Michael A. Amon, SB# 226221
Amon@fr.com
Madelyn S. McCormick, SB#320063
MMcCormick@fr.com
FISH & RICHARDSON P.C.
12390 El Camino Real
San Diego, CA 92130
Telephone: (858) 678-5070
Fax: (858) 678-5099

*[Additional counsel listed on following page]*

Attorneys for Plaintiffs

**UNITED STATES DISTRICT COURT**

**SOUTHERN DISTRICT OF CALIFORNIA**

MICHAEL BLOOM, STEPHEN CHATZKY, TONY DIAZ, VALERIE GRISCHY, PENNY HELMS, BENJAMIN HERNANDEZ, DOUG HIGGINS, SUZONNE KEITH, GERALD STARK, ANNA STARK, and DAVID WILSON, individually and on behalf of themselves and all others similarly situated,

Plaintiffs,

vs.

CITY OF SAN DIEGO,

Defendant.

Case No.: 3:17-cv-02324-AJB-MSB

**DECLARATION OF ELIZABETH FRYE IN SUPPORT OF EMERGENCY *EX PARTE* MOTION FOR TEMPOARARY RESTRAINING ORDER**

Maria Foscarinis, DC SB # 397792 (Admitted *Pro Hac Vice*)
mfoscarinis@nlchp.org
NATIONAL LAW CENTER ON HOMELESSNESS AND POVERTY
2000 M Street, NW, Suite 210
Washington, DC 20036
Telephone: (202) 638-2835 x 102/Fax: (202) 628-2737

Ann E. Menasche, SB # 74774
Ann.Menasche@disabilityrightsca.org
Nichole Marie Mendoza, SB # 276632
Nichole.Mendoza@disabiltyrightsca.org
Lili V. Graham, SB# 284264
Lili.Graham@disabilityrightsca.org
DISABILITY RIGHTS CALIFORNIA
530 B Street, Suite 400
San Diego, CA 92101
Telephone: (619) 814-8524/Fax: (619) 239-7906

Benjamin Conway, SB # 246410
ben.conway@disabilityrightsca.org
DISABILITY RIGHTS CALIFORNIA
350 S. Bixel St., Suite 290
Los Angeles, CA 90017
Telephone: (213) 213-8000/Fax: (213) 213-8001

Stuart Seaborn, SB# 198590
sseaborn@dralegal.org
Shira Tevah, SB # 307106
stevah@dralegal.org
DISABILITY RIGHTS ADVOCATES
2001 Center Street, 4th Floor,
Berkeley, CA 94704
Telephone: (510) 665-8644/Fax: (510) 665-8511

Robert Scott Dreher, SB #120527
scott@dreherlawfirm.com
DREHER LAW FIRM
350 Ash Street, Ste. 101
San Diego, CA 92101
Telephone: (619) 230-8828/Fax: (619) 687-0142

Manfred P. Muecke, SB # 222893
mmuecke@bffb.com
Patricia Syverson, SB # 203111
psyverson@bffb.com
BONNETT FAIRBOURN FRIEDMAN & BALINT PC
600 West Broadway, #900
San Diego, CA 92101
Telephone: (619) 798-4292/Fax: (602) 274-1199

**DECLARATION OF ELIZABETH FRYE**

I, Lara Elizabeth Frye, declare:

1. The statements set forth in this declaration are based on my professional knowledge and knowledge of the literature, are accepted in the medical community, and are summarized as expert opinions. If I am called upon to testify thereto, I could and would competently do so under oath.

2. I have been retained to provide expert opinion on the potential spread of COVID-19 among the homeless population in San Diego, on the different risks inherent in different forms of shelter, and on the steps that can be taken to mitigate those risks, both to the homeless population and to the public health as a whole. I submit this declaration in support of Plaintiffs' *Ex Parte* Application for Temporary Restraining Order in *Bloom v. City of San Diego*.

3. I am a Doctor of Medicine, board certified in Psychiatry and a Master of Public Health. I completed medical school at the University of North Carolina at Chapel Hill in 2006. I completed a residency in Psychiatry in 2010, a Community Psychiatry and Public Health Fellowship in 2011, and a Master in Public Health in 2011 all at Emory University. I hold an unrestricted medical license in the state of Georgia.

4. As a Psychiatrist at Mercy Care in Atlanta, Georgia, I created a Street Medicine program designed to provide physical and mental health care to people experiencing unsheltered homelessness where they live outdoors. I was Director of Psychiatry and Street Medicine at Mercy Care from December 2015 to July 2018. Mercy Care provides health care and social services to a homeless and low-income population in the Atlanta metro area. As Director of Psychiatry and Street Medicine, I managed and supervised two multi-disciplinary teams of 11 clinical staff including primary care, behavioral health, and case management staff. I founded and expanded the Street Medicine program at Mercy Care.

5. I have extensive experience teaching graduate students in various allied health fields, including medical, physician assistant, nursing, public health, pharmacy, and social work students. I have also taught residents in psychiatry at Emory University and Morehouse School of Medicine. In my various positions as a psychiatrist since 2009, I have provided education to students and residents from each of these fields on clinical rotations and in didactic courses. Through lectures and workshops, I have also taught learners who completed their educations, such as physicians, social workers, and other allied health professionals. I have been a member of the American Psychiatric Association and the American Association for Community Psychiatrists since my residency in psychiatry. I am a member of the board of directors of the Street Medicine Institute and I have directed the Institute's annual International Street Medicine Symposium, a conference for over 500 health professionals engaged in street medicine, for the past 3 years.

6. I have participated in research and co-authored articles on issues pertaining to street medicine, including open defecation among people experiencing unsheltered homelessness and approaches to providing street-based psychiatric care to people living outdoors. As a part of my Master of Public Health, I completed research and wrote my thesis on the stigma and discrimination towards people with mental illness experiencing homelessness by providers of homeless services in Atlanta, Georgia. Through the Street Medicine Institute, I have co-authored publications on alternative clinical guidelines for the streets and street medicine practice during the COVID19 pandemic. *See* Street Med. Inst., *Street Med. Prac. During the COVID-19 Pandemic* (2020), https://www.streetmedicine.org/assets/docs/COVid19%20SM%20 Guidance%203-20- 20.pdf.

7. I have extensive experience working with people experiencing homelessness and have provided psychiatric care for this population for the past 14

years. Through a variety of positions, I have provided inpatient and outpatient psychiatric care for both sheltered and unsheltered people experiencing homelessness. I have provided outpatient treatment through a variety of modalities including street medicine, Assertive Community Treatment, and clinic-based outpatient care. My curriculum vitae is attached to this declaration as Exhibit A.

**Summary of My Opinions**

8. People experiencing homelessness have a higher prevalence of health conditions that place them at risk of severe illness or death from COVID-19 than housed individuals.

9. People without housing also have higher prevalence of psychiatric and mental health disorders, which in turn can cause them to be more likely to contract infectious disease.

10. Congregate emergency shelters are not an adequate replacement for the stable, private shelter available to people who live in their vehicles during the COVID-19 pandemic, increasing both physical risk and mental health symptoms.

11. Inhibiting the ability of plaintiffs who live in their vehicles to safely and most effectively shelter in place, in their vehicles, to reduce exposure to COVID-19, could have dangerous and potentially lethal consequences. These consequences will in turn negatively impact public health overall.

12. Restricting access to public restrooms during the COVID-19 pandemic places plaintiffs who rely on these bathrooms at increased risk for contracting COVID-19, and also jeopardizes public health for the community where they live overall.

13. The plaintiffs who submitted declarations in support of the temporary restraining order have already suffered worsening of their various health conditions due to enforcement or threat of enforcement of parking regulations during the current pandemic.

**Overview of Health and Homelessness**

14. Individuals experiencing homelessness have higher prevalence of acute and chronic health conditions, with increased morbidity and early mortality from physical, mental, and substance use disorders. In a landmark study published in 2018, Roncarati and colleagues documented that, in a state with universal healthcare access, people experiencing homelessness were roughly 10 times more likely to die than the general population during the study period and people sleeping unsheltered were 3 times more likely to die compared to people sleeping in shelters. The average age of death of homeless individuals in this study was 53. Jill Roncarati et al., *Mortality Among Unsheltered Homeless Adults in Boston, Massachusetts, 2000-2009*, 178 JAMA Internal Med. 1242 (2018). This data was collected prior to the coronavirus pandemic. While it is too early to evaluate data on morbidity and mortality of homeless subpopulations during the COVID-19 pandemic, the novel coronavirus has the potential to infect people sleeping in homeless shelters more rapidly than people sleeping in cars or recreational vehicles (RVs) or outdoors, as shelters often house anywhere from 20 to several hundred people within the same room and usually do not offer enough restrooms to meet the United Nations' minimum standard of one toilet per every 20 people. UNHCR, *Emergency Sanitation Standards*, UNHCR EMERGENCY HANDBOOK, https://emergency.unhcr.org/entry/33014/emergency-sanitation-standards (v.1.6, last visited Apr. 29, 2020). With lack of access to the most basic of human needs, including running water, toilets and trash disposal, infectious diseases—like COVID-19—can spread quickly among unsheltered individuals, particularly those living in environments with minimal protective barriers between them.

15. People experiencing homelessness experience chronic health conditions that place them at high risk of serious illness or death from COVID-19. They have higher rates of hypertension and heart disease, asthma and chronic obstructive

pulmonary disease (COPD), diabetes, chronic liver disease and HIV/AIDS than the general population. As homeless individuals tend to have compromised immune systems, they are at even higher risk of contracting infectious diseases. Making matters worse, the lack of a safe, reliable place to get adequate rest, to stay clean, to store and administer medications, and/or to charge and store necessary medical equipment make treatment of homeless persons' health conditions much more difficult than it is for people with stable housing. Such conditions also contribute to the spread of infectious disease.

16. People without housing experience a higher burden of psychiatric and mental health disorders. The Brain and Behavior Research Foundation cites findings that in 2015, 25% of people experiencing homelessness at a single point in time count had a serious mental illness and 45% of people experiencing homelessness at that time had at least one mental illness. Peter Tarr, *Homelessness and Mental Illness: A Challenge to Our Society*, BRAIN AND BEHAVIOR RESEARCH FOUNDATION: BRAIN MATTERS BLOG (Nov. 19, 2018), https://www.bbrfoundation.org/blog/homelessness-and-mental-illness-challenge-our-society. Comparatively, only 4.2% of adults in the United States have a serious mental illness. Specifically, psychotic disorders such as schizophrenia are over-represented in homeless populations. The Substance Abuse and Mental Health Services Administration (SAMHSA) reports that Post-traumatic Stress Disorder (PTSD) disproportionately affects people experiencing homelessness, with 17.3% of people who have been homeless for 1 week or more meeting diagnostic criteria compared to 6.3% of people who have always been domiciled. SAMHSA notes many people experiencing homelessness have more than one psychiatric diagnosis, stating that roughly 50% of people with Major Depressive Disorder, Schizophrenia, Bipolar disorder, and Generalized Anxiety Disorder also have co-morbid PTSD. Substance Abuse and Mental Health Services Administration, U.S. Dep't of Health and Human Servs., *A Treatment Improvement Protocol:*

*Behavioral Health Services for People Who are Homeless* (2013). A meta-analysis found that in Western countries, including the United States, 12.7% of homeless individuals had psychotic illness, compared to 1% of the general population with Schizophrenia. Seena Fazel et al., *The Prevalence of Mental Disorders among the Homeless in Western Countries: Systematic Review and Meta-Regression Analysis*, 5 PLOS Med. 1670 (2008); Carol North et al., *Are Rates of Psychiatric Disorders in the Homeless Population Changing?*, Am. J. of Public Health, Jan. 2004, at 103. The National Coalition for the Homeless connects the dots between mental illness and poor physical health: "Poor mental health may also affect physical health, especially for people who are homeless. Mental illness may cause people to neglect taking the necessary precautions against disease. When combined with inadequate hygiene due to homelessness, this may lead to physical problems such as respiratory infections, skin diseases, or exposure to tuberculosis or HIV." Nat'l Coalition for the Homeless, *Mental Illness and Homelessness* (2009), https://www.nationalhomeless.org/factsheets/Mental_Illness.pdf.

17. As a result of physical and mental health conditions that are caused or exacerbated by a lack of stable and adequate housing, people without housing are significantly more likely to be admitted to the hospital than other populations. According to the American Medical Association ("AMA"), nearly 66% of people experiencing homelessness individuals visit the emergency room annually, compared to 20% of the general population. Sara Berg, *Homeless people need more help, not stays in jail: AMA*, A.M.A. (Jun. 12, 2019), https://www.ama-assn.org/delivering-care/population-care/homeless-people-need-more-help-not-stays-jail-ama. As much as a third of people experiencing homelessness are hospitalized during a given year, and they are likely to have a longer length of stay and return more frequently than people with housing. See e.g. Margot B. Kushel, *Emergency Department Use Among the Homeless and Marginally Housed: Results From a Community-Based Study*, 92

Am. J. Pub. Health 778 (2002), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1447161/pdf/0920778.pdf. People experiencing homelessness are also twice as likely as members of the general public to return to emergency departments within only one week of a hospitalization—often in an ambulance, contributing to high treatment costs and strain on limited emergency resources. COVID-19 has exacerbated these problems. According to a study by researchers at the University of Pennsylvania, UCLA, and Boston University, people experiencing homelessness are projected to be 2 to 3 times more likely to require hospitalization, 2 to 4 times more likely to require critical care in an ICU, and twice as likely to die as a result of COVID-19 infection. Dennis Culhane et al., *Estimated Emergency and Observational/Quarantine Capacity Need for the US Homeless Population Related to COVID-19 Exposure by County; Projected Hospitalizations, Intensive Care Units and Mortality* (2020), https://endhomelessness.org/wp-content/uploads/2020/03/COVID-paper_clean-636pm.pdf.

18. Congregate emergency shelters are not an adequate replacement for the stable, private shelter available to people who live in their vehicles during the COVID-19 pandemic. Congregate emergency shelters expose people to communicable disease, infestations, and parasites that are more easily spread in crowded conditions. Congregate shelters frequently struggle with inadequate ventilation, overcrowding, and insufficient procedures for handling contagious clients. According to the Centers for Disease Control and Prevention, these factors contribute to the spreading of diseases such as tuberculosis, influenza, and COVID-19. A recent publication documented that 36% of residents and 30% of staff in a large shelter in Boston tested positive for SARS-CoV-2, even though shelter-sleepers were screened for symptoms prior to entering and cleaning procedures recommended by the Centers for Disease Control and Prevention (CDC) were implemented. Travis Baggett, *COVID-19 Outbreak at a Large Homeless Shelter in Boston: Implications*

*for Universal Testing* (2020), https://www.medrxiv.org/content/10.1101/2020.04.12.20059618v1. These examples demonstrate the futility of using symptom screening tools to limit the spread of the virus in congregate shelters. In its Morbidity and Mortality Weekly Report on April 22, 2020, the CDC identifies emergency shelters and transitional housing as "settings that can pose risks for communicable diseases." The CDC cites an outbreak in a San Francisco shelter, finding that 66% of shelter residents and 16% of staff were infected with the novel coronavirus. Emily Mosites et al., CDC, Assessment of SARS-CoV-2 Infection Prevalence in Homeless Shelters — Four U.S. Cities, March 27-April 15, 2020 Morbidity and Mortality Rep. 69 (2020), https://www.cdc.gov/mmwr/volumes/69/wr/pdfs/mm6917e1-H.pdf.

19. Because of the risk of infection in shelters, if I were the physician for plaintiff Patrick Quinones and his fiancé, Christopher Voelp, I would strongly advise them to avoid homeless shelters, given Mr. Voelp's high risk of death if he were to develop COVID-19. In considering various risks, the RV pictured in exhibits C and D of Mr. Quinones' declaration is one of the safest options to reside in during the COVID-19 pandemic, though even a tent or sleeping completely unsheltered in an isolated location would be safer compared to a homeless shelter for Mr. Voelp.

20. In addition to physical health risks, congregate shelters may not be medically appropriate settings for people with a history of trauma and/or mental illness. For example, people with schizophrenia may experience a worsening of paranoia and auditory hallucinations when surrounded by large groups of people. Equally, flashbacks, nightmares, anxiety, and hypervigilance related to post-traumatic stress disorder may make it difficult for people to cope with the noisy and crowded conditions in shelters. Equally, avoidance of people, places, and objects that remind people of past traumas is a diagnostic feature of PTSD. For many people who experience homelessness and PTSD, avoidance of homeless shelters is a survival

strategy, as the avoidance reduces PTSD symptoms.

21. Plaintiff David Wilson's declaration provides an example of this avoidance among people experiencing homelessness. Given his PTSD, Mr. Wilson would likely opt to live outdoors rather than in a homeless shelter if his truck were impounded. Living unprotected outdoors would place Mr. Wilson at much higher risk of death from his other medical conditions, as a result of enforcing parking restrictions. In many large cities in the US currently, Mr. Wilson would be offered food delivery and a private motel room with a parking space for his truck, in which to weather the pandemic due to his high risk of death if he were to contract COVID-19.

22. In addition, many shelters do not allow family members to be in them together. In my experience, people experiencing homelessness usually refuse to enter shelters if it means being separated from their partners. If a person experiencing homelessness had to separate from their partner in a shelter, I would expect it to cause significant mental health deterioration. This is especially true during the pandemic, during which time, for many, human contact is limited to partners and family. Taking away the physical comfort of touch, which is very important for human wellness, as well as the emotional comfort of having someone with you that you rely on for survival, could be devastating. It could result in significant mental health impact, up to and including suicide. Separation from service animals or emotional support animals (whether registered or not) could have a similar impact. In my experience, most people will not leave the street for a shelter if it requires separation from a pet or support animal. Particularly in a time of crisis, causing such a separation could have extreme mental health consequences. In a congregate shelter environment, that negative impact could compound with the other negative mental health impacts for people with certain trauma histories or conditions associated with being in a loud, crowded environment.

23. For individuals with mental health conditions who tend to externalize

stress, shelter conditions could cause a fight-or-flight response of violence or aggression, jeopardizing their own safety and the safety of others. For those who internalize stress, shelter conditions could cause suicidal ideation and even suicide completion. In my experience, many people who live on the streets do so because they cannot tolerate many aspects of living in a shelter.

24. Policies that penalize people who lack traditional housing for meeting their survival needs, such as the need for shelter from the outdoor elements, can exacerbate the physical and mental health disorders that people experiencing homeless face. For example, San Diego's policies prohibiting people from sheltering in their vehicles or parking their vehicle homes between 2am and 6am—a time when most people sleep—could cause San Diego's residents who live in vehicles to move frequently and experience chronic sleep deprivation. Chronic sleep deprivation, in turn, is linked to immune suppression, hypertension, diabetes, obesity, and cardiovascular disease, and is a known risk factor for exacerbation of many psychiatric disorders.

25. Losing a vehicle that a person resides in is like losing one's home. That vehicle and its contents are all that person has in the world, and the mental health consequences of losing everything one owns are devastating. This is especially true for people who have a history of complex or multiple traumas, which is the case for an overwhelming majority of people experiencing homelessness. There is a dose response relationship between trauma and poor physical and mental health outcomes: the more traumas people accrue in their lives, the worse their health and quality of life outcomes. In reviewing the plaintiffs' declarations, I was particularly struck by the repeated loss that Patrick Quinones and his fiancé experienced. For someone like Mr. Quinones, losing the only place he and his partner feel safe—especially during the pandemic and considering Mr. Voelp's high risk of COVID-19 complications—could cause the type of stress that could lead to psychiatric hospitalization. For

example, stress of that magnitude can exacerbate hallucinations for someone who experiences them. In addition, the mental health impact of actually losing a loved one is enormous, and for someone with a mental health diagnosis it can be deadly. If I encountered someone in an emergency room who, like Mr. Quinones, had lost their only shelter and belongings, I would consider that a major loss factor. If they were having suicidal thoughts, that factor would create a higher risk of suicide completion and would make me strongly consider psychiatric hospitalization.

**Homelessness and COVID-19**

26. People experiencing homelessness are especially vulnerable during the global COVID-19 pandemic. COVID-19 is the disease caused by the SARS-CoV-2 pathogen. Research on COVID-19 is developing, but there are some known facts. The virus which causes COVID-19 typically has a two to fourteen day incubation period in human beings, and a person can remain infectious for fourteen days past initial symptoms. During the incubation period, infected people are asymptomatic – meaning they will not exhibit the physical symptoms associated with COVID-19, such as fever or coughing. An estimated 18-30% of people will remain asymptomatic even after the incubation period ends. Asymptomatic people are contagious and can spread the disease in the same way as people exhibiting symptoms. In addition to person to person transmission, the virus can live on surfaces for 72 hours or longer. It can be transmitted through respiratory droplets and surfaces, and recent studies suggest they it may be spread in the air or in fecal matter. The virus can remain infectious on surfaces for multiple days, and respiratory droplets can travel up to 27 feet after someone coughs or sneezes, and those droplets may remain in the air for over three hours. There is no vaccine for the virus. Medications used to treat COVID-19 are experimental and none are currently approved by the Food and Drug Administration at this point. National Institutes of Health, *COVID-19 Treatment Guidelines*, NIH.gov, https://covid19treatmentguidelines.nih.gov/introduction/ (last

updated Apr. 21, 2020).

27. There are two primary tools currently available to limit COVID-19 infections. The first is to decrease the likelihood that susceptible people in the population are exposed to COVID-19 infected people through physical distancing, sheltering in place to avoid non-essential contact with others, and quarantining of people who are infected. These measures involve asking people not to visit public spaces or to congregate, keep at least 6 feet away, and to stay at home as much as possible. Quarantining involves no contact with the community and keeping oneself isolated for 2 weeks. The second is to decrease the probability of transmission of infection from someone with the virus to someone who is susceptible if and when such contact takes place. Key ways to do this are to ensure frequent access to handwashing and hygiene in sanitary sites and access to masks that can filter out the virus. Partial social distancing or social distancing of only especially vulnerable individuals, such as people aged 65 and older, is far less effective overall. Thus, it is critical for all people to be able to safely shelter in place and to maintain necessary physical distancing—including people living in vehicles as their only form of available housing.

28. Policies like San Diego's that prohibit people from living in and parking certain vehicles encourage people living in vehicles to move frequently to avoid arrest, ticketing, and towing and impoundment of their vehicles. Such policies can result in further destabilization of their lives, requiring repeated moves to different and possibly less safe locations, and reducing their access to the healthcare and social service providers who know them best and provide resources in times of crisis. Healthcare is already fragmented for people experiencing homelessness, sheltered or otherwise, and most have complicated physical and mental health histories. Moving reduces access to their healthcare providers who prescribe medications for their chronic illnesses. Without these medications, people experiencing homelessness will

be more likely to visit an emergency room for reasons that could have been avoided. When they visit an emergency room where they have already received treatment in the past, they will receive better, more comprehensive care than in a new location, because the providers will have access to their medical record and may already know them. For a homeless person who contracts COVID-19 somewhere different from where they usually stay, the difference could be critical.

29. In recognition of the potential for disease spread through displacement of homeless people from areas where they live, the U.S. Centers for Disease Control and Prevention (the "CDC") explained in its *Interim Guidance for Responding to Coronavirus Disease 2019 (COVID-19) among People Experiencing Unsheltered Homelessness*:

> Unless individual housing units are available, do not clear encampments during community spread of COVID-19. Clearing encampments can cause people to disperse throughout the community and break connections with service providers. This increases the potential for infectious disease spread.

Center for Disease Control and Prevention, *Interim Guidance for Responding to Coronavirus Disease 2019 (COVID-19) among People Experiencing Unsheltered Homelessness* (2019), https://www.cdc.gov/coronavirus/2019-ncov/community/homeless-shelters/unsheltered-homelessness.html (last visited Mar. 26, 2020). The rationale for this guidance extends to people living in vehicles and the CDC recommendations should also equally apply to this population. Indeed, based in part on this guidance, the National Health Care for the Homeless Council, which is the premier national organization working at the nexus of homelessness and health care with thousands of members, including health care professionals and medical respite care providers, also recommends that every jurisdiction "ban encampment clearings and RV/car tow-aways."

30. Even the threat of punishment related to vehicle habitation can undermine plaintiffs' health by interrupting sleep, raising stress levels, and causing

people not to access necessary goods and services. As an example, plaintiff Mr. Michael Walsh has experienced an exacerbation of his anxiety disorder due to ticketing of his RV during the COVID-19 pandemic. Though moving to another location to avoid ticketing may have reduced his anxiety to some extent, he now has limited access to the healthcare providers who know him best. Equally, because stress suppresses immune response, these living conditions contribute to a higher likelihood that homeless people, who are already more likely to have poor health than the general population, will suffer serious illness or death from COVID-19 infection. Stress impairs immune function in the human body by creating the steroid hormone, cortisol. Cortisol functions to down-regulate immune function, thus leaving a chronically stressed person unable to mount a sufficient immune response to infectious diseases, such as COVID-19. *See* Jennifer Morey et al., *Current Directions in Stress and Human Immune Function*, 5 Current Op. in Psychology 13 (2015), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4465119/pdf/nihms-673410.pdf. Policies prohibiting or penalizing vehicle habitation therefore increase the likelihood that people living in vehicles will need to use limited emergency transportation, hospital beds, and ventilators that could have been used for other members of the community if the policies were not enforced.

31. People experiencing homelessness, who suffer worse health than housed people in general, are more likely to become severely ill or die from COVID-19 whether or not they fall into the currently accepted vulnerable groups. A collaborative publication between researchers from Boston, New York, and Los Angeles, "The Emerging Crisis of Aged Homelessness" documents that adults experiencing homelessness have "medical ages that far exceed their biological ages." Dennis Culhane et al., *The Emerging Crisis of Aged Homelessness: Could Housing Solutions be Funded by Avoidance of Excess Shelter, Hospital, and Nursing Home Costs?*, ACTIONABLE INTELLIGENCE FOR SOCIAL POLICY at 2,

https://1slo241vnt3j2dn45s1y90db-wpengine.netdna-ssl.com/wp-content/uploads/2019/01/Emerging-Crisis-of-Aged-Homelessness-1.pdf (Jan. 2019). They cite research demonstrating that people experiencing homelessness have "geriatric medical conditions such as cognitive decline and decreased mobility at rates that are on par with those among their housed counterparts who are 20 years older." *Id.* For example, a 60—year-old person experiencing homelessness would likely have a similar risk of death due to COVID-19 as an 80 year-old person who has never been homeless. In addition, the accepted risk categories identified by the CDC are underinclusive. For example, all people who smoke are at increased risk because of the impact of smoking on respiration, but the accepted vulnerable groups only specifies people with lung disease. In addition, people who have sickle cell disease are at increased risk because of poor blood oxygenation, but are not included in the currently accepted vulnerable groups. Prohibiting people living in vehicles from sheltering within their private vehicles during the COVID-19 outbreak, as in the case of Mr. Michael Walsh, will not only threaten their lives, but also the health and lives of the community at large by making physical distancing harder. Moreover, prohibiting people living in vehicles from using their best available form of shelter undermines shelter-in-place efforts by others. This can prolong the life of the pandemic.

32. Unrestricted access to public bathrooms equipped with toilets, running water, and soap for individuals experiencing homelessness is also extremely important to COVID-19 mitigation and public health generally. Lack of access to toilets and hand washing leads to increased frequency of open defecation (OD) where people are forced to defecate in public spaces. This is a significant health concern. In one U.S. city, over one quarter of human feces collected from open defecation sites was found to contain at least one infectious pathogen. Elizabeth Frye et al., *Open Defecation in the United States: Perspectives from the Streets*, Environmental Justice,

Aug. 2019, at 226, http://doi.org/10.1089/env.2018.0030. Flush toilets and portable toilets remove solid waste from the environment safely and limit fecal exposure to people experiencing homelessness and the general public. Outbreaks of Hepatitis A and other infectious diseases in the United States have been linked with lack of access to toilets within homeless encampments. *Id.*

33. Based on my experience, I believe that police presence at public bathrooms would likely prevent people experiencing homelessness who need to use the bathroom, and who have no other option for access to a toilet or handwashing facility, from doing so, to the detriment of public health. Encounters with police can be anxiety-inducing for all people, but especially traumatic for people with PTSD. Additionally, encounters with police are more likely to end in incarceration and even death for people with untreated psychiatric disorders. Yanick Charette et al., *Police Encounters Involving Citizens With Mental Illness: Use of Resources and Outcomes*, 65 Psychiatric Servs. 511 (2014); *People with Untreated Mental Illness 16 Times More Likely to Be Killed by Law Enforcement*, Treatment Advocacy Center, https://www.treatmentadvocacycenter.org/key-issues/criminalization-of-mental-illness/2976-people-with-untreated-mental-illness-16-times-more-likely-to-be-killed-by-law-enforcement- (last visited Apr. 28, 2020).

34. Furthermore, homeless people are experiencing heightened stigma during the pandemic that could make them wary of approaching a highly policed area. While people who experience homelessness have often dealt with being seen by the general public as dirty before the pandemic, this experience has been exacerbated by COVID-19. *See, e.g.*, Coronavirus New York Update, *Cuomo Calls Subway Cars Filled With Homeless People 'Disgusting'*, N.Y. TIMES (Apr. 28, 2020, 8:51 PM), https://www.nytimes.com/2020/04/28/nyregion/coronavirus-new-york-update.html.

35. Similarly, access to safe and free black water dump sites, relied upon by people living in RVs, is critical for COVID-19 mitigation and public health.

Decreasing the availability of dumping sites or increasing the distance to a dump site in the setting of financial strain experienced by homeless people, especially during the pandemic which has impacted already meager incomes for many, increases the likelihood of illegal dumping and for waste to enter into the community.

36. It is much safer to shelter in private vehicles—in particular RVs with working amenities—than in other settings available to people without permanent housing. It also more protective of public health. RVs with working amenities are no different than private single-family homes in terms of safety related to the transmission of SARS-CoV-2, the novel coronavirus. RVs connected to power and water are likely the most safe option for people experiencing homelessness, even compared to hotels or some apartment buildings, as relatively few people will touch the same door handles and other fomites within the living environment. Even vehicles without amenities such as running water, toilets, refrigeration, cooking facilities, lighting, and electricity can be better options than congregate shelters or living unsheltered outdoors. Vehicles provide an impenetrable barrier between people within them and the outside world, limiting the possibility of SARS-CoV-2 transmission. Vehicles may be used for storing water, food, medicine, medical equipment, and other necessities, but they also provide a psychologically safe space for people living within them. Allowing people to remain in places where they feel psychologically safe reduces stress and anxiety, allows people to sleep more soundly or for longer hours, reduces cortisol levels and potentially improves immune function, and reduces the risk for death by suicide.

37. Congregate parking lots could be a reasonable option for some people living in vehicles to weather the pandemic under certain conditions, provided that physical distancing of at least 6 feet can be maintained and adequate access to clean water and sanitation exists. The United Nations recommends a minimum of one toilet for every 20 people. *Emergency Sanitation Standards*, Supra, at 7. During the

COVID-19 pandemic, public restrooms should be disinfected after each use. Handwashing stations that do not require users to touch any surfaces, including faucet handles and soap dispensers, are also necessary to maintain adequate hand hygiene and prevent the spread of the novel coronavirus. Equally, for plaintiffs such as Mr. Stephen Chatzky, electricity would be necessary to make it possible for him to use his c-pap, a medically necessary device. Lastly, any congregate parking lot for people residing in their vehicles should allow people to remain in the lot 24 hours per day, to minimize excursions and the spread of coronavirus during the daytime hours.

38. Hotels can also be a reasonable option for homeless people to weather the pandemic, provided certain conditions are met. Most importantly, for homeless people with vehicles, they must be provided space to park their vehicles safely at the hotel. Most of the people experiencing homelessness I have worked with who have vehicles would refuse temporary hotel housing if it meant losing a vehicle. The effectiveness of hotels as an alternative to allowing people to shelter in their vehicles would also require enough hotel rooms to provide one for every individual or family living in a vehicle. In addition, the safest type of hotel would be a motel where the temporary resident only touches their own outside door handle. Hotels with elevators would likely be a worse option than sheltering in a vehicle. This is because a person would be exposed to potential virus particles by touching an elevator button and even by breathing the air inside, which would contain prior occupants' respiratory secretions. Someone with congestive heart failure, for example, would be unable to use stairs and would need to use the elevator, putting them at risk. Any hotel space housing both individuals with known COVID-19 infections and individuals at high risk for COVID-19 complications would be a particularly risky situation. Hotel housing, to be adequate, would also have to allow people to bring their animals. Isolation in a hotel room could be extremely lonely, and much more so without a person's pet or service animal. The American Psychiatric Association and other mental health professionals

have identified serious psychological consequences of quarantine, analogous to solitary confinement. In an article recently published in The Lancet Psychiatry, Gunnell et al. note,

> "The likely adverse effects of the pandemic on people with mental illness, and on population mental health in general, might be exacerbated by fear, self-isolation, and physical distancing. Suicide risk might be increased because of stigma towards individuals with COVID-19 and their families. Those with psychiatric disorders might experience worsening symptoms and others might develop new mental health problems, especially depression, anxiety, and post-traumatic stress (all associated with increased suicide risk)."

Isolation in a hotel room, away from the vehicle, people, pets and other coping mechanisms would place people experiencing homelessness at even higher risk of suicide during the pandemic. Gunnell et al., *Suicide Risk and Prevention During the COVID-19 Pandemic*, THE LANCET (Apr. 21, 2020), https://www.thelancet.com/action/showPdf?pii=S2215-0366%2820%2930171-1. Compared to a vehicle where a person already resides, that is comparable to their home, and through which they can safely interact with other people through a window barrier, isolation in a hotel room could be significantly more difficult from a mental health perspective.

39. As I have cited with specific examples from plaintiffs' declarations throughout this document, it is my professional opinion as a physician and a public health professional that each plaintiff who provided a declaration has already suffered worsening of their various health conditions due to enforcement or threat of enforcement of parking regulations during the current pandemic. Further, each of these plaintiffs described at least one, and sometimes multiple, factors that significantly elevate their risk of death if they were to become infected with SARS-CoV-2. The safest, most effective way to reduce risks for the plaintiffs, others like them, and the general public is to allow people living in their vehicles to shelter in

place—in their own vehicles—in the same parking place for the duration of the pandemic.

I declare under penalty of perjury that the foregoing is true and correct. Executed on April 29, 2020 at Atlanta, Georgia.

DocuSigned by:
Elizabeth A. Frye
E82AB22BC01444C...

Elizabeth A. Frye, MD, MPH

EXHIBIT A

**Curriculum Vitae**
**Lara Elizabeth Aycock Frye, MD, MPH**

PERSONAL INFORMATION

Address 520 Scott Boulevard Decatur, GA 30030
Cell 404-694-3954
Email lefrye@gmail.com
Preferred name: Liz

EDUCATION

University of North Carolina, Chapel Hill, NC
Bachelor of Science, Biology, 1998-2002

University of North Carolina, Chapel Hill, NC
Doctor of Medicine, 2002-2006

Emory University, Atlanta, GA
Master of Public Health, 2009-2011

POSTGRADUATE TRAINING

Emory University, Atlanta, GA
General Psychiatry Residency, 2006-2010
Fellowship in Community Psychiatry and Public Health, 2009-2011

CERTIFICATION AND LICENSURE

American Board of Psychiatry and Neurology, 2012 – present
Georgia Medical license (65550) 2012 – present
Tennessee Medical license (58247), 2018 – present

PROFESSIONAL EXPERIENCE

Georgia Regional Hospital Atlanta, Psychiatrist
04/16/19 – 4/16/20

- Direct patient care on an adult inpatient psychiatric unit at a state hospital
- Clinical teaching of 3rd and 4th year medical students on their psychiatry rotations

Southern Regional Medical Center, Locum Tenens Psychiatrist
04/12/19 – 04/18/19

- Provided direct patient care coverage on a geriatric psychiatry unit during vacation of the primary psychiatrist

Cherokee Health Systems, Psychiatrist
08/06/2018 – 03/29/19

- Direct patient care in outpatient clinic via telepsychiatry
- Consulting psychiatrist to primary care within an integrated care setting
- Development of integrated care training opportunity with Meharry School of Medicine

- Development/presentation of training/educational materials in association with the Cherokee Integrated Behavioral Health Training Academy

Mercy Care, Director of Psychiatry and Street Medicine
12/2015-7/16/18

- Direct management and supervision of two multi-disciplinary teams of 11 clinical staff (primary care, behavioral health, and case management)
- Development and leadership of behavioral health and Street Medicine programs designed to address health care shortages and health disparities in Fulton/DeKalb county
- Responsible for oversight of clinical activities for psychiatric staff and volunteers, including problem-solving to expand capacity for services on a limited budget
- Recruiting and managing over 100 Street Medicine volunteer providers, clinicians, students, and medical office specialists in the past 3 years
- Developing and expanding Street Medicine program
- Represented Mercy Care at local, national, and international meetings
- Liaised with community partners for expansion of Psychiatric and Street Medicine services
- Responsible for grant-writing and reporting
- Responsible for program budget development and tracking
- Clinical leadership and consultation with primary care providers and behavioral health specialists in Integrated Care program
- Preceptor for Emory's Rollins School of Public Health students in program evaluation/research of Street Medicine.
- Teaching/training allied health students to provide excellent healthcare for homeless individuals
- Clinical teaching of Emory Physician Assistant students during Psychiatry rotations
- Direct patient care for psychiatric clinic and Street Medicine patients

Mercy Care, Psychiatrist
07/2013-12/2015

- Direct patient care for psychiatric clinic and Street Medicine patients
- Clinical leadership and consultation with primary care providers and behavioral health specialists in Integrated Care program
- Creation and management of Street Medicine program
- Teaching/training allied health students to provide excellent healthcare on Street Medicine rounds
- Clinical teaching of Emory Physician Assistant students during Psychiatry rotations
- Preceptor for public health students at Georgia State in research of the Street Medicine program

Morehouse School of Medicine, Instructor of Clinical Psychiatry
07/2011-07/2013

- Medical Director of Assertive Community Treatment (ACT) at Grady Health System

- Psychiatric consultant for the Satcher Health Leadership Institute Integrated Care Initiative (included research, program implementation, and clinical components)
- Direct patient care for people with severe mental illness on ACT team
- Clinical teaching of psychiatry residents and medical students
- Course director of Community Psychiatry elective, 2012-2013

Emory University School of Medicine, Adjunct Assistant Professor of Psychiatry
2011-2013; 04/2016-present

- Teaching in clinical and classroom settings of psychiatry residents and medical students
- Teaching/precepting public health students

Emory University School of Medicine, Senior Associate, 2011

- Clinical leadership of ACT team
- Direct patient care for people with severe mental illness on ACT team
- Supervision of psychiatry residents working on ACT team
- Grant-writing to expand ACT services at Grady Hospital

PROFESSIONAL SERVICE

Street Medicine Institute
Member, Board of Directors, 2016 – present
Chair, International Street Medicine Symposium, 2016 – present

- Responsible for planning and leadership of the Street Medicine Institute's current and past two annual symposia in the United States and abroad for approximately 500 attendees

American Association of Community Psychiatrists
Board of Directors, 2015 – 2017
Newsletter Editor, 2015 - 2017

Atlanta/Fulton County Pre-Arrest Diversion Initiative
Member, Design Team, 2016

Morehouse School of Medicine
Department of Psychiatry Committee on Faculty Appointments and Promotions Chair, 2012 – 2013
Residency Education Committee, 2012 – 2013

SCHOLARSHIP AND RESEARCH

1. Frye, Elizabeth A. Capone, D. Evans, D. "Open Defecation in United States: Perspectives from the Streets" *Environmental Justice.* 12(5). 2019. Available online: https://www.liebertpub.com/doi/10.1089/env.2018.0030
2. Frye, Elizabeth A. Mcquistion, H. "Psychiatry in the Streets: Unique Services for People Experiencing Homelessness." *Psychiatric Times*, 2016
3. Frye, Elizabeth A. et al. "Systems-Based Practice." *Psychiatric Times*, October 2016 issue

4. Clinical research in piloting primary care-behavioral health integration through the Satcher Health Leadership Institute, 2011-2013
5. “Crazy, Dirty, Lazy: Stigmatization of the Homeless Mentally Ill by Providers of Homeless Services” - Research project and thesis for Masters in Public Health at Emory School of Public Health, 2011

PRESENTATIONS AND WORKSHOPS (full list available upon request)
Homeless Health Care

- Keynote presentation, JC Lewis Primary Health Care Center’s 3rd annual gala, 08/2019
- “Street-based Psychiatric Assessment and Treatment: Schizophrenia and Beyond,” University of Southern California Los Angeles Street Medicine Symposium, 07/2019
- “Outside the box: Providing Mental Health Care for People Without Shelter,” SAMHSA’s Homeless and Housing Resource Network webinar, 06/2019
- “Everyone Poops: A Dialogue About Open Defecation, Public Policy, and Human Rights,” National Health Care for the Homeless Conference and Policy Symposium, 05/2019
- “Reality-based Medicine and Alternative Clinical Guidelines for the Street,” Street Medicine Pre-conference Institute, National Health Care for the Homeless Conference and Policy Symposium, 05/2019
- “Street Medicine: Comprehensive Street-based Care for Unsheltered Homeless People,” National Council for Behavioral Health, 04/2018
- "Caring for/Decision Making with Unrepresented Patients," Healthcare Ethics Consortium, 03/2018
- International Street Medicine Symposium
    - "Street-based Trauma-informed Care," 10/2017, 10/2018, 10/2019
    - "Consult the Psychiatrist: Everything You Wanted to Know, but Never had a Street Psychiatrist to Ask," 10/2017
    - "Strategies for Establishing Conservatorship in Severely Mentally Ill Rough Sleepers," 10/2016
    - "Fast-track Disability for the Mentally Ill, Unsheltered Homeless Person: Navigating the Complex Social Security System," 10/2015
    - “Telemedicine on the Streets," 2015
    - “Curbside Consults II: Next Steps for Existing Street Medicine Programs,” Expert panel participant, 2015
    - “Street Psychiatry for the Non-Psychiatrist," 2014
    - “Mindfulness for Physical and Mental Pain,” 2014
    - "Stigmatization of Homeless Mentally Ill People," 2012
    - “Creative Solutions for Homeless Mental Health Treatment,” 2010
- "Homelessness and Behavioral Health," Center for Public Service Psychiatry, 09/2016
- "Reaching Our Potential: Why Atlanta Will Do It Right," The Atlanta/Fulton County Pre-Arrest Diversion Initiative Launch, 06/2016
- "Street Psychiatry: Integrated Care for Atlanta's Unsheltered Homeless," American Psychiatric Association annual meeting, 05/2016
- "Homeless Psychiatry Forum," panel at APA Institute on Psychiatric Services, 10/2015

- "Expanding Street Medicine Through Telemedicine," National Health Care for the Homeless Conference and Policy Symposium, 05/2015

Integrated Primary Care and Behavioral Health

- "Risk and Liability with Integrated Care," webinar for Cherokee Health System, 09/2018
- "Behavioral Health Integration into Primary Care for Vulnerable Populations – Key Components to Population Health," Catholic Health Assembly 06/2016
- "Leading System Change Toward Integrated Care: Unfunded, Not Ready, Unsure? Start Here," American Psychiatric Association, 05/2016
- "Integrated Care and Health Equity Institute for Healthcare Improvement," Institute on Healthcare Improvement, 2014-2015
- "Medical Homes for the Homeless," Third National Medical Home Summit, 03/2011

Additional Presentations

- "Reducing Unnecessary Antipsychotic Use in Nursing Home Patients with Dementia," webinar for ATOM Alliance, 09/2018

PROFESSIONAL SOCIETIES

American Association of Community Psychiatrists, 2010 – present
Georgia Psychiatric Association, 2007 – present
American Psychiatric Association Member, 2007 – present
Eugene S. Mayer Community Service Honor Society, 2004 – present

LANGUAGE FLUENCY

I am fluent in English and proficient in French.

REFERENCES

Available upon request