Berkeley Mental Health Department Homeless and Outreach Treatment Team (HOTT) Evaluation

Final Evaluation Report

Prepared by:

Resource Development Associates

July 2020

Berkeley Mental Health Department Homeless Outreach and Treatment Team (HOTT) Evaluation

Final Evaluation Report

Kevin Wu, MPH

Jamie Dorsey, MSPH

This report was developed by Resource Development Associates under contract with the City of Berkeley, Mental Health Services

Resource Development Associates, 2020

About Resource Development Associates

Resource Development Associates (RDA) is a consulting firm based in Oakland, California, that serves government and nonprofit organizations throughout California as well as other states. Our mission is to strengthen public and non-profit efforts to promote social and economic justice for vulnerable populations. RDA supports its clients through an integrated approach to planning, grant-writing, organizational development, and evaluation.

Table of Contents

I. Introduction

Background

The City of Berkeley's Homeless Outreach Treatment Team (HOTT) is a homeless outreach and engagement pilot program established in May 2017 with the goal of engaging homeless individuals with significant mental health needs who are living on the streets of Berkeley and Albany, connecting them to emergency housing resources (such as emergency shelters and motels), and assisting them with referrals to temporary and permanent housing programs and resources. The HOTT 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 serious mental illness (SMI), services for individuals to prevent SMI, and services for those with functional impairments due to a mental health disorder or high profile, problematic behavior on the streets.

The City of Berkeley's Mental Health Division (BMH) 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 spanning from January 2018 through February 2020.

HOTT Program Model

HOTT 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. Rather than focusing on direct problem solving, the HOTT program focuses on building trusting relationships with participants to assist them with navigating the transition from homelessness.

Initially, the HOTT program was intended to serve high-risk individuals identified by the Berkeley Housing Resource Center (HRC, also known as the Hub) as experiencing chronic homelessness in addition to serious mental illness and/or a history of psychiatric hospitalization and co-occurring substance use.[2] In this model the HRC/Hub served as the single point of entry to the HOTT program. The intended design was for HOTT to work with referred clients for a period of up to six months. During this time, HOTT would work with clients to address their basic needs, address their initial barriers to obtaining housing, and support clients in the transition from homelessness. HOTT services could include connecting clients to immediate short-term emergency housing resources (e.g., motels or shelters), mental health services, and other wraparound services and supports. At the same time, the HRC/Hub would connect individuals to housing

[1] Center for the Advancement of Critical Time Intervention, (2014). *CTI Model.* Retrieved fromhttps://www.criticaltime.org/cti-model/
[2] The HRC/Hub was formerly operated by the Berkeley Food and Housing Project, and is now operated by Bay Area Community Services (BACS).

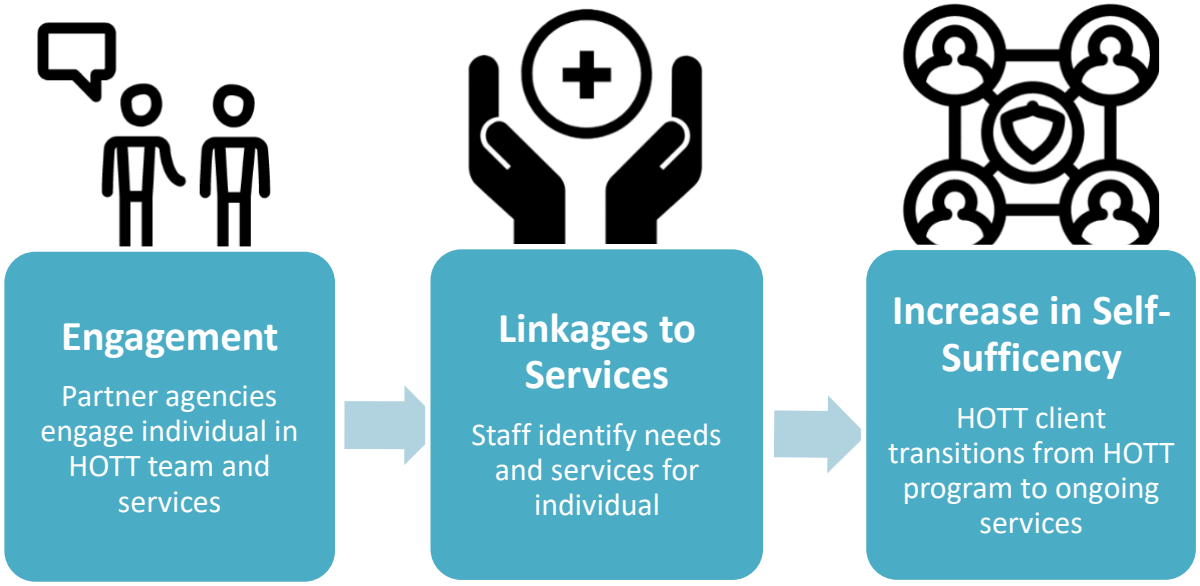
services and provide permanent housing vouchers, when available. Over the course of the three-year pilot, the program intended to serve a total of 100 individuals (or approximately 30 individuals each year). However, the HOTT program received fewer referrals from the HRC/Hub than anticipated and also faced a number of other implementation challenges, such as barriers to accessing housing vouchers within the Alameda County system.

In response to these challenges, BMH adapted by being more flexible in HOTT program implementation. Notably, in January 2018, HOTT expanded services to respond to the general homeless population with varying levels of mental health needs, rather than just the highest risk individuals. At the same time, HOTT allowed multiple points of entry to the program and began accepting referrals and requests for HOTT services from the broader community, including City agencies, community-based organizations, and other community members.

Program Activities

The ultimate goal of the HOTT program is to provide support for the client to successfully connect to the appropriate services to navigate the transition from homelessness. 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 (**Error! Reference source not found.**).

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 and utilize motivational interview techniques to engage individuals, as well as 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, the City's 311 service information and access line, community-based organizations, and community members to assist with providing supportive services to homeless individuals.

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, case managers conduct a strengths-based assessment to identify the client's needs. At the outset, the 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 emergency housing (e.g., motels or shelters). Case managers then work with the client to assess what additional supports are needed to address their basic needs and other barriers to housing—including benefits assistance, referrals to existing services throughout the city and county, food resources, hygiene kits, transportation vouchers, and other goods and services.

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. Through facilitating connection to ongoing services, the HOTT program aims to help individuals engage in longer-term services that prevent further episodes of homelessness and promote improved health, mental health, and self-sufficiency.

Target Population

As previously mentioned, the HOTT program serves homeless individuals with varying level of needs—which may include serious mental illness and/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 HOTT's target population, the City of Berkeley hired a HOTT team comprised of one program manager, four case managers, and an administrative support personnel. The program manager oversees and manages the daily program activities. The case managers' primary focus is to outreach to and engage potential clients and provide case management support for clients who choose to work with the HOTT team. One case manager is a licensed clinician who can also conduct clinical assessments and review Medi-Cal documentation. The administrative support personnel assists with client paperwork for emergency housing, organizing data collection, and ensuring assessments are completed on time in addition to other office support and administrative responsibilities.

Initially, the HOTT program had also intended to hire a registered nurse. However, the program had difficulty hiring and retaining nursing staff due to the program's emphasis on case management and service linkage, rather than directly providing medical or nursing services. Due to these hiring challenges and the program's high demand for case management, the program ultimately hired a fourth, clinical case manager.

It also important to note that because the HOTT program was developed as a three-year pilot, HOTT staff positions were categorized as temporary, rather than permanent positions. With a temporary staffing designation, HOTT positions filled with non-City staff (i.e., staff who were not already employed by the City of Berkeley in career-appointed positions) were not guaranteed employment after the conclusion of the HOTT pilot period. In contrast, HOTT positions filled with existing, career-appointed City employees were guaranteed reassignment to another program or department following the conclusion of the HOTT pilot. The temporary staffing designation contributed to staffing issues as temporary staff (often left the program when opportunities for more stable or longer-term employment arose. Additionally, as the pilot period progressed, it was more challenging to fill vacant positions as there was less time in the pilot and therefore a shorter employment period. For example, staff who are hired half-way through the pilot would only have approximately one and half years of guaranteed employment with the HOTT program.

II. Evaluation Design and Methodology

To effectively measure the implementation of HOTT program activities and outcomes, RDA used a mixed methods approach, which uses different types of data from multiple sources. By utilizing mixed methods, RDA is able to triangulate findings to better program implementation and outcomes.

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 referrals to the HOTT program, program enrollment, HOTT services provided, and client outcomes. In addition, RDA gathered qualitative data through a total of 12 interviews with program staff (5 interviews), clients (4 interviews), and community partners (3 interviews) to better understand the program model, assess program implementation successes and challenges, and understand HOTT staff and clients' perceptions of the impact of HOTT services. Specific data collection tools are described in *Appendix A*.

Data Analysis. RDA conducted descriptive statistics for client-level data to determine who is being referred and served, the types of services individuals are receiving, the types of service linkages, and changes in participants' self-sufficiency. To analyze qualitative data from key informant interviews, RDA transcribed interview responses and thematically analyzed responses to identify reoccurring themes and key takeaways. During the previous year, RDA also summarized impact stories gathered during focus groups with clients. These impact stories are available in *Appendix E.*

Limitations. As in all evaluations, there are data limitations that need to be considered. On March 16th, the Health Officer of Alameda County issued a shelter-in-place order to reduce the spread of COVID-19. At this time, HOTT (along with other Alameda County outreach teams) was tasked with assisting the City and County's coordinated COVID-19 response efforts. The HOTT program was redeployed as an encampment outreach team. As a result of this change, the evaluation period only extends through February 2020, before the HOTT shifted to the COVID-19 response efforts. Program data collection also did not start until 2018, and activities conducted in 2017 are not captured. Therefore, quantitative data is limited to the 26-month period from January 1, 2018 through February 29, 2020.

Another data limitation is that individuals served by the HOTT program are not assigned a unique identifier. Due to the HOTT service model of providing direct outreach to encampments, ad hoc homeless response, and ongoing services, it would be challenging for HOTT staff to reliably and consistently assign

a unique ID to each individual served. However, the absence of unique identifiers also makes it challenging to identify unduplicated individuals within and across datasets as individuals' names were often spelled or captured differently. RDA manually cleaned and inspected data files to estimate the number of unduplicated individuals served using client name as well as date of birth and social security number, when available. However, it is likely that some duplicated individuals were missed, and the number of unique individuals may be slightly over- or underreported.

Additionally, service data were not always reported consistently. At times, services and referrals provided are listed in the case notes rather than in the designated check list. This makes it challenging to examine the totality of services provided by HOTT in a standardized way. As a result, material supports, referrals, and other services provided are likely underreported.

Lastly, 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. There may be other factors that influence client and program outcomes. Examples may include the availability of permanent supportive housing and other needed resources required to support clients to transition from homelessness and increase self-sufficiency.

III. Evaluation Findings

HOTT Outreach and Engagement

HOTT engages homeless individuals who may be in need of mental health support by responding to community referrals, working in collaboration with other City and nonprofit partners to identify potential clients through the HOTT Officer of the Day, and conducting in-person direct outreach to potential clients across the City of Berkeley and Albany. The three modes of engaging clients allow HOTT the flexibility to meet clients' complex needs, while also being responsive to community member concerns. The three primary modes of HOTT outreach and engagement are briefly summarized in Table 1 below.

Table 1. HOTT Engagement Pathways

Modes of Client Engagement
Direct Referrals HOTT's referral process is one of the methods community members and other city providers use to notify the HOTT team of individuals with emergent needs for mental health and other services. Individuals may also self-refer to the HOTT team for ongoing engagement.
Officer of the Day (OD) Requests During HOTT operating hours, a HOTT staff member (i.e., the Officer of the Day) remains in the HOTT office to respond to requests for HOTT services. Community members, city agencies, and other homeless service providers may call or email the Officer of the Day to request the HOTT team respond to an immediate concern regarding homelessness and/or mental health needs of a homeless individual. Former or current clients may call the Officer of the Day for immediate support or one-time needs. Additionally, non-enrolled individuals may also call the Officer of the Day for information or to request HOTT services.
Street and Encampment Outreach HOTT staff maintain ongoing contact with current, former, and potential clients by proactively visiting locations across the city where people experiencing homelessness are located, including formal congregate settings like shelters and street-side encampments.

It is important to note that while this evaluation presents these engagement pathways as distinct, there are several ways the engagement pathways overlap. For example, referrals may be received through the Officer of the Day, in which case the Officer of the Day will complete the referral form on behalf of the requestor. Additionally, individuals experiencing homelessness who have worked with HOTT may also refer other individuals while HOTT staff are conducting street and encampment outreach.

While referral information is tracked in a separate referral form, outreach efforts in response to direct referrals, OD requests, and street outreach efforts are all tracked in the same forms. This makes it difficult to distinguish the volume of OD requests and direct outreach efforts. As a result, quantitative information is only presented for direct referrals to HOTT, while OD requests and direct outreach efforts are described based upon qualitative information collected through interviews with HOTT staff and program partners. Specific information about HOTT enrollment, HOTT encounters, and service linkages is presented in the following section, *HOTT Enrollment and Services*.

Direct Referrals to HOTT

HOTT's referral system is an outgrowth of the initial program design to engage individuals identified through the Housing Resource Center (HRC, also known as the Hub). As mentioned, HOTT was intended to serve individuals identified as being high-risk, and who had serious mental illness and/or a history of psychiatric hospitalization and co-occurring substance use. The referral process was in place to determine whether individuals were likely to meet HOTT program criteria and could be formally enrolled as clients. As the HOTT program expanded, there were no longer formal eligibility criteria and referrals became just one way to connect individuals to HOTT services.

Between January 1, 2018 and February 29, 2020, the HOTT team received a total of 532 referrals from a wide variety of sources, exceeding the initial target of 100 individuals (Table 2). Referral records indicate thirty-eight percent (38%) of referrals came from agencies or programs that serve individuals experiencing homelessness (PEH) and offer housing and homeless services—including the Berkeley or Albany Mental Health departments, other City programs, and/or community-based organizations (CBOs).[3] Additionally, 20% of referrals came from individual seeking services for themselves. The remaining 42% of referrals were from other City agencies (including police and fire departments, school districts, and other City departments), Berkeley and Albany businesses, individual residents, University of California (UC) Berkeley, or other referral sources (including hospitals and health clinics, churches, or calls to the City of Berkeley's 311 line).

Table 2. Number of Referrals by Referral Source Type, January 1, 2018 – February 29, 2020

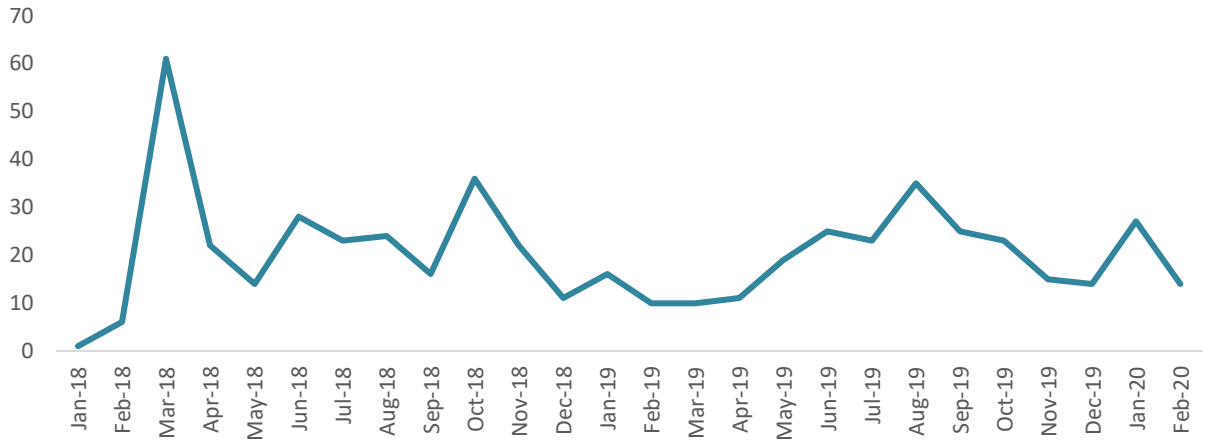
Referral Source	Referrals	% of Total
Services for PEH	**201**	**38%**
Berkeley or Albany Mental Health Department	78	15%
CBO serving PEH	70	13%
City Services serving PEH	53	10%
Self-Referral	**106**	**20%**
All Others	**225**	**42%**
City Department	85	16%
Business / Business Association	36	7%
Community Member, Resident, Citizen	35	7%
UC Berkeley	29	5%
Other	26	5%
Unknown	14	3%
TOTAL	**532**	**100%**

Data Source: HOTT Referral Log.

[3]City agencies serving homeless individuals include the Berkeley Emergency Storm Center and Berkeley Food Network. Community-based organizations serving PEH include the Berkeley Food and Housing Project, Women's Daytime Drop-in Center (WDDC), Bay Area Community Services (BACS), Berkeley Community Resource Center and Dorothy Day House, BOSS Berkeley Multi-Agency Service Center, Homeless Action Center, and the YEAH! Shelter.

Figure 1 depicts the volume of referrals received during each month of the evaluation period. **Overall, the HOTT team received an average of approximately 20 referrals per month.** However, the referral volume tended to vary, ranging from a low of one referral in January 2018 to a high of 61 referrals in March 2018. The referral spike in March 2018 was largely attributed to an increase in referrals from the Berkeley Emergency Storm Shelter (BESS), which may reflect a weather-related event at that time resulting in a higher number of individuals seeking support through BESS.

Figure 1. Referral Volume per Month, January 1, 2018 – February 29, 2020 (N=531 Referrals)



Data Source: HOTT Referral Log. The referral date was unreported for one referral.

About 80% of individuals were experiencing unsheltered homelessness at the time of referral (Table 3). A relatively small proportion of individuals reported their current living situation as sheltered (16%), in a vehicle (9%), at a hospital (3%), or couch surfing (3%).

Referral records indicate that most individuals were referred due to a history of chronic homelessness and/or engaging in disruptive or problematic behavior, suggesting the need for support or intervention (
Figure 2). Additionally, at the time of referral, **over half individuals reported mental health needs, while about one-third reported substance use needs and/or a history of hospitalization.** Seventeen percent (17%) of individuals reported a history of incarceration or criminal justice involvement.[4]

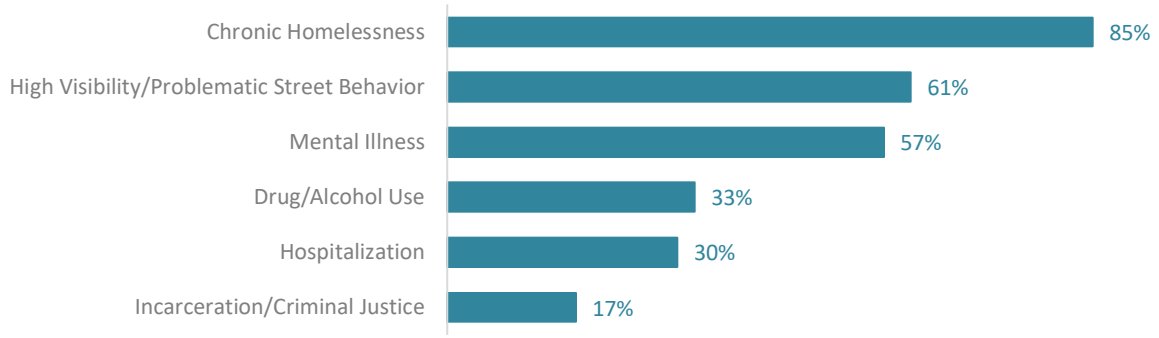
Table 3. Housing Status at the Time of Referral, January 1, 2018 – February 29, 2020 (N=532 Referrals)

Housing Status	Referrals	% of Total
Unsheltered	**385**	**79%**
Sheltered	79	16%
Vehicle	41	9%
Hospital	14	3%
Couch Surfing	12	3%
Unknown	37	7%

Data Source: HOTT Referral Log. Note: Percentages add up to greater than 100% as some individuals may have reported multiple housing statuses (e.g., hospital and unsheltered).

[4]In the referral records, consumer information—including housing status and history of homelessness, demographic information, mental health and substance use needs, and criminal justice involvement—are obtained through consumer self-report.

Figure 2. Reason for HOTT Referral, January 1, 2018 – February 29, 2020 (N=532 Referrals)



Data Source: HOTT Referral Log. Note: Percentages add up to greater than 100% as some individuals may have had more than one identified reason for referral (e.g., chronic homelessness and mental illness).

The 532 referrals reflect an estimated 434 unique individuals, with approximately 60 people referred more than once between January 2018 and February 2020.[5] Demographic information were unavailable or unreported for approximately 20-40% of individuals, depending on the specific characteristic.[6] Among those who had demographic information available, the majority of the individuals reported their race as either Black/African American (42%) or White (41%). Most individuals reported they were not Hispanic or Latino (90%) and nearly all individuals reported English as their primary language (96%). More than half of referred individuals were over the age of 45 years (57%).

Officer of the Day (OD) Requests and Street Outreach

Community partners and HOTT staff noted that the Officer of the Day has been an important avenue for the broader community to request support for immediate concerns regarding homelessness. As part of the expansion of the HOTT program in January 2018, HOTT also began accepting calls and inquiries from City agencies, community partners, as well as residents and business owners through the Officer of the Day. HOTT staff noted that the specific reasons for request vary, with some calling if an individual appears to be in mental distress or is displaying erratic or disruptive behavior. Others may call if a new encampment popped up or individuals are staying on private property. Individuals may also call the program to request HOTT services for themselves. As previously mentioned, OD requests may result in referrals to the HOTT program, whereas other requests may be for one-time support.

Community partners often request HOTT services to respond to homeless individuals experiencing mental health issues. Community partners and staff both noted that the HOTT team's mental health training and background help the HOTT staff better engage with chronically homeless individuals—many of whom have experienced trauma or have mental health challenges. Many program partners lack staff with mental health training, and as a result, community partners, residents, and business owners frequently request HOTT staff to respond to non-emergency mental health issues among the homeless

[5] The unique number of individuals referred is estimated. As mentioned in the *Data Limitations* section, individuals served did not have a unique identifier, and name was used to match individuals within and across datasets. However, due to discrepancies in the way names were spelled or captured (e.g., at times only a first name or nickname provided), it is possible that not all unique individuals could be identified accurately. As a result, the number of unique individuals may be slightly over- or underreported.
[6] See Appendix B for more detailed demographic information.

population. In many cases, HOTT staff are able to address the individual's immediate needs, and potentially prevent escalation to a mental health crisis. Stakeholders noted that this is an important function of HOTT, as it also helps limit the need for law enforcement involvement with crisis response. However, HOTT staff noted they are not crisis clinicians and are not intended to provide crisis intervention services. If based on the information provided, an individual appears to be experiencing a mental health crisis, medical emergency, or public safety concern, HOTT will direct the requestor to call crisis services or 911.

Providing direct outreach in the streets and encampments has greatly expanded the reach of HOTT services. As part of the expansion of HOTT services, HOTT staff also began providing direct outreach to individuals in encampments or known street locations where homeless individuals reside throughout Berkeley and Albany. As part of this outreach, HOTT staff may provide material goods (e.g., food, water, hygiene kits, etc.), share information about HOTT services, and support interested individuals with immediate, one-time needs or engage individuals in ongoing HOTT services and support. HOTT staff estimated that between 50-60% of individuals served through the HOTT program are a direct result of street and encampment outreach.

Responding to such a high volume of HOTT requests through multiple modes of engagement requires effective coordination within the HOTT team and across partner agencies. **To help coordinate services within the HOTT team, HOTT staff developed strategies to help organize outreach efforts and more efficiently respond to HOTT requests.** One of the most effective strategies is that convening HOTT staff each morning to discuss referrals, requests, and client needs and then develop an outreach plan for the day. To the extent possible, HOTT also introduces clients to all HOTT staff so the client feels more comfortable working with the team if a specific case manager is unavailable. As multiple or all staff are often working with the same individual, the morning meetings also help ensure that staff are not duplicating efforts or responding to the same individual. The addition of the administrative support position has also been instrumental to assist with documentation when placing individuals in motels for emergency housing as well as helping to organize and track data collection and client assessments. However, as noted previously, the HOTT team also experienced staff turnover which, at times, has made it difficult for staff to respond to the high volume of requests, ensure service consistency, and maintain team cohesion.

Stakeholders noted that communication and coordination across partner agencies can still be a challenge. Both the HOTT program and partner agencies experienced significant staff turnover, which can make it difficult to establish effective partnerships. Additionally, the HOTT program does not have access to Alameda County's Homeless Management Information System (HMIS), and therefore cannot track services provided by other housing agencies. Information sharing can be slowed further if a release of information (ROI) for the client has not been established. These limitations in data and information sharing further contribute to coordination challenges. Most partner agencies serving homeless individuals now participate in a bimonthly housing case conference to discuss shared clients' housing needs and better coordinate service delivery. However, some information sharing can still be limited at the case conference. Some partner agencies are required to comply with HIPAA (the Health Insurance Portability and

Accountability Act), and cannot discuss protected health information at the case conference or with other providers without the client's consent.

HOTT Enrollment and Services

Within the engagement phase, HOTT staff conduct initial outreach to individuals proactively through encampment visits and presence at known places, or in response to referrals or OD requests. In most cases, HOTT staff will follow-up on the referral or request, and attempt to locate and engage the individual on the same day either in-person or over the phone. Once initial contact is made, HOTT staff first introduce themselves and work with the individual to understand and address the immediate situation (e.g., urgent mental health or medical needs, emergency housing, need for material supports such as food or water, etc.). During this initial visit, staff also share information about the HOTT program with the hope to engage individuals in longer-term HOTT services, wherein the HOTT staff work more closely with clients to connect them to ongoing services.

If the individual agrees to continue formally working with HOTT to receive longer-term services, HOTT staff enroll the individual in the program and conduct a strengths-based intake assessment. The intake assessment is designed to learn more about the individual's history, identify the client's needs and barriers to service, and develop a plan to connect the client to the appropriate services and resources. When working with individuals, HOTT staff use motivational interviewing techniques to engage clients and help clients address their identified needs. Individuals are discharged from the program when the client's identified needs have been met and/or the client is securely connected to another longer-term service provider—typically housing or mental health services.

If an individual declines to enroll in the HOTT program, the team will still work to address the individual's immediate needs and refer the individual to other service providers as appropriate. HOTT staff also continue to attempt to outreach to and build rapport with non-enrolled individuals through street and encampment visits. HOTT may also have continued interaction if the individual is re-referred or support is requested through the Officer of the Day. The following sections describe program enrollment of individuals served, the volume and duration of HOTT encounters provided, and the types of services provided during HOTT encounters.

HOTT Program Enrollment

During the evaluation period, HOTT served an estimated 734 unique individuals.[7] Of the individuals that the HOTT team encountered, most were not interested in ongoing services (76%, n=555 individuals) and declined program enrollment. However, 179 individuals (24%) agreed to follow-up support and were formally enrolled in the HOTT program. Table 4 summarizes enrollment definitions and enrollment status of individuals served.

[7] The number and enrollment status of individuals served is estimated. As mentioned in the *Data Limitations* section, individuals did not have a unique identifier, and name was used to match individuals within and across datasets. However, due to discrepancies in the way names were spelled or captured (e.g., at times only a first name or nickname provided), it is possible that not all unique individuals were identified accurately. The number of unique individuals may be over- or underreported and some individuals' enrollment status may be miscategorized.

Table 4. HOTT Program Enrollment Status and Definitions

Status	Definition	Individuals
Enrolled in HOTT Program	Individuals who agree to HOTT services and would like to continue formally working with the HOTT staff are enrolled into the HOTT program.	**179 Individuals**
Not Enrolled in HOTT Program	Individuals who decline HOTT services or decline to continue working with the HOTT staff after an initial visit are not enrolled in the HOTT program. Individuals who decline to enroll in the program may still receive ad hoc support through the HOTT's street outreach, or if the individual is re-referred or support is requested through the Officer of the Day.	**555 Individuals**

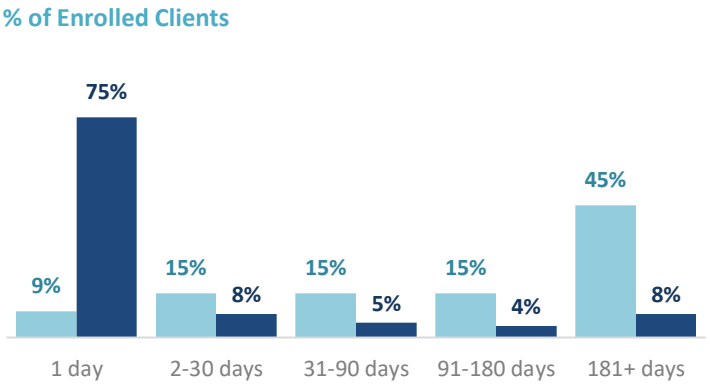
Data Sources: HOTT Contact Form and Intake Assessment

Most non-enrolled individuals (75%, n=415) only engaged with HOTT staff during the initial encounter, and had an engagement period of one day (Figure 3).[8] Non-enrolled individuals may have had a longer engagement period (i.e., more than one day) if the individual had subsequent interactions with HOTT, either through HOTT street and encampment visits or through referrals and/or OD requests.

As of the end of the reporting period, most enrolled clients (75%, n=106) engaged with the HOTT program for at least one month (31 days or more), with approximately half (45%, n=80) engaging with the HOTT program for more than 6 months (181 days or more). Among enrolled clients, the average length of engagement was 7.4 months (221 days), ranging from 1 to 740 days. Clients who engaged with the HOTT program for a shorter period of time (less than one month), may have been connected to the appropriate resources and no longer required HOTT services, declined further HOTT services, could no longer be located, or had recently enrolled and were still working with the HOTT program at the end of the reporting period.

Initially, HOTT program enrollment was intended to last a maximum of six months. However, some individuals may require longer engagement periods to connect to the appropriate resources. In particular, staff noted that it can sometimes take several weeks to connect individuals to housing service providers due to the high demand for housing support and limited availability of adequate housing options.

Figure 3. Length of HOTT Engagement Period, January 1, 2018 - February 29, 2020 (N=734 Individuals)



Data source: HOTT Contact Form

[8] Engagement period was determined by calculating the time between the first encounter and last encounter during the evaluation period. Individuals may have been formally enrolled with the program for a shorter period of time. However, due to data limitations in matching clients within and across data sets, it was challenging to determine client's enrollment period.

Additionally, HOTT staff noted that consistently connecting with clients for follow-up can be challenging. Staff noted that many clients are transient or frequently change locations, and in some cases, individuals may not have cell phones or reliable means of communication. To attempt to locate clients, HOTT staff visit known encampments or locations where the individual has stayed, and also reach out to other outreach teams or service providers who may have had contact with the individual. Despite these efforts, the engagement period may be longer if HOTT staff are unable to consistently connect with clients.

In other cases, individuals who have been connected to other longer-term services may periodically reach out to HOTT staff for support or encouragement, or HOTT staff may periodically reach out to previous clients to check-in on them. This ad hoc support with previous clients also likely contributes to the extended engagement periods beyond six months.

Volume and Duration of HOTT Encounters

During the evaluation period, HOTT had 4,435 total encounters with all individuals (both enrolled and non-enrolled), averaging 171 encounters per month (range: 72 to 245 encounters in a month). Most contacts (73%, n=3,257 contacts) were provided in-person in the field, while 26% (n=1,145 contacts) were provided over the phone.[9]

The majority of HOTT encounters (81%, n=3,585 contacts) were with enrolled clients, with the intensity of services varying according to clients' needs and level of responsiveness. Enrolled clients had an average of 20 total encounters with HOTT staff (range: 1 to 134 total encounters), with an average of 4 encounters per month (range: <1 to 20 encounters per month). Overall, encounters with clients lasted an average of 47 minutes each (range: <1 minute to 8.5 hours), although in-person encounters tended to be longer than encounters over the phone. HOTT staff noted that the degree of service intensity largely depends on the client's specific needs. Some clients may have more acute needs and/or require a high level of support to get connected to services. In these cases, HOTT staff may connect with the client multiple times a week or every day. Clients who are more self-sufficient, have less acute needs, or are less responsive or difficult to locate may only meet with HOTT staff once or a week or less frequently.

Table 5. Volume and Duration of HOTT Encounters per Person by Enrollment Status, January 1, 2018 – February 29, 2020 (N=734 Individuals)

Encounter Information	Enrolled Clients (N=179)	Non-Enrolled Individuals (N=555)
Number of Encounters		
Average	20 encounters	2 encounters
Range	1 – 134 encounters	1 – 15 encounters
Length of Encounters		
Average	47 minutes	25 minutes
Range	0 – 510 minutes	0 – 290 minutes

Data Source: HOTT Contact Form

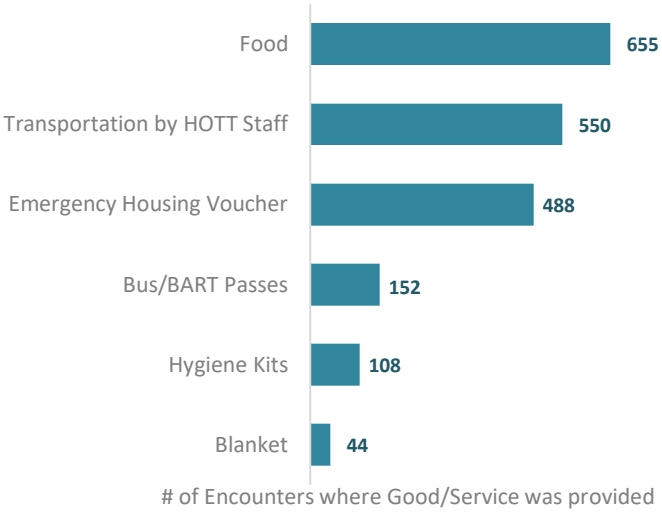
[9] The encounter location was not reported for 31 encounters (<1% of all encounters).

In comparison to HOTT clients, non-enrolled individuals had far fewer and shorter HOTT encounters. Non-enrolled individuals had an average of 2 total encounters with HOTT staff (range: 1 to 15 encounters), with each encounter lasting an average of 25 minutes (range: <1 minute to 4.8 hours). This reflects the more limited and informal interaction with non-enrolled individuals, wherein HOTT staff are either attempting to engage individuals or are responding to an immediate situation or need. The volume and duration of HOTT encounters among enrolled and non-enrolled individuals is summarized in Table 5. Additionally, more detailed information about service encounters is included in Table 10 in *Appendix C*.

Services Provided during HOTT Encounters

During encounters, HOTT staff provide a variety of material supports and services to respond to clients' immediate and longer-term needs. During the evaluation period, HOTT provided individuals with a total of at least 1,845 material supports.[10] According to outreach records, the most commonly provided material support was food, which was provided during 655 HOTT encounters (Figure 4). HOTT staff provided transportation during 550 encounters and/or bus or BART passes during 152 encounters to help individuals attend appointments or access services or resources. Additionally, HOTT provided hygiene kits during 108 encounters, and blankets during 44 encounters. HOTT staff and clients noted that HOTT also provides water, clothing, tents, cell phone chargers, or other basic necessities. As part of the COVID-19 response, HOTT has also recently been providing masks and hand sanitizer.

Figure 4. Material Goods Provided during all HOTT Encounters, January 1, 2018 - February 29, 2020 (N=4,435 Encounters)



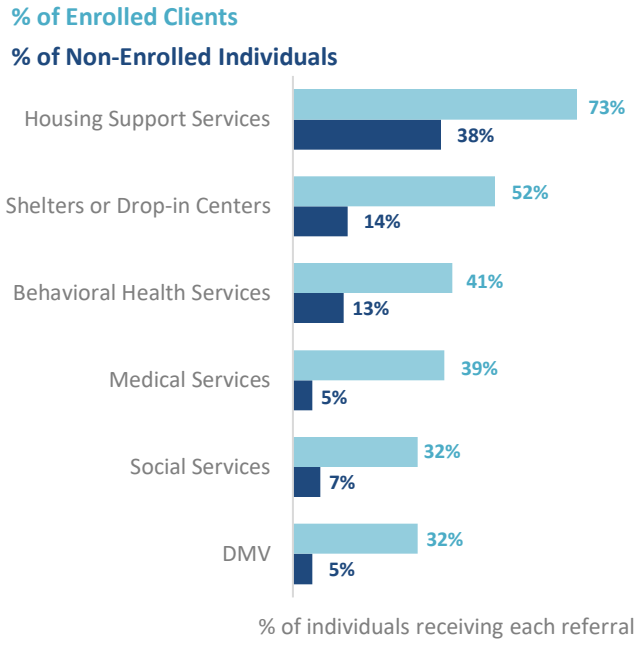
Data Source: HOTT Contact Form. These data do not include referrals and service connections provided by HOTT.

During 488 encounters, HOTT provided emergency or temporary housing vouchers (e.g., for a motel) to individuals who required immediate shelter. Some examples of individuals who may receive vouchers for emergency housing include highly vulnerable individuals who are experiencing medical issues, who are experiencing threats to safety, or who have children or families, among other reasons. Vouchers allow for a one-week stay but may be extended up to 29 days if the individual continues to qualify for emergency shelter.

[10]The number of materials and supports provided during HOTT encounters is likely higher than 1,845 and than those reflected in Figure 4. Services and referrals provided during HOTT encounters are tracked in the HOTT contact form, however it does not appear that services are entered consistently. At times, services provided are listed in the case notes rather than in the service check list, making it challenging to examine the totality of services provided in a standardized way. As a result, material supports and other services provided are likely underreported.

HOTT was more likely to provide materials during encounters with HOTT clients; however, HOTT still provided material supports to non-enrolled individuals (see Table 11 in *Appendix C*). While HOTT may provide non-enrolled individuals with material supports to address individuals' specific needs, HOTT staff also regularly distribute food, water, or other basic necessities to any homeless individuals in need during their direct outreach visits to the streets or encampments. In addition to providing needed resources, this strategy helps HOTT staff build rapport with individuals and may facilitate a conversation about what other services or supports individuals may need. As HOTT staff become known entities and establish trust, some individuals may be more likely to accept HOTT services and formally enroll in the program.

Figure 5. Referrals or Connections Provided during HOTT Engagement by Enrollment Status, January 1, 2018 - February 29, 2020 (N=734 Individuals)



Data Source: HOTT Contact Form. These data do not include material goods provided by HOTT.

In addition to providing material supports, a key component of HOTT is to help individuals connect to longer-term housing services and other supportive services. Figure 5 summarizes the types of referrals and connections provided during HOTT engagement.[11] More detailed information about the specific referrals and connections is available in Table 12 in *Appendix C*.

Approximately three-quarters of enrolled clients (75%) and over a third of non-enrolled individuals (38%) were referred or connected to housing support services. Most individuals were referred to the Housing Resource Center (HRC, also known as the Hub, currently run by BACS) for housing services, although some individuals were referred directly to rapid rehousing services or temporary housing. The HRC/Hub conducts housing assessments and provides continued case management to support individuals to obtain housing. HOTT coordinates with the HRC/Hub to provide a warm hand-off as the individual transitions to HRC/Hub for follow-up and housing navigation. At the client's or HRC/Hub's request, staff may accompany the client to the HRC/Hub, help clients fill out the initial paperwork, or even stay during the assessment to provide encouragement and moral support. In some cases, HRC/Hub staff may also reach out to HOTT after a client has transitioned to HRC/Hub services. In most cases, HRC/Hub staff will reach out if they are having difficulty locating the client or if the client appears to be experiencing non-emergency mental health issues and could benefit from HOTT support. HOTT also referred or connected

[11] As is the case with material supports, the volume of individuals receiving various referral types may be underestimated due to inconsistencies in how services and referrals are tracked in the HOTT contact form.

52% of enrolled clients and 14% of non-enrolled individuals to local homeless shelters or drop-in centers—including the Homeless Action Center, Women's Daytime Drop-in Center (WDDC), Berkeley Drop-in Center, Dorothy Day House, Dwight Way Women's Shelter, and Bonita House.

In addition to connecting individuals to housing services, HOTT also connected individuals to other supportive services to help reduce or address initial barriers to obtaining housing. For example, some individuals may need to be connected to social services to enroll in medical insurance, apply for food assistance, or obtain social security benefits. Other individuals may require a new identification card (ID) in order to even begin the process of applying for benefits or obtaining emergency housing. To address these needs, HOTT referred or connected approximately one-third of enrolled clients (32%) and approximately 5% of non-enrolled individuals to social services and/or the Department of Motor Vehicles (DMV) to acquire an ID. For some individuals, HOTT accompanied individuals to appointments or supported individuals to complete applications. Some individuals may also have unaddressed medical or behavioral health needs. Forty-one percent (41%) of enrolled clients and 13% of non-enrolled individuals were referred to behavioral health services through Berkeley Mental Health, Alameda County Behavioral Health Care Services, or substance use services. Thirty-nine percent (39%) of enrolled clients and 5% of non-enrolled individuals required medical attention and were referred to Lifelong Medical or other medical service providers.

Client Outcomes

In the HOTT program model, HOTT either directly connects or refers individuals to agencies and service providers that can address client's longer-term needs—including obtaining housing and improving individuals' health and self-sufficiency. To assess these client outcomes, the evaluation examined service enrollment, housing linkages, and changes in self-sufficiency. To better understand individuals' experience with the HOTT program, the evaluation team also interviewed four consumers to learn more about their perceived impact of HOTT services.

Service Enrollment

Client records indicated that approximately one-quarter (27%) of HOTT clients and 6% of non-enrolled individuals successfully enrolled in social service benefits (Table 6)**. In comparison, only 9% of HOTT clients and 1% of non-enrolled clients ultimately enrolled in mental health services**, despite a greater percentage of clients being referred to mental health compared to social services (see Figure 5 above).

Table 6. Benefits and Mental Health Service Enrollment by HOTT Enrollment Status, January 1, 2018 – February 29, 2020 (N=734 Individuals)

Service Enrollment	Enrolled Clients	Non-Enrolled Individuals
Enrolled in Benefits	48 (27%)	36 (6%)
Enrolled in Mental Services	17 (9%)	6 (1%)
TOTAL	179 (100%)	555 (100%)

Data Source: HOTT Contact Form and Follow-up Assessments.

HOTT staff noted that many clients experienced stigma around mental health services, and often times clients declined to participate in mental health services if and when referred. In other cases, HOTT staff observed that some clients' mental health needs lessened after being placed in temporary or permanent housing, likely due to the alleviation of some stress from being unsheltered. As a result, some clients no longer appeared to meet criteria for specialty mental health services through Berkeley Mental Health or Alameda County Behavioral Health Care Services.

Housing Linkages

Over half of all HOTT clients (58%) and 9% of non-enrolled clients obtained emergency or temporary housing (e.g., motel or shelter) at some point during their engagement with HOTT. In comparison, 12% of HOTT clients and 1% of non-enrolled clients obtained permanent housing (Table 7). It is important to note that while the HOTT program can and does provide vouchers for emergency or temporary housing, the HOTT program is not intended to provide linkages to longer-term or permanent housing. Rather, the HOTT program aims to connect individuals to housing services, such as through the HRC/Hub, that can facilitate longer-term housing support and linkages. Therefore, linkages to permanent housing do not necessarily reflect HOTT services. Additionally, given the high demand and limited availability of adequate housing options in the County, there are long wait times for placement in longer-term or permanent housing. It is possible that some HOTT clients and non-enrolled individuals obtained housing through the HRC/Hub after engagement with the HOTT team ended; however, that information was unavailable.

Table 7. Housing Linkages by Enrollment Status, January 1, 2018 – February 29, 2020 (N=734 Individuals)

Housing Linkage	Enrolled Clients	Non-Enrolled Individuals
Obtained Temporary Housing	104 (58%)	49 (9%)
Obtained Permanent Housing	22 (12%)	8 (1%)
TOTAL	179 (100%)	555 (100%)

Data Source: HOTT Contact Form and Follow-up Assessments.

Self-Sufficiency

To assess changes in self-sufficiency, HOTT staff completed the client self-sufficiency matrix (SSM) at program intake, on a quarterly basis (i.e., every 3 months) after program enrollment, and/or at program discharge.[12] Clients do not complete the SSM, rather HOTT staff complete the SSM based on information obtained through client interactions, information and assessments, and observations during encounters. In some cases, different HOTT staff may complete the baseline and follow-up SSM for an individual client. However, staff may rate SSM domains slightly differently. In turn, this can contribute to variability in SSM scores across individuals and from baseline to follow-up.

At the end of the reporting period, baseline and follow-up SSM assessments (either a quarterly or discharge assessment) were completed for 69 out of the 179 HOTT clients (39%). On average, the time between the client's baseline and follow-up assessments was approximately six months. SSM domains are rated on a scale from 1 to 5, with 1 indicating the individual is in crisis for that given domain and 5

[12] The Self-Sufficiency Matrix (SSM) is only completed for HOTT clients. It is not completed for non-enrolled individuals.

indicating empowerment. Changes in selected self-sufficiency domains are presented in Table 8, while scores across all domains are presented in Table 13 in *Appendix D*.[13]

Overall, HOTT clients' SSM scores remained relatively unchanged from baseline to follow-up. On average, clients' total SSM score increased by 0.2 points, indicating slight improvement in overall self-sufficiency. Clients who were enrolled in the program longer tended to have slightly larger increases in overall self-sufficiency scores. Regardless of enrollment length, clients generally scored between a 2 and 3 in most SSM domains. However, clients tended to score lower—between a 1 and 2—in the housing and family/social relationships domains, indicating a higher degree of vulnerability in these areas (Table 8). The low housing score reflects the unsheltered or temporary housing status of most clients during program enrollment. Additionally, the low family and social relationship domain score may reflect the isolation and lack of social supports that some homeless individuals experience.

In comparison, clients scored higher—between a 4 and a 5—in the health insurance and legal domains. The health insurance domain scores indicate that most individuals had access to medical care when needed, and/or were covered by adequate health insurance. Health insurance improved slightly from baseline to follow-up, and may reflect the HOTT program's efforts to connect individuals to appropriate medical services and benefits, such as health insurance. The legal domain scores indicate that most individuals either did not have active criminal justice involvement or completed probation or parole within the past year.

Table 8. Average Self-Sufficiency Matrix Scores in Selected Domains for HOTT Program Clients at Baseline and Follow-Up, January 1, 2018 – February 29, 2020, (N=69 Enrolled HOTT Clients)

Domain	Average Baseline Score	Average Follow-up Score	Interpretation
Housing	1.4	1.7	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).
Family/Social Relationships	1.8	1.8	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.
Health Insurance	4.1	4.6	4 = All members can get medical care when needed, but may strain budget. 5 = All members are covered by affordable, adequate health insurance.
Legal	4.3	4.4	4 = Has successfully completed probation/parole within past 12 months, no new charges filed. 5 = No active criminal justice involvement in more than 12 months, and/or no felony criminal history

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

Data Source: Self-Sufficiency Matrix; Note: the most recent follow-up assessment was used if an individual had multiple follow-up assessments.

[13]The SSM is completed by HOTT staff rather than by clients, and there may be slight variability in how staff rate each domain which can contribute to differences in scores across assessments for the same individual, and across individuals. Given the relatively small percentage of clients with baseline and follow-up SSM assessments, changes may also not be representative of all clients. Due to these limitations, data should be interpreted cautiously.

Client Experience of Services

In July 2020, RDA interviewed four previous and existing clients to learn more about individuals' experiences working with HOTT staff and participating in HOTT services. Common themes identified through the interviews are summarized below. In addition to these interviews, RDA conducted focus groups with HOTT clients during a previous year of the evaluation, and developed brief client impact stories based on clients' experiences. The impact stories are available in *Appendix E*.

HOTT staff are reliable and responsive. Multiple clients shared that the most helpful aspect of the program was the reliability of staff. Some clients had previously attempted to access services through other providers or pathways, but were unable to get connected to the appropriate resources, leading to frustration and disenchantment with the system. As a result, some clients had low expectations for HOTT services. However, clients shared that HOTT staff check-in with clients frequently and respond quickly, start providing services immediately, and follow-through on resources and service linkages—all which helped build clients' trust.

> *I really didn't expect anything, but when I called the City, they said someone [from HOTT] would meet me right then. They got me a hotel room that day. I wasn't expecting the City to help.*
>
> *-HOTT Client*

> *They help people, not just me. I introduce people on the street to them, and I say you can talk to the HOTT team and they will help you.*
>
> *-HOTT Client*

HOTT staff help individuals with whatever they need. All of the clients interviewed stated that the HOTT staff helps clients with whatever they need, either providing the service directly or referring clients to other resources and centers. Several clients shared that HOTT staff regularly brought them fresh food and snacks or helped them buy groceries. Other clients shared that the HOTT staff provided BART tickets, helped clients get a new ID card, arranged and transported clients to medical appointments, followed up with clients to remind them to take their medication or obtain necessary medical equipment (e.g., crutches or eye glasses), helped clients clean their encampment, and provided short-term hotel rooms or connected clients to shelters. Some clients were already in the process of applying for longer-term housing, but clients noted that HOTT offered to write letters of support, coach clients for the housing assessment, and accompany clients to housing service appointments.

HOTT staff are caring and encouraging. Clients felt like the HOTT staff genuinely cared about them and wanted to help. Some clients shared that they were desperate before they were connected with HOTT, but HOTT staff were encouraging and confident that they could support clients with their needs. The HOTT staff's encouragement, dedication, and follow-through helped give some clients a renewed sense of hope.

> *They were so helpful. I felt like if I didn't get the hotel room, they would have let me stay at their personal house.*
>
> *-HOTT Client*

Service Model and Delivery Challenges

HOTT program data demonstrate that the HOTT team is providing important services to a high volume of individuals to address their immediate needs, address initial barriers to obtaining housing, as well as facilitate referral and connection to longer-term services. However, stakeholders noted that the expansion of HOTT services and outreach efforts may also be contributing to some challenges in service delivery. In particular, the expanded HOTT service model has multiple objectives which may be straining staff capacity. Additionally, with the expansion of HOTT services, some stakeholders are unclear about the role of the HOTT team which may contribute to unrealistic expectations for HOTT services and outcomes.

Community partners and HOTT staff shared that many stakeholders feel the HOTT services are valuable and are addressing important needs within the community. Within the current HOTT model, staff respond to a high volume of immediate concerns regarding homelessness, as well as provide more intensive ongoing case management and service linkage support to a smaller group of enrolled clients. While stakeholders believe that both objectives and types of services are essential to support homeless individuals within Berkeley and Albany, some stakeholders noted that the expanded modes of outreach and engagement may be straining staff capacity.

For example, to help better meet the mental health needs of individuals served, HOTT hired a clinician in 2019 to provide mental health assessments and review documentation for Medi-Cal billing. However, to support the HOTT team to respond to the high volume of requests, the clinician assumed a dual role and spent a lot of time engaging in direct outreach and providing case management and linkage services, rather than providing clinical services. Although data demonstrate that HOTT is providing a high level of service and support, staff noted that it can be challenging to respond to all of the requests for HOTT services while also providing direct outreach and case management, particularly if the team is short-staffed or recently experienced staff turnover. Some stakeholders noted that the program may be more effective if program objectives are more refined and targeted, so staff can better focus their efforts.

Additionally, the broadened scope of HOTT services may also be contributing to confusion or unrealistic expectations about what the program can and is intended to achieve. For example, some stakeholders are unaware that the HOTT program does not have the capacity or ability to directly connect individuals to housing, other than emergency housing (e.g., motels and shelters) for the most vulnerable clients. In other cases, staff noted that community members are not always aware that HOTT cannot force individuals to leave a location, and that HOTT staff may not be able to address an individual's needs if the individual does not consent to HOTT services and support. This gap in community knowledge and awareness of the limitations of HOTT services can lead to feelings of frustration among the community that HOTT is not doing enough to address homeless issues and concerns.

IV. Conclusion

The Berkeley HOTT program aims to respond to the needs of homeless individuals in Berkeley and Albany and connect individuals to the appropriate services needed to navigate the transition from homelessness. HOTT identifies and responds to individuals in need of support through three modes of engagement, including: responding to community referrals, responding to inquiries and requests through the Officer of the Day, and providing direct in-person outreach. These engagement mechanisms allow HOTT flexibility to meet clients' complex needs, while also being responsive to community member concerns.

Through these engagement mechanisms, the Berkeley HOTT program served a total of 734 individuals through a total of 4,435 encounters over the course of the evaluation period (January 1, 2018 – February 29, 2020). Most individuals who interacted with HOTT received one-time or ad hoc support to address the individual's immediate needs (76%, n=555). However, 179 individuals (24%) agreed to enroll in the HOTT program to receive ongoing services to connect to longer-term housing and supportive services. Overall, enrolled HOTT clients engaged with the HOTT team an average of 20 times over an average period of 7 months. However, the intensity of services and length of engagement period varied in accordance with each client's specific needs.

As part of HOTT's outreach efforts with both enrolled clients and non-enrolled individuals, HOTT provided an array of material supports to meet individuals' basic necessities, including food and water, transportation and bus/BART passes, hygiene kits, blankets, emergency housing vouchers for highly vulnerable individuals, and other materials individuals may need. In addition to providing material supports, HOTT also facilitated linkages and referrals to housing services and other supportive services to help reduce or address initial barriers to obtaining housing. However, HOTT does not directly connect individuals to permanent housing options.

HOTT referred or connected 73% of all enrolled clients to housing services for longer-term support to connect to permanent housing, 52% to shelters or drop-in centers, 40% to behavioral health and/or medical services, and 32% to social services or the DMV. Ultimately, 12% of enrolled individuals were connected to permanent housing through a housing service provider by the end of the evaluation period. Although this number is relatively low, this likely reflects the long wait times to obtain housing due to the high demand and limited availability of housing options within the County. When possible, HOTT also attempted to provide service linkages for non-enrolled individuals. Owing to the one-time nature of interactions with most non-enrolled individuals, service linkages for those individuals were much lower.

Program partners and clients shared that the HOTT staff are reliable, responsive, and caring, and stated that the program is providing important services to help address the needs of individuals experiencing homelessness. However, some stakeholders also shared that the broad scope of services provided by the HOTT team may be straining staff capacity and contributing to a lack of clarity about HOTT team's role and intended objectives. Moving forward, BMH may wish to clarify or refine program goals to continue to strengthen program services and partnerships.

V. Appendices

Appendix A. HOTT Program Evaluation Data Sources

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 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.

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 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[14] 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.

Interviews with Clients. RDA conducted a total of four interviews with HOTT clients to better understand clients' experiences with HOTT staff and services and the perceived impact of the program. Before the interviews, the intention of the focus groups was explained and informed consent was obtained from all participants.

Interviews with HOTT Staff. RDA conducted a total of five interviews with HOTT program staff (including two case managers, program clinician, program manager, and administrative support staff) to better understand staff members' experiences throughout the referral, outreach, and engagement process and

[14] (2009, September). *HMIS Self-Sufficiency Matrix (Sample)*. Retrieved from https://www.hudexchange.info/resource/1625/hmis-self-sufficiency-matrix-sample/

gain an understanding of the successes and challenges of program implementation. Before beginning the interviews, the intention of the interviews was explained and informed consent was obtained from all participants.

Interviews with Program Partners. RDA conducted a total of three interviews with leadership from HOTT program partners, including Bay Area Community Services (BACS), the Women's Daytime Drop-in Center (WDDC), and the City of Berkeley Health, Housing, and Community Services Department to better understand how program partners work with the HOTT team during the referral, outreach, and engagement process as well as gain an understanding of what has been working well and any opportunities for improvement in HOTT implementation. Before beginning the interviews, the intention of the interviews was explained and informed consent was obtained from all participants.

Appendix B. Detailed Demographic Profile of HOTT Referrals

Table 9. Demographic Profile of Unique Individuals Referred to HOTT, (January 1, 2018 – February 29, 2020)[15,16]

Referral Source	Individuals	% of Total
Age Group		
18-24 years	8	2%
25-44 years	100	23%
45-64 years	119	27%
65 years and older	29	7%
Unknown / Unreported	178	41%
Race		
Black or African American	149	34%
White	146	34%
Multi-racial	45	10%
Other	13	2%
Unknown / Unreported	81	19%
Ethnicity		
Non-Hispanic / Non-Latino	317	73%
Hispanic / Latino	37	9%
Unknown / Unreported	80	18%
Language Spoken		
English	339	78%
Other	14	3%
Unknown / Unreported	81	19%
TOTAL	434	100%

Data Source: HOTT Referral Log.

[15] Other races include Asian, American Indian or Alaska Native, or another race. Other languages include Spanish, Vietnamese, or another non-English language.

[16] The evaluation team manually cleaned and inspected the referral file to estimate the number of unduplicated persons. This was a necessary step to more accurately depict the age, racial background, and other demographic characteristics of the persons referred. The evaluation team first inspected the file for any entries for persons with the same name, date of birth, and social security number. Next, the evaluation team conducted a check of any names that were either an exact match. This process improved the file slightly, but is likely to have missed other duplicates and we therefore advise caution when interpreting the data presented about persons' demographic characteristics

Appendix C. Detailed Information about HOTT Services

Table 10. Detailed HOTT Encounters and Engagement Period by Enrollment Status, January 1, 2018 – February 29, 2020 (N=734 Individuals)

Encounter Information	Enrolled Clients (N=179)	Non-Enrolled Individuals (N=555)	Total Individuals (N=734)
Number of All Encounters			
Average	20 encounters	2 encounters	6 encounters
Range	1 – 134 encounters	1 – 15 encounters	1 – 134 encounters
Number of In-Person Encounters			
Average	14 encounters	1 encounter	2 encounters
Range	0 – 105 encounters	0 – 15 encounters	0 – 105 encounters
Number of Phone Encounters			
Average	6 encounters	<1 encounters	2 encounters
Range	0 – 80 encounters	0 – 5 encounters	0 – 80 encounters
Length of Encounters			
Average	47 minutes	25 minutes	43 minutes
Range	0 – 510 minutes	0 – 290 minutes	0 – 510 minutes
Length of In-Person Encounters			
Average	60 minutes	27 minutes	52 minutes
Range	0 – 510 minutes	0 – 290 minutes	0 – 510 minutes
Length of Phone Encounters			
Average	16 minutes	15 minutes	16 minutes
Range	0 – 120 minutes	0 – 35 minutes	0 – 120 minutes

Data Source: HOTT Contact Form

Table 11. Detailed Material Goods Provided during HOTT Encounters by Enrollment Status, January 1, 2018 - February 29, 2020 (N=4,435 Encounters)

Material Goods	Enrolled Clients	Non-Enrolled Individuals	Total Individuals
Food	555 (15%)	100 (12%)	655 (15%)
Transportation by Staff	529 (15%)	21 (2%)	550 (12%)
Housing Voucher	426 (12%)	62 (7%)	488 (11%)
Bus/BART Pass	124 (3%)	18 (2%)	152 (3%)
Hygiene Kit	68 (2%)	40 (5%)	108 (2%)
Blanket	30 (1%)	14 (2%)	44 (1%)
TOTAL	850 (100%)	3,585 (100%)	4,435 (100%)

Data Source: HOTT Contact Form. Note: These data do not include referrals and linkages to services provided by HOTT. These data reflect the number and percentage of encounters in which HOTT provided the given material goods or supports. Service linkages and referrals provided to individuals are reported in Table 12.

Table 12. Detailed Referrals and Service Connections Provided during HOTT Engagement by Enrollment Status, January 1, 2018 - February 29, 2020 (N=734 Individuals)

Referral Information	Enrolled Clients	Non-Enrolled Individuals	Total Individuals
Housing Support	**130 (73%)**	**210 (38%)**	**340 (46%)**
HRC	130 (73%)	206 (37%)	336 (46%)
Temporary Housing	14 (8%)	8 (1%)	22 (3%)
Rapid Rehousing	1 (1%)	1 (<1%)	2 (<1%)
Shelters or Drop-in Centers	**93 (52%)**	**75 (14%)**	**168 (23%)**
Homeless Action Center	61 (34%)	37 (7%)	98 (13%)
Women's Daytime Drop-in Center	26 (15%)	12 (2%)	38 (5%)
Berkeley Drop-in Center	23 (13%)	11 (2%)	34 (5%)
Dorothy Day House	21 (12%)	13 (2%)	34 (5%)
Dwight Way Women's Shelter	17 (9%)	7 (1%)	24 (3%)
Bonita House	4 (2%)	1 (<1%)	5 (1%)
Behavioral Health Services	**73 (41%)**	**71 (13%)**	**144 (20%)**
Berkeley Mental Health	68 (38%)	67 (12%)	135 (18%)
Alameda County Behavioral Health	5 (3%)	2 (<1%)	7 (1%)
Options Recovery Services	3 (2%)	2 (<1%)	5 (1%)
Other Supportive Services	**123 (69%)**	**132 (24%)**	**255 (35%)**
Medical Provider	70 (39%)	28 (5%)	98 (13%)
Social Services Provider	57 (32%)	37 (7%)	94 (13%)
Department of Motor Vehicles	58 (32%)	30 (5%)	88 (12%)
TOTAL	179 (100%)	555 (100%)	734 (100%)

Data Source: HOTT Contact Form; Note: These data do not include materials supports provided to individuals by HOTT staff. These data reflect the number and percent of individuals who received each referral or service linkage. Material goods and supports provided during encounters are reflected in Table 11. Additionally, individuals receiving each broad referral type (i.e., Housing Support, Shelters or Drop-in Centers, Behavioral Health Services, and Other Referrals) reflects the number and percentage of individuals receiving any of the referral types within the category. For example, an individual would be categorized as receiving a referral for housing support if they received a referral for the HRC, and/or temporary housing, and/or rapid rehousing.

Appendix D. Self-Sufficiency Matrix Scores for HOTT Program Clients

Table 13. Average Self-Sufficiency Matrix Scores for HOTT Program Clients at Baseline and Follow-Up, (January 1, 2018 – February 29, 2020, N=69 Enrolled Clients)

Domain	Interpretation	Average Baseline Score	Average Follow-up Score
Housing	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).	1.4	1.7
Income	2 = Inadequate income and/or spontaneous or inappropriate spending. 3 = Can meet basic needs with subsidy; appropriate spending.	2.1	2.5
Food	2 = Household is on food stamps. 3 = Can meet basic food needs, but requires occasional assistance.	2.2	2.5
Insurance	4 = All members can get medical care when needed, but may strain budget. 5 = All members are covered by affordable, adequate health insurance.	4.1	4.6
Life Skills	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.	2.5	2.3
Family/Social Relationships	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.	1.8	1.8
Mobility	2 = Transportation is available, but unreliable, unpredictable, unaffordable; may have care but no insurance, license, etc. 3 = Transportation is available and reliable, but limited and/or inconvenient; drivers are licensed and minimally insured.	2.4	2.6
Community Involvement	1= Not applicable due to crisis situation; in "survival mode" 2 = Socially isolated and/or no social skills and/or lacks motivation to become involved.	1.9	2.0
Legal	4 = Has successfully completed probation/parole within past 12 months, no new charges filed. 5 = No active criminal justice involvement in more than 12 months, and/or no felony criminal history	4.3	4.4
Mental Health	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.	2.6	2.5
Substance Use	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. 4 = Client has used during last 6 months, but no evidence of persistent or recurrent social, occupational, emotional, or physical problems related to use; no evidence of recurrent dangerous use.	3.2	3.1
Safety	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.	2.4	2.4
Disabilities and Physical Health	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.	2.2	2.4

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

Data Source: Self-Sufficiency Matrix. Note: Follow-up assessment scores reflect the most recent assessment if individuals had more than one follow-up assessment.

Appendix E. Impact Stories from Berkeley HOTT Program Clients

Note: Names have been changed to protect client confidentiality.

Impact Story about Sarah and Tim

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 motel but waiting for our application to get approved so we can finally have a more stable home for us and the baby."

HOTT Impact Story about John

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 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."

HOTT Impact Story about Gary

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!"

Impact Story about Fred

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."

Impact Story about David

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 addiction, 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 addiction, and I'm working on building back my relationships with people."