it wasn't for HOTT. I could have died and no one would have cared. Doctors told me I had months to live and I gave up on living. I gave up on everything for help. No one cared but the HOTT team did care. I'm the type of person that never asks for help, and here they were offering to help and they never gave up on me. I lived on the same spot for six years and never got medical care. They checked up on me and came back multiple times, even though*

[10] Names have been changed to protect client confidentiality.

*I was turning them away in the beginning. I figured HOTT team was just like the other programs where they would just disappear after the first meeting. But I know the HOTT team is there. And everything the HOTT team said they would do came true. Now I am in hospice care getting the care that I need. I don't know how much longer I have to live, but it's a hell of a lot longer than a couple months which is what the doctors said. This gives me the opportunity to live my life with dignity. The HOTT team provided me with the positive energy just like hospice care that is so needed for people like me."*

## People experience immediate and tangible support

"We roll with the change and see how we can fit into the system to help. We find the best way to strategize and get the process going. We have close relationships with other agencies."
- Berkeley HOTT Program Staff

Part of the critical factor that successfully engaged people to be connected to services again was the HOTT team's ability to provide immediate and tangible support. Clients perceive the HOTT program as being different than other homeless outreach programs they've interacted with. Clients noted that the persistence and resourcefulness of the HOTT program staff helped them get immediate and tangible support. In particular, clients who participated in the focus group highlighted the following goods and services as being most helpful in their times of need:

- "Helping me to keep appointments and follow-up appointments."
- "I was able to get social security card and SSI. This made a huge impact in my life."
- "Basic meaningful human things that I need, like medical care and the safety kit and health kit."
- "SSI changed my life. I was able to pay off rent and get groceries and they referred me to ACT."
- "Housing vouchers"
- "Bus pass"
- "Motel stays"

"They relate to me. And so I am more likely to open up to them and get the sufficient help that I need."
- Berkeley HOTT Client

Clients reported that goods and resources provided by the HOTT program helped them regain a sense of dignity and hope. The Berkeley HOTT team provided a total of 2,203 goods in 2018 to support homeless individuals, including housing vouchers (n=352), medical supplies (n=292), goods for shelter (n=127), goods to help them get connected to benefits (n=108), food (n=107), housing application (n=80), bus passes (n=67), identification card (n=64), information about services and resources (n=49), hygiene kit (n=27), blanket and bedding (n=10), and other goods (n=920).[11,12] HOTT program staff described the importance of helping clients understand the link between required documentation (e.g., identification card) and housing. HOTT staff noted that many

[11] Other goods included information and handouts about existing programs and services, clothing and shoes, disability supplies, phone call assistance, and food.
[12] The cumulative total is higher, since this estimate does not include goods and services provided in 2017.

clients were often not in the mental or emotional space to make those connections, so they make efforts to have conversations with clients to establish that link.

In addition to items to support their basic needs, the Berkeley HOTT program made 921 referrals in 2018 for homeless individuals to many critical services and resources, including services for transportation (n=192), local homeless shelter (n=162), health (n=121), mental health (n=96), community resource centers (n=73), legal support (n=58), social services (n=38), and other services (n=181).[13,14] Individuals formally enrolled in the HOTT program received a higher number of goods and referrals per person compared to non-enrolled individuals (Table 2).

**Table 2. Goods and Service Linkages Provided, by Enrollment Status, 2018**

| | Non-enrolled Clients (n=282) | Enrolled Clients (n=37) |
|---|---|---|
| **Goods Provided** | | |
| Total Goods | 847 | 1,356 |
| Total Persons Served | 274 | 33 |
| Average Per Person | 3 | 41 |
| **Referrals Provided** | | |
| Total Referrals | 323 | 598 |
| Total Persons Served | 127 | 31 |
| Average Per Person | 3 | 19 |
| **Benefits Program Enrollments** | | |
| Total | 44 | 73 |
| Total Persons Served | 23 | 15 |
| Average Per Person | 2 | 5 |
| **Mental Health Program Enrollment** | | |
| Total | 22 | 32 |
| Total Persons Served | 7 | 8 |
| Average Per Person | 3 | 4 |

The HOTT program helped facilitate linkage to services through referrals as well as enrollments into benefits or mental health programs. The HOTT program enrolled a total of 38 individuals into benefits programs and 15 individuals into mental health programs. Individuals formally enrolled in the HOTT program had a higher rate of enrollment into benefits or mental health programs compared to non-enrolled individuals (Table 2).

The following impact story describes how a Berkeley HOTT program client struggled with getting support as a chronically homeless person and the Berkeley HOTT staff were able to connect him to services and help him navigate the complex system of public services and resources.

[13] Other services included assistance at DMV, AC3, Options program, pharmacy, housing programs, senior services, hospital or emergency department, medical supply centers, and food pantry.
[14] The cumulative total is higher, since this estimate does not include referrals and enrollments made in 2017.

**Impact Story from Berkeley HOTT Program Client[15]**

Gary is a middle-aged man who is a native to Berkeley. He has been chronically homeless for nearly 20 years. He experienced frustration and closed doors when he first lost housing and tried to gain access to homeless support programs and services. After many years of living without secure housing and giving up on the system, he describes the HOTT program as a different type of program that finally was able to help him get housing when no one else could.

> *"I wouldn't be where I am today without them. In the beginning, I thought I was going to be homeless for a couple months, maybe 6 or 7 months at most. I lived out of my van and thought I just needed to get connected to the right programs that could help me through this rough patch. I'm a Berkeley native, born and raised. This is my home. When I was first homeless, it was really difficult to navigate through all the long list of agencies and the cycling of endless referrals. I went through the whole list of 28 people to call, and no one was able to help me. They kept referring me to each other. I got frustrated and fed up. I was on the streets after that for 17 years and had given up on the system. Then I met the HOTT team and that all changed. This was the first time that anyone from City of Berkeley did anything and in a short amount of time. It was amazing. Other programs have directed me to a website. I know how to navigate a website. What I need is actual help. And the HOTT team has connected me to those services and resources that I really needed. Now I am safely housed and have a key to my own home!"*

## The HOTT team successfully engaged with chronically homeless individuals who had a history of refusing services

Clients reported how they were moved by the multiple attempts and persistence of the HOTT program staff. They have experienced many other government programs which made an attempt and never came back, or they made promises they did not keep. This inconsistency from public systems caused many homeless individuals to lose faith in the system. The HOTT program staff familiarized themselves with the homeless communities in different areas throughout Berkeley, and established a presence among those communities. By becoming a familiar face, they were able to earn the trust and respect of individuals who would then open up and share their hardships.

> "The first thing they see is the badge and they think we are here for enforcement. So I always come at them offering services. Then, they change their behavior once they realize that we are not here for enforcement. They start to feel a little more trust after seeing you the second and third time."
>
> – Berkeley HOTT Program Staff

[15] Names have been changed to protect client confidentiality.

Clients reported dealing with various crisis situations, such as having just gotten their stuff stolen or dealing with health issues, when the HOTT program staff approached them. They reported how the extra support from the HOTT program staff helped them through those crisis situations. In some cases where a client is having a mental health crisis, HOTT program staff have referred them to mobile crisis to get immediate support to get the individual to a safe healing space to recover.

"We've worked with people who have not had medical care for years, and we were able to link them back to medical care."
– Berkeley HOTT Program Staff

The following impact story summarizes the experience of two Berkeley HOTT program clients who were able to connect to supportive services in a way that matched their values and needs:

**Impact Story from Berkeley HOTT Program Client[16]**

Fred is a middle-aged man with disabilities. He and his sister, Ruth, are native to Berkeley and have been chronically homeless for many years. They have a close relationship and are crucial social supports for each other. The HOTT program recognized the importance of their values and social connections, and worked with the siblings to find an apartment they could live in together.

> *"I used to live with my sister under the bridge in Berkeley, where we were minding our own business and living day by day. We found out about housing programs, but none of them would let us be housed together. And there was no way that we were going to leave each other. That's not who we are. It's just not right if one of us gets housed, and the other has to stay in the streets. So we decided to stay together in the encampment. We didn't know of any other way until the HOTT team found us and started talking to us. First thing they did was get me a wheelchair which I need because of my disability. I thought, 'Wow, they really mean what they say and can do what other programs cannot.' The electric wheelchair has been a lifesaver and really changed my life for the better. Then, they helped me and my sister do the housing application and find a place where we can live together. It was unbelievable. Now, me and my sister live together in an apartment and we are very happy being housed together because we support each other every day."*

## The HOTT program stays with clients throughout their experience navigating the system

One of the critical aspects of the HOTT program highlighted by clients was feeling like they were not alone in the process of navigating the system while homeless. Many clients discussed the hardship of being homeless and the daily struggles they dealt with, which made it even more difficult to navigate the system on their own.

"The HOTT team takes you through every part of the process, which is really hard to do on your own."
- Berkeley HOTT Client

[16] Names have been changed to protect client confidentiality.

Furthermore, past experiences with failed public services and resources left many clients feeling distrustful and frustrated.

Clients noted that the HOTT program is different from other government programs, particularly because the staff stay with clients as they navigate the different parts of the system. For example, in addition to referring clients to a disability program, the HOTT program staff provide other supports, such as reminders about their appointment, accompanying clients to appointments, and providing bus passes to help clients get to their next appointment. This is particularly helpful for many of the clients who were homeless, vulnerable, with low self-sufficiency, and oftentimes faced other challenges that exacerbated their situation, such as mental health, disability, or substance use.

The following impact story summarizes how a Berkeley HOTT program client received critical linkages to supportive resources and services during his period of homelessness, which started him on a path towards housing, self-sufficiency, stability, and sobriety.

**Impact Story from Berkeley HOTT Program Client**[17]

David is a middle-aged man who became unexpectedly homeless. The HOTT program helped him rebuild his life, obtain sobriety, and regain his sense of well-being and stability.

> *"Because of my alcohol addition, I lost my job, my wife divorced me, and wouldn't let me see the kids. I could not even go back to my own home. I had nowhere to go but to sleep on the streets and shelter. I did not know what to do, or where to start, or who to ask for help. Everything just spiraled out of control and I hit rock bottom. I was really not doing well, mentally and physically. Then, I was referred to the HOTT team and they helped me figure out how to access services and find programs that can help people who are like me. Now I have a home to go to, I'm staying sober and attending support groups to recover from my addition, and I'm working on building back my relationships with people."*

## Despite challenges in navigating housing system, the HOTT team has successfully connected homeless individuals to housing

> "The people we put in rapid-rehousing have maintained their housing and their health has improved."
> – Berkeley HOTT Program Staff

Both HOTT program staff and clients highlighted the difficulty of navigating the housing system. They reported the housing application process as rigid and cumbersome. Despite these challenges, the HOTT program was able to address barriers and connect a total of 83 individuals to housing opportunities. Among the 68 individuals who were connected to temporary housing, such as shelters and motels, 32% (n=22) were formally enrolled in the HOTT program. Among the 17 individuals who were connected to permanent housing, 47% (n=8) were

[17] Names have been changed to protect client confidentiality.

formally enrolled in the HOTT program. Among individuals connected to permanent housing, the HOTT program engaged with them for an average of 5 months and had an average of 23 encounters with them.

# Discussion

Through the HOTT program, the City of Berkeley has added a crucial link between public systems that has helped homeless or housing-insecure individuals connect to supportive services and resources. In addition, the HOTT program has connected with chronically homeless individuals who have historically been disconnected from the system and disengaged from previous outreach efforts. The establishment of strong relationships and values as a foundation of trust is a critical component of HOTT program's service model, which can inform other outreach programs in City of Berkeley who are trying to engage with chronically homeless individuals.

The following section describes recommendations on ways to improve this important program, as well as next steps for future evaluation reports.

## Recommendations

**Continue to build awareness of the HOTT program in community.** The HOTT program staff have relied primarily on outreach and word-of-mouth to inform the community about what HOTT program does and have been effective building awareness of the program in this way. Now that the program is established, it may benefit from looking at opportunities to further build awareness of the program through outreach activities aimed at other groups, such as community organizations and government agencies.

**Continue to build capacity to address clients' mental health challenges.** The HOTT program has demonstrated the powerful impact of coordination between public agencies and local homeless shelters. Because many homeless individuals are struggling with stress, mental health issues, substance use, and crisis, it is important for the HOTT program and behavioral health services agencies to collaborate closely to reduce stigma and connect people to critical mental health services. In addition, recruiting a licensed or license-eligible clinician into the HOTT program team or seeking mental health training opportunities for HOTT program staff would increase the HOTT program's capacity to assess mental health needs and connect clients to appropriate services and resources.

**Refine data collection process to track changes in clients' housing status.** Linkage to stable housing is one of the primary goals of the HOTT program so it is important to track clients' housing status, particularly among clients who were connected to housing services through the HOTT program. HOTT program staff should seek ways to improve the data collection processes for housing status data. This will help inform future evaluation reports and better capture housing outcomes for HOTT program clients.

**Continue to build staffing capacity and resources available to the HOTT program.** The HOTT program staff have demonstrated resilience and resourcefulness during their first year of implementation. However, staff hiring and retention challenges have strained the resources available to the HOTT program. Challenges were further exacerbated by the time-limited nature of the program, which led to hiring staff

on a contract basis rather than a permanent basis. To the extent possible, the program should focus efforts on ensuring there are adequate program staff and resources in place in subsequent years; this is especially important since awareness of the program will likely increase over time, and the HOTT program would then receive more referrals and clients.

## Next Steps

RDA will continue to work with HOTT program staff to collect data to inform future evaluations. Future reports will have larger sample samples, allowing RDA to conduct more rigorous analysis on client outcomes and program impacts.

# Appendices

## Appendix A. HOTT Program Evaluation Data Sources

- **HOTT Contact Form.** The contact form captured the encounters that the HOTT team had with clients. The form was used to gather data on the location of the interaction, time spent by staff during the engagement, and any outcomes as a result of the interaction. This form was completed for all persons who engaged with HOTT program staff.
- **HOTT Referral Form.** This form tracked the name of the agency that referred a potential client to the HOTT program. Client demographic information (such as age, ethnicity and race, income, primary language, insurance type, and current living situation) were also captured. The form also indicated whether or not a person had experienced the following: chronic homelessness, mental illness, hospitalization, incarceration or criminal justice involvement, drug/alcohol use, and high visibility/problematic street behavior. This form was completed for all persons who were referred to the HOTT program.
- **HOTT Client Intake and On-Going Assessment Form.** The intake assessment was used to gather demographic client data, gather baseline information of client needs, and identify any services provided during that intake process. The on-going assessment form was administered on a quarterly basis and was used to assess changes in client needs and housing status. This form was completed for all persons who formally enrolled in the HOTT program.
- **Self-Sufficiency Matrix.** The Self-Sufficiency Matrix is a peer-approved resource[18] adapted for this program and evaluation, which provides a high-level picture of a client's status across a number of domains. HOTT program staff completed the Self Sufficiency Matrix at intake and on a quarterly basis thereafter to assess changes in clients' self-sufficiency over time. This was completed for all persons who formally enrolled in the HOTT program.
- **HOTT Office of the Day (OD) Tracking Log.** The HOTT OD Tracking Log captured all calls from the city requesting the HOTT team to respond to a public concern regarding homelessness within the city.
- **Focus Groups with Clients.** RDA facilitated focus groups with HOTT clients to gauge clients' experiences with HOTT staff and services. Before beginning the focus groups, the intention of the focus groups was explained and informed consent was obtained from all participants. In addition, consent was obtained from clients who agreed to share their impact story in the report.
- **Focus Groups with Staff.** RDA will facilitated focus groups with HOTT program staff to explore staff members' experiences throughout the referral, outreach, and engagement process and gain an understanding of the successes and challenges of program implementation. Before beginning the focus groups, the intention of the focus groups was explained and informed consent was obtained from all participants.

[18] (2009, September). *HMIS Self-Sufficiency Matrix (Sample).* Retrieved from https://www.hudexchange.info/resource/1625/hmis-self-sufficiency-matrix-sample/

## Appendix B. Demographic Profile of HOTT Program Clients

**Table 3. Demographic Profile of Individuals Referred to HOTT Program (n=244)**

| Demographic | N | Percent |
|---|---|---|
| **Race** | | |
| Black or African American | 82 | 34% |
| White | 81 | 33% |
| Unknown | 61 | 25% |
| Other | 20 | 8% |
| **Ethnicity** | | |
| Non-Hispanic/Non-Latino | 164 | 67% |
| Hispanic/Latino | 25 | 10% |
| Unknown or Refused | 54 | 22% |
| **Language Spoken** | | |
| English | 188 | 77% |
| Other | 9 | 3% |
| Unknown | 47 | 19% |
| **Homeless Status** | | |
| Sheltered | 50 | 20% |
| Unsheltered | 156 | 64% |
| Unknown | 38 | 16% |
| **Primary Income Source** | | |
| SSI | 54 | 22% |
| None | 37 | 15% |
| SSDI | 11 | 5% |
| Other | 14 | 6% |
| Unknown | 128 | 52% |

## Appendix C. Self-Sufficiency Matrix Scores for HOTT Program Clients

**Table 4. Self-Sufficiency Matrix Scores for HOTT Program Clients at Intake (n=30)**

| Domain | Average Score | Interpretation |
|---|---|---|
| **Housing** | 1.3 | 1 = Homeless or threatened with eviction<br>2 = In transitional, temporary or substandard housing; and/or current rent/mortgage payment is unaffordable (over 30% of income). |
| **Income** | 2.2 | 2 = Inadequate income and/or spontaneous or inappropriate spending.<br>3 = Can meet basic needs with subsidy; appropriate spending. |
| **Food** | 2.4 | 2 = Household is on food stamps.<br>3 = Can meet basic food needs, but requires occasional assistance. |
| **Insurance** | 4.3 | 3 = Some members (e.g. children) have medical coverage.<br>4 = All members can get medical care when needed, but may strain budget. |
| **Life Skills** | 2.5 | 2 = Can meet a few but not all needs of daily living without assistance.<br>3 = Can meet most but not all daily living needs without assistance. |
| **Family and Social Relationships** | 1.9 | 1 = Lack of necessary support form family or friends; abuse (e.g., domestic violence abuse, child abuse) is present or there is child neglect.<br>2 = Family/friends may be supportive, but lack ability or resources to help; family members do not relate well with one another; potential for abuse or neglect. |
| **Mobility** | 1.9 | 1 = No access to transportation, public or private; may have car that is inoperable.<br>2 = Transportation is available, but unreliable, unpredictable, unaffordable; may have care but no insurance, license, etc. |
| **Community Involvement** | 2.1 | 2 = Socially isolated and/or no social skills and/or lacks motivation to become involved.<br>3 = Lacks knowledge of ways to become involved. |
| **Legal** | 3.9 | 3 = Fully compliant with probation/parole terms.<br>4 = Has successfully completed probation/parole within past 12 months, no new charges filed. |
| **Mental Health** | 2.6 | 2 = Recurrent mental health symptoms that may affect behavior, but not a danger to self/others; persistent problems with functioning due to mental health symptoms.<br>3 = Mild symptoms may be present but are transient; only moderate difficulty in functioning due to mental health problems. |
| **Substance Use** | 2.9 | 2 = Meets criteria for dependence; preoccupation with use and/or obtaining drugs/alcohol; withdrawal or withdrawal avoidance behaviors evident; use results in avoidance or neglect of essential life activities.<br>3 = Use within last 6 months; evidence of persistent or recurrent social, occupational, emotional or physical problems related to use (such as disruptive behavior or housing problems); problems have persisted for at least one month. |
| **Safety** | 2.3 | 2 = Safety is threatened/temporary protection is available; level of lethality is high.<br>3 = Current level of safety is minimally adequate; ongoing safety planning is essential. |
| **Disabilities and Physical Health** | 2.1 | 2 = Vulnerable – sometimes or periodically has acute or chronic symptoms affecting housing, employment, social interactions, etc.<br>3 = Safe – rarely has acute or chronic symptoms affecting housing, employment, social interactions, etc. |

| **Legend:** | 1 = In Crisis | 2 = Vulnerable | 3 = Safe | 4 = Building Capacity | 5 = Empowered |
|---|---|---|---|---|---|

# MENTAL HEALTH EQUITY COMMITTEE MINUTES

December 5, 2:00PM-3:00PM

Co-Facilitators: Yvette Katuala & Barbara White

| AGENDA | | ACTION ITEM(S) |
|---|---|---|
| I. Welcome & Introductions Yvette | **Facilitator(s) Present:** Yvette Katuala & Barbara White<br>**Committee Members Present:** Boona Cheema, Dan Ezekiel, Steve Grolnic-McClurg, Babalwa Kwanele, Conor Murphy, Sabirah Mustafa, Laura Schroeder and Estela Alvarez<br><br>**Absent:** Letteria Fletcher, Merlenet Riley, and Roxanna Tejada-Joya | |
| II. Announcements & Addition to the Agenda | **Announcement:**<br>This meeting will be combined for both November/December 2018 meetings. Next meeting will on January 23, 2019. | |
| III. Ice Breaker | What healthy dessert do you like to make and eat during the holidays? | |
| IV. Approval of October 31, 2018 minutes. | Motion to approve the October 31, 2018 minutes<br>Motion Seconded. Motion Carried. | |
| V. Data Presentation | Data Reporting:<br><br>➢ **<u>Discharges for FY 15/16, 16/17and 17/18 (Separate Handout)</u>**:<br>Summary for the combined three years and the details of each year were passed out to the committee in a separate handout. The acronyms were also described FIT = Focus on Independence Team, CCT= Comprehensive Community Treatment, and FSP = Full Service Partnership.<br><br>**Discussion:**<br>• Committee suggested that the report breakdown the discharge codes by ethnicity and gender.<br>• On an average, BMH discharges 50 clients per year.<br><br>**Committee Questions:** What does "Client services were changed within BMH system of care" mean? This statement on the Discharge code form was potentially a clerical error. | Compliance to Include Discharge category to QA &QI audit list.<br><br>Compliance to revise the Discharge report to include the breakdown of codes by ethnicity and gender.<br><br>Remove data on number 10 of the discharge report. (NOA-A).<br><br>Need data Reasons for Discharge matched against ethnicity and gender. |

<table>
<tr><td></td><td>Committee requested a Children's Discharge report with to include the same breakdown of gender and ethnicity.<br><br>➢ <u>BMH Client Ethnicity FY 16-17 & 15-18 (Separate Handout):</u><br>Discussion:<br>The BMH Open Client Report shows that the number of open clients dropped from 428 cases in FY 16/17 to 398 cases in 17/18, possibly due to the Adult Clinic being dislocated. The percentage of clients who are African American increased between FY16/17 and FY17/18 by 3%, from 34% to 37%.<br><br>Discussion about the increase:<br><br>Committee discussed the increase and one possible explanation was that the open clients' ethnicity and gender distribution might be very similar to the ethnic and gender composition of the homeless population of BMH Open Cases.<br><br>Report shows that the number of open cases dropped from FY 17/18 and 16/17, possibly due to Adult Clinic being dislocated.<br><br>Questions:<br>Why the African American population 15% higher compared to their percentage of Medi-Cal population?<br><br>The committee suggested that it review what percentage of the clients are listed as Homeless at intake. How is homeless being defined by BMH and other groups? It was suggested that BMH define the term "Homeless."</td><td>Compliance to provide a Children's Discharge report.<br><br>Look at data from 5 minute Presentations to Level of Care to determine homeless at intake count and include gender and ethnicity.<br><br><u>Data to be Collected:</u><br><br>1. Reach out to Kristen Lee in Housing and ask how Housing defines "Homeless," when they do the homeless count.<br>2. Review city of Berkeley Homeless population using Housing data.<br>3. Compare Homeless population with BMH Open clients.<br>4. Include homeless breakdown on percentage of group who are homeless by ethnicity and gender.</td></tr>
<tr><td>VI. Next Steps:</td><td>Top 6 Proposed Measures and additional Measures - Table for January 23, 2019</td><td></td></tr>
<tr><td>VII. Next Meeting:</td><td>Wednesday, January 23, 2019, 2:00-3:00pm</td><td></td></tr>
</table>

## Berkeley Mental Health Caseload Statistics for January 2019

| Adult Services | Intended Ratio of staff to clients | Clinical Staff Positions Filled | # of clients | Monthly Cost Per Participant Per Budget* | Fiscal Year 2019 Demographics as of January, 2019 – Data Incomplete Per YellowFin |
|---|---|---|---|---|---|
| **Adult, Older Adult and TAY Full Service Partnership (FSP) (Highest level outpatient clinical case management and treatment)** | 1-10 for clinical staff. | 6 Clinicians<br>1 Team Lead | 70 | $1,742 | 75 Clients<br>American Indian: 1<br>API: 3<br>African-American: 25<br>Hispanic: 4<br>Other: 25<br>White: 17<br>Male: 46<br>Female: 29 |
| **Adult FSP Psychiatry** | 1-100 | .35 FTE | 58 | $497 | |
| **Comprehensive Community Treatment (CCT) (High level outpatient clinical case management and treatment)** | 1-20 | 9.5 Clinicians<br>.5 Lead Clinician<br>1 Non-Degreed Clinical<br>1 Manager | 162 | $870 | 181 Clients<br>API: 9<br>African-American: 64<br>Hispanic: 7<br>Other: 48<br>White: 53<br>Male: 101<br>Female: 80 |
| **CCT Psychiatry** | 1-200 | 1.0 | 128 | $317 | |
| **Focus on Independence Team (FIT) (Lower level of care, only for individuals previously on FSP or CCT)** | 1-20 Team Lead,<br>1-50 Post Masters Clinical<br>1-30 Non-Degreed Clinical | 1 Clinical Supervisor, I Licensed Clinician, 1 CHW Sp./ Non-Degreed Clinical | 98 | $359 | 102 Clients<br>API: 3<br>African American: 39<br>Hispanic: 3<br>Other: 17<br>White: 40<br>Male: 64<br>Female: 38 |
| **FIT Psychiatry** | 1-200 | .5 | 87 | $346 | |

| Family, Youth and Children’s Services | Intended Ratio of staff to clients | Clinical Staff Positions Filled | # of clients | Monthly Cost Per Participant Per Budget* | Fiscal Year 2019 Demographics as of January, 2019 – Data Incomplete Per YellowFin |
|---|---|---|---|---|---|
| **Children’s Full Service Partnership** | 1-8 | 2.0 Clinical | 12 | $2,207 | 17 Clients<br>API: 1<br>African-American: 8<br>Hispanic: 2<br>Other: 2<br>White: 4<br>Male: 10<br>Female: 7 |
| **Early and Periodic Screening, Diagnostic and Treatment Prevention (EPSDT) /Educationally Related Mental Health Services (ERMHS)** | 1-20 | 2.5 Clinical | 55 | $895 | 66 Clients<br>API: 4<br>African-American: 24<br>Hispanic: 9<br>Other: 15<br>White: 14<br>Male: 44<br>Female: 22 |
| **High School Health Center and Berkeley Technological Academy** | 1-6 Clinician (majority of time spent on crisis counseling) | 1 Clinical Lead,1.5 Clinical, 5 Interns | Treatment: 70<br>Groups: 8 offered, 7 conducted<br>Drop In (Crisis): 49 | N/A | N/A |

| Crisis, ACCESS, and Homeless Services | Staff Ration | Clinical Staff Positions Filled | Total # of Clients/Incidents |
|---|---|---|---|
| **Homeless Outreach and Treatment Team (HOTT)** | 1-10 Case Manager<br>1-3 Team Lead | 1 Team Lead<br>2 Case Managers | 30 enrolled clients for the month. |

| | | | |
|---|---|---|---|
| | | | 44 non-enrolled individuals received outreach. |
| **HOTT Psychiatry** | 1-100 | 0 | 0 |
| **Mobile Crisis** | N/A | 3 Clinicians, | • 137 Incidents<br>• 63 5150 Evals<br>• 21 5150 Evals leading to involuntary transport |
| **Transitional Outreach Team (TOT)** | N/A | 1 Clinician, 1 Non-Licensed Staff | 92 Incidents |

Not reflected in above chart is Early Childhood Consultation, ACCESS, Wellness and Recovery Programming, or Family Support.

*Monthly Cost To Be Determined – Budget in new format, requires additional analysis to identify treatment team costs.

## BMH HOMELESS COUNT AT INTAKE: OPEN CLIENTS FY 17/18

| | African American | API | White | Other | Totals | |
|---|---|---|---|---|---|---|
| **Gender** | | | | | | |
| Female | 5 | 0 | 5 | 0 | **10** | 45% |
| Male | 4 | 0 | 8 | 0 | **12** | 55% |
| **Total** | **9** | **0** | **13** | **0** | **22** | |
| | 41% | 0% | 59% | 0% | | |

## BMH TOTAL OPEN CLIENTS FY 17/18

| | African American | API | White | Other | Totals | |
|---|---|---|---|---|---|---|
| **Gender** | | | | | | |
| Female | 8 | 1 | 10 | 2 | **21** | 48% |
| Male | 8 | 1 | 12 | 2 | **23** | 52% |
| **Total** | **16** | **2** | **22** | **4** | **44** | |
| | 36% | 5% | 50% | 9% | | |

## COB CALENDAR YR 2017 "Point-In-Time" Homeless Count

| Gender | | |
|---|---|---|
| Male | 590 | 61% |
| Female | 368 | 38% |
| Transgender | 10 | 1% |
| Another Gender | 4 | 0% |
| Total | 972 | |

| Race | | |
|---|---|---|
| White | 262 | 27% |
| Black | 486 | 50% |
| Asian | 25 | 3% |
| Amer. Ind. | 35 | 4% |
| Oth. Pac. Isl. | 2 | 0% |
| Multiple Races | 162 | 17% |
| Total | 972 | |

"Point-in-Time": The US Department of Housing & Urban Development requires any jurisdiction receiving federal money to complete a survey of all homeless individuals every two years.

## Federal Definition of Homelessness

Individuals and families: Living in a supervised publicly or privately operated shelter designated to provide temporary living arrangement (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state, or local government programs for low income individuals); or with a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground.

RESOLUTION NO. 68,752-N.S.

CONTRACT: B-BROS CONSTRUCTION, INC. FOR THE CITY OF BERKELEY'S ADULT MENTAL HEALTH SERVICES CENTER RENOVATIONS PROJECT

WHEREAS, the project consists of interior renovation and seismic upgrade of the Adult Mental Health Services Center; and

WHEREAS, The City has neither the labor nor the equipment necessary to undertake this renovation and seismic upgrade project; and

WHEREAS, an invitation for bids (Plans and Specifications No. 19-11267-C) was duly advertised, and B-Bros Construction Inc. was determined to be the lowest responsive and responsible bidder; and

WHEREAS, funds are available in the FY 2019 budget in the Mental Health Services Act Fund, Mental Health State Aid Real Fund, Community Development Block Grant (CDBG) Fund, T1 Fund, and Capital Improvement Fund.

NOW THEREFORE, BE IT RESOLVED by the Council of the City of Berkeley that Plans and Specification No. 19-11267-C for the Mental Health Services Center Renovation Project are approved, and B-Bros Construction Inc. is determined to be the lowest responsive and responsible bidder.

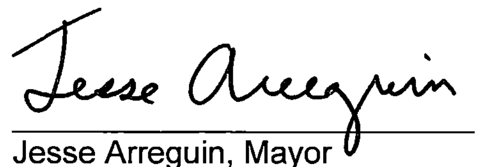
BE IT FURTHER RESOLVED, that the Council of the City of Berkeley authorizes the City Manager to execute a contract and any amendments, extensions or change orders, until completion of the project in accordance with the approved plans and specifications with B-Bros Construction Inc. for the Mental Health Services Center Renovation Project at 2640 Martin Luther King, Jr Way, in an amount not to exceed $4,886,293. A record signature copy of the agreement and any amendments will be on file in the Office of the City Clerk.

The foregoing Resolution was adopted by the Berkeley City Council on January 29, 2019 by the following vote:

Ayes: Bartlett, Davila, Droste, Hahn, Harrison, Kesarwani, Robinson, Wengraf, and Arreguin.

Noes: None.

Absent: None.



Jesse Arreguin, Mayor

Attest:

Mark Numainville, City Clerk

## SECTION I : ALL LEGAL ENTITIES :

***All Legal Entities are to complete Section I.***

| | |
|---|---|
| **Name of Preparer:** | KAREN MILES, KV CONSULTING |
| **Date:** | 1/28/2019 |
| **Legal Entity Name:** | CITY OF BERKELEY |
| **Legal Entity Number:** | 00065 |
| **County:** | ALAMEDA |
| **County Code:** | 01 |
| **Is this a County Legal Entity Report? (Yes or No)** | No |
| **Are you reporting SD/MC? (Yes or No)** | Yes |

## SECTION II:COUNTY LEGALENTITY ONLY:

***Only County Legal Entities are to Complete Section II.***

| | |
|---|---|
| **Address:** | |
| | |
| | |
| **Phone Number:** | |
| **County Population : Over 125,000? (Yes or No):** | Yes |

***Contract Provider Other Medi-Cal Direct Service Gross Reimbursement (Used to populate MH1979 Line2)***

| | |
|---|---|
| **Inpatient Services** | |
| **Outpatient Services** | |

***Contract Provider SD/MC Enhanced (Children) Direct Service Gross Reimbursement ( Used to populate MH1979 Line 8)***

| | |
|---|---|
| **Inpatient Services** | |
| **Outpatient Services** | |

***Fee For Service - Mental Health Specialty***

| | |
|---|---|
| **Legal Entity Number (FFS):** | |
| **Psychiatrist:** | |
| **Psychologist:** | |
| **Mixed Specialty Group:** | |
| **RN:** | |
| **LCSW:** | |
| **MFCC (MFT):** | |

**Adjust Medi-Cal FFP Due to Costs in Excess of FFP**

**Adjustments by Mode of Service (Used to Calculate FFP on the MH1992)**

| Mode of Services | SD/MC |
|---|---|
| Mode 05 - Hospital Inpatient Services | |
| Mode 05 - Other 24 Hour Services | |
| Mode10 - Day Services | |
| Mode15 - Outpatient Services | |
| MAA | |
| Total Adjustments to FFP | $ - |
| Cross Checks | OK |

**Adjustments by Settlement Group (Used to Populate Col.I - MH1979)**

| Settlement Group | AdjustmentstoFFP |
|---|---|
| SDMC-07/01/17 - 06/30/18 | |
| SD/MC Enhanced-Children E2, E4, E5-07/01/17 - 06/30/18 | |
| SD/MC Enhanced-Children-07/01/17 - 06/30/18 | |
| SD/MC Enhanced-BCCTP-07/01/17 - 06/30/18 | |
| SD/MC Enhanced-Pregnancy-07/01/17 - 06/30/18 | |
| SD/MC Enhanced-Refugee-07/01/17 - 06/30/18 | |
| Affordable Care Act-07/01/17 - 12/31/17 | |
| Affordable Care Act-01/01/18 - 06/30/18 | |
| MAASFC01-09 | |
| MAASFC11-19,31-39 | |
| MCAP 07/01/17 - 06/30/18 | |
| Total Adjustments to FFP | $ - |

State of California Health and Human Services Agency — Department of Health Care Services

DETAIL COST REPORT

## SCHEDULE OF STATEWIDE MAXIMUM ALLOWANCES AND PUBLISHED CHARGES

MH1901 SCHEDULE A (Rev. 04/2018) — FISCAL YEAR 2017-18

Entity Name:CITY OF BERKELEY — Entity Number: 00065

| | | A | B | C | D | E | F | G |
|---|---|---|---|---|---|---|---|---|
| | SERVICE FUNCTION | MODE | SERVICE FUNCTION CODE | SMA | STATE APPROVED (NR) | PUBLISHED CHARGE | COUNTY NONM/C CONTRACTRATE | RATE FOR ALLOCATION |
| | **A. 24-HOUR SERVICES** | | | | | | | |
| 1 | Hospital Inpatient | 05 | 10-18 | | | | | $0.00 |
| 2 | Hospital Administrative Day | 05 | 19 | $489.28 | | | | $0.00 |
| 3 | Psychiatric Health Facility (PHF) | 05 | 20-29 | | | | | $0.00 |
| 4 | SNF Intensive | 05 | 30-34 | | | | | $0.00 |
| 5 | IMD Basic (No Patch) | 05 | 35 | | | | | $0.00 |
| 6 | IMD (With Patch) | 05 | 36-39 | | | | | $0.00 |
| 7 | Adult Crisis Residential | 05 | 40-49 | | | | | $0.00 |
| 8 | Jail Inpatient | 05 | 50-59 | | | | | $0.00 |
| 9 | Residential Other | 05 | 60-64 | | | | | $0.00 |
| 10 | Adult Residential | 05 | 65-79 | | | | | $0.00 |
| 11 | Semi-Supervised Living | 05 | 80-84 | | | | | $0.00 |
| 12 | Independent Living | 05 | 85-89 | | | | | $0.00 |
| 13 | MH Rehab Centers | 05 | 90-94 | | | | | $0.00 |
| 14 | Therapeutic Foster Care | 05 | 95-98 | | | | | $0.00 |
| | **B. DAY SERVICES** | | | | | | | |
| 15 | Crisis Stabilization<br>Emergency Room | 10 | 20-24 | | | | | $0.00 |
| 16 | Urgent Care | 10 | 25-29 | | | | | $0.00 |
| 17 | Vocational Services | 10 | 30-39 | | | | | $0.00 |
| 18 | Socialization | 10 | 40-49 | | | | | $0.00 |
| 19 | SNF Augmentation | 10 | 60-69 | | | | | $0.00 |
| 20 | Day Treatment Intensive<br>Half Day | 10 | 81-84 | | | | | $0.00 |
| 21 | Full Day | 10 | 85-89 | | | | | $0.00 |
| 22 | Day Rehabilitation<br>Half Day | 10 | 91-94 | | | | | $0.00 |
| 23 | Full Day | 10 | 95-99 | | | | | $0.00 |
| | **C. OUTPATIENT SERVICES** | | | | | | | |
| 24 | Case Management , Brokerage | 15 | 01-09 | | | $6.82 | | $0.00 |
| 25 | Mental Health Services | 15 | 10-19 | | | $7.01 | | $0.00 |
| 26 | Mental Health Services | 15 | 30-59 | | | $6.63 | | $0.00 |
| 27 | Medication Support | 15 | 60-69 | | | $13.56 | | $0.00 |
| 28 | Crisis Intervention | 15 | 70-79 | | | $6.26 | | $0.00 |
| | | | | | | | | |
| 29 | Mental Health Promotion | 45 | 10-19 | | | | | $0.00 |
| 30 | Community Client Services | 45 | 20-29 | | | | | $0.00 |
| | **E. MEDI-CAL ADMINISTRATIVE ACTIVITIES** | | | | | | | |
| 31 | Medi-Cal Outreach | 55 | 01-03 | | | | | |
| 32 | Medi-Cal Eligibility Intake | 55 | 04-06 | | | 91.76% | Quarter1 | |
| 33 | Medi-Cal Contract Administration | 55 | 07-08 | | | 90.87% | Quarter2 | |
| 34 | MAA Coordination and Claims Administration | 55 | 09 | | | 87.86% | Quarter3 | |
| 35 | Referral-Crisis,Non-Open Case | 55 | 11-13 | | | 89.18% | Quarter4 | |
| 36 | MH Services Contract Administration | 55 | 14-16 | | | 89.92% | Average | |
| 37 | Discounted Mental Health Outreach | 55 | 17-19 | | | | | |
| 38 | SPMP Case Management,Non-Open Case | 55 | 21-23 | | | | | |
| 39 | SPMP Program Planning and Development | 55 | 24-26 | | | | | |
| 40 | SPMP MAA Training | 55 | 27-29 | | | | | |
| 41 | Non-SPMP Case Management , Non-Open Case | 55 | 31-34 | | | | | |
| 42 | Non-SPMP Program Planning and Development | 55 | 35-39 | | | | | |
| | **F. SUPPORT SERVICES** | | | | | | | |
| 43 | Conservatorship<br>Investigation | 60 | 20-29 | | | | | $0.00 |
| 44 | Administration | 60 | 30-39 | | | | | $0.00 |
| 45 | Life Support / Board & Care | 60 | 40-49 | | | | | $0.00 |
| 46 | Case Management Support | 60 | 60-69 | | | | | $0.00 |
| 47 | Client Housing Support Expenditures | 60 | 70 | | | | | $0.00 |
| 48 | Client Housing Operating Expenditures | 60 | 71 | | | | | $0.00 |
| 49 | Client Flexible Support Expenditures | 60 | 72 | | | | | $0.00 |
| 50 | Non Medi-Cal Capital Assets | 60 | 75 | | | | | $0.00 |
| 51 | Other Non Medi-Cal Client Support Expenditures | 60 | 78 | | | | | $0.00 |

State of California Health and Human Services Agency — DepartmentofHealthCareServices

DETAIL COST REPORT

# WORKSHEET FOR UNITS OF SERVICE AND REVENUE BY MODE AND SERVICE FUNCTION

MH1901 SCHEDULE B 07/01/17 - 06/30/18 — FISCALYEAR2017 - 2018

Entity Name : CITY OF BERKELEY

| Settlement Types | | |
|---|---|---|
| | MAA-Medi-Cal Administrative Activities | CR-Cost Reimbursement |
| | TBS-Therapeutic Behavioral Services | MHS-Mental Health Specialty |
| | ISA-Integrated Service Agency | HOSP-Hospital |
| | ASO-Administrative Services Organization | CCR - Continuum of Care Reform |

| | A | B | C | D | E | F | G | H | I | J | K | L | M | N | O | P | Q | R | S | T | U | V | W | X | Y | Z |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | ALL UNITS 07/01/17 - 06/30/18 | | | | REGULAR FMAP SHORT/DOYLE MEDI-CAL 07/01/17 - 06/30/18 | | | ENHANCED FMAP SHORT/DOYLE MEDI-CAL 07/01/17 - 06/30/18 | | | | | | | | | | Affordable Care Act 07/01/17 - 12/31/17 | | Affordable Care Act 01/01/18 - 06/30/18 | | Medi-Cal Access Program (MCAP) 07/01/17 - 06/30/18 | | MediCal for all Children 07/01/17 - 06/30/18 | | |
| | Settlement Type | Mode | SF | Total Units of Service | SD/MC Units | Medi-MediCrossover Units | SD/MC 3rd Party Revenue | Children Units 07/01/17 - 06/30/18 E2, E4, E5 | Children Units 3rd Party Revenue 07/01/17-06/30/18 E2,E4 E5 | Children Units 07/01/17 - 06/30/18 | Children Units 3rd Party Revenue 07/01/17-06/30/18 | BCCTP Units | BCCTP 3rd Party Revenue | Pregnancy Units | Pregnancy 3rd Party Revenue | Refugee Units | Refugee 3rd Party Revenue | Affordable Care Act Units | 3rd Party Revenue | Affordable Care Act Units | 3rd Party Revenue | MCAP Units | 3rd Party Revenue | SB75 Units | SB75 3rd Party Revenue | Non Medi-Cal Units |
| 1 | CR | 15 | 01 | 184,872 | 101,809 | | | | | 1,735 | | | | | | | | 10,762 | | 22,565 | | | | | | 48,001 |
| 2 | CR | 15 | 10 | 67,861 | 46,925 | | | | | 9,469 | | | | | | | | 395 | | 820 | | | | | | 10,252 |
| 3 | CR | 15 | 30 | 160,880 | 114,169 | | | | | 8,957 | | | | | | | | 7,399 | | 8,399 | | | | | | 21,956 |
| 4 | CR | 15 | 40 | 553,338 | 449,369 | | $ 24,344 | | | 25,742 | | | | | | | | 17,520 | | 15,407 | | | | | | 45,300 |
| 5 | CR | 15 | 50 | 632 | - | | | | | 466 | | | | | | | | 0 | | 0 | | | | | | 166 |
| 6 | CR | 15 | 60 | 122,438 | 109,279 | | | | | - | | | | | | | | 3,042 | | 2,671 | | | | | | 7,446 |
| 7 | CR | 15 | 70 | 13,375 | 9,780 | | | | | 830 | | | | | | | | 1,010 | | 1,340 | | | | | | 415 |
| 8 | CR | 45 | 20 | 1 | | | | | | | | | | | | | | | | | | | | | | 1 |
| 9 | CR | 45 | 21 | 1 | | | | | | | | | | | | | | | | | | | | | | 1 |
| 10 | MAA | 55 | 01 | 92,549 | | | | | | | | | | | | | | | | | | | | | | 92,549 |
| 11 | MAA | 55 | 04 | 600 | | | | | | | | | | | | | | | | | | | | | | 600 |
| 12 | MAA | 55 | 10 | 30 | | | | | | | | | | | | | | | | | | | | | | 30 |
| 13 | MAA | 55 | 11 | 90,305 | | | | | | | | | | | | | | | | | | | | | | 90,305 |
| 14 | MAA | 55 | 21 | 122,412 | | | | | | | | | | | | | | | | | | | | | | 122,412 |
| 15 | MAA | 55 | 27 | 46,300 | | | | | | | | | | | | | | | | | | | | | | 46,300 |
| 16 | MAA | 55 | 31 | 42,817 | | | | | | | | | | | | | | | | | | | | | | 42,817 |
| 17 | CR | 60 | 70 | 1 | | | | | | | | | | | | | | | | | | | | | | 1 |
| 18 | CR | 60 | 72 | 1 | | | | | | | | | | | | | | | | | | | | | | 1 |
| 19 | CR | 60 | 75 | 1 | | | | | | | | | | | | | | | | | | | | | | 1 |
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DETAIL COST REPORT

# WORKSHEET FOR UNITS OF SERVICE AND REVENUE BY MODE AND SERVICE FUNCTION

MH1901 SCHEDULE B 07/01/17 - 06/30/18

FISCALYEAR2017 - 2018

Entity Name : CITY OF BERKELEY

| Settlement Types | | |
|---|---|---|
| | MAA-Medi-Cal Administrative Activities | CR-Cost Reimbursement |
| | TBS-Therapeutic Behavioral Services | MHS-Mental Health Specialty |
| | ISA-Integrated Service Agency | HOSP-Hospital |
| | ASO-Administrative Services Organization | CCR - Continuum of Care Reform |

| | A | B | C | D | E | F | G | H | I | J | K | L | M | N | O | P | Q | R | S | T | U | V | W | X | Y | Z |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | ALL UNITS 07/01/17 - 06/30/18 | | | | REGULAR FMAP SHORT/DOYLE MEDI-CAL 07/01/17 - 06/30/18 | | | ENHANCED FMAP SHORT/DOYLE MEDI-CAL 07/01/17 - 06/30/18 | | | | | | | | | | Affordable Care Act 07/01/17 - 12/31/17 | | Affordable Care Act 01/01/18 - 06/30/18 | | Medi-Cal Access Program (MCAP) 07/01/17 - 06/30/18 | | MediCal for all Children 07/01/17 - 06/30/18 | | |
| | Settlement Type | Mode | SF | Total Units of Service | SD/MC Units | Medi-MediCrossover Units | SD/MC 3rd Party Revenue | Children Units 07/01/17 - 06/30/18 E2, E4, E5 | Children Units 3rd Party Revenue 07/01/17-06/30/18 E2,E4 E5 | Children Units 07/01/17 - 06/30/18 | Children Units 3rd Party Revenue 07/01/17-06/30/18 | BCCTP Units | BCCTP 3rd Party Revenue | Pregnancy Units | Pregnancy 3rd Party Revenue | Refugee Units | Refugee 3rd Party Revenue | Affordable Care Act Units | 3rd Party Revenue | Affordable Care Act Units | 3rd Party Revenue | MCAP Units | 3rd Party Revenue | SB75 Units | SB75 3rd Party Revenue | Non Medi-Cal Units |
| 61 | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 62 | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 83 | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 84 | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Totals | | | | 1,498,414 | 831,331 | | $ 24,344 | - | - | 47,199 | | - | | - | | - | $ - | 40,128 | $ - | 51,202 | $ - | - | $ - | - | $ - | 528,554 |

DETAIL COST REPORT

## SUPPORTING DOCUMENTATION FOR THE METHOD USED TO ALLOCATE

MH1901 SCHEDULE C (Rev. 04/2018) FISCAL YEAR 2017 - 2018

Entity Name : CITY OF BERKELEY Entity Number : 00065

Fiscal Year: 2017 - 2018

Allocation
- ( ) Rate for Allocation
- (•) Published Charges
- ( ) Directly Allocated

| COSTS TO BE ALLOCATED | |
|---|---|
| Allowable Non-Hospital Mode Costs (MH1960 Line34,Col.J) | 14,735,311 |
| | |

OK

| | A | B | C | D | E | F | G | H | I |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | Allocation Basis | | | |
| | Settlement Type | Mode | SF | Total Units | Eligible Direct Cost | Directly Allocated Data | Relative Value | Allocation % | Allocated Cost |
| 1 | CR | 15 | 01 | 184,872 | | | 1,260,827 | 15.34% | 1,713,122 |
| 2 | CR | 15 | 10 | 67,861 | | | 475,706 | 5.79% | 646,355 |
| 3 | CR | 15 | 30 | 160,880 | | | 1,066,634 | 12.98% | 1,449,267 |
| 4 | CR | 15 | 40 | 553,338 | | | 3,668,631 | 44.63% | 4,984,673 |
| 5 | CR | 15 | 50 | 632 | | | 4,190 | 0.05% | 5,693 |
| 6 | CR | 15 | 60 | 122,438 | | | 1,660,259 | 20.20% | 2,255,842 |
| 7 | CR | 15 | 70 | 13,375 | | | 83,728 | 1.02% | 113,763 |
| 8 | CR | 45 | 20 | 1 | 1,144,187 | | - | | 1,144,187 |
| 9 | CR | 45 | 21 | 1 | 10,814 | | - | | 10,814 |
| 10 | MAA | 55 | 01 | 92,549 | | 161,006 | - | | 161,006 |
| 11 | MAA | 55 | 04 | 600 | | 1,016 | - | | 1,016 |
| 12 | MAA | 55 | 10 | 30 | | 47 | - | | 47 |
| 13 | MAA | 55 | 11 | 90,305 | | 159,045 | - | | 159,045 |
| 14 | MAA | 55 | 21 | 122,412 | | 226,645 | - | | 226,645 |
| 15 | MAA | 55 | 27 | 46,300 | | 87,782 | - | | 87,782 |
| 16 | MAA | 55 | 31 | 42,817 | | 74,251 | - | | 74,251 |
| 17 | CR | 60 | 70 | 1 | 14,500 | | - | | 14,500 |
| 18 | CR | 60 | 72 | 1 | 292,469 | | - | | 292,469 |
| 19 | CR | 60 | 75 | 1 | 1,394,835 | | - | | 1,394,835 |
| 20 | | | | - | | | - | | - |
| 21 | | | | - | | | - | | - |
| 22 | | | | - | | | - | | - |
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| 80 | | | | - | | | - | | - |
| 81 | | | | - | | | - | | - |
| 82 | | | | - | | | - | | - |
| 83 | | | | - | | | - | | - |
| 84 | | | | - | | | - | | - |
| | | | | 1,498,414 | 2,856,805 | 709,792 | 8,219,975 | 100% | 14,735,311 |

Summary

| | Non-Hospital Costs | |
|---|---|---|
| Mode | Allocated Cost | Allocated % |
| 5 10-19 | | 0.00% |
| 5 Other | | 0.00% |
| 10 | | 0.00% |
| 15 Program_1 | 11,168,714 | 75.80% |
| 45 | 1,155,001 | 7.84% |
| 55 | 709,792 | 4.82% |
| 60 | 1,701,804 | 11.55% |
| Total | 14,735,311 | 100.00% |

| | Non-Hospital Costs | |
|---|---|---|
| | Settlement Type | Allocated Cost |
| 15 Program_2 | TBS | |
| | ASO | |
| | MHS | |
| | **Total** | |

| | Hospital Costs | |
|---|---|---|
| | Allocated Cost | Allocated % |
| 5 10-19 | | 0.00% |
| 5 Other | | 0.00% |
| 10 | | 0.00% |
| 15 Program_1 | | 0.00% |
| 45 | | 0.00% |
| 55 | | 0.00% |
| 60 | | 0.00% |
| Total | | 0.00% |

DETAIL COST REPORT

**ALLOCATION OF COSTS TO MODES OF SERVICE**

MH 1964 (Rev. 04/2018) — FISCAL YEAR 2017 - 2018

County: ALAMEDA
County Code: 01

| | Legal Entity: CITY OF BERKELEY | A |
|---|---|---|
| | Legal Entity Number: 00065 | **Total Costs** |
| 1 | Mode Costs (Direct Service and MAA) | 14,735,311 |
| | **Modes** | |
| 2 | Hospital Inpatient Services (Mode 05-SFC 10-19) | |
| 3 | Other 24 Hour Services (Mode 05-All Other SFC) | |
| 4 | Day Services (Mode 10) | |
| 5 | Outpatient Services (Mode 15 Program 1 + Program 2) | 11,168,714 |
| 6 | Outreach Services (Mode 45) | 1,155,001 |
| 7 | Medi-Cal Administrative Activities (Mode 55) | 709,792 |
| 8 | Support Services (Mode 60) | 1,701,804 |
| 9 | Total - Lines 2 through 8 | 14,735,311 |

***Crosscheck OK***

DETAIL COST REPORT

# ALLOCATION OF COSTS TO SERVICEFUNCTIONS - MODE TOTAL

MH1966 (Rev. 04/2018)

County: ALAMEDA
County Code: 01

Legal Entity: CITY OF BERKELEY
Legal Entity Number: 00065
Mode: 15 - Outpatient Services (Program 1)

| # | Item | Period | A Non-Hospital Mode Total | B Hospital Mode Total | C Mode Total | D Service Function (CR) 01 | E Service Function (CR) 10 | F Service Function (CR) 30 | G Service Function (CR) 40 | H Service Function (CR) 50 | I Service Function (CR) 60 | J Service Function (CR) 70 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | Allocation Percentage | | 100.00% | | 100.00% | 15.34% | 5.79% | 12.98% | 44.63% | 0.05% | 20.20% | 1.02% |
| 2 | Total Units | | | | | 184.872 | 67.861 | 160.880 | 553.338 | 632 | 122.438 | 13.375 |
| 3 | Gross Cost | | 11.168.714 | | 11.168.714 | 1.713.122 | 646.355 | 1.449.267 | 4.984.673 | 5.693 | 2.255.842 | 113.763 |
| 4 | Cost per Unit | | | | | 9.27 | 9.52 | 9.01 | 9.01 | 9.01 | 18.42 | 8.51 |
| 5 | Published Charge per Unit | | | | | 6.82 | 7.01 | 6.63 | 6.63 | 6.63 | 13.56 | 6.26 |
| 6 | Medi-Cal Units | 07/01/17 - 06/30/18 | | | | 101.809 | 46.925 | 114.169 | 449.369 | | 109.279 | 9.780 |
| 7 | Medicare/Medi-Cal Crossover Units | 07/01/17 - 06/30/18 | | | | | | | | | | |
| 8 | Enhanced SD/MC (Children) Units E2, E4, E5 | 07/01/17 - 06/30/18 | | | | | | | | | | |
| 9 | Enhanced SD/MC (Children) Units | 07/01/17 - 06/30/18 | | | | 1.735 | 9.469 | 8.957 | 25.742 | 466 | | 830 |
| 10 | Enhanced SD/MC (BCCTP) Units | 07/01/17 - 06/30/18 | | | | | | | | | | |
| 11 | Enhanced SD/MC Pregnancy Units | 07/01/17 - 06/30/18 | | | | | | | | | | |
| 12 | Enhanced SD/MC (Refugees) Units | 07/01/17 - 06/30/18 | | | | | | | | | | |
| 13 | Affordable Care Act Units | 07/01/17 - 12/31/17 | | | | 10.762 | 395 | 7.399 | 17.520 | | 3.042 | 1.010 |
| 14 | Affordable Care Act Units | 01/01/18 - 06/30/18 | | | | 22.565 | 820 | 8.399 | 15.407 | | 2.671 | 1.340 |
| 15 | MediCal for all Children (SB75) Units | 07/01/17 - 06/30/18 | | | | | | | | | | |
| 16 | Medi-Cal Access Program (MCAP) | 07/01/17 - 06/30/18 | | | | | | | | | | |
| 17 | Non-Medi-Cal Units | 07/01/17 - 06/30/18 | | | | 48.001 | 10.252 | 21.956 | 45.300 | 166 | 7.446 | 415 |
| 18 | Medi-Cal Costs | 07/01/17 - 06/30/18 | 8.563.501 | | 8.563.501 | 943.416 | 446.946 | 1.028.477 | 4.048.082 | | 2.013.395 | 83.185 |
| 19 | Medi-Cal Published Charges | 07/01/17 - 06/30/18 | 6.302.585 | | 6.302.585 | 694.337 | 328.944 | 756.940 | 2.979.316 | | 1.481.823 | 61.223 |
| 20 | Medicare/Medi-Cal Crossover Costs | 07/01/17 - 06/30/18 | | | | | | | | | | |
| 21 | Medicare/Medi-Cal Crossover Published Charges | 07/01/17 - 06/30/18 | | | | | | | | | | |
| 22 | Enhanced SD/MC (Children) Costs E2, E4, E5 | 07/01/17 - 06/30/18 | | | | | | | | | | |
| 23 | Enhanced SD/MC (Children) Published Charges E2, E4, E5 | 07/01/17 - 06/30/18 | | | | | | | | | | |
| 24 | Enhanced SD/MC (Children) Costs | 07/01/17 - 06/30/18 | 430.106 | | 430.106 | 16.077 | 90.189 | 80.688 | 231.893 | 4.198 | | 7.060 |
| 25 | Enhanced SD/MC (Children) Published Charges | 07/01/17 - 06/30/18 | 316.550 | | 316.550 | 11.833 | 66.378 | 59.385 | 170.669 | 3.090 | | 5.196 |
| 26 | Enhanced SD/MC (BCCTP) Costs | 07/01/17 - 06/30/18 | | | | | | | | | | |
| 27 | Enhanced SD/MC (BCCTP) Published Charges | 07/01/17 - 06/30/18 | | | | | | | | | | |
| 28 | Enhanced SD/MC (Pregnancy) Costs | 07/01/17 - 06/30/18 | | | | | | | | | | |
| 29 | Enhanced SD/MC (Pregnancy) Published Charges | 07/01/17 - 06/30/18 | | | | | | | | | | |
| 30 | Enhanced SD/MC (Refugees) Costs | 07/01/17 - 06/30/18 | | | | | | | | | | |
| 31 | Enhanced SD/MC (Refugees) Published Charges | 07/01/17 - 06/30/18 | | | | | | | | | | |
| 32 | Affordable Care Act Costs | 07/01/17 - 12/31/17 | 392.606 | | 392.606 | 99.726 | 3.762 | 66.653 | 157.827 | | 56.047 | 8.591 |
| 33 | Affordable Care Act Published Charges | 07/01/17 - 12/31/17 | 288.951 | | 288.951 | 73.397 | 2.769 | 49.055 | 116.158 | | 41.250 | 6.323 |
| 34 | Affordable Care Act Costs | 01/01/18 - 06/30/18 | 491.972 | | 491.972 | 209.099 | 7.810 | 75.661 | 138.792 | | 49.211 | 11.398 |
| 35 | Affordable Care Act Published Charges | 01/01/18 - 06/30/18 | 362.082 | | 362.082 | 153.893 | 5.748 | 55.685 | 102.148 | | 36.219 | 8.388 |
| 36 | MediCal for all Children (SB75) Costs | 07/01/17 - 06/30/18 | | | | | | | | | | |
| 37 | MediCal for all Children (SB75) Published Charges | 07/01/17 - 06/30/18 | | | | | | | | | | |
| 38 | Medi-Cal Access Program (MCAP) Costs | 07/01/17 - 06/30/18 | | | | | | | | | | |
| 39 | Medi-Cal Access Program (MCAP) Published Charges | 07/01/17 - 06/30/18 | | | | | | | | | | |
| 40 | Non-Medi-Cal Costs | 07/01/17 - 06/30/18 | 1.290.530 | | 1.290.530 | 444.803 | 97.647 | 197.788 | 408.079 | 1.495 | 137.188 | 3.530 |

| K | L | M | N | O | P | Q | R | S | T | U | V | W | X | Y | Z | AA | AB | AC | AD | AE | AF | AG | AH | AI | AJ | AK | AL | AM | AN | AO | AP | AQ | AR | AS | AT | AU | AV | AW | AX | AY | AZ | BA | BB | BC | BD | BE | BF | BG | BH | BI | BJ | BK | BL | BM | BN | BO | BP | BQ | BR | BS | BT | BU | BV | BW | BX | BY | BZ | CA |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Service Function | Service Function | Service Function | Service Function | Service Function | Service Function | Service Function | Service Function | Service Function | Service Function | Service Function | Service Function | Service Function | Service Function | Service Function | Service Function | Service Function | Service Function | Service Function | Service Function | Service Function | Service Function | Service Function | Service Function | Service Function | Service Function | Service Function | Service Function | Service Function | Service Function | Service Function | Service Function | Service Function | Service Function | Service Function | Service Function | Service Function | Service Function | Service Function | Service Function | Service Function | Service Function | Service Function | Service Function | Service Function | Service Function | Service Function | Service Function | Service Function | Service Function | Service Function | Service Function | Service Function | Service Function | Service Function | Service Function | Service Function | Service Function | Service Function | Service Function | Service Function | Service Function | Service Function | Service Function | Service Function | Service Function | Service Function | Service Function | Service Function |

DETAIL COST REPORT

**ALLOCATION OF COSTS TO SERVICE FUNCTIONS - MODE TOTAL**



MH1966 (Rev. 04/2018)

FISCAL YEAR 2017 - 2018

**County:** ALAMEDA

**County Code:** 01

| | | | CR | CR | | | | |
|---|---|---|---|---|---|---|---|---|
| | **Legal Entity:** CITY OF BERKELEY | **A** | **B** | **C** | **D** | **E** | **F** | **G** |
| | **Legal Entity Number:** 00065<br>**Mode: 45 - Outreach Services** | **Mode Total** | **Service Function** | **Service Function** | **Service Function** | **Service Function** | **Service Function** | **Service Function** |
| | | | **20** | **21** | | | | |
| 1 | Allocation Percentage | 100.00% | 99.06% | 0.94% | | | | |
| 2 | Total Units | | 1 | 1 | | | | |
| 3 | Gross Cost | 1,155,001 | 1,144,187 | 10,814 | | | | |
| | | | | | | | | |
| 4 | Cost per Unit | | 1,144,187.05 | 10,814.00 | | | | |
| 5 | Non-Medi-Cal Units | | 1 | 1 | | | | |
| | | | | | | | | |

DETAIL COST REPORT

**ALLOCATION OF COSTS TO SERVICE FUNCTIONS - MODE TOTAL**

MH1966 (Rev. 04/2018)



FISCAL YEAR 2017 - 2018

**County:** ALAMEDA
**County Code:** 01

| | | | MAA | MAA | MAA | MAA | MAA | MAA |
|---|---|---|---|---|---|---|---|---|
| **Legal Entity:** CITY OF BERKELEY | | **A** | **B** | **C** | **D** | **E** | **F** | **G** |
| **Legal Entity Number:** 00065<br>**Mode: 55 - Medi-Cal Administrative Activities** | | **Mode Total** | **Service Function** | **Service Function** | **Service Function** | **Service Function** | **Service Function** | **Service Function** |
| | | | **01** | **04** | **10** | **11** | **21** | **27** |
| 1 | Allocation Percentage | 100.00% | 22.68% | 0.14% | 0.01% | 22.41% | 31.93% | 12.37% |
| 2 | Total Units | | 92,549 | 600 | 30 | 90,305 | 122,412 | 46,300 |
| 3 | Total Expenditures | 709,792 | 161,006 | 1,016 | 47 | 159,045 | 226,645 | 87,782 |
| 4 | Cost per Unit | | 1.74 | 1.69 | 1.57 | 1.76 | 1.85 | 1.90 |
| 5 | Non-Medi-Cal Costs | 55,271 | | | | | | |

DETAIL COST REPORT

**ALLOCATION OF COSTS TO SERVICE FUNCTIONS - MODE TOTAL**

MH 1966 (Rev. 04/2018)



FISCAL YEAR 2017 - 2018

**County:** ALAMEDA
**County Code:** 01

| | | | CR | CR | CR | | | |
|---|---|---|---|---|---|---|---|---|
| **Legal Entity:** CITY OF BERKELEY | | **A** | **B** | **C** | **D** | **E** | **F** | **G** |
| **Legal Entity Number:** 00065 / **Mode:** 60 - Support Services | | **Mode Total** | **Service Function** | **Service Function** | **Service Function** | **Service Function** | **Service Function** | **Service Function** |
| | | | **70** | **72** | **75** | | | |
| 1 | Allocation Percentage | 100.00% | 0.85% | 17.19% | 81.96% | | | |
| 2 | Total Units | | 1 | 1 | 1 | | | |
| 3 | Gross Cost | 1,701,804 | 14,500 | 292,469 | 1,394,835 | | | |
| 4 | Cost per Unit | | 14,500.00 | 292,469.08 | 1,394,835.00 | | | |
| 5 | Non-Medi-Cal Units (Same as Line 2) | | 1 | 1 | 1 | | | |
| 6 | Non-Medi-Cal Costs (Same as Line 3) | 1,701,804 | 14,500 | 292,469 | 1,394,835 | | | |

DETAIL COST REPORT

**SD/MC PRELIMINARY DESK SETTLEMENT**

MH 1979 (Rev. 04/2018)

County: ALAMEDA
County Code: 01

| Legal Entity: CITY OF BERKELEY | | | A | B | C | D | E | F | G | H | I | J | K |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Legal Entity Number: 00065 | | | Total MAA | Total Inpatient | Total Outpatient | Total | 50.00% FFP | 50.00% FFP | [1]Variable % FFP | 75.00% FFP | Adjustments to FFP | Total FFP | Total SGF |
| | **SD/MC Other Administrative Reimbursement (County Only)** | | | | | | | | | | | | |
| 1 | County SD/MC Other Direct Service Gross Reimbursement | | | | | | | | | | | | |
| 2 | Contract Providers Other Medi-Cal Direct Service Gross Reimbursement | | | | | | | | | | | | |
| 3 | Total Medi-Cal Direct Service Gross Reimbursement | | | | | | | | | | | | |
| 4 | Medi-Cal Administrative Reimbursement Limit | | | | | | | | | | | | |
| 5 | Medi-Cal Administration | | | | | | | | | | | | |
| 6 | Continuum of Care Reform Administration | | | | | | | | | | | | |
| 7 | Medi-Cal Administrative Reimbursement | | | | | | | | | | | | |
| | **SD/MC Enhanced (Children) Administrative Reimbursement (County Only)** | | | | | | | | | | | | |
| 8 | County SD/MC Enhanced (Children) Direct Service Gross Reimbursement | | | | | | | | | | | | |
| 9 | Contract Providers SD/MC Enhanced (Children) Direct Service Gross Reim | | | | | | | | | | | | |
| 10 | Total SD/MC Enhanced (Children) Direct Service Gross Reimbursement | | | | | | | | | | | | |
| 11 | SD/MC Enhanced (Children) Administrative Reimbursement Limit | | | | | | | | | | | | |
| 12 | SD/MC Enhanced (Children) Administration | | | | | | | | | | | | |
| 13 | SD/MC Enhanced (Children) Administrative Reimbursement | | | | | | | | | | | | |
| | **SD/MC Net Reimbursement for MAA** | | | | | | | | | | | | |
| 14 | Medi-Cal Admin. Activities Svc Functions 01 - 09 | | 162,022 | | | 162,022 | 81,011 | | | | | 81,011 | |
| 15 | Medi-Cal Admin. Activities Svc Functions 11 - 19, 31 - 39 | | 209,774 | | | 209,774 | 104,887 | | | | | 104,887 | |
| 16 | Medi-Cal Admin. Activities Svc Functions 21 - 29 (County Only) | | 282,725 | | | 282,725 | | | | 212,044 | | 212,044 | |
| 17 | Utilization Review-Skilled Prof. Med. Personnel (County Only) | | | | | | | | | | | | |
| 18 | Other SD/MC Utilization Review (County Only) | | | | | | | | | | | | |
| 19 | SD/MC Net Reimbursement for Direct Services | 07/01/17 - 06/30/18 | | | 6,278,241 | 6,278,241 | | 3,139,120 | | | | 3,139,120 | |
| 20 | Enhanced SD/MC Net Reimb. (Children) E2, E4, E5 | 07/01/17 - 06/30/18 | | | | | | | | | | | |
| 21 | Enhanced SD/MC Net Reimb. (Children) | 07/01/17 - 06/30/18 | | | 316,550 | 316,550 | | | 278,564 | | | 278,564 | |
| 22 | Enhanced SD/MC Net Reimb. (BCCTP) | 07/01/17 - 06/30/18 | | | | | | | | | | | |
| 23 | Enhanced SD/MC Net Reimb. (Pregnancy) | 07/01/17 - 06/30/18 | | | | | | | | | | | |
| 24 | Enhanced SD/MC Net Reimb. (Refugees) | 07/01/17 - 06/30/18 | | | | | | | | | | | |
| 25 | Affordable Care Act (ACA) Net Reimbursement | 07/01/17 - 12/31/17 | | | 288,951 | 288,951 | | | 274,503 | | | 274,503 | 14,448 |
| 25A | Affordable Care Act (ACA) Net Reimbursement | 01/01/18 - 06/30/18 | | | 362,082 | 362,082 | | | 340,357 | | | 340,357 | 21,725 |
| 26 | MCAP Net Reimbursement | 07/01/17 - 06/30/18 | | | | | | | | | | | |
| 27 | Total SD/MC Reimbursement Before Excess FFP | 07/01/17 - 06/30/18 | | | | | | | | | | 4,430,487 | |

County: ALAMEDA
County Code: 01

| | | | Total Certified Public Expenditures (CPE) | | | | |
|---|---|---|---|---|---|---|---|
| | | | A | B | C | D | E |
| | | | County | Contract Providers | Total | FMAP | FFP |
| | **Short/Doyle Medi-Cal** | | | | | | |
| 1 | Medi-Cal Administrative Reimbursement | | | | | 50% | |
| 2 | SD/MC Enhanced (Children) Administrative Reimbursement | | | | | 50% | |
| 3 | Medi-Cal Administrative Activities (Svc Functions 01 - 09) | | 162,022 | | 162,022 | 50% | 81,011 |
| 4 | Medi-Cal Administrative Activities (Svc Functions 11 - 19, 31 - 39 ) | | 209,774 | | 209,774 | 50% | 104,887 |
| 5 | Medi-Cal Administrative Activities (Svc Functions 21 - 29) | | 282,725 | | 282,725 | 75% | 212,044 |
| 6 | Utilization Review-Skilled Prof. Med. Personnel (SPMP) | | | | | 75% | |
| 7 | Other SD/MC Utilization Review | | | | | 50% | |
| 8 | SD/MC Net Reimbursement for Direct Services | 07/01/17 - 06/30/18 | 6,278,241 | | 6,278,241 | 50% | 3,139,120 |
| 9 | Enhanced SD/MC Net Reimbursement (Children) E2, E4, E5 | 07/01/17 - 06/30/18 | | | | 65% | - |
| 10 | Enhanced SD/MC Net Reimbursement (Children) | 07/01/17 - 06/30/18 | 316,550 | | 316,550 | 88% | 278,564 |
| 11 | Enhanced SD/MC Net Reimbursement (BCCTP) | 07/01/17 - 06/30/18 | | | | 65% | |
| 12 | Enhanced SD/MC Net Reimbursement (Pregnancy) | 07/01/17 - 06/30/18 | | | | 65% | |
| 13 | Enhanced SD/MC Net Reimbursement (Refugees) | 07/01/17 - 06/30/18 | | | | 100% | |
| 14 | Affordable Care Act (ACA) Net Reimbursement | 07/01/17 - 12/31/17 | 288,951 | | 288,951 | 95% | 274,503 |
| 15 | Affordable Care Act (ACA) Net Reimbursement | 01/01/18 - 06/30/18 | 362,082 | | 362,082 | 94% | 340,357 |
| 16 | MCAP Net Reimbursement | 07/01/17 - 06/30/18 | | | | 88% | - |
| 17 | **Total Short/Doyle Medi-Cal Reimbursement** | 07/01/17 - 06/30/18 | **7,900,345** | | **7,900,345** | | **4,430,487** |

DETAIL COST REPORT

## FUNDING SOURCES

MH 1992 (Rev. 4/18)

FISCAL YEAR 2017 - 2018

County: ALAMEDA
County Code: 01

| | Legal Entity: CITY OF BERKELEY | A | B | C | D | E | F | G | H | I | J | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Legal Entity No.: 00065 | | | Direct Services/MAA | | | | | | | | |
| | | Administration | Utilization Review | Mode 05 Hospital Inpatient | Mode 05 Other 24 Hour Services | Mode 10 Day Services | Mode 15 Outpatient Services | Mode 45 Outreach Services | Mode 55 MAA | Mode 60 Support Services | Total Legal Entity | CROSSCHECKS |
| 1 | Gross Cost | | | | | | 11,168,714 | 1,155,001 | 709,792 | 1,701,804 | 14,735,311 | |
| 2 | Adjustments | | | | | | | | | | | |
| 3 | Adjusted Gross Cost | | | | | | 11,168,714 | 1,155,001 | 709,792 | 1,701,804 | 14,735,311 | OK |
| | Funding Sources | | | | | | | | | | | |
| | Grants | | | | | | | | | | | |
| 4 | SAMHSA Grants | | | | | | | | | | | |
| 5 | PATH Grants | | | | | | | | | | | |
| 6 | RWJ Grants | | | | | | | | | | | |
| 7 | Other Grants | | | | | | | 10,814 | | | 10,814 | |
| 8 | Total Grants Accrued | | | | | | | 10,814 | | | 10,814 | OK |
| 9 | Patient Fees | | | | | | 3,067 | | | | 3,067 | |
| 10 | Patient Insurance | | | | | | | | | | | |
| 11 | Federal IDEA funds | | | | | | | | | | | |
| 12 | Low Income Health Program (LIHP) FFP | | | | | | | | | | | |
| 13 | Regular/Enhanced SD/MC (FFP only) | | | | | | 4,032,545 | | 397,942 | | 4,430,487 | OK MH1979 SDMC MATCH |
| 14 | Medicare - Fed. Share | | | | | | 21,277 | | | | 21,277 | |
| 15 | Conservatorship Admin. Fees | | | | | | | | | | | |
| 16 | Other Revenue | | | | | | 149,187 | | | | 149,187 | |
| 17 | 16-17 SGF Rollover | | | | | | | | | | | |
| 18 | 2011 Realignment | | | | | | | | | | | |
| 19 | 1991 Realignment Funds and MOE | | | | | | 3,213,201 | | 311,850 | | 3,525,051 | |
| 20 | Prior Years MHSA | | | | | | | | | | | |
| 21 | MHSA | | | | | | 3,713,264 | 1,144,187 | | 1,701,804 | 6,559,255 | |
| 22 | County Overmatch | | | | | | | | | | | |
| 23 | CALWORKS | | | | | | | | | | | |
| 27 | State General Fund | | | | | | | | | | | |
| 28 | SB75 Revenue - 07/01/17 - 06/30/18 | | | | | | | | | | | |
| 29 | ACA (5% SGF) - 07/01/17 - 12/31/17 | | | | | | 14,448 | | | | 14,448 | OK MH1979 SDMC MATCH |
| 30 | ACA (6% SGF) - 01/01/18 - 06/30/18 | | | | | | 21,725 | | | | 21,725 | |
| 31 | Total Funding Sources | | | | | | 11,168,714 | 1,155,001 | 709,792 | 1,701,804 | 14,735,311 | OK |
| CROSSCHECKS | ***Line 3 = Line 31*** | **OK** | **OK** | **OK** | **OK** | **OK** | **OK** | **OK** | **OK** | **OK** | **OK** | |
| | ***Amt. to Balance to Line 3:*** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |

**MENTAL HEALTH COMMISSION**
**2/2019 SUBCOMMITTEE UPDATE***

| Subcommittee | Date Formed | Current Subcommittee Members | Meetings Held/or Scheduled |
|---|---|---|---|
| Accountability Subcommittee (Originally named the Fiscal/Programmatic/Accountability Subcommittee) | 10/26/17 | Cheema, Davila, Fine | 11/30/17<br>2/15/18<br>4/13/18<br>7/19/18<br>10/17/18<br>12/7/18<br>2/22/19 |
| Diversity Subcommittee | 4/26/18 | Castro, Fine, Lubke | 5/15/18<br>7/24/18<br>8/21/18<br>9/18/18<br>10/18/18<br>11/19/18<br>1/17/19<br>2/19/19 |
| Site Visit Subcommittee | 4/26/18 | Castro, cheema, Kealoha-Blake, Posey | 5/21/18<br>7/19/18<br>8/21/18<br>11/19/18<br>1/17/19 |
| Membership Subcommittee | 12/13/18 | Heda, Fine, Posey | 1/17/19<br>2/20/19 |

*As of February 2019

Police Use of Restraint Devices—Spit Hoods—to Respond to
People Experiencing Severe Mental Illness and/or Substance Use Disorder Crises
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The Berkeley Police Department is often called as a first responder to individuals who are experiencing severe mental illness and/or substance use disorder crises in the community. In Berkeley, the number of police calls for people having a mental health crisis is 35 percent or more (Dinkelspeil, Berkeleyside; 2015). Over the past 5 years, police have seen a 43 percent increase in calls for 5150s or people who are a danger to themselves or others (Dinkelspeil, Berkeleyside, 2015). As a result, the Berkeley Police Department has committed resources to address those individuals as first responders with crisis inventions and not force, coercion and punishment in the line of duty.

Specifically, the Berkeley Police Department (BPD) specially trains police officers to use crisis intervention responses; the Department has a Crisis Intervention Team. Further, the BPD has a formal partnership with the Division of Mental Health for the Cities of Berkeley and Albany to serve these individuals who need first responders to assist them during crises. Both the Police Department and this Division provide multiple details for coordinated crisis intervention response on their websites, as well as listing other resources.

It is evident the BPD and the Division of Mental Health are designed to work in tandem to respond in these types of crises. Overall BPD serves adults with severe mental illness and substance use disorder who are served by the Adult Clinic of the Division of Mental Health for the Cities of Berkeley and Albany—the public mental health system ("Berkeley Mental Health").

Currently, however, the BPD is reconsidering the use of restraint devices—spit hoods—as an option to address people who engage in spitting and biting during a police encounter. For people needing crisis intervention services in the community, the use of this restraint device can violate their human and civil rights and cause psychological and physical harms. In fact, it may escalate crises. Additionally, some individuals living with severe mental illness and substance use disorder may also live primarily in public spaces so they are more exposed to policing than people who can afford to live in privacy—in part or whole.

Most important, human and civil rights can be violated when police use restraint devices in these types of crises to control or coerce people into police custody. It may violate of the United Nations Convention on Torture, and Other Inhuman, Cruel and Degrading Treatment or Punishment (UNCAT). Amnesty International has publicly commented on how use of spit hoods can violate this international treaty's formal guidelines. The use of spit hoods may further violate the United Nations Convention on the Rights of People with Disabilities.

Police Use of Restraint Devices—Spit Hoods—to Respond to
People with Severe Mental Illness and/or Substance Use Disorder in the Community
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Using restraint devices such as spit hoods may have a disproportionate and discriminatory impact on minorities who are experiencing severe mental illness and/or substance use disorder living in the community. Their use can possibly violate the exercise of civil rights and/or result in discriminatory treatment towards them under civil rights law. It is also notable that mental illness and substance use disorder can both manifest as psychosis to where the diagnoses are indistinguishable and thus, may invoke disability rights protections.

Third, there is the likelihood individuals will be traumatized by a devastating experience of police covering their head with a restraint device; it can create alarming fear, distress, panic and humiliation. There is also risk of serious injuries or death (such as asphyxiation). Using both restraint devices—spit hoods and hand cuffs—can further injure an individual.

Historically, this restraint device has been used in perpetuating extreme human brutality, systemic oppression and monstrous human atrocities. Its use today can immediately traumatize individuals, as well as perpetuate and reinforce generational trauma and horrifying symbolism, especially considering its use against minorities to degrade, torture and execute.

Police claim there is a need to protect their health from individuals who spit and bite and the use of restraint devices like spit hoods will keep them safe. In this regard, there must be an evidence-based approach by city government to justify overriding any human or civil rights violations and likely psychological and physical harms. People living with severe mental illness and substance use disorder are likely more vulnerable than others without disabilities.

The systematic literature review of scientific studies addressing transmission of HIV and Hepititis B and C from spitting and biting can serve as an evidenced-based approach to determining the level of risk, if any, from these types of behaviors. First, a systematic review of studies concluded the risk of transmitting HIV through spitting as no risk, and further concluded the risk through biting as negligible (Cresswell, et al; 2018; 1).

In addition, a systematic literature review of Hepatitis C and B transmission concluded the risk of acquiring Hepititis C (HCV) through spitting as negligible and as very low for Hepititis B (HBV)(Pintillie & Brooks, 2018; 1). This review also showed the risk as low for acquiring HBV and HCV through biting (Pintillie & Brooks, 2018; 1). It is notable that the former study on HIV focused on police, while the later study addressed emergency workers.

Police Use of Restraint Devices—Spit Hoods—to Respond to
People with Severe Mental Illness and/or Substance Use Disorder in the Community
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Overall it is considerably more important to preserve human and civil rights when an evidence-based approach shows this result and there is likely an alternative to using these restraint devices against people experiencing severe mental illness and substance use disorder crises. There are face guards that police can choose to use. Emergency medical and mental health workers may use them in assisting people experiencing these crises and in other roles.

In some localities, mental health clinicians are first responders who accompany police to assist individuals experiencing severe mental health and substance use disorder crises in the community. The aim again is not to use force, coercion and/or punishment. If anything, the use of restraint devices like spit hoods may result in more severe harms as here is no visual ability to observe individual's face and head while in crisis.

For these reasons, the Berkeley Police Department should not use restraint devices like spit hoods in the line of duty. Thank you for your time.

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ORIGINAL RESEARCH

# A systematic review of risk of HIV transmission through biting or spitting: implications for policy

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**Objectives**

The perceived threat of HIV transmission through spitting and biting is evidenced by the increasing use of "spit hoods" by Police Forces in the UK. In addition, a draft parliamentary bill has called for increased penalties for assaults on emergency workers, citing the risk of communicable disease transmission as one justification. We aimed to review literature relating to the risk of HIV transmission through biting or spitting.

**Methods**

A systematic literature search was conducted using Medline, Embase and Northern Lights databases and conference websites using search terms relating to HIV, AIDS, bite, spit and saliva. Inclusion and exclusion criteria were applied to identified citations. We classified plausibility of HIV transmission as low, medium, high or confirmed based on pre-specified criteria.

**Results**

A total of 742 abstracts were reviewed, yielding 32 articles for full-text review and 13 case reports/series after inclusion and exclusion criteria had been applied. There were no reported cases of HIV transmission related to spitting and nine cases identified following a bite, in which the majority occurred between family (six of nine), in fights involving serious wounds (three of nine), or to untrained first-aiders placing fingers in the mouth of someone having a seizure (two of nine). Only four cases were classified as highly plausible or confirmed transmission. None related to emergency workers and none were in the UK.

**Conclusions**

There is no risk of transmitting HIV through spitting, and the risk through biting is negligible. Post-exposure prophylaxis is not indicated after a bite in all but exceptional circumstances. Policies to protect emergency workers should be developed with this evidence in mind.

**Keywords:** bite, emergency workers, HIV, spit, transmission

*Accepted 4 April 2018*

## Introduction

Detailed epidemiological studies since the 1990s have provided insight into the risk of HIV transmission through sexual exposure and needlestick injuries, and have informed policy and behaviour around the use of barrier contraception, universal precautions and HIV post-exposure prophylaxis (PEP) [1–8]. Recent longitudinal studies have also shown that HIV-positive individuals on antiretroviral therapy (ART) with an undetectable plasma HIV viral load do not transmit HIV and there is increasing acceptance of the concept "undetectable = untransmissible" (U=U) [9,10]. National guidelines on HIV PEP have used these data in informing their recommendations. Provision of PEP is not recommended following potential exposure from biting and spitting; however, the risk of HIV transmission

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from such exposures has not been systematically evaluated [11].

In the UK, human bite injuries are a common presentation to the emergency department, comprising around 0.1% of all attendances [12]. Bites represent an occupational risk to emergency workers such as policemen, paramedics, doctors and nurses, and are more likely to occur when dealing with patients with seizures, aggressive members of the public, children and those with cognitive impairment [13]. In the USA there are an estimated 622 bites to emergency workers per year [14]. A retrospective 4-year review of attendees to a single UK emergency department identified 421 presentations with human bites, amounting to one every 3 days [12]. Bites vary in severity from petechial haemorrhage to contusion, abrasion, laceration and avulsion [15].

Spitting represents another occupational hazard faced by emergency workers, with the Metropolitan Police alone reporting 264 spitting incidents between 2014 and 2016 [16]. Saliva has been shown to lyse HIV particles *in vitro* as a result of hypotonicity and many salivary proteins inhibit and inactivate HIV particles [17].

The perceived threat of HIV and other blood-borne virus transmission through spitting and biting is evidenced by the increasing use by police forces of "spit hoods" (which are placed on potential assailants to reduce the risk of exposure to arresting officers). As of November 2016, 17 out of 49 police forces in the UK now use "spit hoods" [18]. In addition, a draft parliamentary bill has called for increased penalties for assaults on emergency workers, citing the risk of communicable disease transmission as one justification [19]. The draft bill also recommends mandatory provision of "intimate samples, without reasonable excuse" from those accused of spitting on emergency workers, with refusal to provide such specimens punishable as an offence. In the USA, harsh sentencing for those accused of spitting while knowingly HIV positive has been carried out, with the accused charged with causing harm by "means of a deadly weapon" [20].

We undertook a systematic literature review of HIV transmission related to biting or spitting to ensure that decisions about future policy and practice pertaining to biting and spitting incidents are informed by current medical evidence.

## Methods

### PICO (P, patient, problem or population; I, intervention; C, comparison, control or comparator; O, outcome)

The authors used the PICO framework, with the PICO "question" being formulated and answered as follows: (1) population: adults, adolescents and children; (2) intervention: bites, spitting; (3) comparator: none; (4) outcome: HIV transmission or documented absence of HIV transmission.

### Search strategy

The goal was to identify evidence relating to the risk of transmission, or lack of transmission of HIV following a biting or spitting incident. A systematic electronic search was conducted using Medline, Embase and Northern Lights databases from inception to 5 January 2018. Key natural language and controlled vocabulary search terms were used related to "HIV", "human immunodeficiency virus", "AIDS", "acquired immune deficiency syndrome" AND "bites", "bitten" OR "spit", "spat", "spitting". A second search was run using the terms relating to "HIV transmission" AND "saliva". For full search terms, see Supporting Information Notes S1. We also hand searched the British HIV Association conference abstracts from 2007 onwards and Conference for Retroviruses and Opportunistic Infections abstracts from 2014 onwards, as well as the reference lists from the papers we reviewed.

### Eligibility criteria

The following inclusion criteria were applied in article selection for full-text review: (1) exposure of interest (biting, spitting or saliva) discussed and (2) outcome of interest described (by documented HIV antibody testing, with or without additional antigen testing, HIV viral load testing or phylogenetic analysis) or absence of HIV seroconversion (by documented negative HIV antibody test).

### Study selection

Two reviewers (JH and TR) independently conducted selection for full-text review by applying eligibility criteria to titles and abstracts. Two reviewers (JE and FVC) then independently assessed full-text articles for how HIV transmission had been determined and excluded articles that did not describe the exposure and outcome of interest or did not provide original case data such as narrative reviews. A list of studies for inclusion was finalized.

### Assessment of quality and data extraction

Reviewers designed a data extraction tool and independently applied it to each article. Data were extracted on study design, the perpetrator (HIV status, HIV viraemia, presence of blood in the mouth of the perpetrator,

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whether medically unwell and use of ART), the nature of the incident (whether biting or spitting, and the severity of the wound inflicted), the timing of HIV diagnosis, the nature of HIV testing and other HIV risk factors. Data were compared for consistency. No formal statistical analyses were undertaken in view of the nature of the studies identified.

No randomized controlled trials or cohort or case–control studies were identified, so a formal tool to assess risk of bias for the articles identified was not used. Instead, we discussed the plausibility of HIV transmission being attributable to the incident described based on documentation of baseline HIV status, the nature of the injury, the temporal relationship between the incident and a positive HIV test and phylogenetic analysis, where available. The plausibility of the incident being responsible for the subsequent HIV diagnosis was then classified as low, medium, high or confirmed based on pre-specified criteria (Table 1). Any disagreements were resolved by consensus or a third reviewer (JH).

## Results

### Search results and study selection

Our literature search found 1357 citations: 1342 via database searches, and 15 from hand searching of conferences and reference lists. Of these, 615 were duplicates, leaving 742 for title or abstract review. A further 710 were removed because they clearly did not meet the inclusion criteria based on information contained in the title or abstract. The remaining 32 articles underwent full-text review, of which 19 were subsequently removed because they met the exclusion criteria (no primary data, $n$ = 13; exposure of interest not described, $n$ = 1; outcome of interest not described, $n$ = 5), leaving 13 articles in the final data set (Fig. 1).

### Study characteristics and quality

Of the 13 studies selected, 11 were case reports and two were case series detailing HIV transmission, or absence of HIV transmission, following a biting episode. There were no reported cases of HIV transmission attributable to spitting. Several of the selected studies were published during the 1980s and 1990s prior to the availability of potent ART.

Of the 13 identified articles that reported alleged HIV transmission related to biting, none related to a bite in the UK and none concerned emergency care workers. The reports included information on a total of 23 people bitten by HIV-positive individuals, of whom nine (39%) seroconverted to HIV positivity following the incident and 14 (61%) did not seroconvert (Table 2). Of these, the alleged transmissions occurred between family members (six of nine), in fights involving infliction of serious wounds (three of nine), or as a result of untrained first-aiders placing fingers in the mouth of someone having a seizure (two of nine).

There was significant heterogeneity in the quality of the reports: a minority had a negative baseline HIV test in the person bitten (two of nine) or phylogenetic analysis of viruses (three of nine). Only four cases in total were classified as having high plausibility or confirmation of HIV infection being attributable to the bite.

### Highly plausible or confirmed cases of HIV transmission following bites

*Vidmar et al.* [21]

A first aider was bitten on the hand during a seizure by a man with advanced HIV disease. The biter had confirmed blood in his mouth and was on zidovudine monotherapy, his HIV viral load (VL) was not known and he died 13 days after the incident of primary central nervous system (CNS) lymphoma. The first aider had broken skin at the site of the bite and was HIV-negative on the day of

Table 1 Criteria applied to determine plausibility of HIV transmission relating to incident

| | Plausibility | | | |
|---|---|---|---|---|
| | Low | Medium | High | Confirmed |
| Number of cases | 3 | 2 | 1 | 3 |
| Documented baseline negative HIV test | No | No | Yes or no | Yes or no |
| Temporal relationship | Positive HIV test a significant time after the incident | Positive HIV a significant time after incident | HIV seroconversion within 2 months of incident | HIV seroconversion within 2 months of incident |
| Phylogenetic analysis | Not done | Not done | Not done | Phylogenetic analysis suggestive of transmission |
| Other potential source of HIV infection | Other HIV risk factors prior to positive HIV test | No other HIV risk factors prior to positive HIV test | No other HIV risk factors | No other HIV risk factors |

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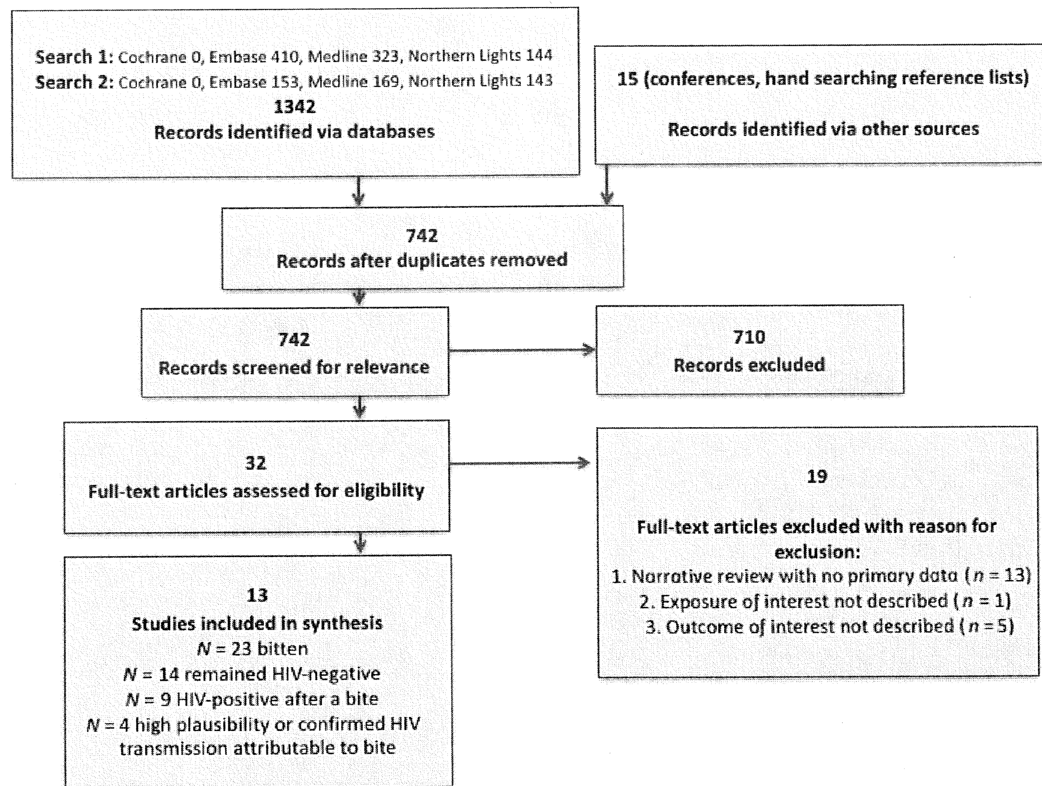


**Fig. 1** Flowchart illustrating outcomes of search citations.

the incident. Despite post-exposure prophylaxis (zidovudine 1200 mg once daily), 33 days later the recipient developed an acute illness and antibody seroconversion was confirmed 54 days after the incident. The recipient had no other risk factors for HIV infection identified.

*Centers for Disease Control and Prevention* [22]

A person sustained multiple bites from an HIV-positive woman who was reported to have bleeding gums, but who had unknown HIV stage, VL and ART status. It is not reported whether the bites resulted in skin breakage. The recipient was confirmed HIV-negative immediately after the attack and seroconverted 6 weeks later, with RNA sequencing confirming that the perpetrator and recipient shared the same viral strain.

*Deshpande et al.* [23]

A father sustained a bite from his HIV-positive son, causing avulsion of the thumb nail and leaving an exposed bleeding nail bed. The father was not screened for HIV at the time of the bite but presented 4 weeks later with a meningoencephalitis and was found to have acute HIV infection. The son had never received ART and had a VL of 17 163 HIV-1 RNA copies/ml in plasma and 2405 copies/mL in saliva. There were no other risk factors for HIV transmission reported. Sequencing revealed 91% homology between perpetrator and donor HIV RNA.

*Andreo et al.* [24]

A mother was bitten by her son in the context of a seizure. The son was subsequently diagnosed with neurotoxoplasmosis and HIV infection. Blood from a bitten tongue was present in the son's mouth at the time of the incident. The mother's wound was deep and required suturing. She was not screened for HIV at the time of the incident but presented 27 days later with fever and was found to be HIV-positive. DNA sequencing demonstrated that viruses from the mother and son belonged to the same HIV-1 quasi-species.

## Medium plausibility of HIV transmission following a bite

*Bartholomew and Jones* [25]

A 3-year-old child, born to an HIV-negative mother, was bitten by her father who had dental caries and bleeding gums. He was found to be HIV positive 3 years later (CD4 count 4 cells/$\mu$L; HIV VL not measured) and died soon afterwards. The child was therefore tested for HIV and

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Table 2 Summary table of articles included in final data set

| Authors [reference] | Year | Country | Exposure (nature of incident) | Outcome (HIV seroconversion) | Nature of injury | Number exposed | Blood in mouth of perpetrator | Perpetrator HIV viraemic* | Perpetrator on ART | Plausibility of transmission attributable to bite | Comment |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Tereskerz *et al.* [14] | 1996 | USA | Bite (HCW) | No | Skin intact | 1 | Unknown | Unknown | Unknown | NA | 50 bites; 1.7% from a known HIV-positive individual; no transmission reported |
| Tsoukas *et al.* [30] | 1988 | Canada | Bites (HCW) | No | Skin intact ($n = 5$), skin broken ($n = 3$) | 8 | Yes | Yes | No | NA | 2.5-year follow-up |
| Drummond [31] | 1986 | Unknown | Bite (during seizure) | No | Skin broken | 1 | Unknown | Yes | No | | 18-month follow-up |
| Shirley and Ross [32] | 1989 | USA | Bite (community, intentional) | No | Skin intact | 4 | Unknown | Yes | No | NA | Good follow-up of cases |
| Vidmar *et al.* [21] | 1996 | Slovenia | Bite (during seizure) | Yes | Skin broken (nail) | 1 | Yes | Yes | ZDV monotherapy | High | Blood in mouth from bitten tongue and a deep injury caused to nail bed. Baseline HIV test negative and seroconversion within 1 month |
| Akani *et al.* [28] | 2007 | Nigeria | Bite (community, intentional) | Yes | Deep bite (lip (sutured) | 1 | No | Unknown | Unknown | Low | HIV test negative 1 year previously but had been sexually active in the interim. Tested HIV positive during antenatal care |
| Batholomew and Jones [25] | 2006 | Trinidad | Bite (community, intentional) | Yes | Skin broken | 1 | Yes | Yes | No | Medium | Child tested HIV positive 4 years after being bitten by father. No baseline HIV test. No other HIV risk factors reported |
| CDC [22] | 1996 | USA | Bite (community, intentional) | Yes | Multiple bites | 1† | Yes | Unknown | No | Confirmed | HIV negative at time of bite and confirmed linkage on phylogenetics |
| Deshpande *et al.* [23] | 2011 | India | Bite (community, intentional) | Yes | Deep bite (nail bed exposed) | 1 | No | 17 163 copies/mL (plasma); 2405 copies/mL (saliva) | No | Confirmed | High-risk injury. 91% sequence homology on phylogentic analysis |
| Wahn *et al.* [26] | 1986 | Germany | Bite (community, intentional) | Yes | Skin intact | 1 | No | Yes | No | Medium | Child bitten by sibling 6 months prior to his death from AIDS. No baseline HIV test. Tested HIV positive after death of sibling. No other HIV risk factors reported |

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Table 2 (*Continued*)

| Authors [reference] | Year | Country | Exposure (nature of incident) | Outcome (HIV seroconversion) | Nature of injury | Number exposed | Blood in mouth of perpetrator | Perpetrator HIV viraemic* | Perpetrator on ART | Plausibility of transmission attributable to bite | Comment |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Anonymous [29] | 1987 | Unknown | Bite (community, intentional) | Yes | Bite to leg | 1 | Yes | Yes | No | Low | HIV negative 4 years before the bite. HIV positive when tested 2 years post incident. Untraceable sexual partner. Higher risk injury as blood in mouth from teeth being knocked out |
| Khajotia [27] | 1997 | Columbia | Bite (community, unintentional) | Yes | Mucosa on lip broken by kissing | 1 | No | Unknown | Unknown | Low | Bite is unlikely route of transmission: the biter was not confirmed to be HIV positive; recipient remained HIV negative at 7 months after bite and seroconverted 10 months after the bite |
| Andreo *et al.* [24] | 2004 | Brazil | Bite (during seizure) | Yes | Deep bite (sutured) | 1 | Yes | Yes | No | Confirmed | Mother bitten by son during a seizure relating to AIDS-defining illness. Seroconversion 27 days later and phylogenetic linkage |

*Protagonist presumed viraemic if report is from pre-ART era or protagonist has AIDS-defining or critical illness in the absence of documented ART.
†Two cases described. Only one description provided original data; the other was a repetition of a case reported elsewhere.
ART, antiretroviral therapy; CDC, Centers for Disease Control and Prevention; HCW, health care worker; ZDV, zidovudine.

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found to be HIV positive. No other risk factors were reported. No phylogenetic analysis was undertaken.

*Wahn et al.* [26]
A child was bitten by his brother who died 6 months after the incident and was diagnosed with toxoplasmosis and HIV infection post-mortem (having received HIV-infected blood during prior cardiac surgery). Family members were screened after his death and the child who had sustained the bite was found to be HIV-positive. The bite allegedly did not result in skin breakage and there was no documentation of blood in the biting child's mouth.

### Low plausibility of HIV transmission following a bite

*Khajotia* [27]
A man alleged that he contracted HIV infection from kissing during which he sustained a bite on the lip with skin breakage. He reported that the lady who bit his lip was a commercial sexual worker, although she was never confirmed to be HIV positive. He was not screened for HIV at the time of the incident but self-reported multiple negative HIV tests in the subsequent 7 months. He was found to be HIV seropositive while undergoing investigation for gastroenteritis 10 months later. He denied any other risk factor for HIV transmission.

*Akani et al.* [28]
During a fight, a woman was bitten on the lip by her HIV-positive relative. The HIV stage and ART history of the perpetrator were not known, nor was it known whether she had blood in her mouth at the time of the incident. The bite resulted in a deep lip wound requiring suturing. The recipient was not tested for HIV at the time of the bite, but was found to be HIV-positive during antenatal screening 1 year later. The recipient self-reported a negative HIV test prior to the bite, self-reported that her husband was HIV-negative and denied other risk factors for HIV infection, although she had been sexually active and fallen pregnant in the interim.

*Anonymous* [29]
A woman was bitten by her HIV-positive sister during a fight. The perpetrator was known to be HIV positive and had blood in her mouth at the time of the bite, although her HIV stage, VL and ART status at the time of the incident were not reported. It was not reported whether the bite resulted in breakage of the skin. The recipient was not screened for HIV at the time of the bite, but was found to be HIV seropositive on occupational screening 2 years later. She had a documented negative HIV test 2 years prior to the bite and disclosed three sexual partners in the interim, two of whom were reportedly HIV negative but one of whom was untraceable.

## Discussion

We sought to evaluate the risk of HIV transmission from biting or spitting incidents through a systematic review of all English language literature published since the start of the HIV epidemic. Of the 742 records reviewed, there were no published cases of HIV transmission attributable to spitting, which supports the conclusion that being spat on by an HIV-positive individual carries no possibility of transmitting HIV. Despite biting incidents being commonly reported occurrences, there were only a handful of case reports of HIV transmission secondary to a bite, suggesting that the overall risk of HIV transmission from being bitten by an HIV-positive person is negligible. The risk of transmission of other blood-borne viruses through biting and spitting is beyond the scope of this review and warrants further investigation.

There was significant heterogeneity in the quality of the published reports detailing HIV transmission secondary to biting episodes. Poor-quality case reports that were published as evidence of HIV transmission secondary to a bite included those in which: (1) the recipient had no HIV-negative test at baseline; (2) the recipient had other significant potential risk factors for HIV transmission; (3) HIV seroconversion was reported to have occurred at a time interval incompatible with transmission secondary to the bite. Therefore, of the nine reported cases of HIV infection potentially attributable to a bite, the scientific plausibility of the reports was variable and in only three cases were the attributions confirmed by RNA sequencing.

There were four cases of highly plausible HIV transmission resulting from a bite. In each case, the perpetrator had advanced HIV infection, was not on combined ART and was therefore likely to have high-level HIV viraemia. In the majority of these cases, the bite resulted in a deep wound and the perpetrator had blood in the mouth at the time of the incident. Two cases occurred in the context of a seizure whereby an untrained first-aid responder was bitten while trying to protect the seizing person's airway. It is therefore important that both emergency workers and first-aid responders are trained in safe seizure management including noninvasive airway protection and use of universal precautions. It is important to note that we found no cases where an emergency care worker or police officer acquired HIV infection through being bitten.

Strengths of this systematic review include the comprehensive search strategy adopted and the clear

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population, intervention and outcome criteria that were adhered to. Data were extracted systematically by two independent reviewers and study quality and validity were considered and described throughout. A limitation of this review is that we only included published English language literature. More important limitations relate to the limitations of the available evidence; firstly, to date there have been no prospective studies in which the actual number of biting or spitting incidents by HIV-positive individuals in a given time, or associated HIV seroconversions, have been documented. Secondly, two sources of bias may be important. Publication bias may potentially result in only cases of HIV seroconversion being published (significant result) as opposed to cases of no seroconversion, which could result in overestimation of the risk. Conversely, ascertainment bias, whereby individuals who have HIV-seroconverted are not asked about biting and spitting incidents and the transmission is put down to a sexual exposure, may lead to an underestimation of the risk. The overall direction of bias is difficult to predict.

Data from England suggest that there were 89 400 people living with HIV at the end of 2016, of whom 82% had an undetectable VL, and were thus not capable of transmitting infection; this proportion has increased significantly in recent years. Current UK guidance on indications for PEP state that ‘PEP is not recommended following a human bite from an HIV positive individual unless in “extreme circumstances” and after discussion with a specialist’ [11]. Necessary conditions for the transmission of HIV from a human bite appear to be the presence of untreated HIV infection, severe trauma (involving puncture of the skin), and usually the presence of blood in the mouth of the biter. In the absence of these conditions, PEP is not indicated, as there is no risk of transmission.

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*Conflicts of interest:* The authors have no conflicts of interest.

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[Correction added on 29 June 2018, after first online publication: Reference 22 was changed to “To transmit HIV, biter must have blood in the mouth. *AIDS Policy & Law*. 1996; 11: 5”]

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## Supporting Information

Additional Supporting Information may be found in the online version of this article at the publisher's web-site:

**Notes S1.** Full search description for HIV transmission by human bite and spitting

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Journal of Viral Hepatitis / Volume 25, Issue 12

COMMENTARY

# Commentary: A review of risk of hepatitis B and C transmission through biting or spitting

Hannah Pintilie, Gary Brook

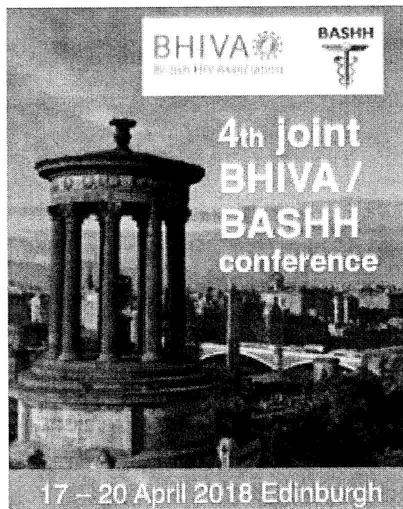
First published: 26 July 2018
https://doi.org/10.1111/jvh.12976

## Abstract

A draft UK Parliamentary Bill sought to criminalize assaults on emergency workers through biting and spitting. This seemed to be based on a fear of bloodborne virus transmission. We undertook a literature search to clarify the risk of hepatitis infection from such exposures. We identified 245 possible papers and then reduced these to those relevant to HBV and HCV transmission through biting or spitting and the scientific plausibility. Nine papers were identified, reporting 16 possible cases of HBV (15 bites, 1 spitting) and 2 of HCV transmission (both bites). Only 3 HBV transmissions by bites and 1 by spitting and both HCV transmissions were felt to be plausible. Although both HBV DNA and HCV RNA can be found in the saliva of infected patients, it seems unlikely that there is enough to transmit infection unless there is blood contamination. In conclusion, the risk of acquiring HCV through spitting is negligible and is very low for HBV. The risk is also low for acquiring HBV and HCV through biting, especially if no blood is apparent in the saliva.

# Zero or negligible risks of HIV, HBV or HCV transmission by biting or spitting

21 May 2018. Related: Conference reports, Prevention and transmission, BHIVA/BASHH 4th Edinburgh 2018.




**Simon Collins, HIV i-Base**

**Two related posters presented results from literature searches on the risk of transmission of HIV or viral hepatitis from biting or spitting. These reviews were prompted by recent parliamentary debates on a proposed parliamentary bill that sought to increase penalties for assaults on staff.**

The HIV review concluded "there is no risk of transmitting HIV through spitting and only a negligible risk from biting" and that this would be zero too if someone is on ART. Policy to protect emergency workers should be made with this evidence in mind, and balanced with respecting the rights and dignity of people living with HIV.

The hepatitis review concluded "although transmission of HBV and HCV via spitting or biting is biologically plausible, the virulence and risk of this is not established. Only a small number of transmissions of HBV and HCV from spitting or bite injuries have been reported and that the overall risk appears to be very low."

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Links to other websites are current at date of posting but not maintained.

Information on this website is provided by treatment advocates and offered as a guide only. Decisions about your treatment should always be taken in consultation with your doctor.

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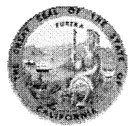
# Specialty Mental Health Services (SMHS)

- Mental Health Services (Assessment, plan development, rehabilitation, collateral, individual and group therapy)
- Crisis intervention services
- Crisis stabilization services
- Day treatment intensive services
- Day rehabilitation services



# Specialty Mental Health Services (SMHS) (cont.)

- Adult residential treatment services
- Crisis residential treatment services
- Medication support services
- Psychiatric health facility services
- Psychiatric inpatient hospital services
- Targeted case management
- Therapeutic behavioral services
- Pathways to Well-Being services (Intensive Care Coordination, Intensive Home Based Services, and Therapeutic Foster Care services)

# Specialty Mental Health Services

## Mental Health Services

Individual or group therapies and interventions are designed to provide a reduction of mental disability and restoration, improvement or maintenance of functioning consistent with the goals of learning, development, independent living, and enhanced self-sufficiency. These services are separate from those provided as components of adult residential services, crisis intervention, crisis stabilization, day rehabilitation, or day treatment intensive. Service activities may include, but are not limited to:

1. Assessment - A service activity designed to evaluate the current status of mental, emotional, or behavioral health. Assessment includes, but is not limited to, one or more of the following: mental status determination, analysis of the clinical history, analysis of relevant cultural issues and history; diagnosis; and the use of mental health testing procedures.
2. Plan Development - A service activity that consists of development of client plans, approval of client plans, and/or monitoring and recording of progress.
3. Therapy - A service activity that is a therapeutic intervention that focuses primarily on symptom reduction as a means to reduce functional impairments. Therapy may be delivered to an individual or group and may include family therapy at which the client is present.
4. Rehabilitation - A service activity that includes, but is not limited to, assistance, improving, maintaining or restoring functional skills, daily living skills, social and leisure skills, grooming and personal hygiene skills; obtaining support resources; and/or obtaining medication education.
5. Collateral - A service activity involving a significant support person in the beneficiary's life for the purpose of addressing the mental health needs of the beneficiary in terms of achieving goals of the beneficiary's client plan. Collateral may include, but is not limited to, consultation and training of the significant support person(s) to assist in better utilization of mental health services by the client, consultation and training of the significant support person(s) to assist in better understanding of mental illness, and family counseling with the significant support person(s) in achieving the goals of the client plan. The client may or may not be present for this service activity.

## Crisis Intervention Services

Crisis intervention services last less than 24 hours and are for, or on behalf of, a beneficiary for a condition that requires more timely response than a regularly scheduled visit. Service activities include, but are not limited to, assessment, collateral and therapy. Crisis Intervention services may either be face-to-face or by telephone

with the beneficiary or the beneficiary's significant support person and may be provided anywhere in the community.

**Crisis Stabilization Services**
Crisis stabilization services last less than 24 hours and are for, or on behalf of, a beneficiary for a condition that requires a more timely response than a regularly scheduled visit. Service activities include but are not limited to one or more of the following: assessment, collateral, and therapy. Collateral addresses the mental health needs of the beneficiary to ensure coordination with significant others and treatment providers.

**Day Treatment Intensive Services (Half-Day & Full-Day)**
Day treatment intensive services are a structured, multi-disciplinary program of therapy that may be used as an alternative to hospitalization, or to avoid placement in a more restrictive setting, or to maintain the client in a community setting and which provides services to a distinct group of beneficiaries who receive services for a minimum of three hours per day (half-day) or more than four hours per day (full-day). Service activities may include, but are not limited to, assessment, plan development, therapy, rehabilitation and collateral. Collateral addresses the mental health needs of the beneficiary to ensure coordination with significant others and treatment providers.

**Day Rehabilitation (Half-Day & Full-Day)**
Day rehabilitation services are a structured program of rehabilitation and therapy with services to improve, maintain or restore personal independence and functioning, consistent with requirements for learning and development and which provides services to a distinct group of beneficiaries who receive services for a minimum of three hours per day (half-day) or more than four hours per day (full-day). Service activities may include, but are not limited to assessment, plan development, therapy, rehabilitation and collateral. Collateral addresses the mental health needs of the beneficiary to ensure coordination with significant others and treatment providers.

**Adult Residential Treatment Services**
Adult Residential Treatment Services are rehabilitative services provided in a non-institutional, residential setting for beneficiaries who would be at risk of hospitalization or other institutional placement if they were not receiving residential treatment services. The services include a wide range of activities and services that support beneficiaries in their effort to restore, maintain, and apply interpersonal and independent living skills and to access community support systems. Service activities may include assessment, plan development, therapy, rehabilitation, and collateral. Collateral addresses the mental health needs of the beneficiary to ensure coordination with significant others and treatment providers.

**Crisis Residential Services**
Crisis residential services provide an alternative to acute psychiatric hospital services for beneficiaries who otherwise would require hospitalization. The CRS programs for adults provide normalized living environments, integrated into residential communities.

The services follow a social rehabilitation model that integrates aspects of emergency psychiatric care, psychosocial rehabilitation, milieu therapy, case management and practical social work.

**Medication Support Services**
Medication support services include prescribing, administering, dispensing and monitoring of psychiatric medications or biologicals that are necessary to alleviate the symptoms of mental illness. Service activities may include but are not limited to: evaluation of the need for medication; evaluation of clinical effectiveness and side effects; obtaining informed consent; instruction in the use, risks and benefits of, and alternatives for, medication; collateral and plan development related to the delivery of service and/or assessment for the client; prescribing, administering, dispensing and monitoring of psychiatric medications or biologicals; and medication education.

**Psychiatric Health Facility (PHF) Services**
A Psychiatric Health Facility is a facility licensed under the provisions beginning with Section 77001 of Chapter 9, Division 5, Title 22 of the California Code of Regulations. "Psychiatric Health Facility Services" are therapeutic and/or rehabilitative services provided in a psychiatric health facility on an inpatient basis to beneficiaries who need acute care, which meets the criteria of Section 1820.205 of Chapter 11, Division 1, Title 9 of the California Code of Regulations, and whose physical health needs can be met in an affiliated general acute care hospital or in outpatient settings. These services are separate from those categorized as "Psychiatric Inpatient Hospital".

**Psychiatric Inpatient Hospital Services**
Psychiatric inpatient hospital services include both acute psychiatric inpatient hospital services and administrative day services. Acute psychiatric inpatient hospital services are provided to beneficiaries for whom the level of care provided in a hospital is medically necessary to diagnose or treat a covered mental illness. Administrative day services are inpatient hospital services provided to beneficiaries who were admitted to the hospital for an acute psychiatric inpatient hospital service and the beneficiary's stay at the hospital must be continued beyond the beneficiary's need for acute psychiatric inpatient hospital services due to lack of residential placement options at non-acute residential treatment facilities that meet the needs of the beneficiary.

Psychiatric inpatient hospital services are provided by SD/MC hospitals and FFS/MC hospitals. MHPs claim reimbursement for the cost of psychiatric inpatient hospital services provided by SD/MC hospitals through the SD/MC claiming system. FFS/MC hospitals claim reimbursement for the cost of psychiatric inpatient hospital services through the Fiscal Intermediary. MHPs are responsible for authorization of psychiatric inpatient hospital services reimbursed through either billing system. For SD/MC hospitals, the daily rate includes the cost of any needed professional services. The FFS/MC hospital daily rate does not include professional services, which are billed separately from the FFS/MC inpatient hospital services via the SD/MC claiming system.

## Targeted Case Management (TCM)

Targeted case management is a service that assists a beneficiary in accessing needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. The service activities may include, but are not limited to, communication, coordination and referral; monitoring service delivery to ensure beneficiary access to services and the service delivery system; monitoring of the beneficiary's progress, placement services, and plan development. TCM services may be face-to-face or by telephone with the client or significant support persons and may be provided anywhere in the community. Additionally, services may be provided by any person determined by the MHP to be qualified to provide the service, consistent with the scope of practice and state law.

## Therapeutic Behavioral Services (TBS)

Therapeutic behavioral services are intensive, individualized, short-term outpatient treatment interventions for beneficiaries up to age 21. Individuals receiving these services have serious emotional disturbances (SED), are experiencing a stressful transition or life crisis and need additional short-term, specific support services to accomplish outcomes specified in the written treatment plan.

## Intensive Care Coordination (ICC)

Intensive Care Coordination is a targeted case management service that facilitates assessment of, care planning for and coordination of services to beneficiaries under age 21 who are eligible for the full scope of Medi-Cal services and who meet medical necessity criteria for this service. ICC service components include: assessing; service planning and implementation; monitoring and adapting; and transition. ICC services are provided through the principles of the Core Practice Model (CPM), including the establishment of the Child and Family Team (CFT) to ensure facilitation of a collaborative relationship among a youth, his/her family and involved child-serving systems. The CFT is comprised of – as appropriate, both formal supports, such as the care coordinator, providers, case managers from child-serving agencies, and natural supports, such as family members, neighbors, friends, and clergy and all ancillary individuals who work together to develop and implement the client plan and are responsible for supporting the child/youth and family in attaining their goals. ICC also provides an ICC coordinator who:

- Ensures that medically necessary services are accessed, coordinated and delivered in a strength-based, individualized, family/youth driven and culturally and linguistically competent manner and that services and supports are guided by the needs of the child/youth;
- Facilitates a collaborative relationship among the child/youth, his/her family and systems involved in providing services to the child/youth;
- Supports the parent/caregiver in meeting their child/youth's needs;
- Helps establish the CFT and provides ongoing support; and
- Organizes and matches care across providers and child serving systems to allow the child/youth to be served in his/her community

## Intensive Home Based Services (IHBS)

Intensive Home Based Services are individualized, strength-based interventions designed to ameliorate mental health conditions that interfere with a child/youth's functioning and are aimed at helping the child/youth build skills necessary for successful functioning in the home and community and improving the child/youth's family's ability to help the child/youth successfully function in the home and community. IHBS services are provided according to an individualized treatment plan developed in accordance with the Core Practice Model (CPM) by the Child and Family Team (CFT) in coordination with the family's overall service plan which may include IHBS. Service activities may include, but are not limited to assessment, plan development, therapy, rehabilitation and collateral. IHBS is provided to beneficiaries under 21 who are eligible for the full scope of Medi-Cal services and who meet medical necessity criteria for this service.

## Therapeutic Foster Care (TFC) Services

The (TFC) service model allows for the provision of short-term, intensive, highly coordinated, trauma informed and individualized SMHS activities (plan development, rehabilitation and collateral) to children and youth up to age 21 who have complex emotional and behavioral needs and who are placed with trained, intensely supervised and supported TFC parents. The TFC parent serves as a key participant in the therapeutic treatment process of the child or youth. The TFC parent will provide trauma informed interventions that are medically necessary for the child or youth. TFC is intended for children and youth who require intensive and frequent mental health support in a family environment. The TFC service model allows for the provision of certain SMHS activities (plan development, rehabilitation and collateral) available under the EPSDT benefit as a home-based alternative to high level care in institutional settings such as group homes and an alternative to Short Term Residential Therapeutic Programs (STRTPs). The TFC service model will be implemented, effective January 1, 2017.

THE HOMELESS

# They were Sacramento County's 250 costliest, most vulnerable homeless. A new effort is helping.

BY ALEXANDRA YOON-HENDRICKS

JANUARY 25, 2019 03:30 AM, UPDATED JANUARY 25, 2019 02:46 PM

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Marcelous Bell, holding his newborn girl in the crook of his arm and with a roof over his head to call his own, is a new man.

By his account, at 18, while he was still a senior in high school in Sacramento, his mother kicked him out of his house after a chaotic upbringing. He was always "different" from his family, he said, but once he was finally "exiled," and his mother was arrested and sent to jail, Bell was lost – "Where do I go from here?" he wondered.

"From being out there woken up 3 o' clock in the morning, 2 o' clock in the morning by the police, just to tell you to leave when you want to sleep, and then it's so cold outside that your bones are achy," Bell recalled.

"I'd wake up at 4 o' clock to catch a train just to ride around for two hours before you go to school," he said, "and then you're not going to be able to tell your friends or teachers, because you're embarrassed or they might think less of you."


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Couch-surfing with friends and family lasted only so long, he said. He had a "short fuse" and was angry all the time. Though Bell had a loving, long-term girlfriend, his new lifestyle pushed him towards crime, he said. He used to go to Wind Youth Services, but finding a shelter that would accept the young man despite his criminal record proved challenging — until last year, when he was tapped for a new program focused on assisting the county's costliest and most vulnerable homeless individuals.

One year after Sacramento County launched the $5.1 million program to house and provide wrap-around social services to 250 homeless individuals who were top users of public resources, officials and homeless advocates say their efforts are working.

As of January, 213 of the 250 individuals identified by the county have enrolled in the

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"It was hell," Bell said. "But I always knew that if I kept my head in the right place I could make it out."

A study by county staff found that the group of high-frequency users cost Sacramento County more than $11 million in 2015-16 after breaking down the cost of services such as jail stays, ambulance rides, emergency police response and addiction and mental health treatment.

Pete Taneyhill, the man who used more services than any other homeless person in the agency's records, cost the county nearly $150,000 a year. With the county's help, he secured an apartment, a job and a car, and he recently graduated from re-entry court, a criminal justice realignment program, said the county's program manager Meghan Marshall.

"Without this help, I'd be one of those guys again, out on my bicycle with my backpack full of drug paraphernalia," Taneyhill previously told The Bee. "I had no idea that my addiction cost the county so much money. At the time, I wouldn't have cared."

Marshall said Taneyhill's success proves that with sustained guidance and treatment while staying in a stable home environment, some experiencing cyclical homelessness can re-establish themselves in the community. Too often, agencies attempt to solve the symptoms of homelessness — addiction, mental health — rather than addressing the "core issue," said Ben Avey, spokesman for Sacramento Steps Forward, the county's nonprofit partner agency that helps secure housing and coordinates homeless services.

"They do not have the ability to get other aspects of their life in order until they have a bed to sleep in and a door to lock," he said. "Once you're safe and warm, and you'll be safe and warm for an extended period of time, a lot of things that may have seemed unimaginable may seem possible."

The county program is modeled after one in Los Angeles County called Housing for Health, which a RAND Corp. report found led to a cost saving of 20 percent for the county, with reductions in emergency room and outpatient visits.

The Los Angeles program doesn't even target the costliest homeless individuals in the county, said Sarah Hunter, the lead author of the 2017 study. Given those results, she said, it's not

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"Because they are the highest users," she said, "once you can get them into a stabilized setting and regulated care, you're more likely to see these huge reductions in cost."

"If you look at the bottom line, if you're saving money and improving the community, it's a win-win," she said.

The program was approved in 2017 by the Sacramento County Board of Supervisors as one prong of a major multimillion-dollar, four-part initiative to curb homelessness. The program, called Flexible Supportive Re-Housing, was initially budgeted for $5.1 million to run for 18 months through June 2019.

Marshall said the program will be a permanent fixture of the county's homelessness efforts, costing about $3.9 million each fiscal year, aided by a big funding boost this year: Sacramento County declared an emergency homeless shelter crisis last year, giving it access to nearly $20 million in state funding to tackle homelessness in collaboration with the city of Sacramento. The county also is set to apply and accept more than $5 million in noncompetitive award funding this year from the state towards the development of permanent supportive housing.

For the past month, Bell, his girlfriend Ja'Meesha Tripplett and now their baby Amelia Bell, less than 2 weeks old, have been living in a two-story tan apartment complex in south Sacramento. Most of the rooms are empty, save for the assortment of baby furniture and necessities strewn about.

Bell, now 21, is hopeful for the future. He's finally starting to put on weight. He's happier, calmer. He's applying to jobs, maybe at a warehouse like where he used to work. Right now, he's focused on saving enough money to buy a car, and support his burgeoning family.

"To see something like this, it gets you emotional," said Bell's case manager, Azzie Thomas, wiping tears from eyes as he looked on. "To see him so young and strive like he's doing with the baby, it's amazing. People may look at him like he's a bad kid, but they don't know the inside."

"I don't want to start crying stop crying," Bell told Thomas with a smile.

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NEWS

# Meth's Comeback: A New Speed Epidemic Takes Its Toll on San Francisco

She and her roommate had been awake for two days straight. They decided to spray paint the bathroom hot pink. After that, they laid into building and rebuilding the pens for the nine pit bull puppies they were raising in their two-bedroom apartment.

> ***Over the last five years, hospitalizations and emergency room visits have spiked and deaths have doubled.***

Then the itching started. It felt like pin pricks under the skin of her hands. Amelia was convinced she had scabies, skin lice. She spent hours in front of the mirror checking her skin, picking at her face. She even got a health team to come test the apartment. All they found were a few dust mites.

"At first, with meth, I remember thinking, 'What's the big deal?' " Amelia says. "But when you look at how crazy things got, everything was so out of control.

Clearly, it is a big deal."

While public health officials have focused on the opioid epidemic in recent years, tallying heroin deaths and cracking down on pill prescriptions, another epidemic has been brewing quietly, but vigorously behind the scenes.

Methamphetamine is back. In San Francisco, over the last five years, Drug Enforcement Administration seizures of meth have jumped, hospitalizations and emergency room visits have spiked and deaths have doubled. The toll the drug is taking on the city's public health, emergency response and police departments is now spurring the mayor to establish a task force to combat the new speed epidemic.

"It's something we really have to interrupt," says San Francisco District 8 Supervisor Rafael Mandelman, who will co-chair the meth task force with Mayor London Breed. "Over time, this does lasting damage to people's brains. If they do not have an underlying medical condition at the start, by the end, they will."

Since 2011, emergency room visits related to meth have jumped 600 percent to 1,965 visits. Admissions to the hospital are up 400 percent to 193. At Zuckerberg San Francisco General Hospital, of 7,000 annual psychiatric emergency visits, 47 percent are people who are not necessarily mentally ill – they're high on meth.

"They're often paranoid, they're thinking someone might be trying to harm them. Their perceptions are all off," says Dr. Anton Nigusse Bland, medical director of psychiatric emergency services, describing the signs of methamphetamine-induced psychosis.

For example, someone starts walking into traffic on 6th Street, shouting, taking off his shirt. A bystander calls 911 and reports a mentally disturbed person, then

the police come and deliver him to Nigusse Bland's department at San Francisco General.

Dr. Anton Nigusse Bland, head of psychiatric emergency services at Zuckerberg San Francisco General Hospital. *(April Dembosky/KQED)*

"They can look so similar to someone that's experiencing chronic schizophrenia," he says. "It's almost indistinguishable in that moment."

If the person is really agitated, doctors might give them a benzodiazepine to calm down, or even an anti-psychotic. Otherwise the treatment is just waiting 12 to 16 hours for the meth to wear off. No more psychosis.

"Their thoughts are more organized, they're able to maintain adequate clothing. They're eating, they're communicating," Nigusse Bland says. "The improvement in the person is rather dramatic because it happens so quickly."

## 'Meth causes people to act completely insane'

For some people recovering from addiction, the memories of meth-induced psychosis are part of what motivate them to stay sober.

For Amelia, the scabies scare is what alerted her mother to her addiction, forcing an intervention. Even though she did not have scabies, the itchy feeling and the fear are vivid, even a year and a half later.

“I still don’t really want to say it out loud that it wasn’t real,” says Amelia, now 33, who asked that we not reveal her last name to protect her family’s privacy.

> ***'It is an epidemic wave that’s coming, that’s already here.'***
>
> — Dr. Daniel Ciccarone, professor, UCSF

For Kim, another woman in recovery, there was one day last year when she says she went wine tasting with a friend in Sonoma. She was high on Xanax and speed.

“I was crazy,” says Kim, 47, who also asked that we not reveal her last name. “Meth causes people to act completely insane.”

She and her friend got in an argument in the car. Kim thought someone was behind them, following them. She was utterly convinced. And she had to get away.

“I jumped out of the car and started running, and I literally ran a mile. I went through water, went up a tree, and I was literally running for my life,” she says. “I literally thought I was being chased.”

Kim was soaking wet when she walked into a woman’s house, woke her from bed and asked for help. When the woman went to call the police, Kim left and

found another woman's empty guest house to sleep in — Goldilocks style. Kim says she just wanted to get warm.

"But then I woke up and stole her car," she says.

That's how Kim ended up in jail. She's in a residential treatment program in San Francisco now, part of the steady rise in people seeking help for meth addiction. Rehab admissions for meth are up 25 percent since 2015.

The trend in rising stimulant use is nationwide: cocaine on the East Coast, meth on the West Coast, says Dr. Daniel Ciccarone, a professor and substance use researcher at UCSF.

"It is an epidemic wave that's coming, that's already here," he says. "But it hasn't fully reached our public consciousness."

Drug preferences are generational, Ciccarone says. They change with the hairstyles and clothing choices. It was heroin in the 1970s, cocaine and crack in the '80s. Then opiate pills. Then methamphetamine. Then heroin. And now meth again.

"The culture creates this notion of let's go up, let's not go down," Ciccarone says. "New people coming into drug use are saying, 'Whoa, I don't really want to do that, I hear it's deadly, people look really doped up and they're not that fun to be with, I'm going in a different direction.' "

Kim has been with meth through two waves. When she got into speed in the 1990s, she was hanging out with a lot of bikers, going to clubs in San Francisco.

"Now what I see, in any neighborhood, you can find it. It's not the same as it used to be where it was kind of taboo," Kim says. "It's more socially accepted now."

## Meth-related deaths

A hint about who is using meth today comes from the data on deaths. Since 2011, meth-related deaths in San Francisco have doubled.

One hypothesis that experts have come up with to explain this is that meth users are aging. Most meth deaths are from brain hemorrhage or a heart attack – that would be highly unusual for a 20-year old.

"Because your tissue is so healthy at that age," says Dr. Phillip Coffin, director of substance use research at the San Francisco Department of Public Health. "Whereas when you're 55-years old and using methamphetamine you might be at higher risk for bursting a vessel and bleeding and dying from that."

Older adults have higher blood pressure, maybe heart disease, that makes their heart weaker.

"So stimulant-related death, really, you shouldn't see it affect so many young people," Coffin says.

At the San Francisco AIDS Foundation, which runs a 12-week program to help men who have sex with men stop using meth called Positive Reinforcement Opportunity Project (PROP), program manager Rick Andrews has noticed a trend in older men coming in for help.

"Older gentlemen who grew up in the time of HIV and AIDS initially, maybe they led very safe lifestyles, and now they're older," he says.

**MENTAL HEALTH COMMISSION**
**for the**
**CITIES OF BERKELEY and ALBANY**

## Is Seeking Candidates to Join the Commission

The Mental Health Commission (MHC) is comprised of 13 residents who advise the Division of Mental Health for the Cities of Berkeley and Albany and the Berkeley City Council on mental health in the community. This Division has an approximate annual budget of $13-14 million, including funding for a new Adult Clinic.

- There are 11 Mental Health Commissioners from the City of Berkeley and 2 from the City of Albany. One member represents the City of Berkeley Mayor's Office.

- Under California law, the Commission members is comprised of special and general public interest categories except for the Mayor's appointment.

Here are the details on the vacancies:

- **Special Public Interest Vacancies**

  There are vacancies for City of Berkeley residents who have or are receiving public mental health services.

- **General Public Interest Vacancies**

  There are vacancies for City of Berkeley residents who have expertise who represent a broad range of disciplines, professions, and fields of knowledge.

**Please note**: Residents may have a combination of knowledge and lived experience but must apply for membership in one category.

Applicants can request an application from (details needed):

- City Clerk's Office – 2180 Milvia Street, Berkeley, CA – 510-981-6908
- Commission Secretary, Karen Klatt- (510) 981-7644 or KKlatt@cityofberkeley.info

## Klatt, Karen

**From:** Kim Nemirow [mailto:nemirowkimmy@aol.com]
**Sent:** Monday, January 28, 2019 12:56 PM
**To:** Klatt, Karen <KKlatt@cityofberkeley.info>
**Cc:** boonache@aol.com
**Subject:** Re: STATEMENT FOR SUBMISSION TO NEX MH COMMISSION MTG: BMH's role in Child Endangerment Case

Karen:

PLEASE REDACT ALL NAMES OF CLIENTS OF BMH

AND REDACT ALL INDIVIDUALS NOT WORIKING IN CITY DIVISIONS

Redact

-----Original Message-----
From: Kim Nemirow <nemirowkimmy@aol.com>
To: kklatt <kklatt@cityofberkeley.info>
Cc: boonache <boonache@aol.com>
Sent: Mon, Jan 28, 2019 12:48 pm
Subject: STATEMENT FOR SUBMISSION TO NEX MH COMMISSION MTG: BMH's role in Child Endangerment Case

To: CHILD PROTECTIVE SERVICES- ALAMEDA COUNTY

City Manager- Paul Budenhagen- City of Berkeley

Health, Housing, Community Services Manager- Kristen Lee

Berkeley Mental Health: Supervisors-Matthew McKinley;

Nancy Nigisang; Marianne Davis- HOT TEAM- Vivian Slaherty

cc: Chief of Police Greenwood- Berkeley Police Department

e: Statement of Witness to Child Endangerment

Letter of Concern Regarding MH Division's

Failure/Refusal to Supervise and Report Child Endangerment

**STATEMENT OF WITNESS TO CHILD ENDANGERMENT BY CLIENT OF ADULT SERVICES MH DIVISION CITY OF BERKELEY**

On or about January 4, 2019, I encountered a person named [redacted] at the Seven Eleven on University Avenue in Berkeley.

I recognized [redacted] as one person, among many, I interviewed regarding her experiences of Berkeley's Mental Health Division for

a personal project I began two years ago on the quality of mental health services in Berkeley and Alameda County.

At around 4:15 on January 4th, 2019 I observed [redacted] talking to a staff member at the door of the local mental health clinic in Berkeley

( Berkeley Mental Health). The content of the conversation was not overheard by me as I was observing the interaction from across

the street however the animated character of the interaction was clear even from across the street and the brevity of the encounter

caught my attention ( it only lasted a few minutes).

I approached [redacted] and a male who accompanied her, later introduced as [redacted]. I asked them what had happened

in their encounter with BMH at the door. Both [redacted] and [redacted] that the clinician with whom they spoke, explained the overall context

of their encounter with the mental health division that day.

Apparently, [redacted] who had recently given birth to a four month year old infant son, had been offered an ONGOING arrangement with

the City of Berkeley- through its Mental Health Homeless Outreach Team- that as long as she"made contact" each week with her assigned

worker, ( Ms Vivian Lee), she would "always" have a room for her and the baby at a hotel paid for, by voucher by the City of Berkeley.

She reported to me that she was assured by the Mental Health Hot Team that she would "always" have a room with the baby,

so long as she made weekly contact with mental health services in Berkeley.

Unfortunately, on this day, her phone was not taking a charge and was not operable to make phone calls. She was not able to but frantically

attempting to make phone contact with her case manager as a condition necessary to have the room re-financed ( on a weekly basis).

Therefore her purpose in making contact with BMH late afternoon January 4th was to either obtain access to a phone to contact Ms Lee to

ensure her room for the next week or to allow her to attempt to charge the phone at the clinic ( to determine if a different outlet would

allow her phone to take a charge).

Mr Eziekiel denied both requests and sent both parties away. At or around 4:15 the clinic for mental health services was open for approximately

forty five minutes after those requests were made and the waiting room was empty.

I informed and believe and thereupon allege that Mr Ezekiel fully understood what he was doing when he sent [redacted] and her infant son away

with no form of shelter and visiting the contract she had with the City to protect her and her son from exposure on the streets. At the time of the

encounter the weather in Berkeley was 37 degrees and dropping. A major rain storm with dropping temperatures into freezing was forcast

for the subsequent day and night.

According to earlier contact with [redacted] she had been assessed by Mr Eziekiel and also seen by him for an appreciable time as her case

manager. He had to have direct knowledge regarding her arrangement for shelter with the HOT team through City funds and his refusal to

provide minimal aide to her to complete her part of the agreement amounts to a breach of that agreement and to the knowledge of this

writer, it also amounted to active participation in child endangerment.

Mr Eziekiel was aware of the city system's policies for arriving or registering at a shelter and no regular shelter would do intake as late as 4pm

unless a party notified them especially as one would from a city agency or city division, According to [redacted] no information was offered at the door

for the City's emergency shelter. Beyond leaving [redacted] with no options to shelter her and her son, clinical staff were familiar with [redacted]

impairments and her appreciable difficulty retaining a shelter bed in the past. The agreement was effectively broken at the door by Mr Eziekiel

and the infant and mother were left with no public options to house themselves in weather dangerous to an infant exposed overnight.

I initially recognized the clinician with whom she was speaking as Dan Ezekiel both from my experiences with him during my subscription to BMH

and because [redacted] had referred to him by name in the video interview for my documentary project. The clinician who encountered

[redacted] near the 4 O'clock hour at the clinic door was Daniel Eziekiel , a long time staff member of the division and a person with at least

two documented cases of arguable negligence in ensuring the safety of adults in crisis with severe presenting mental health impairments.

Two documentable cases include the statements of one former person who had a clinical assessment for intake screening done by

Mr Eziekiel. In this encounter, the persons seeking services was not properly assessed for suicidality despite earnest attempts by that person

to communicate her suicidal obsession, her overall circumstances with chronic depression and homelessness and the assistance ( post initial

assessment) of a , then, advocate from the Homeless Action Center ( and now BMH outreach worker- Vivian Lee). That person who refers to

herself as [redacted] attempted suicide shortly after the assessment and denial of services including emergency services.

In another known instance, I observed the same clinician, Mr Ezekiel, refuse to assess or assist a person presenting as suicidal in the lobby

of the clinic who, like the prior example, was not a current client or former client. He indicated that the emergency mobile crisis unit was not

on duty and instead of assessing the individual in distress and making a determination as to whether she needed to be placed on a welfare

hold by contacting the local police, he simply told her there was nothing he could do and recommended she go to the police or to the

hospital "if she wanted to". The woman was visibly distressed and wandered from one side of MLK Way to the other until I personally

contacted Berkeley Police and she ultimately was admitted to a local hospital.

These two examples are intended to form a backdrop for the purposes of analyzing the state of mind, commitment to welfare, level of

concern or alternatively degree of indifference or negligence Mr Ezekiel may have had late afternoon on January 4th when encountering

and denying her pleas for reasonable assistance.

Both parties presented to me as fairly desperate to make contact with Ms Lee, the case manager or outreach worker, prior to 5 pm.

asked me if I had a charger so they could charge their phone and I told him he and could come to my apartment and charge the phone.

Notwithstanding the offer the two did plug in the phone but disappeared for several hours leaving the phone in my apartment.

It was true that the phone was not able to be charged by plugging it into any outlet the phone was only taking a 1 percent charge which occasionally

rose to 2 percent, and they were not certain why the phone was not taking a charge. Once the phone option failed both parties left my apartment

for approximately six hours leaving many possessions inside my apartment.

and arrived driving a car with darkened windows. I was not able to see into the vehicle which was parked in m

driveway so I do not know if the infant son was in the car when they first came into my apartment. Much later in the evening, they returned

and I offered to have them spend the night as they had no place to go during extremely cold weather. At this time, I did not know that

was in custody of an infant or that she had and infant because no infant entered the unit until January 5th.

**During a conversation with later that night on January 4th, she told me she had an infant son. She further told me that the son- only four**

**months old- had been left by her in a tent surrounded by others tents in an illegal encampment. The person occupying and owning the tent was**

**described to me as a "major meth dealer who is the son's biological father".**

The occupant of the tent in which the infant resided had purportedly threatened grave bodily harm on [redacted] " if she took the baby away before morning".

A heater INSIDE an enclosed tent was the only form of protection against health hazards to the infant during a cold spell - weather ranging in the 30-'s and

impacted by the sea breeze near the [redacted].

[redacted] further described to me the threat that she believed this man posed to the child if she did not arrive before 6 am to retrieve the infant as the

"infant will cry and they don't know how to deal with that" When asked what she meant, **she expressed fear that occupants of the tent would harm the**

**infant to keep him quiet.** The person making these threats and holding the infant hostage name was reported to me as [redacted].

I asked [redacted] why she did not rescue her son by contacting the local police and having them retrieve the child. She told me that she feared retaliation.

I asked her how anyone could retaliate against her if she did not know her whereabouts and she explained to me that she works in Berkeley and goes to an athletic

group in Berkeley and could be identified by the biological father's meth "runners' on the streets.

She had previously told me that her hotel room was located near the Oakland airport so I asked her again why she could not leave Berkely

but for meetings with local providers inside closed doors. She responded that she "liked her athletic activity and liked Berkeley. She did not answer and adopted

a look that suggested to me that she neither understood why I asked the question nor the underlying concern that her interests in enjoying or accessing Berkeley

should be secondary or superseded by her obligations to protect herself and the child from potential violence.

**STATEMENT OF CONCERN FOR MINOR'S WELFARE: BASIS OF-**

[redacted] statement of preferentially preferring to live in Berkeley over moving to any other location where she would not have to fear recrimination by meth dealers who

might harm her or her infant son was the second indication to me of cause for alarm regarding [redacted] present capacity to care for her infant son.

Initially, I did not fully appreciate the gravity of her willingness to allow her son to be held hostage by a man who deals meth, lives in a tent illegally surrounded

by weapons and drugs and violence, and who had just threatened her to gain temporary custody of the child. The danger of a heater inside a closed tent

tent also did not catch my attention immediately.

The reason for this is that I was focused on helping and I somehow normalized the situation. I have witnessed on the streets of Berkeley among the chronically homeless

many extremely dangerous scenarios, and at first, without more information, I did not react to the information that an infant was sleeping overnight under these conditions.

Once [redacted] exoplained that her personal desire to dwell in Berkeley overshadowed her obligation to care for an protect her son, I became alarmed and that alarm

only escalated during [redacted] stay at my apartment.

Among the facts that escalated my concern was that prior to reaching my unit- about two blocks away from where I encountered both parities, the car driven and owned by [redacted] - a [redacted] - was hit [redacted], The collision produced [redacted] This fracture both slowed the car down and caused the car to swere out of control of the driver.

At once point in the ride to the grocery store with [redacted] and [redacted] the car swerved into the right lane involuntarily. The state of the vehicle which was not safely operable indicated in yet another way that the child's safety was being placed in avoidable jeopardy .Notwithstanding the danger of the car's condition in which all three adults and the infant were passengers, I was the only party to recommend that once we reached one of our nearby destinations at a local market, the car be towed by a triple A. The car was not towed that day and was subsequently driven back to my apartment with all three adults and the infant on board. Subsequently on January 6th, the car was again driven by [redacted] with both [redacted] and the infant in the car.

After allowing both parties and the infant son to reside in my unit through late afternoon on Saturday January 5th, [redacted] contacted her mother and grandmother who both live out of state. Both relative expressed intense and, frankly, desperate fear and panic concerning [redacted] inablity to secure the hotel room expressing via speaker phone in a closed car that they filed a missing person's report and would put out an all points bulletin if she did not allow the UC police to do a welfare check immediately. Both relative were consistent and additionally extremely persistent in expressing immediate

fear that their child/grandchild was not fit to care for the son without supervision and without a place to reside indoors that was safe and stable.

I personally spoke with the mother who instructed me to contact UC Police and allow that division to do a welfare check on the infant. I resisted disclosing my address as I was not yet fully appreciating

the validity of their fears. I was then contacted by a UC officer and provided my address as two UC police conducted a welfare check.

Because [redacted] minimized her responses and minimized the length in which the infant was held in the tent with the biological father overnight, UC police allowed the infant to remain in her custody.

At the time I reported that I thought I could house them until Monday or find a shelter for them before that.

After the welfare check I made multiple calls to local domestic violence and other emergnecy shelters. Despite multiple calls no beds or no compatible sheleters or programs would take [redacted] and her son. At one point, [redacted] was exhausted and began yelling at an intake worker and becoming illogical reprimanding the worker for asking "too many questions' and upsetting her and not letting her "just sleep"

At this point the stress and impairment of my own mental and physical health AS WELL AS my heightened concern for the welfare of the infant motivated me to contact BPD to do a welfare check and to help resolve the need to place [redacted] and her son somewhere safe for Sunday- pending reconnection with her case worker at BMH on Monday.

One motivation for contacting BPD was the quality of psychological responses and dynamics [redacted] evidenced. For example, she would often change the subject, randomly distract her attention of bizarrely unrelated subject matter, show total discontinuity /disassociation with what others were saying or telling her they thought or felt. In one specific example she interrupted her grandmother who had just relayed to me on the phone that her mental health was in jeopardy and her funds exhausted by trying to help [redacted] over the years as she raised her voice and verged on crying noticeably, [redacted] responded in an almost infantile voice saying " how are you doing grandma?".

Many many more examples ensured of what mental health clinicians might call inappropriate responses and dissociative responses.

Asking her to take responsibility during a housing and health crisis was often responded to with her re-focusing on random and irrelevant tangental concerns, acting as if nothing was occurring

( blocking), denying that anything important was happening, and various forms of checking out suchas speaking in a small child's voice and complaining that others were being mean to her or

spending a lot of time and interest on self grooming.

I told [redacted] that I was going to call BPD and see if they could help obtain some form of shelter.

[redacted] became anxious starting to express concerns that I was planning to "have the baby taken away".

The anxiety escalated to hysteria when she subsequently spoke to her grandmother with whom I also spoke who advised her that I was concerned and to take steps to make sure the baby was safe " so that he won't be taken by CPS". This communiunication was distorted by [redacted] and led her to believe I was then planning to place the baby in the custody of the police. I later learned from [redacted] that **she told the Shell Station agent that I was attempting to kidnap her and hold her hostage**

as I obtained her license plate information parked at the Shell station.

She demanded that [redacted] immediately give her the keys to her car and anticipating the action she was about to take I attempted to persuade [redacted] to not surrender the keys. He did give her the keys.

Notwithstanding my very determined attempt to stop [redacted] from fleeing into a potentially unsafe situation ( the temperature at the time was below 35 degrees and it was raining- she was given the keys

and proceeded to look for her vehicle. Her vehicle was spotted by her across four lanes of traffice at a local Shell station/

Notwithstanding the fact that there is a legal cross walk with a signal light making passage through traffic safe on the same block on which [redacted] stood as she spotted her car, [redacted] CROSSED

AGAINST FOUR LANES OF ONCOMING TRAFFIC with an infant son in his carrying case on her arm. She also crossed again to re-obtain possessions in the apartment she believed she left there.

[redacted] had already taken most of her belongings and placed them in her car and drove away intending according to his statements to me to bring her to his grandmother's house in Berkeley.

Given the weather, the immediate danger I witnessed the infant placed in in crossing four lanes of traffic against two lanes of oncoming traffic ( the light was changing on both sides); the statements made to the gas station attendant that I was trying to "kidnap her"; her subsequent disassociate behavior in laughing when leaving the scene and the inoperable or unsafe operation of the vehicle

she drove away in, I contacted BPD to do a welfare check.

I learned that her family also contacted BPD to do a welfare check.

Despite providing many of the details enumerated above- notably the behavior or [redacted] in crossing against traffic with an infant in rainy weather, NO POLICE OFFICER TOOK MY STATEMENT, but two officers were assigned to the complaint.

Officer Gibson and Officer Doe 1 ( name unknown to me) stopped the vehicle ( I provided the license plates). They appeared to have conducted a grossly inadequate and potentially negligent welfare check. The welfare check- later reported to me by [redacted] - failed to ask any investigative questions about any recent or current risk [redacted] was placing the minor under. No questions were asked about her running in the rain in freezing weather against traffic; no questions were asked about how long she was operating a vehicle not able to be driven safely with an infant inside; no questions were verified or asked me about these immediate risks or her apparent anxiety and impulse control.

Although at least one officer recognized the boy friend, [redacted]- as a former felon for assault and drug dealing, officers were not sufficiently concerned about releasing the infant into the custody of an mentally impaired mother and an individual on whom she was relying who was a former felon. [redacted] was known or should have been know to BPD through the UC welfare report as the cousin of the

biological father. On January 4th, UC police knew or should have known that permitted his cousin to retain the infant inside a tent illegally located at a by a known meth dealer by force or threat of force against the mother. The only heat in that tent, again was a space heater and the temperture was in the 30's.

When the infant arrived at my unit on the morning of January 5th he had substantial coughing and was crying for long periods and had to be given expectorants regularly to restore his breathing

and allow him to sleep.

Up until the moment left my apartment she expressed persistent interest in keeping plans to take the infant on a plane and go to Las Vegas Nevada to see her other child's father. And the focus and clarity of this plan _ however unrelated to the infants needs and her own interests in obtaining long term shelter, were remarkable for their clarity and purpose. She would evidence clear decisiveness any time she really wanted something and grossly deny, minimize, and project unto others all sorts of malicious intention during any conversation or event involving her immediate circumstances. Her mother and grandmother consistently told me that she lies and manipulates to get "what she wants' and that was apparent to me along with the fact that her capacity or willingness to hierarchalize and make decisions was extremely poor. It became evident that all others around her were in a life long pattern of making major decisions for her at which point she reacted with anxiety, or denial or dissociation or changing the subject.

Her mood varied markedly in part based on her interation immediately with others; her behavior was often eractic - at one point she ran out in 35 degree weather in the rain because she was afarid that her compantion who had just returned after borrowing her care for most of the afternoon without notice of when he would return left again to walk my dog. At another point,. she sat naked in the apartment yelling that she felt like an animal because she had an accident in the bathroom and saying she had no clothes where many of there clothes were within arms reach.

On the basis of the behaviors previously referenced in this letter and others I will also reference and on the basis of the psychological state of evidenced in her focus and interpersonal responses and psycho-social impact on others, I believe that would only be capable of caring for her son at this time IF SHE WERE PLACED IN A FACLITY OR PROGRAM WITH 24 HOUR A DAY SUPERVISION

A few days later, I encountered a BPD officier whom I knew Officer Dozier. He informed me that a current search was underway for the infant whom the police suspected might be in a tent ( again) at the . He promised to come to my unit near the time when he would leave duty to take this statement, He never arrived to take the statement.

BEHAVIORS INDICATING A LACK OF CAPACITY TO SELF CARE AND CARE FOR INFANT SON:

Behavrios referenced in this letter include:

- her refusal to seek police intervention to obtain custody of an infant in weather conditions placing the childs welfare at risk and in social conditions endangering the child's safety with potential violence, inhalation of toxic illegal substances severely imparting to an infant or chlld, in a location where a tent was dangerously enclosed inside a tent
- her running across four lanes of traffic against the lights jeopardizing the immediate safety of her infant who she was holding in a carrying device at the time
- her use of funds from her food card to purchase unnecessary items unmask and also offers to allow me to use up her $200 in food purchase for myself
- her unwillingness or present ability to participate in any form of planning whatsoever for her and her child's immediate shelter on Friday, Saturday and Sunday but for her unrealistic
- and denial based assertions that she could be my "roommate" not withstanding my multiple attempts to convince her that that was neither possible or acceptable to me or my landlord
- Her running out in weather below 35 degrees in a sun dress without shoes after taking a shower in a frantic attempt to make contact with [redacted] after he had come back to the unit
- on Saturday and went on the walk with my dog prior to greeting her.
- Her allowing [redacted] to take her vehicle on Saturday in the morning with no plan as to when he would return and ahisrtory of him disappearing for over four hours and even a day at a tduring a housing crisis involving her infant.
- A consistent pre-occupation with her appearance, her immediate needs, her mood, and random concerns completely unrelated to reality where she would interrupt serous communications about planning her shelter arrangements by asking inappropirioate and bizarre questions or focus on such unrelated tasks as painting her nails or taking about anything which came to ming
- Her inabiltiy to do an interview with an intake line at BAY WAR and her anger at the intake staff
- Her use of an impaired vehicle to drive with her infant son in the car
- Laughter immediately after running away from my unit ( reported to me later by [redacted] ) grossly inappropriate to her circumstances

PSYCHO-SOCIAL STATES

- ANXIETY PERSISTENT TO THE POINT OF ONGOING HYSTERIA
- CHILD LIKE ANSWERS, BLOCKNG, DENIAL AND AVOIDANCE OF DIRECT RESPONSES TO QUESTIONS, CONCERNS AND SHELTE PLANNING
- HER ARTICULATION IN TONE OF VOICE OF A REGRESSEIVE STATE SOUDNING LIKE A SMALL CHILD OR PURPOSELY MANIPULATING OTHERS WHEN THREATENED INTER PERSONALLY
    - HER MANIFEST LACK OF INTERST IN OR ABLIT YTO RELATE TO OTHERS EVEN IN LANGUAGE WHEN UNDER STRESS
- HER WILLINGNESS TO LIE OR PRETEND TO ASCEDE TO TOHERS CONCERNS OR WARNINGS JSUT TO AVOID THE IPACT OF THOSE ADMONSTION ON HER AND PLACATE
- HER LACK OF APPRECIATION EXPRESSED AS ENTITLEMENT FOR MANY PARTIES ATTEMPTING TO ACT ON HER BEHALF
- HER NOTABLE INABLITY TO HEAR OR INTERNALIZE ANYTHING ANY PARTY ATTEMPTED TO COMMUNCIATE ABOUT HER SAFETY

**City of Berkeley Liability . Culpability, Professional Obligations:**

On January 9th both I and [redacted] and [redacted] in separate conversations were told by the HOT team staff- Vivian Lee- that "no more funds"

existed for the voucher program".

This explanation , Offered to [redacted] and [redacted] on Monday January 9th, appears on the surface, to be false .

[redacted] and [redacted] ( who was accompanying her at the hòtel) were never given NOTICE of any cessation on Friday or the beginning of the same

week of funds for an arrangement GUARANTEED them due to the obligation to protect a minor or not allow a minor to be placed in peril with a city

department's full knowledge of the peril .

Even the most negligent provider knows that it is obligated to keep an agreement or de facto contract and if relevant provide notice PRIOR to the last moment

if any other change in ensuring a safe environment had to be made. The failure to fulfill the agreement, aide in its fulfillment, or - potentially provide

adequate notice and ensure other arrangements including- if necessary mandatory reporting to CPS in freezing weather with no options for shelter known

or elected by [redacted] amounts to a broken agreement or contract under a theory of quasi contractual reliance and it amounts to child endangerment .

As well it places Berkeley Mental Health, its supervisors and all clinical staff involved in the case under potential scrutiny in placing [redacted] and her infant son at

peril in freezing weather and further not reporting this predicament - which they themselves created- to Child Protective Services due to the extremity of cold

weather and rain storms imminent at the time she was turned away from the clinic on Friday, and later cessated from relying on a hotel voucher on Monday.

There is a history, only partially known to this writer, of one staff member- Daniel Ezekiel, refusing to taking responsibility for the welfare of adult's

with mental health impairments in crisis when the law requires him to do so. In this instance he declined the most basic assistance to adult with

severe mental health impairments and her dependent infant son knowingly placing both parties and notably the minor in peril.

Supervisors and members of the HOT Team are likewise responsible for misleading or misrepresenting the ongoing character of the assistance to

[redacted] and her infant son in ensuring their welfare and safety and permitting staff to use their discretion or personal preference in making

decisions in crisis bearing on the immediate welfare of a minor.

Likewise, the manager of the Division and the City Manager are ultimately responsible for not providing appropriate oversight, accountability through

adequate standards and monitoring of all practices particularly those bearing on emergencies placing cliental or those seeking services and especially

clients with dependent minors at grave risk of physical danger or harm.

Berkeley Police failed to take all information into account when doing the welfare check on January 5th including but not limited to :

not taking information from one reporting party of potential child endangerment; not doing any in depth questioning of [redacted] or [redacted];

allowing [redacted] to "take responsibility" when his criminal history suggested he was not fit to take this role in relation to a minor infant

and when his recent behavior contributed or allowed an infant to spend the night in frigid weather in a tent with a meth dealer in what was

effectively a kidnapping of the infant. As well, the condition of the vehicle transporting the infant and the mother's presenting condition

ought to have triggered a CPD investigation.

Subsequent to the Janaury 5th BPD welfare check, the infant was again reported missing along with the mother. I was informed of this by Officer Dozier of Bpd

And a search was being conducted at the same [redacted] and tent areas in which the infant was originally placed in danger.

I will submit and internal investigation request for Officer Gibson of BPD and his partner in conducting what appears to have been a substandard welfare check.

I believe CPS should investigate the role of Berkeley Mental Health and the City of Berkeley in its polices, practices and specific encounters in this case in providing

or failing to provide, in assisting or failing to assist, in guaranteeing and breaking reliances on clients with minors relying on vouchers to ensure child welfare.

In particular the breaches of promises, the refusals for service and assistance by BMH in this instances appear to make them responsible for placing that infant

in danger on a perpetual basis.

## Klatt, Karen

**From:** Kim Nemirow [mailto:nemirowkimmy@aol.com]
**Sent:** Tuesday, January 29, 2019 1:10 PM
**To:** Klatt, Karen <KKlatt@cityofberkeley.info>
**Cc:** boonache@aol.com; [redacted]
**Subject:** Fwd: DRAFT PROPOSAL FOR MENTAL HEALTH COMMISSION: ( please include in next commission mtg packet)

**To MENTAL HEALTH COMMISSION CITY OF BERKELEY**
**Fr Kim Nemirow**
**Re: Proposal for Review: potential AGENDA ITEM**

**Current Situation**

The City of Berkeley Health Housing and Community Services manages and oversees HUD Shelter Plus vouchers held by tenants subscribing to local social or mental health services within Berkeley city limits. A large number of mental health clients or those with diagnosed or self-diagnosed mental health conditions or persistent problems are participants in this HUD subsidy designed to add a service component in addition to subsidized housing to help these tenants holding HUD vouchers negotiate landlord/tenant relations. rights, responsibilities, conflicts and the array of circumstances that can arise in low income housing situations.

Unfortunately, the Shelter Plus contract between clients/tenants/ participants in the program mandates that all housing related problems and needs be addressed- if the clients needs assistance- through their local social or mental health service provider. More unfortunately, local providers including agencies like- the Women's Day Time Drop In Center, Life Long Medical, Berkeley Food and Housing Project;
and Berkeley Mental Health are not equipped in knowledge, training, preparedness, time, resources or orientation to ADVOCATE on behalf of clients in a wide array of situations that can and do present themselve to tenants and can and do place tenants at risk of loosing their housing, suffering from conditions on their rental property without recourse to rights or code or contract enforcement,
subject to any number of stressors including harassment by neighbors or landlords or just the impact of other tenants violation of law or their lease terms.

Within Berkeley's social service history, there is a long standing distinction between those providing social services and those advocating in legal or quasi legal capacity to assert the rights and responsibilities of parties to the rental contract and protect tenant's rights- including their ADA rights as HUD recipients under this program. The reason for this longstanding separation of roles is that social services, including the mental health division have proven over decades to lack both an ability, an inclination and a willingness to learn about the law relative to client's rights, to be sensitive to special needs and rights pursuant to the ADA, and to be willing to fight for, negotiate, investigate, resolve conflicts and situations which both place the client's housing at risk and also place the client's mental health status at risk.

The East Bay Community Law Center- in one example, had to create a special mediation component of its practice for which it had no prior ear marked funding to handle negotiations with landlords around retaining Berkeley Shelter Plus and regular HUD subsidy holders who were BMH clients or who had mental health conditions but were not helped in any way by BMH in dealing with their housing problems.
In fact, this component of EBCLC was created because clinicians at BMH either did nothing to help their clients negotiate these situations OR they actually took the side or position of the adversarial party against the client- taking a punitive position of believing the party situated in antagonism to the client's rights and needs and supporting their view and actions even to the point of re0-inforcing evictions as behvarioal consequences of the purported misbehavior or misfeanace of a client.

The Homeless Action Center likewise finds that their clients end up housed in situations where their rights are perpetually violated and none except EBCLS or the Eviction Defense Center or Legal Aide is positioned to help and usually at the point of where eviction proceedings are initiated. These three primary free or low fee legal clinics are regularly overflowing with Berkeley HUD Shelter Plus clients who have no one to advocate on their behalf but those trained to handle unlawful evictions.

The City of Berkeley's Health Housing and Community Services Division HUD Shelter plus administration has alocated the responsibility of resolving conflicts in housing between client/tenants/ participants and landlords, neighbors. co-tenants soley to social and mental health service providers,. Some of these providers are not and do not claim to be qualified mental health providers so that the trauma, stress, disturbances of emotions, perceptions, functioning that may be engendered by housing problems cannot - in theory- be supported psychologically- by those holding vouchers who are not trained in any form of mental health provision.

There is a long history in Berkeley now becoming more widely known to many city officials and advocates of social and mental health services not meeting the basic bio-psycho-social needs of clients and having themselves many allegations raised against them by hundreds of clients over the years of being not only substandard and harmful in their service models, delivery and treatment, but also of violating clients rights. Given the combination of having severe deficiencies and harmful attitudes and orientation and perhaps clinical capacity to deliver recovery services along with a total unpreparedness in legal, contractual, and conflicts negotiations, it is foreseeable that social and mental health services within Berkeley would perpetually fail too often at helping their client retain housing and avoiding detrimental impact to their mental, emotional, motivational, behavioral health and morale. Housing retention rates for COB in Shelter Plus Program may be available through a FOIA.

The way the City of Berkeley's Health Housing and Community Services Division has written the Shelter Plus agreement between the City, the Client/Participant and the Provider ( voucher holder)
forces the clients to tolerate, accept and obey all judgments, conclusions, actions, inactions of both the services provider's assessment of the housing conflicts and this City departments formulaiton of the problem. There are two problem with this beyond the lack of qualification of providers to act as legal and quasi legal advocates in the retention of housing under a Federal Program.

There is NOTHING in place to safeguard the rights of due process of a participant in a federal program who thereby has the full rights of due process prior to termination termed "an entitlement"

The process the City of Berkeley HHCS Division interprets HUD regulation to require becomes effective ONLY IF AND WHEN A NOTICE OF TERMINATION is issued to a participant.
Prior to receving a termination letter, the client/ tenant/participant is supposed to receive one or several "warning letters", a letter of probation, and at the notice of termination an opportunity to be heard by a neutral third party in an "informal hearing". At each and every point prior to that hearing any and all allegations made against the client/tenant/participant and and are taken as true and accurate by Berkeley's HHCs

Both allegations by service providers of noncompliance or any serious disruption in services and allegations by owners, landlords, neighbors, co-tenants- other tenants are received as true and accurate and reproduced to participants of the program much of the time with absolutely no informal or formal inquiry about the accuracy, veracity, motive, or context from which the allegations derive.
That is- there is absolutely no process and no means to inquire or confront facts for the person in the program against which allegations are made.

The City of Berkeley reserves on its own recognizance the right to interpret due process in the context of a federal entitement to mean that any and all allegation are replicated in warning and probationary letters if not "resolved" and then form the foundation for a notice of termination, At the point of receiving a notice of termination, the program participant THEN is afforded a modest opportunity to confront the facts but not the party or parties making the allegations. And the "neutral" third party at the "informal hearing" has -in the past been- Kristen Lee - the Department Manager with a substantial stake in the outcome of the hearing.

In an atmosphere where program participants due process rights are denied from the moment they sign into the program, social services have no reference point and often do not feel obligated to confront facts alleged against their clients. The client/tenant/ participant is thereby subject to ongoing violations of their due process rights and tenant rights- potentially and often actually-while a file of false, misleading, inaccurate and sometimes illegally motivated allegations amass against them and force them to try to defend "negatives" one step away from losing their housing

Neither the City of Berkeley HHCS nor the social or mental health providers are held to a standard of participating in a fact finding process to determine if false allegations are being made against the program participant amounting - often to harassment in housing- And indeed, the opposite is true- both the City HHCS and providers are encourage to participate in the issuing of warnings with no evidence available or required necessarily- and to for all intents and purposes fully collaborate in a witch hunt against disabled tenants.

The City of Berkeley has justified its issuance of warning and probationary letters absent proof of wrongdoing by the tenant or mitigating circumstances, by claiming that once a termination letter is sent the client has the opportunity to "set the record straight". But due process is not a right that occurs once allegations amass and reach a final stage just prior to loss of a right or entitlement. Due Process is foundational and applies at each and every stage where an entitlement is threatened. Parallel entitlements like social security income require the government to establish evidence of a violation in income reception and reporting and an immediate opportunity to be heard prior to any action being taken as against the entitlement of SSI or SSDI.

As both the City of Berkeley and Providers can adopt and republish false, misleading ,inaccurate, out of context allegations as against the participant's housing rights, needs, or lease or housing retention, the situation is currently ripe for abuse. And the motivation to abuse the participant's right includes an array of historic problems in both services and city administration of services and program including but not limited to the openly disclosed "need" for COB HHCS staff to pander to slum lord or abusive landlords to retain them in the program, the politics of maintaining housing retention rates even if individual tenants suffer when one or more tenant is pitted against a whole building in a competition of rights and needs; the stigma of the division is prejudicial assumptions about capacity of "mental health clients' to conform to the law. to leases, and to housing situations. On the side of the provider motivations to not be concerned about the veracity of claims the provider or third parties make against clients may likewise include stigma as research confirms that mental health clinicians are the number one group most likely to evidence stigma against clients- but it also includes their general pathologizing of the client and their long histories of "siding with" persons in the communicates who appear more "normal" or not mental ill. As well, providers evidence bias towards clients- favoring some over others - and there is currently no mechanism in place to protect them against subtle forms of retaliation like failing to advocate for their housing or taking the side of parties adversarial to their clients airport.

Again, there is a long history of both this city department and local providers denying clients due process, stigmatizing, pathologizing, delegitimizing clients and generally assuming they are "the problem" in each and every juncture where a conflict arises with services or in housing. This form of discrimination is not only harmful mentally, emotionally and physically - it is invidious for its
indicia of the status those diagnosed with mental illness- as basically having little to no rights- in their housing once local services and city administrators oversee their HUD entitlements.

There is NOTHING in place to safeguard the rights of shelter plus tenants subscribing to this adhesion clause of the shelter plus contract for their ordinary tenants rights.

Absent contacting code enforcement or the City's own Shelter Plus inspector, the client has no advocacy around the wide array of tenant's rights presented in many housing situations. This means that such things as habitability violations, criminal activity on the premises, health hazards, non secure areas, blight, attractive nuisances, drug use and dealing, rules around service animals, ADA accommodations, and a wide array of factual conflicts around such things as timely rent payments- can and do arise without the client having a neutral but supportive advocate who can defend, protect, negotiate their rights and needs and interests while reminding them and trying to work with them to meet their lease and contractual agreements with the HUD program. The program prohibits the Rent Board from mitigating and representing conflicts as would be available to other tenants in Berkeley.

There is a gross CONFLICT OF INTEREST by both the City and the Provider with the Client/Tenant/ Partipant in so far as a mental health provider cannot provide mental health services
that are founded in trust and an expectation of support, while taking any position even if "supportive" in relaition to legal or quasi legal conflicts in housing as the impact of their actions, inactions or positions can and do put client and clinician in disagreement if not adversarial positions around any number of issues impacting the client's survival and welfare. Where injustice and abuse of the clients is ripe to occur- any failure by a social service or mental health provider to remedy the injustice or abuse in a housing contextbecomes a basis to destroy or further damage a clinical relationship
The city's conflicts have been outlined in part, but generally subsist in little investment in each individuals housing rights and constitutional rights and more interest in a the outcomes of the larger
participant group- as well as the politics of public assisted housing.

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**RECOMMENDATION:**

THAT A NEUTRAL THIRD PARTY ADVOCATE FUNCTION TO PROTECT AND ADVOCATE FOR PROGRAM PARTICIPANT RIGHTS- AS TENANTS, UNDER THE ADA, AND LEGAL PROTECTIONS EXCEEDING THE LEASE AGREEMENT.

THAT THAT PARTY BE BAY AREA COMMUNITY SERVICES LANDLORD LIASION SERVICES WHICH HAS A PROVEN TRACK RECORD OF DEALING WITH DIFFICULTE AND ABUSIVE LANDLORDS AND CLIENTS WITH SIGNFICIANT HEALTH CHALLENGES AND RETAINING THESE CLIENTS IN HOUSING

THAT ACCESS TO THIS LANDLORD LIASON SERVICE EITHER BE INCLUDED IN THE SHELTER PLUS AGREEMENT AS A NEUTRAL ADVOCACY SERVICE WHICH EITHER PROVIDERS OR PATIENT CAN ACCESS AT EITHER PARTY'S ELECTION OR AS A SERVICE COMPONENT OF THE SHELTER PLUS AGREEMENT ASSIGNING TO THIS SERVICE THE DISCREATE ROLE OF ADVOCACY IN HOUSING AND ALLOWING LOCAL VOUCHER HOLDERS TO RETAIN THE DISCRETE ROLE OF TRADTIONAL SERVICE PROVISION IN THEIR AREAS OF PRACTICE OR SERVICE S

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**RATIONALE**:

SHELTER PLUS CLIENTS WITHIN THE CITY OF BERKELEY CURRENTLY LACK ADEQUATE AND SOMETIMES ANY FORM OF SUPPORTIVE ADVOCACY TO DEAL WITH HOUSING PROBLEMS AND EVEN TO MAKE SURE THEY RETAIN HOUSING WHENVER POSSIBLE

BOTH THE CITY OF BERKELEY'S HEALTH HOUSING AND COMMUNITY SERVICES AND LOCAL SOCIAL AND MENTAL HEALTH SERVICE PROVIDERS LACK SUFFICIENT KNOWLEDGE, TRAINING, RESPECT, ACCOUNTABILITY AND A PROVEN TRACK RECORD OF SAFEGUARDING SHELTER PLUS TENANT'S LEGAL RIGHTS INCLUDING TENANT'S RIGHTS, ADA RIGHTS, AND OTHER CIVIL AND CRIMINAL RIGHTS THAT MAY AND OFTEN DO BECOME THREATENED IN LOW INCOME HOUSING SITUATIONS.

BOTH THE CITY OF BERKELEY HEALTH, HOUSING AND COMMUNITY SERVICES AND LOCAL SOCIAL AND MENTAL HEALTH SERVICES PROVIDERS LACK AN APPARENT WILLINGNESS TO AFFORD AND PROTECT SHELTER PLUSE PROGRAM'S DUE PROCESS RIGHTS PLACING THEM UNDER CONSTANT PERIL OF LOOISNG THEIR HOUSING.

MANY SERVICES PROVIDERS HAVE MADE ALLEGATIONS AGAISNT THEIR OWN CLIENTS, WHICH CLIENTS DISPUTE AND MAY EVEN PROOVE TO BE FALSE, BUT IMBALANCES OF POWER CAUSE THE CLIENT TO SUFFER DEPRIVATIONS AS A RESULT OF PROVIDER'S ALLEGATIONS INCUDING - LOSSE OF ACCESS TO SERVICE SITES; LOSS OF LIBERTY IN POLICE ENCOUNTERS; LOSS OF ACCESS TO MEDICAL CARE, LOSS OF LIBERTY IN ILLEGAL 51.50'S

THE CITY OF BERKELEY HHCS HAVE MADE FALSE ALLEGATIONS IN THE FORM OF RE-PUBLICATIONS OF ANY AND ALL UNSUBSTANTIATED ALLEGATIONS MADE BY LANDLORDS, MANAGERS, NEIGHBORS, CO-TENANTS, TENANTS AND IN THE ISSUANCE OF WARNINGS, PROBATIONRARY, AND TERMINATION LETTERS WITHOUT FACTUAL OR LEGAL BASIS

SINCE MENTAL HEALTH CLIENTS MUST HAVE THEIR TENANT'S RIGHTS, THEIR CONSTITUTIONAL RIGHTS TO DUE PROCESS AND EQUAL PROTECTION, AND THEIR TENANT'S RIGHTS PROTECTED TO ENJOY AND RETAIN HOUSING- IN A MANNER SAFE TO THEIR OVERALL HEALTH AND WELL BEING- AN ENTITY WHO IS NOT OF LONG STANDING INVOLVEMENT IN SOCIAL OR MENTAL HEALTH SERVICES IN CITY OF BERKELEY LIMITS AND WHO DOES NOT HOLD THE SHELER VOUCHER IN BERKELEY SHOULD PROVIDE A LIASION SERVICE WHICH DEALS WITH ALL AREAS OF CONFLICT, PROBLEMS, ABUSES, DISCREPANCIES AND IMPACT ON THE TENTANT'S HOUSING

BAY AREA COMMUNITY SERVICES ALREADY PROVIDERS SUCH A SERVICES EXCLUSIVELY COMMITTED TO THIS PURPOSE AND DISTINCT FROM OTHER SERVICES THEY PROVIDE AND SHOULD BE CONTRACTED OR PERMITTED TO PROVIDE THESE SERVICES TO SHELTER PLUS CLIENTS IN BERKELEY CITY LIMITS AND ALSO THOSE HOLDING CITY BASED VOUCHERS WHO RENT OUTSIDE BERKELEY

SOCIAL AMD MENTAL HEALTH PROVIDERS CAN, AT THEIR ELECTION, PROVIDE EMOTIONAL, MOTIVATIONAL, COGNITIVE, PERCEPTUAL, MORAL SUPPORT FOR CLIENT PARTICIPATNS UNDERGOING CONFLICTS IN HOUSING, OFFER TREATMENT OPTIONS AND SERVICES, BUT NOT INTERVENE DIRECTLY IN AREAS OF PRACTICE FOR WHICH THEY ARE WHOLLY UNQUALIFIED

AND HAVE EVIDENCE A HISTORY OF DISINTEREST, INCOMPETENCE, AND/OR ANTAGONISM TO CLIENT'S NEEDS AND INTERESTS.

THE PROVIDERS CAN AND SHOULD BE INFORMED OF PROBLEMS IN HOUSING AND WORK COLLABORATIVELY WITH A NEUTRAL ADVOCATE TO HELP THEM BETTER UNDERSTAND
THE CHALLENGES. LEGAL AND OTHERWISE, FACING CLIENTS WHEN SITUATIONS ARISE REQUIRING ADVOCACY THE FRAMING OF ISSUES BY WELL TRAINED ADVOCATES WITH
KNOWLEDGE AND THE CAPACITY TO APPLY LANDLORD/TENANT LAW; INTERPET CONTRACTS; ACT AS ARBITRATORS TO HELP RESOLVE QUESTIONS OF FACT, HELP INTERPRET AND NEGOTIATE ADA NEEDS AND REQUESTS; UNDERSTAND AND SEEK THIRD PARTY INTERVENTION OF EXTRA CONTRACTUAL THREATS SUCH AS BREAKINS TO THE BUILDING OR PROPERTY;
OR NOISE IN THE NEIBHBORHOOD EXCEEDING CODE LIMITS; OR VIOALTIONS OF LAW NOT WRITTEN IN THE LEASE BUT MANDATED BY CIVIL LAW FOR LANDLORDS

THE PROVISIONS OF ACCESS TO SUCH A SERVICE AVOIDS VIOLATING THE RIGHTS OF PROGRAM PARTICIPANTS WHILE ALSO PROVIDING THE BEST POSSIBLE MEANS OF ACHIEVING BOTH HOUSING RETENTION AND THE POSSIBILITY OF RECOVERY IN ANY SERVICE PROVISION SCENARIO

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**COST**:

MINIMAL.

AS WRITTEN THE ADVOCACY/LIASION SERVICE IS TO BE FUNDED THROUGH BACS PREEXISTING OR NEW FUNDING STREAMS FROM PRIVATE OR COUNTY GRANTS
THE CITY OF BERKELEY, CAN OF COURSE, CHOOSE TO FUND THIS SERVICE- AS IT DOES E.G. EAST BAY COMMUNITY LAW CENTER TO PROVIDE LOW INCOME LEGAL
COUNSELLING , MEDIATION, AND REPRESENTATION

STAFF TIME IN COMMUNICATING WITH THIS ADVOCACY SERVICE WILL CREATE LESS OF A BURDEN ON STAFF TIME THAN THE HOURS CURRENTLY SPENT ISSUING FACETIOUS WARNINGS TO CURRENT PARTICIPANTS, COMMUNICATING WITH LANDLORDS ATTEMPTING TO FORCE TENANTS' OUF OF HOUSING; ATTEMPTING TO BALANCE SOME SEMBLANCE OF TENANT'S RIGHTS WITH POLICES FAVORING LANDLORD'S DESIRES IN RUNNING THEIR PROPERTY FREE OF MANY NORMATIVE LEGAL CONSTRAINTS; AND TIME SPENT TRYING TO DETERMINE IF SOCIAL OR MENTAL HEALTH SERVICES CAN MITIGATE SITUATIONS

HUD FUNDING TO THIS AND OTHER HUD PROGRAMS REQUIRES CONSISTENT OUTCOMES AND THE LOSS OF PARTICIPANTS HOUSING MAY RESULT IN REDUCED HUD FUNDING

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