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

Evaluation Report

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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

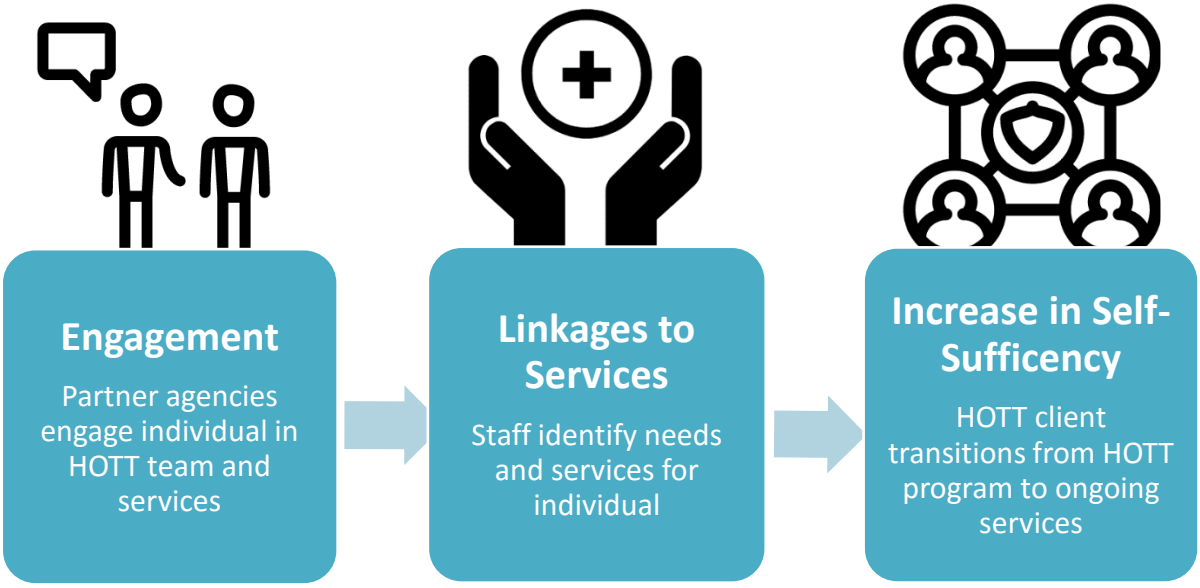
staff adapted by managing program resources and budget judiciously. Despite these challenges, the HOTT program staff have created an impactful and resilient program that effectively engages and helps homeless individuals in Berkeley and Albany.

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:

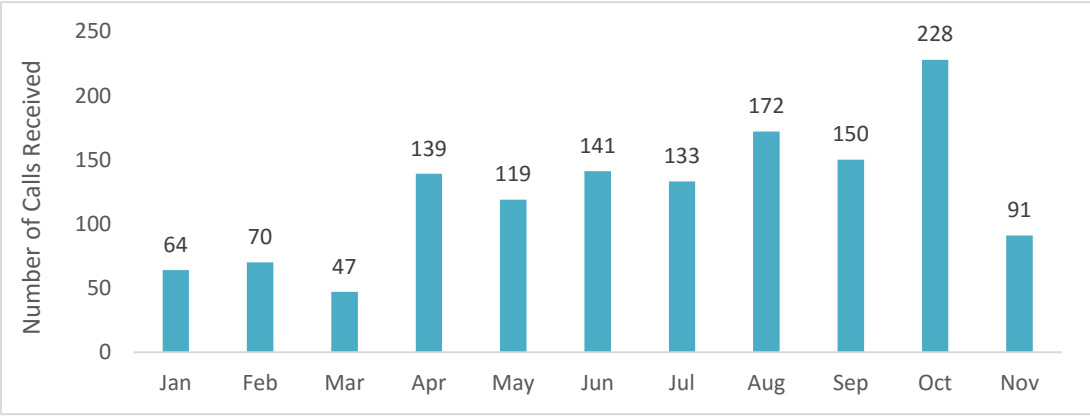
- The HOTT program serves as an important resource for the local community.
- The HOTT program works with anyone and meets them where they are.
- The HOTT Program is rooted in compassion and dignity.
- People experience immediate and tangible support.
- The HOTT program successfully engaged with chronically 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)



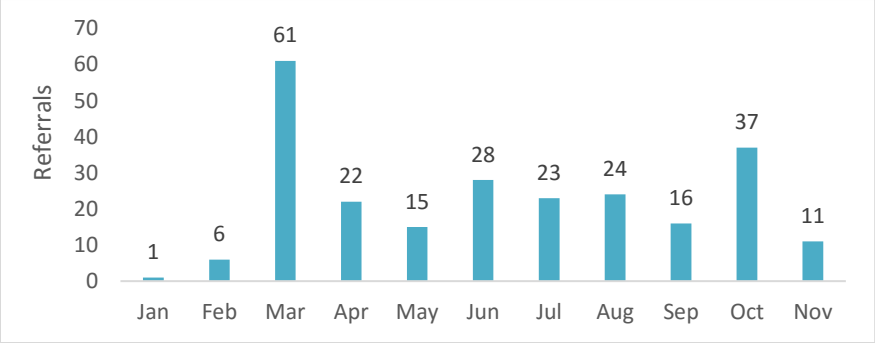
[3] The cumulative total is higher, since this estimate does not include calls in 2017.

> "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

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.

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.

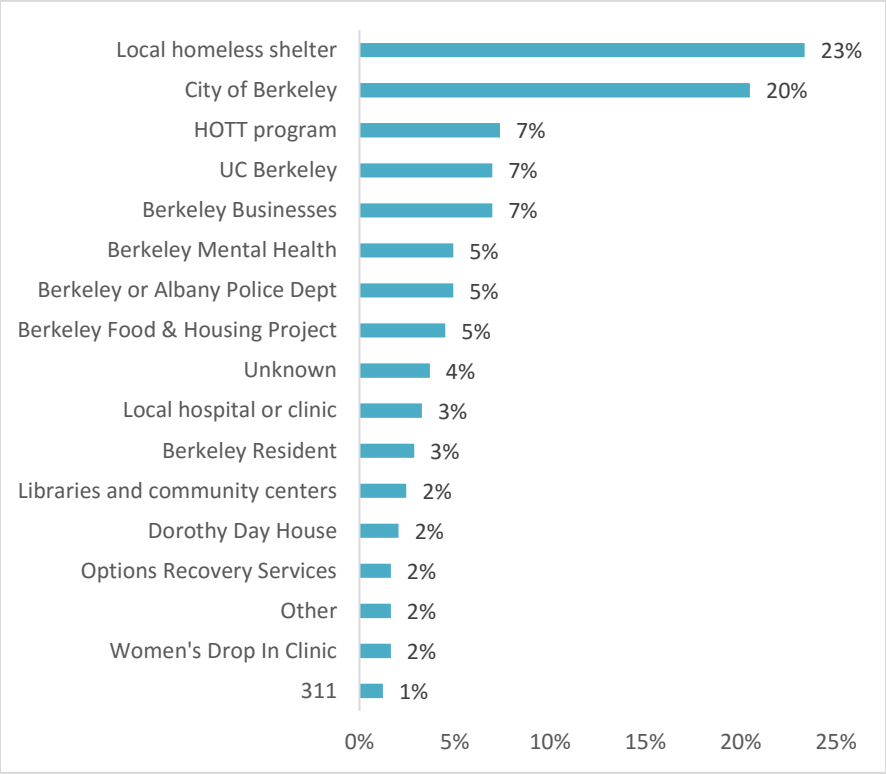
Figure 2. HOTT Program Referrals Received, 2018 (n=244)



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]

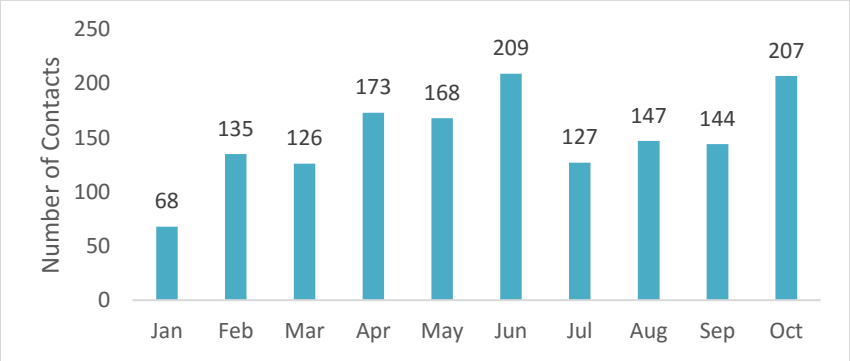
The HOTT program conducted self-sufficiency assessments with 30 individuals, the majority (57%) of whom were formally enrolled in the program. Most (90%) were chronically homeless and were assessed to be highly vulnerable (i.e., scored low on self-sufficiency assessment) when they initially made contact 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 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. 3 = Can meet basic needs with subsidy; appropriate spending.
Food	2.4	2 = Household is on food stamps. 3 = Can meet basic food needs, but requires occasional assistance.
Insurance	4.3	3 = Some members (e.g. children) have medical coverage. 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. 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. 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. 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. 3 = Lacks knowledge of ways to become involved.
Legal	3.9	3 = Fully compliant with probation/parole terms. 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. 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. 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. 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. 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