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IHOT Scope of Practice

Title	Education, Experience & Credentialing Minimum Requirements	Role
Program Manager	• Master's Degree in Bx science with 1-2 years related experience, or BA with 2-4 years related experience required. • PP+ or higher credential	• Oversees the program and whole team • Manages and supervises the staff
Case Manager	• Bachelor's level of education required, plus lived experience and some related experience working with similar populations preferred. • PP- or PP+ credential	• Leads team of 2 CSS • Oversees caseloads for both CSS on team • Provides outreach to participants • Supports CSS and FA
Client Support Specialist	• HS diploma required, plus lived experience and some related experience working with similar populations preferred. • PP- or PP+ credential	• Primary worker and contact for participants • Takes the lead on outreach and assessment • Engage in street outreach
Family Advocate	• HS diploma required, plus lived experience and some related experience working with families and similar populations preferred. • PP- or PP+ credential	• Supports families of active CSS participants • Supports CSS' with outreach for participants • Engage in street outreach

Program Manager is responsible for:

- Hiring, Performance evaluation, Performance management, and Termination related staffing tasks
- Weekly administrative supervision and non-clinical guidance on participant cases for each member of the team.
- Completing and submitting reports to the county Program Manager as requested
- Approving reimbursement requests and providing other administrative supports
- Ordering supplies for the office and outreach kits
- Facilitating regular team meetings and joint capacity meetings
- Supporting staff needs

Case Managers are responsible for:

- Completing intake and discharge administrative tasks (i.e. opening/closing in AWARDS, updating Participant tracker)
- Facilitating regular capacity meetings to review caseloads and communicate referral needs for each CSS/FA on their team.
- Writing Needs and Service Plans with the support of CSS and completed assessments
- Coordinating care for participants
- Providing outreach and advocacy for participants
- Helping to guide CSS toward next steps for participant
- Completing and Submitting APS/CPS reports and incident reports
- Engaging in street outreach and/or Agency outreach as needed

Client Support Specialists are responsible for:

- Leading outreach attempts and being primary contact for participants
- Gathering signatures and completing intake documents with participants
- Completing assessments with/for participants (i.e. SSM, WEBMS, MH Screening tool, etc.)
- Uploading documents and assessments to participant chart/file cabinet
- Care coordination and linking client to needed services (i.e. Snap benefits, SUTS/MH programs, shelter, etc.)
- Completing and Submitting APS/CPS reports and incident reports
- Communicating caseload and participant needs to CM and coordinating care with CM
- Engaging in street outreach and/or Agency outreach as needed

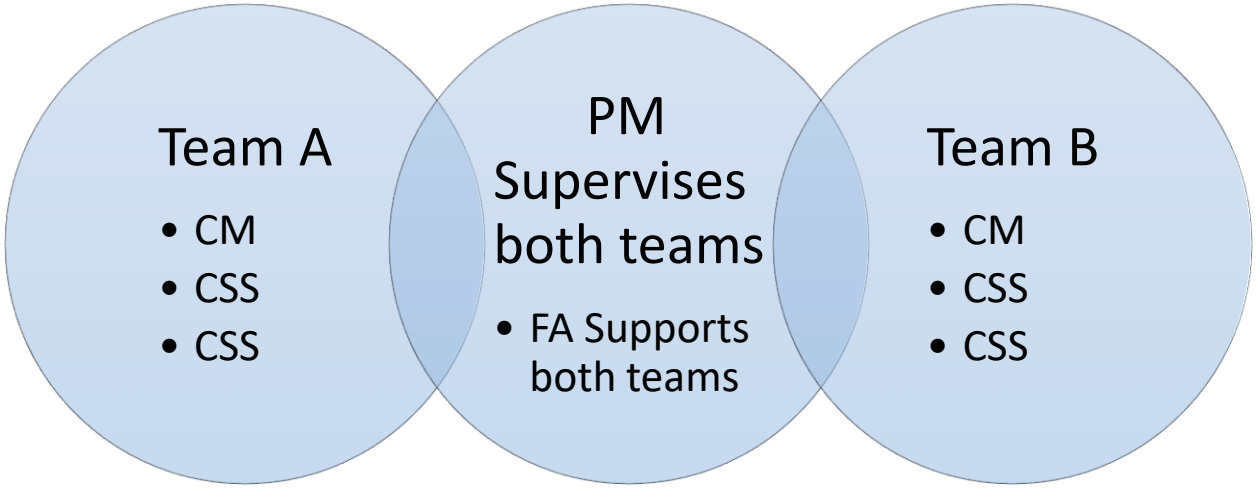
Family Advocate is responsible for:

- Supporting participant families as requested
- Supporting CSS with outreach for participants
- Uploading assessments and documents completed with participants
- Completing and Submitting APS/CPS reports and incident reports
- Engaging in street outreach and/or Agency outreach as needed
- Communicating caseload and participant/family needs to CM
- Coordinating care with the team and other providers

IHOT Team Structure:

- The larger IHOT team is made up of 2 smaller teams.

- The Program Manager (PM) supervises staff on both teams
- Each team is led by a Case Manager (CM)
- The CM leads a team of 2 Client Support Specialist (CSS)
- The Family Advocate (FA) supports both teams



Additional IHOT Staff Requirements

Required access:

- Homeless Management Information System (HMIS) access
  - VI-SPDAT – complete trainings to gain ability to complete VI-SPDATs with clients
  - See OwnCloud for instructions on gaining HMIS access with VI-SPDAT permissions
- Jail Clearance/2 year security clearance
  - See OwnCloud for instructions on gaining jail clearance
- Peer Credentialing (optional currently)
  - See OwnCloud for instructions on completing Peer Credentialing process

Trainings:

- New Hire trainings – See agency training policy & new hire training checklist for list of initial trainings required
- Annual trainings – See agency training policy, and Relias assignments for list of annual trainings required.
  - From county (SCC Learn) we need 12 hours of cultural competency training and training on working with HIV/AIDS clients each year.

Supervision requirements:

- Individual supervision with IHOT Program Manager – 30 minutes to 1 hour each week
    - Review administrative requirements and deadlines
    - Review active cases and ask PM case-related questions
    - PM provides performance reviews and improvement plans
    - PM provides coaching on areas of growth
- Parapro Group supervision – 1-2 hours per week
    - Review active cases
    - Ask case-related questions
    - Get support on difficult cases
    - Share resources and techniques within scope
    - Get coaching on skills and techniques related to position
- Joint capacity meetings with large IHOT team, led by IHOT PM – approximately 3 hours per month.
    - Review active cases
    - Ask case-related questions
    - Get support on difficult cases
    - Share resources and techniques within scope
    - Get coaching on skills and techniques related to position
    - Engage in deeper discussions about topics related to position/IHOT

Meetings:

- MH division meeting – Wednesdays 1pm, usually every other week
- MH Division training – Wednesdays 1pm – 3pm, usually on last week of each month
- IHOT staff meetings – Wednesdays 1pm – 2pm, on remaining weeks

Caseloads

1. Program Manager and/or Director review staff workloads weekly to support the best outcomes for participant and recipients of services.

2. Manager will ensure that participant assignments match the qualifications, competencies, and experience of the worker. The manager may change the level of supervision required, add additional case support, and/or switch primary providers as needed to meet participant's changing needs.

3. Additional assigned tasks and job responsibilities will be taken into account when assigning cases and managing personnel caseloads.

4. Staff caseload and additional workload duties are reviewed and discussed weekly in supervision in order to problem-solve, remove barriers, and balance workload. As much

as possible, staff are involved in collaborating and determining strategies to support participant care while balancing staff's workload, including agreed upon use of resources, support, and number of pending referrals to be assigned to staff.

5. IHOT Staff Caseloads are determined both by the number of assigned cases as well as weekly participant service hours or "productivity" expectations:

    a) Caseloads are dependent on the participant needs and intensity of services. Each Client Support Specialist will have an average of 10 active cases. Case Managers will have an average of 20 active cases. The IHOT Family Advocate will primarily engage in Outreach activities and be added to cases for familial support; therefore their caseload may rotate and vary from 5-20 participants at a time, dependent on dosage. There is no limit on inactive cases that staff may carry but every effort will be made to discharge inactive cases once time limits are met and/or every avenue is exhausted so that inactive caseloads do not become excessive.

    b) A provider is assigned at referral to minimize changes in assigned staff during the participant's time in services. All efforts are made to avoid arbitrary or indiscriminate reassignment of direct service personnel.

    c) Each IHOT Staff is expected to maintain 30% productivity; or 2.4 hours of billable time for any day worked. Part time, split positions, and supervisors may have adjusted productivity expectations based on their role.

    d) The dosage of service for each participant may vary depending on need, phase of service, and location where service is provided.

    e) At times, IHOT program may receive unanticipated referrals that exceed the agency's requested capacity. When this occurs cases will be distributed to staff based on current active caseload, productivity, and pending discharges.

    f) At times, there may be additional cases added to a staff's caseload for participants with specialized needs (such as language). When this occurs all efforts will be made to minimize the impact on staff's workload by adjusting for case intensity where possible, removing additional responsibilities where appropriate, etc.

    g) All efforts will be made to pace referrals appropriately such that staff are not assigned more than 5 cases per week, dependent on their caseload.

Productivity

1. Productivity is tracked on a weekly basis by management, shared with staff, and discussed in individual supervision.

    a) Each IHOT Staff is expected to maintain a minimum of 30% productivity; or 2.4 hours of billable time for any day worked. Part time, split positions, and supervisors may have adjusted productivity expectations based on their role.

    b) The 30% productivity is designed to already account for administrative tasks, regularly scheduled meetings and supervision, and other non-billable activities related to participant services. PTO, training time, and certain activities related to program functioning that are otherwise not reimbursable are excluded from productivity (i.e. they are accounted for in calculation of staff productivity).

    c) Staff are responsible for submitting exclusions to productivity at minimum on a monthly basis to the Google Doc or other assigned method of reporting (see chart below). PTO is tracked in Paycom and does not need to be included.

    d) Final productivity is calculated after the 5th of each month for the month prior; therefore all notes must be completed by the 5th to be included in productivity calculations. In addition, all exclusions to productivity (i.e. Google Doc entries) must be submitted by the 5th for the month prior.

    e) Staff are responsible for monitoring their billable hours throughout the week and month to ensure they are on target, and requesting new cases as needed.

    f) Staff whose productivity falls below the 25% minimum standard for their position for a given month will be engaged in performance management processes including coaching, a collaborative plan of improvement, and/or a Corrective Action Plan (CAP) Failure to improve productivity up to standard will result in further disciplinary action

    g) Upon a new staff's hire date, their productivity expectations will increase over the first 3 months:

        i. 1st month: 5%

        ii. 2nd month: 15%

        iii. 3rd month: 30%

Included *Part of 70% non-billable time each week*	Excluded *Accounted for to determine basis for weekly hours worked* Submit to Google Doc https://forms.gle/MiyLJyoUEKzXRhj6A
Scheduling and participant reminders	Training time
Administrative tasks related to participant chart: Admit, submitting intake documents or other forms for participant chart, updating diagnosis, processing discharge, etc.	Travel time between BWC Medi-cal certified sites for the purpose of meeting with a participant for session
Regularly scheduled staff meetings (1 hour per week)	Translation time or time setting up translation services (to be documented via NB-Translation Progress note)
Group, individual, and administrative supervision	Additional meetings scheduled for team coordination, special projects, or to attend community meeting as requested by your supervisor
Checking voicemail or emails	Agency appreciation, staff wellness activities, team building or appreciation events
Submitting mileage, timesheet, reimbursements, or other agency required forms	Excess time spent on technological issues or malfunction (with Corpwest)- please discuss with supervisor.
Participant cancellations & no shows	Peer audit *(will be automatically entered for you)*
Making mandated reports	PTO, Holiday, or other approved time off/ leave *(will be automatically entered for you)*

IHOT Safety in the field Policies and Procedures

Safety in the field overview

Staff safety is our top priority. Please review this document and complete all related trainings as required, to ensure you can keep yourself safe while providing services in the community. As a guiding principal, if you ever feel unsafe do not continue to provide the service in the unsafe conditions, please stop and leave the situation as quickly and safely as possible. Also, most of this document is geared toward maintaining physical safety, but you are encouraged to monitor and maintain your emotional safety as well. This includes setting firm boundaries and not accepting verbal/emotional abuse from clients, collaterals, other providers, or other community members.

Staff should consider their safety starting from the receipt of the referral and continuing through every interaction with the client, their collaterals, and the community. This P&P document will walk you through each step of working with clients and how to maintain safety in that phase of your work.

Researching new Referrals

- Read the referral and any accompanying information on the client and note any areas of concern and any previous safety issues involving the client.
- If there are current or previous charges/arrests noted in the referral information, you may reach out to the appropriate law enforcement liaison for more information that may help you plan for meeting safety needs with the client.

Scheduling & Preparing

- Consider weather, daylight, and time when scheduling appointments.
- You may want to avoid meeting with clients in the field at the end of the workday, especially when the days are shorter.
- Coordinate with team members to work in pairs/teams for safety in numbers.
- Reach out to law enforcement MH Crisis teams for support if meeting with a new client with high safety risks or other appropriate reasons.
- Ensure your Outlook calendar is up to date with accurate addresses for your outreach.
- Ensure your cell phone is charged, and have a car charger on hand.
- Consider your clothing choices – avoid dangling jewelry, thin/open shoes, “nice” clothes that you don’t want to get dirty, etc.

Driving

- Give yourself plenty of time to get to your meeting on time. Assume you will hit traffic and schedule in a cushion around your travel time.
- Drive the speed limit and follow traffic laws, take extra care here when transporting clients or other staff members.
- Avoid distractions while driving (i.e. texting, phone calls, eating, etc.)
- When transporting clients:
    - Whenever possible have them sit in the back seat on the passenger side and crack the windows for fresh air flow to reduce risk of Covid-19.
    - Consider your rapport and the client's historical behavior. Do not transport unsafe clients.
    - When clients are in the backseat, it may be helpful to engage child locks to prevent them opening the door while you are driving.
    - Have a plan for getting the client out of the car if they suddenly refuse to leave at the destination.

Parking

- Park as close as you can to your destination, and make sure you aren't blocked in.
- Be aware of your surroundings, note the people, places, and circumstances around you
- Look out for broken glass that could indicate frequent break-ins and sharp objects that could puncture your tires.
- Try to park in highly visible, well lit areas
- Carpool or try to park near other team members who are outreaching with you.

Walking

- Remain continually aware of your surroundings, paying special attention to unknown people around you.
- Use your senses, listen and look to keep a safe distance between you and others.
- Best practice is to walk together with other team members for safety in numbers.
- Use clearly marked cross-walks
- Do not enter too deep into an encampment, especially if you are not familiar with the people and environment around you.

Visiting Participants

- Outreach in pairs/teams for optimal safety, especially when meeting new participants and families.
- Listen and look around before approaching the door or participant in the field.
- Follow your instincts, if you don't feel safe, excuse yourself and leave the situation immediately. Call for help if needed.
- Keep participants, collaterals, and others in the area as de-escalated as possible.
- Set and maintain firm boundaries, do not accept verbal abuse or threats.
- Protect your participant's privacy and reputation, don't show pictures to local store owners who may then discriminate against your participant for being in our program.
- Identify yourself as a BWC outreach worker through shirt/vest, badge, and/or your words. Reiterate your goal to help.
- Remain situationally aware throughout your visit, notice changes in the environment and new people entering the space, routinely note the body language of everyone in the room/near you to monitor for signs of escalation.
- When possible position yourself nearest to the door and keep a clear escape route in mind during interactions.
- Keep your phone on you at all times and ensure that it has a good charge.
- Take care with phone use, some community members are paranoid about pictures and videos being taken of them.

De-Escalation

- Keep calm and show others that you are in control of your emotions and behaviors.
- Use a soft tone of voice, calm body language, and agree with the escalating person as much as possible to reduce conflict.
    - Validate their feelings, not their inappropriate behaviors.
- Try to re-direct the escalating person back to a productive goal that is important to them.
- Debrief and safety plan after de-escalation where appropriate.

When to Call for Help

- If the person continues to escalate despite your attempts to calm them.

- If the person threatens violence to themselves or others in a meaningful way.
- If you fear for the safety of yourself, your participant, or other community members in the area.
- If weapons are brandished in a threatening way.
- If you are witnessing violence in the moment.

Who to Call for help

- Mobile Crisis Response Team (MCRT)
    - Santa Clara County residents may call the Mobile Crisis Response Teams at **1-800-704-0900**, Monday - Friday, 8:00 a.m. - 8:00 p.m., **select option #2** to request a Mobile Crisis Response Team member.
    - Call 9-8-8 from a local area code (408 or 669) and ask for MCRT support
- **9-8-8 National Suicide prevention hotline**
    - July 16, 2022 established 9-8-8 as the nationwide, easy-to-remember 3-digit dialing code for Americans in crisis to connect with suicide prevention and mental health crisis counselors in their area code based on the number they are calling from.
    - If your client is credibly expressing intent to harm themselves or others (i.e. not venting in anger, but appearing to have intent, plans, means, or specific targets) you should direct them to call 9-8-8 or call on their behalf immediately.
- **9-1-1 Emergency**
    - For current or immanent violence, fire, or medical emergencies please call 911 immediately.
- **Your Manager**
    - If you are unsure of who to call for help, or what to do next, please call and check in with your manager. It is also appropriate to call your manager after you have reached out to other crisis support providers for follow up instructions.
    - If your manager is not available, you may also reach out to any other MH manager for consultation, support, follow-up, and/or further guidance.

Learn More about Safety in the field

- Staff should complete the “Safety in the Field” Relias training within the first 30 days of hire
- Staff may also review the Safety in the Field Relias Training slides at any time as a refresher for the content
- Talk to other outreach staff and teams about how they stay safe.
- Look out for additional safety in the field training opportunities.

- Ask safety related questions in ParaPro group, individual supervision, and/or team meetings as concerns come up for you in your work.

Staff Safety from outreach manual

Safety is a major concern for both yourself and the Bill Wilson Center. Outreach done effectively and correctly is a very safe job, however because you are oftentimes dealing with distrustful or mentally unstable individuals in their own environment or space, the potential for altercations does exist. However if you read and follow closely the safety guidelines listed below you should be at the least prepared to deal effectively with any situation that might arise while conducting outreach on the streets.

Because of the nature of the position, and outreach workers best tool to remaining safe on the street is his/ her own intuition or gut feeling. Meaning that most people of general observational skills can interpret when someone is feeling scared or uncomfortable, and in the case of the homeless, when forced into this position they could possibly become violent. So the best way to deal with possibly violent contacts is to avoid them in the first place. In order to do so you need only ask yourself if you feel uncomfortable or at risk in any situation you encounter, and if the answer is yes, just walk away. No contact is ever worth jeopardizing your safety, learn to accept no for an answer.

Safety techniques to follow while on outreach:

- Read and abide buy the safety guidelines contained within this manual
- Always do outreach in **pairs,** never stay out of sight of your partner while interacting
- Always carry a cell phone or way of calling for help in an emergency
- Always notify someone (supervisor) of where you plan to go that day and when you plan to return, so incase you do not come back on time they will know where to look, also begin and end outreach at the center so that staff can take note of your presence.
- Always carry identification (agency ID, Drivers license)
- Never carry weapons of any sort while on outreach, they make clients feel uncomfortable and are more likely to be used against you. Your best weapon is your intuition
- Always listen to your instincts, and be willing to take NO for an answer
- Never feel forced to do outreach in an area you do not feel comfortable
- Always maintain the role of a service provider and nothing else
- Never buy, sell, trade, property or drugs, or develop personal relationships with any clients met while on outreach
- Never give out any of your own personal information
- Get to know business owners and employees of the area shops around common

outreach locations, this way if you ever have a problem in the area you will know someone who can help

- Develop “working” relationships with police through public venues such as the
- Community Advisory Board in order to make known your presence and work in the community, however be careful not to be viewed as “working with” the police by clients because if so they may begin to distrust you and your services
- Always protect your reputation. I.E. keep appointments and promises
- If ever caught in a situation in which you feel unsafe, just walk away

Referral Process

The referral process for the IHOT program is different than most other programs, in that rather than an individual reaching out for help themselves, most referrals are on the participant’s behalf by other entities. Most IHOT referrals come through the IHOT county team; however staff may complete referrals with potential participants or their collaterals while in the field.

1. County Referrals
    a. Many referrals coming through the county IHOT team are first identified by staff at Emergency Psychiatric Services (EPS), Mobile crisis response teams, or law enforcement; however they may also receive more direct referrals from family members, peers, and individuals through the 9-8-8 hotline and call center navigators.
    b. Once referrals are received by the county team, their staff review the referral and check for eligibility for IHOT services. If the referral is eligible, the county team then assigns the referral to one of the IHOT teams (county, Starlight, or BWC).
    c. At BWC the IHOT Program Manager receives the referral from the county via secured email, then assigns to a Client Support Specialist (CSS) and Case Manager (CM) team for intake.
    d. BWC IHOT staff open the referral in the electronic health record (EHR) immediately upon receiving the assigned referral.
        i. This includes entering and accepting/admitting the referral through the Census intake function, and completing the Cost Center Open form.
        ii. These tasks may be completed by the program manager or the case manager(s) depending on the circumstances.
        iii. The participant should be opened in the EHR on the same day the referral is received, or within 24 hours at the latest.
    e. Assigned CSS should start trying to locate the referred individual immediately, with the goal of making in-person contact within 3 days whenever possible. For more details see *Outreach Activities* section below.
2. Field Referrals

a. In addition to referrals that come directly from the county team, IHOT staff are able to complete field referrals with individuals and collaterals in the community, which are then approved by the county team if the participant is eligible for IHOT services. These field referrals may come from a variety of places/circumstances, including the following:
    i. Family members and/or other providers
    ii. Individuals met in street outreach
    iii. EPS/MHUC directly (pilot program in progress)
b. BWC Staff may complete the referral form with an individual who is interested in IHOT services themselves, or with a family member or other collateral on that person's behalf.
    i. Once the form is completed with at least the minimum information of Participant name, date of birth and contact information, it should be emailed securely to the county IHOT team at: IHOT@hhs.sccgov.org
        1. The subject line should read "IHOT Field Referral" and "Urgent" should be added to the subject if a quick response is needed, such as when waiting in the field with a client or for an EPC/MHUC field referral.
        2. If staff are unable to complete an eligibility screen and referral form, they may advise the community member to call 9-8-8 and ask for an IHOT referral for Santa Clara County. They will then provide the information over the phone to the call center navigator and the form will be sent to the county IHOT team for review, approval/denial, and assignment.

Intake

The first step to working with participants in the IHOT program is to find them and complete intake. The steps below will walk you through this process.

1. Once a referral is received and assigned to a Case Manager (CM) and Client Support Specialist (CSS) team, the participant should be opened in AWARDS within 24 business hours by the CM, and the CSS should begin attempts to reach the participant using information provided on the referral within 24 business hours.
    a. If the participant is at EPS at the time of referral, the CSS should contact EPS staff within the same day to determine discharge timeline and start coordinating care. Best practice is to meet the participant at EPS prior to their discharge whenever possible, and to get a copy of the discharge plan from EPS staff.
        i. If unable to meet the participant at EPS, next best practice is to attempt to meet them at the location they were discharged to (i.e. at the Sobering center).

1. When this is not possible, refer back to the referral for leads to find and contact the participant.

b. If the participant is not at EPS at the time of referral, then outreach attempts should begin using the phone numbers and addresses listed on the referral as a starting point.
    i. Start by calling all numbers listed on the referral in attempt to reach the participant and/or gather information about the participant from collaterals, then move on to visiting listed addresses/known locations.
c. Further leads toward finding/contacting the participant may be developed through researching local databases (i.e. the inmate locator, HMIS, etc.), requesting additional information from the County IHOT team, requesting Unicare face sheet from BWC Administrative assistants, and speaking to collaterals to gather information about participant whereabouts and best methods of contact.

2. The CSS and CM team should make every attempt to contact the participant within 3 days of receiving the referral.
    a. After the first 3 days, the team should continue attempting to find and contact the participant approximately 2x/week until either the participant is contacted successfully, or all leads have been exhausted.
    b. Participants will be moved to the inactive list once all leads have been exhausted without successful connection.
        i. The team may continue to revisit past leads for the participant as time permits in attempt to locate the participant, but this is not required.
        ii. Participants will be moved back to the active list if a new lead develops (i.e. they are in EPS and we receive notice).
        iii. Participants will remain on the inactive list until they have been in the program for 120 days, at which time they will be discharged.
3. Once a participant has been located, the team's first focus is on building rapport with the participant and/or their collaterals and working to engage the participant in services.
    a. Each staff should have an "elevator speech" that they use to introduce themselves and the IHOT program to participants, collaterals, and other providers. The speech may be different for each of the groups listed above to highlight the parts that are most important to the receiver.
        i. These introductory speeches should include:
            1. Staff name, pronouns, and role
            2. IHOT program overview, including the services we provide, and clarifying that we do not provide clinical services.
            3. An invitation for the receiver to either participate in IHOT services, or assist IHOT staff in engaging the participant in the program.

b. After introductions have been shared and the participant agrees to continue engaging with the staff, additional efforts should be made to connect with the participant, build rapport, and keep the participant engaged.
    i. If speaking over the phone, it is best to share only the basics and then ask to meet in person to share more.
        1. Before meeting in-person, staff should complete the COVID19 screening tool to ensure it is safe to meet with the participant/collateral in-person at the agreed upon setting.
    ii. When meeting in person, staff should make every effort to review informed consent in a way that the participant can understand, and get intake paperwork signed by the participant, including:
        1. Consent for services, including review of grievance process and confidentiality limitations.
        2. Release of Information (ROI) for emergency contact and/or any other collaterals who may be a part of services coordination.
        3. Client Rights and Responsibilities
        4. IHOT Intake Demographics survey
    iii. Intake paperwork may be completed over several sessions as needed to accommodate the participant's ability to attend to such paperwork.
    iv. Incentives may be used to increase engagement with participants, see Service Delivery policy for details on use of flex-funds. Engagement incentives can include:
        1. Buying a meal for the participant/eating with them (healthier options preferred and encouraged by county guidelines).
        2. Providing Hygiene/Outreach kits or parts of the kit
        3. $5-$10 gift cards
        4. Bus tokens – 5 per/bag
        5. Other incentives as approved by CM and/or Supervisor

Outreach Activities

Once a referral is opened and assigned to BWC staff, they will begin outreach for that participant within 24 business hours. In addition to serving our current participant caseload, IHOT staff may also conduct "street outreach" in effort to find and engage additional IHOT referrals/participants. This section will outline many of the tasks and activities covered in both of these types of outreach.

1. Locating a new referral
    a. Often new referrals come in with limited information; it is IHOT staff's responsibility to follow all leads provided, and attempt to generate new leads toward locating each referred individual. This includes (but is not limited to) the following tasks:

i. Calling all phone numbers listed on the referral in attempt to connect with and/or gather more information about the participant.
    1. Phone numbers provided on the referral are often linked with collaterals such as friends, family members, and current or previous providers rather than to the participant themselves.
    2. Phone numbers for participants may not have consistent service or voicemail options, so it is important to try a number at least 3 times on different days and at different times to increase chances of successful connection.
    3. Staff may introduce themselves and the IHOT program as an outreach and linkage program to anyone who answers the phone numbers provided; and may gather information about the participant from any party contacted. However, staff should be careful not to disclose additional information about the participant to any other party without the participant's expressed permission.
    4. Part of gathering information about the participant should include asking anyone contacted if they know how or where to find and contact the participant in an effort to generate additional leads to follow.

ii. Visiting any address or last known location of client provided on the referral or from discussions with collaterals.
    1. When visiting a residential address, staff should:
        a. Knock on the door and attempt to introduce themselves and the IHOT program.
        b. Attempt to connect with the participant and/or learn more about the participant and their whereabouts.
        c. Leave a business card and IHOT brochure at the door if no answer.
    2. When the address turns out to be a business (such as shelter or previous MH program) rather than a residence, staff should:
        a. Speak with the receptionist and attempt to gather information about the participant such as if they are still using services at the location, or if there are any staff who could provide more information about the participant including their potential whereabouts.
        b. Attempt to connect with the participant if they are at the location.
    3. When the address is a homeless encampment or a business (such as a restaurant, store, or shopping center), staff should:

a. Look around the greater area for the participant and ask others in the area about the participant with considerations for staff safety and participant confidentiality.
    i. Proceed with caution and do not enter too far into an unknown area of an encampment.
    ii. Outreach at encampments should be done in pairs or larger teams for staff safety.
    iii. Use best judgement to determine whether asking business staff about a participant will be more helpful or harmful to the participant. Be mindful of participant confidentiality and be cautious that you don't make it harder for the participant to utilize the store/business at which you are inquiring about them.

iii. When unable to locate and connect with the client through any of the methods above, staff may need to conduct additional research to generate more leads. This research may include the following:
    1. Ask a BWC Outpatient Program Assistant or County IHOT team member to run a Unicare/Avatar report that may show previous services provider information.
        a. Staff may then reach out to previous service providers to seek additional information about the participant.
        b. Staff should identify themselves as BWC IHOT providers, part of the client's continuum of care and share that the gathered information will be used to locate the participant and/or help determine their eligibility for our program.
        c. Previous providers may refuse to share information due to HIPAA concerns. Since we are a part of the client's care team, it is not a HIPAA violation for them to share information with us; however we cannot compel them to share information with us if they are not comfortable doing so.
    2. Ask an IHOT County team member to run a report from Healthlink for the participant to see if they are (or were recently) at a local hospital.
        a. Staff may call or visit a hospital where they suspect the client to be and ask to speak with the client directly.
        b. Staff may call a hospital where they suspect a client has been recently and request the client's discharge paperwork.

   c. Hospital staff may or may not cooperate with our requests for information and access to the participant.
   d. Some hospitals are not listed in Healthlink, and may need to be contacted directly, including:
      i. Good Samaritan
      ii. El Camino Hospital
      iii. Stanford
      iv. St. Vincent DuPaul
      v. Regional Medical Center
3. Search the HMIS database for the participant to gather information about previous whereabouts and services accessed.
   a. Staff may call other phone numbers listed as client contact information in the database to try and reach the participant.
   b. Staff may visit locations identified as known whereabouts of participant, even if from a while back, in attempt to locate the participant.
   c. Staff may contact other/previous providers in attempt to gather additional information about the participant. Those providers may or may not agree to share information with our staff.
   d. Staff may put an alert in HMIS so that if any other providers make contact with the participant, they will know to reach out to IHOT staff to support connection to the program.
4. Search the inmate locator to see if the participant is incarcerated locally.
   a. If client is incarcerated, staff may attempt to reach out to their public defender or other court representatives to gather more information about the participant.
   b. Staff should identify whether client is connected to the Mental Health court (Department 60 or 61) and whether or not all charges/cases are consolidated under the MH court.
      i. If not, staff should advocate for this to happen on behalf of the participant, even if no consent or agreement to work with IHOT has been given. This is a purely advocate activity since participants who are eligible for IHOT are also eligible for MH court.
      ii. Once confirmed that the participant is connected to MH court for all cases/charges, they may be

discharged from the IHOT program, as the court will link them to MH services upon their release.

5. Check in with MCRT, Probation/Parole/Reentry Center to identify if client is/has recently been engaged with criminal justice system in other ways.
6. Search social media sites for participant to gather information about their potential whereabouts.
7. Call local morgues to see if participant can be found there.

2. Street Outreach & Pop-up events are other ways that we may identify potential participants.
    a. Staff may engage with community members through street outreach and/or pop-up events to share about IHOT services and attempt to identify potential participants.
        i. Common street outreach locations and activities:
            1. EPS/MHUC outreach - currently in program to provide limited daytime support in rotation with other IHOT teams to complete IHOT referrals with discharging EPS/MHUC clients.
            2. BWC IHOT Outreach table at a local community resource location or coordinated outreach event.
            3. Incidental outreach while in the field for other targeted outreach activities (i.e. looking for a new referral at a homeless encampment, and meeting another unhoused community member who is looking for support and may meet eligibility requirements).
                a. This includes working with other BWC programs such as the Drop-in Center to identify and provide outreach to youth who may be eligible for IHOT services.
            4. Targeted outreach for new referrals in areas commonly frequented by participants, or community members who are likely to be eligible for IHOT services. (i.e. walking through downtown library where many unhoused community members spend time, or walking through homeless encampments specifically looking for new potential referrals to engage).
    b. Once a community member engages with staff and indicates interest in the program for themselves or another person, staff may complete a referral in the field and attempt to assess for eligibility.
        i. Completed referrals should be emailed securely to the IHOT County team at IHOT@hhs.sccgov.org with “Urgent Field Referral” in the subject line.
        ii. Staff should clearly communicate to the referral that they are being screened for eligibility, and will not be opened in the program unless and until the county confirms they are eligible for IHOT services.

1. Staff may provide information about, and support linkage to, common resources for the referral during the assessment and referral process to help them learn how to meet basic needs by utilizing community resources. This can be done over the course of a few weeks and during 2-3 outreach meetings. Even if the referral is not eligible for IHOT services after screening, staff should ensure that the appropriate amount of information is provided to the referral so that they can meet their basic needs and connect to MH or SUTS programs independently.

iii. IHOT County team will review the referral and research eligibility.
1. If referral is eligible for IHOT services, the county team will assign to one of the 3 IHOT teams for service provision. Typically the referral will go back to the team that submitted the referral, but that team can ask for a different assignment if needed.
2. If referral is not eligible for IHOT services, the county team will reply and let the sender know that the referral cannot be opened at this time. They may provide other options (such as HEAT referral or redirection to private insurance providers).
3. If referral is confirmed to be eligible and is assigned to the BWC team, staff will follow-up with the referral for intake.

3. Intake and Assessing for Needs – Once a participant has been contacted the next steps are intake into the program and assessment of the participant's needs. See the *Assessment and Engagement* policy for details on this process.

Engagement Strategies

The next step to working with participants in the IHOT program after finding them and completing intake is to engage the participant and their collaterals. The steps below will help you to build a strong working relationship with your participants.

1. To support rapport building and improve participant engagement staff will be:
   a. Non-stigmatizing and non-judgmental: Staff will be mindful of the language they use with participants, as well as the para-verbals they present to participants and ensure that they are not judging nor stigmatizing participants or their collaterals.
      i. It is important for staff not to make assumptions about what participants or collaterals know, or how they behave.
      ii. Staff should remain curious and open with participants and collaterals.
   b. Sensitive to the willingness of the participant and/or family to be engaged: While we recognize the value of assertive outreach and engagement for underserved populations, IHOT services are voluntary, so if a participant refuses services we are to respect their wishes and discharge them.

i. If a participant initially refuses services, but seems open to further engagement, we may ask for permission to meet with them again and re-assess their interest in services at that time. However, if they refuse to meet with us again and are adamant about their refusal, then we will discharge immediately upon their request.
ii. If a family member is open to services, but the participant refuses services, we may provide resources and 1-3 outreach sessions to the family to support them, but must discharge the participant immediately.
iii. If a participant is not open to having family involved in their services, but family is requesting support, we may provide resources and support directly to the family, but may not share anything about the participant or their services with the family.
iv. Participant engagement in other services (i.e. SUTS program, MH program, Work support program, etc.) is also voluntary, and IHOT staff should not connect participant to any service that the participant is not willing to engage in.
v. Staff should always consult regarding closure of referrals to ensure that adequate outreach and engagement efforts have been made while honoring participant self-determination.

c. Culturally and linguistically responsive: IHOT staff will be culturally humble and responsive to all participants and collaterals and be open to learning how to respectfully engage with members of differing cultures.
    i. BWC leadership will work to hire staff who are reflective of the diversity seen in the populations we serve, including hiring staff who speak other threshold languages.
    ii. Staff may ask for support from co-workers who speak other languages to communicate with participants and collaterals and to provide documentation in languages the receiver can understand.
    iii. Staff may use the language line for support engaging and communicating with participants and collaterals who speak a different language, especially if other staff are not available to support.
    iv. Staff will ask for and use the asserted name and pronouns of each participant and their collaterals.
        1. Staff will allow participants to self-identify their gender and sexual/attractional orientation and will consider appropriate resources based on the information provided.
        2. Staff will record the appropriate demographic information on intake forms and make every effort to use the participants asserted name and pronouns on written documentation.

v. Staff take annual trainings on cultural sensitivity and responsiveness and will seek out additional education as needed to support participants and collaterals on their caseloads.

d. Non-threatening: Staff will remain professional and calm with participants and collaterals, even if others become escalated.
   i. Staff will be trained in de-escalation and therapeutic crisis intervention to support their ability to stay safe and calm during crisis.
   ii. Staff will not threaten or intimidate any participant or collateral.
   iii. Staff will immediately leave any unsafe situation, or any situation where they are not able to keep themselves calm and under control.
e. Respectful of the participant's autonomy and confidentiality
   i. Staff will not force a participant to engage in any service or activity against their will.
   ii. Staff will recognize that participants have personal autonomy and may choose not to follow-through on a task, not to remain sober, not to stay in a placement provided, or not to engage in a recommended service. Staff must allow participants to make these decisions, and continue to provide appropriate services to participants, even when disappointed in their choices.
   iii. Staff may help identify potential risks and benefits of various options and share these with the participant to help the participant make informed decisions. However, staff may not make decisions on the participant's behalf.
   iv. Staff may receive information from collaterals freely, however staff may only share about the participant with others when the participant has given permission or in the case of emergency treatment needs.
      1. ROIs should be signed by participant for every collateral that IHOT staff will need to coordinate with.
      2. Staff should discuss what is okay to share and what should not be shared with each collateral, and respect the participant's wishes in this regard.
      3. Staff will not share any information about the participant with any collateral if permission is not granted to do so.
   v. Staff will use secured methods when sharing client Protected Health Information (PHI), including:
      1. Internal BWC emails
      2. Secured email system for external emails
      3. Phone calls/voicemails
      4. Paper mail
f. Focused on information pertinent for meeting service requests and objectives: While it is important to build trust and rapport with participants and collaterals,

it is important to remember that we are not there to be a friend, but to help the participant identify their needs and link them to resources and services that can meet those needs.

g. Trauma-informed: Staff will be aware that most participants have a history of trauma and work to reduce possibilities for re-traumatizing participants within our program.
    i. Staff will receive training on trauma-informed care and follow best practices from these trainings.
    ii. Staff will make every effort to provide a safe environment for participants and collaterals to engage in IHOT services.

h. Flexible: Staff will make efforts to accommodate participant/collateral needs while maintaining appropriate boundaries.
    i. Staff may adjust meeting times to accommodate participant needs/requests within reason.
    ii. Staff may adjust communication styles or other environmental factors as appropriate to accommodate participant needs.
    iii. Staff will maintain professional and appropriate boundaries and will seek consultation and/or supervision when unsure if a participant request should be accommodated.

i. Persistent: Staff will make multiple attempts to locate, contact, and support participants. Staff will not "give up" after one failed attempt, but instead will make adjustments as needed and try again.
    i. Participants are not moved to inactive until all leads are exhausted, and multiple outreach attempts via various methods have been made.
    ii. Participants are not discharged if a placement does not work out the first time, instead staff will assess for a better fit and try a new placement.

Program Assessments

Once a participant has agreed to receive IHOT services and is engaging with you, then next step is to start assessing for their needs and safety. Assessing for participant needs will help you better understand what resources they should be connected with, and will help you determine their readiness for engaging in longer term mental health (MH) or substance abuse treatment services (SUTS) programs. This information will also be shared with the case manager to help them create a needs and services plan (which will be discussed further in the service provision policy). The steps below will introduce the instruments and skills needed to complete these assessments with your participants and their collaterals.

1. Self-Sufficiency Matrix (SSM)
    a. An SSM should be completed by the CSS and/or Family Advocate (FA) at the start of working with a participant and again just before discharging, whenever possible. The initial SSM will help us determine participant needs and

understand the resources and supports that can help stabilize the participant and move them toward readiness for engaging in MH/SUTS programs. The discharge SSM very helpful with identifying how our services are positively impacting the participants we serve based on the change in their scores between when they started the program and when they leave the program. SSMs are to be done electronically through AWARDS. Having the SSM electronically in the participant's chart will allow us to report on the data and use that data to advocate for our program.

b. Scoring the categories: Each category is scored from 1 (crisis) to 5 (thriving):
    - 1 – CRISIS: Has an immediate need which can impact wellbeing
    - 2 – VULNERABLE: Has access to immediate *temporary* supports and resources
    - 3 – STABLE: Can meet all basic needs with assistance (i.e. SNAP, THP)
    - 4 – SELF-SUFFICIENT: Can meet basic needs with occasional support at times
    - 5 – THRIVING: Can meet all basic needs and beyond
c. Guiding Questions and Definitions: Each category in this document is accompanied by suggestions for questions to guide the assessment and definitions to assist in determining where the household lands on the self-sufficiency continuum. The goal is to ensure consistent and accurate scoring across households, across staff team and across various programs within an organization and/or within the community.
d. Focus on One Category at a Time: When assessing a household, it is imperative that the staff person focuses on ONE CATEGORY at a time. Although some categories may overlap and/or influence each other, staff should look at the household through the lens of just the category they are currently evaluating. For example, if scoring the household's food category, the staff member should not allow the household's housing situation to influence the food category.
e. Household vs. Individual: Staff using the assessment must look at each category from a household perspective. When working with a category where the individual adults in the household have different situations, please score the category with respect to the individual with the highest need.
f. Review each category with the participant and do not assume that any particular category does not apply to a participant. If they report that it is not applicable or refuse to score the category, then you can rate it as N/A. Categories assessed for on the SSM include:
    i. Employment
    ii. Adult Education
    iii. Income
    iv. Housing

v. Transportation
vi. Health Care Access
vii. Physical Health
viii. Substance Use
ix. Mental Health
x. Social Support
xi. Daily Living
xii. Child Care
xiii. Parenting Skills
xiv. Legal
xv. Safety

g. The matrix can be used in a variety of situations:
    i. As a case management tool to document participant progress toward self-sufficiency
    ii. As a self-assessment tool for individuals who wish to determine their own strengths and areas for improvement
    iii. As a program management tool for organizations to assess the effectiveness of services being offered and how to direct resources
    iv. As a measurement tool for grant makers to clearly articulate their funding priorities, and as a communication tool for demonstrating the success of local programs, as well as sharing information about community conditions with the general public, stakeholders and policymakers

2. Additional assessment tools may be used to help in identifying the correct score for a category in the SSM (such as MH, Substance Use, and Safety) and/or to get a more in-depth picture of the participant's needs around that particular category or life domain. The tools below are some that we use most frequently in IHOT:
    a. The Warwick-Edinburgh Mental Well-being Scale (WEMWBS)
        i. This assessment tool is optional for our program based on the participant's ability and willingness to engage with the tool and identify their scores for each question. However, it is encouraged to be used at intake and discharge to evaluate the impact of treatment services on the mental well-being of the participants we serve. Collecting before and after data can tell us a lot about what strategies work best and what helps people improve and sustain mental well-being. This tool can also be used to identify how your participant is functioning and thriving and may help you identify appropriate scoring on the SSM Mental Health category.
        ii. WEMWBS (also called WEBS at BWC) is a validated scale for the measurement of mental well-being among people **aged 13 to 74**. It comprises of **14 positively worded statements** with response categories from 'none of the time' to 'all of the time'. These statements are

answered by participants based on their experiences over the **past two weeks.** The WEMWBS is designed to be **filled in by participants themselves**.

iii. To ensure that we only complete the WEMWBS with participants who are able and willing to complete this assessment form, staff should assess the participant's mental and emotional ability to complete the WEMWBS.

iv. If appropriate for your participant, hand over the **paper form to the participant.** You may describe WEMWBS as '**statements about their thoughts and feelings in the past two weeks'**.

v. Allow enough time for participant to complete the form and be mindful of not interrupting their process. You may even choose to step away for a few minutes to allow participant to reflect on their experiences as they answer each question.

vi. Once they are done, **review the scores** with the participant. The idea is to **engage in a dialogue** about their strengths and challenges as reflected via scores on the WEMWBS. For example: if the participant has scored a 2 on "I have been dealing with problems well", this provides you an opportunity to ask them about what challenges they have encountered in the last 2 weeks, which made them feel as though they were unable to deal with their problems as effectively as they would like. If they have scored a 5 on "I have been feeling loved", you could engage in a discussion about their social support systems and including these people in their services.

vii. Thank your participant for completing the questionnaire and explain that you are going to ask them about these statements again at the **end of treatment**.

viii. Enter the scores into the form on AWARDS for inclusion in the participant's chart. AWARDS will automatically score the form for you by adding all of the scores together for an overall score number. You can do this manually on the paper form as well. The highest possible score is 70 and higher scores indicate a greater sense of wellbeing. Seeing the score increase from initial assessment to discharge assessment also highlights how our services may have positively impacted the participant's wellbeing.

b. The Simple Screening Instrument for Alcohol and Other Drugs (SSI-AOD)

i. This screening Instrument is also optional for our program, but can be used to gather more information about participants' substance use and related needs. It is a helpful tool to use for identifying problematic drug or alcohol use in participants, and to help participants move toward readiness for engagement in a SUTS program by increasing their awareness around how their substance use is impacting their life.

ii. The tool is a short 16 question form that the client can complete independently or with your support. Each question should be answered with either YES or NO.
iii. Question number 5 includes a checklist of possibilities, and should be marked as YES if 1 or more of the items in the list is checked off; only one YES is counted for this question, even if multiple items on the checklist are marked off. If none of the items in the checklist is marked, then the entire question will be scored as NO.
iv. Once completed, the tool can be scored by counting the number of questions marked YES. Questions # 1& 15 are not included in the score, even if marked YES.
v. Participants are considered screened positive if they have a score of 4 or higher. Positive scores indicate the potential need for participant to engage in a SUTS program.
vi. If your participant scores positive on this tool, please discuss treatment options with them, and use motivational interviewing skills to help move them toward readiness to engage in SUTS programs. This need should also be recorded on the SSM Substance Use category score, and be addressed in the Needs & Services Plan for the participant.

c. Mental Health Screening Form Jackson III
i. This screening Instrument is also optional for our program, but can be used to gather more information about participants' mental health and related needs. It does not provide any diagnosis, nor indicate that there is definitely a mental health problem, but does provide an indication of areas that need further assessment by a clinician and potential areas of treatment to be addressed in a MH program.
ii. There are instructions on the first page of the form that staff can follow to complete the assessment with the client. The questionnaire can be given to the client to complete on their own, however best practice is to have the staff member read the questions to the participant and record their YES or NO answers on each of the questions.
iii. Then, after completing all 18 questions (question 6 has two parts), the staff member should inquire about any "yes" response by asking "When did this problem first develop?"; "How long did it last?"; "Did the problem develop before, during, or after you started using substances?"; and, "What was happening in your life at that time?" This information can be written below each item in the space provided. There is additional space for staff member comments at the bottom of the form.
iv. Whether the MHSF-III is read to a client or they read the questions and responds on their own, the completed MHSF-III should be carefully reviewed by a staff member to determine how best to use the

information. Information gathered from this tool about mental health concerns should be included in the SSM Mental Health category score and comments, and addressed in the Needs and Services plan.

1. It is strongly recommended that a qualified mental health specialist be consulted about any "yes" response to questions 3 through 17. The mental health specialist will determine whether or not a follow-up, face-to-face interview is needed for a diagnosis and/or treatment recommendation.
2. A "yes" response to any of questions 5 through 17 does not, by itself, insure that a mental health problems exists at this time. A "yes" response raises only the possibility of a current problem, which is why a consult with a mental health specialist is strongly recommended.

v. The MHSF-III features a "Total Score" line to reflect the total number of "yes" responses. The maximum score on the MHSF-III is 18 (question 6 has two parts). Higher total scores indicate increased need for evaluation and treatment in a MH program.

d. Comparing scores between the Mental Health Screening Form III tool and the SSI-AOD tool can help you determine whether a MH or SUTS program is the right fit for your client. While decisions about placement should not be based on these scores alone, they can provide vital information in the decision making process. The desires and priorities of the participant should also be considered, along with input from other providers and collaterals, and your own judgement about the client's needs when advocating for placement for your participant. While most programs are required to support both substance use and mental health needs, if one need is much higher than the other, it makes more sense to prioritize that need in treatment and link the client to the appropriate program to address that priority need.

Safety/Risk Assessment

Assessing for safety is an ongoing process that helps us ensure our participants remain safe, and are connected to crisis supports as needed. Safety assessments also help us track whether reports need to be completed with Adult Protective Services (APS) or Child Protective Services (CPS) due to reportable behaviors or circumstances.

As outreach providers, we should always be assessing for safety and taking steps to make things safer for ourselves and our participants/collaterals.

1. This risk assessment can be as informal as observing the environment and appearance/behavior of the participant and others in the area to determine risk factors that may lead to unsafe situations.

2. When risk factors are observed, then assessment can move to verbal questioning of the participant to better understand what they are thinking, feeling, and planning, and to help better understand how intense their emotions and intent for action are. The information gathered during this verbal assessment may help you determine what you can safely do with/for the participant that is within your scope of practice, and/or may provide details that you can share with crisis resources if they are needed in the situation.
3. Assessment questions will vary greatly depending on the particular risks, and on the participant/collateral you are working with. If you are ever unsure about what to ask, or whether it is safe to continue assessing the participant, stop to consult with your manager.
4. Assessment for safety should include understanding risks to: yourself and co-workers, as well as to the participant, and the collaterals involved.
5. Staff must remain within their scope of practice when assessing for risk and safety. To help you easily determine when it is appropriate to assess and plan for safety with participants/collaterals, and what to do when it's not appropriate for your role, we use a stop light system.
    a. **Green Light**: When a client is not currently experiencing suicidal thoughts (SI), homicidal thoughts (HI), actively self-harming (SH) or actively threatening danger to others, you may complete safety planning with them and/or their collaterals.
        i. We get many referrals who come in with a history of dangerous situations and even suicide risk and/or attempts. This history does not automatically prevent us from safety planning with them and their collaterals, and in fact may be a good indicator that we should be safety planning with them. This can also be viewed as our version of an admit treatment plan, identifying and addressing the participant's most urgent needs.
        ii. If the client is not currently or very recently suicidal, homicidal, threatening harm to others, or actively self-harming, you may safety plan with them and/or their collaterals.
        iii. Safety planning should center on prevention, meeting basic needs, and providing appropriate resources to help maintain stability.
        iv. The client should be stable before and during the safety planning process.
        v. If the client moves from a place of safety and stability toward crisis, high risk, and/or danger to self or others during the planning process, stop and connect them to crisis supports immediately.
        vi. Safety plans work well in a variety of situations including:
            1. Preventing suicide and managing suicidal thoughts
            2. Preventing or reducing self-harming behaviors
            3. Preventing or managing a drug relapse
            4. Preventing or managing DV in a relationship

5. Increasing safety when living on the streets/sleeping rough
6. Managing homicidal thoughts and urges to harm others
7. Reducing other risky behaviors
8. Planning for how to manage other risky situations

b. **Yellow Light**: When a client has recent (but not current) SI or SH and is at risk for crisis or danger to self/others in the near future, you should consult with your supervisor and/or IHOT clinician on the county team before proceeding. In fact, anytime you are unsure about whether a participant needs crisis supports or is demonstrating suspected reportable behaviors, you should consult with your supervisor or another manager as soon as possible.
   i. Sometimes it is less clear whether the participant is in crisis or stable, often because they are somewhere in-between. This is when you are in the yellow zone and need to proceed with caution and consult with your Supervisor and/or IHOT county clinician.
      1. The higher the risk to the participant and/or others, the more time sensitive this consultation is.
      2. Your supervisor may advise you to proceed with safety planning with the client, or to connect the client to the IHOT clinician or other crisis resources.
      3. If you are asked to safety plan with the client and circumstances change in a way that increases risk, stop and consult again.
      4. If client goes into crisis or becomes a danger to themselves or others at any time, immediately connect them to crisis resources (i.e. MCRT, TAY Crisis Line, EPS, 9-8-8/Crisis hotlines, 911, etc.)
      5. This also applies to situations where you suspect abuse, and are unsure if the behaviors are reportable, or if the victim/target of the abuse is currently in danger. Best practice in these situations is to consult with a manager to help determine next steps.
   ii. Some examples of the yellow light zone are:
      1. Participant has recent suicidal thoughts or attempt, but not within the past 24 hours, and not currently. (Ask about their thoughts, level of intent, plans, and means so you can consult effectively).
      2. Participant was just released from EPS where they were assessed for risk. (Seek out their safety plan and discharge paperwork and help client follow their plan).
      3. Participant has recently engaged in risky/self-harm behaviors (i.e. cutting, driving under the influence, punching walls, etc.), but doesn't have open wounds and is not currently having thoughts about self-harm.
      4. Participant is in a potentially abusive relationship.

5. Participant vaguely threatens violence toward others, but doesn't give a specific target or plan.
6. Participant seems like they may meet the criteria for grave disability (unable to meet their own basic needs).

c. **Red Light**: When a client is sharing that they are actively feeling suicidal (having thoughts, a plan, and means increases risk) OR that they are actively self-harming (have open wounds or means and intent to self-harm imminently) or having active homicidal thoughts (especially if they have a target and/or means) or if they are threatening violence toward a specific target or may imminently be a danger to others, you should connect them to the local mobile crisis response team (MCRT) or other appropriate crisis resources immediately.
   i. Call and connect to qualified crisis support provider immediately (i.e. MCRT, TAY Crisis Line, EPS, 9-8-8/Crisis hotlines, 911, etc.)
   ii. Occasionally you may be working with a participant who is actively in crisis or is a present danger to themselves or others. This is the Red Light Zone and means you should NOT be safety planning with the client. If a client is in the red light zone, you should immediately work to connect them with a crisis support provider.
   iii. Crisis supports to connect participants to:
      1. Mobile Crisis Response Team (MCRT)
      2. BWC TAY Crisis Line
      3. 9-8-8
      4. Emergency Psychiatric Services (EPS)
      5. 9-1-1
      6. D.V. resources like Next Door
      7. Sessions with the county IHOT Clinician (for SH Assessment and safety planning)
   iv. How to know if you are in the red light zone:
      1. SI – Active suicidal ideation observed in client
      2. SH – Active Self-Harm behaviors observed in client
      3. DV – Active domestic violence, especially if the client is an elder
      4. HI – Active homicidal ideation observed in client
      5. Danger to others – Actively threatening or attempting to harm others (especially a specific target, or with weapons/the means to harm others)
      6. Grave Disability – unable to feed self, in need of immediate medical care, disorganized to the point of extreme vulnerability (Start with MCRT, 9-1-1 if urgent or advised to)
      7. External Risk (9-1-1) – Someone threatening with a weapon, or other similar external safety risk.

v. Remember do not physically intervene in unsafe situations. Your safety comes first, participant safety is second.

6. Assessing for safety: Suicide
    a. You do not need to ask every client at every meeting about suicidal ideation (SI). You only need to assess for suicide risk if it comes up with a particular participant.
        i. I.e. Participant tells you they are having suicidal thoughts directly ("I want to kill myself.") or indirectly ("I just want it all to end."); or if participant has a recent attempt with ongoing risk.
    b. You can assess for safety (red/yellow/green category), ask questions to gather information, and determine what level of support is needed.
        i. If a client is actively suicidal, homicidal, or experiencing grave disability, further assessment by a clinician is needed, and they should be linked to an appropriate provider as soon as possible. If client is demonstrating suicidal risks and you are at all unsure about their safety, please consult immediately or link participant to crisis resources for assessment
        ii. Other questions you can ask (to gather information and determine red/yellow/green category):
            1. When is the last time you thought about suicide?
            2. Are you currently thinking about harming or killing yourself?
            3. Do you have any plans for how you would do it?
            4. Do you have the means to carry out your plan?
            5. How intent are you on completing this plan?
                a. If no plan: How intent are you on killing yourself?
            6. What keeps you safe? Or what has kept you from hurting yourself in the past?
            7. Are you worried about being able to keep yourself safe?
            8. Are you willing to talk to someone about this and get help?
7. Assessing for safety: Self-Harm
    a. Self-harm (SH) most often comes in the form of cutting, however there are many other risky behaviors that can be considered self-harm, and we should be assessing for any/all of them if or when they arise.
        i. Some other examples of SH are:
            1. Using substances in risky ways (i.e. sharing needles, driving under the influence, using with unsafe people or in unsafe places that could lead to harm).
            2. Hair pulling or skin picking that leads to bleeding skin/scalp.
            3. Hitting walls/hard surfaces with head, fist, feet, or other body parts.
            4. Hitting self with own fist or other objects
            5. Refusing to eat and/or immediately purging all food after intake

6. Exposing self to trauma and/or triggering reminders when unable to cope
7. Other examples you have seen?

b. Assessing for SH should also start with observations then move into verbal questioning if needed.
    i. Here are some questions you can ask:
        1. Are there any open or healing wounds on the participant?
        2. Has client talked about any SH behaviors recently?
        3. Is participant able to determine/understand when behaviors are safe vs. unsafe?
        4. Is participant able to keep any wounds clean and bandaged so they will heal?
        5. Does participant have access to means to engage in SH behaviors (i.e. a blade for cutting)?
        6. How much risk does the SH behavior put the participant in?
        7. Is the participant willing to make changes or take steps toward more safe behaviors?

c. If SH behaviors are current or highly likely and put participant at moderate to high risk of harm, please consult with your supervisor if appropriate, or connect directly to relevant resources immediately if risk is too high to wait for additional input.

8. Assessing for safety: Danger to others
    a. Danger to others covers homicidal ideation (HI) as well as threats and acts of violence toward others.
    b. You do not need to ask every participant at every session if they are having HI or violent thoughts/urges, however you should be mindful of signs and admissions of these thoughts and behaviors. As with other assessments, start with observations and then move into questioning when appropriate. Danger to others often comes out of either anger or fear triggers, so pay special attention to how you participant responds to these triggers as a part of your observational assessment.
    c. Note that many of our participants do not have the skills to manage emotions, including anger and fear, very well. Keep this in mind and recognize that there is a difference between a participant venting their anger, and making actual threats of violence. If you are unsure about this distinction for your participant, try to help them calm and regulate their emotions first, then ask more questions about what they are thinking, feeling, and intending to do. You may also check in with other team members and witnesses to see how they are interpreting the participant's behavior to gather more context.
    d. If the participant is unable/unwilling to regulate their emotions and continues to escalate, that is an indication that you may need to contact other crisis supports

to help maintain safety for yourself and others. Remember that if you ever feel unsafe, you should leave the situation immediately, then follow up right away to contact crisis supports.

e. Here are some questions you can ask to further assess for danger to others:
    i. I see that you are very upset right now, can we do a calming activity together to see if it will help you feel better?
        1. This question can be used when the participant is triggered to see if they are willing to self-regulate in a safe way.
    ii. When you have thoughts/urges to hurt others, is there a specific person you have in mind?
    iii. How often do you have HI/thoughts of harming others?
    iv. How have you prevented yourself from hurting others in the past? Is that something you could try now?
    v. Do you want to hurt that person, or anyone else, right now?
    vi. Do you have a gun or any other weapons that you might use to hurt others?
    vii. Do you have a plan for how you would hurt that person?
    viii. How intent are you on carrying out this plan?
    ix. What would it take to keep you from hurting this person/others?
    x. What are some consequences you might face if you acted on your plan? Are those consequences worth it to you?
    xi. How would you react if you knew someone else had a similar plan to harm you?
        1. Caution, this question is an attempt to evoke empathy, but should not be used with a participant who experiences paranoia or psychosis, as it may trigger those symptoms.

9. Assessing for safety: Risky Situations
    a. Risky situations is a broad category that covers everything from rough sleeping to DV in relationships to vulnerability to community violence.
    b. Due to this broad definition, it is difficult to provide specific questions for assessment, but like the others it starts with what you observe and moves into having a conversation with those involved to better understand the risks and what can be done to minimize them for the participant/collaterals.
    c. Because risk can come in many forms, it is important to be situationally aware and listen to your instincts about whether circumstances are risky for yourself or your participant (and/or their collaterals).
    d. Some things to be on the lookout for:
        i. Domestic violence/Intimate Partner Violence:
            1. Does participant (or their partner/family member) have visible bruises or defensive wounds?

2. Does participant look to partner before answering even basic questions?
3. Has participant shared any concerns about violence or intense arguments in their relationship?

ii. What is participants living situation? What risks are posed by the setup they have?
iii. How safe/dangerous are the people around participant (i.e. family members, romantic partners, people who live with/near participant, community members with access to participant, etc.)
iv. How does participant's substance use factor into these or other risk factors?

10. Safety Planning within scope
    a. When you have determined that a participant and/or collateral is in need of a safety plan and that it is within your scope to complete one with them (based on Red/Yellow/Green category as explained, in 3.f. above) you can either choose a template to follow, or create a plan from scratch depending on what you have available and what meets the needs of the participant/collateral.
    b. Safety Plans should include:
        i. The name of the participant (who the plan is for)
        ii. The date the plan is being created (always ensure participant is following the most recent plan)
        iii. Contact information for support before, during, and after a crisis. This can include providers, agencies, and natural supports.
        iv. Description of the risky behavior or circumstances
        v. Description of warning signs and/or triggers
        vi. List of action steps for safety including accessing appropriate resources. Use concrete steps here, we are not building wellness skills at this point. Use skills they already have and build on resources they can access.
        vii. Safety planning for families/collaterals – what is different?
    c. For best results create the plan with the participant/collateral. However, you may write the plan on their behalf and share it with them if that works better for their situation.
    d. Have commonly used resources contact information handy to include on the safety plan while in the field.
    e. Ask the participant/collateral what skills and resources they already use/access and include them in the plan.
    f. Define the roles of each contact/resource along with when they are available to be contacted, and when the participant/collateral should reach out to them.
    g. Write in plain language that the participant/collateral can understand, and write it from the plan holder's point of view.

h. You may need to write a safety plan for both the participant and for their collateral around the same concern, but from different POVs and with different action steps, warning signs, and resources

Common Crisis Supports - Contact Information

Crisis supports – If a participant is in crisis, it is our job to link them to the appropriate crisis supports and keep them as de-escalated as possible until those supports arrive. IHOT is a non-clinical program, so our staff should not be conducting full safety assessments or completing safety plans with participants in their moment of crisis. The list below includes some available crisis support options we can link our participants to and the services they may provide.

3. TAY Line: 408-278-2585
    a. This 24/7 crisis line is for all BWC clients and will be answered by our Contact Cares hotline volunteers. The volunteer will then contact the MH Division manager on call, and the manager will assign a clinician to respond within the hour.
    b. This hotline is for use when the participant needs support and evaluation for harm to self or others. If needed a 5150 can be made by this team in most instances.
4. Mobile Crisis Response Team (MCRT): 1-800-704-0900 (for adults age 18 and over)
    a. This 24/7 crisis line is for adults in Santa Clara County. The teams respond to individuals in crisis that exhibit mental health symptoms, may be suicidal, or at-risk and need an evaluation for psychiatric hospitalization. Teams are made of up licensed clinicians and therapists with training and expertise in crisis response. MCRT clinicians assess the situation and if there is a possibility of violence, the clinicians will call for law enforcement support. Officers may stand by or assist in calming the situation, depending on the circumstances. Mobile Crisis Response Teams work closely with law enforcement, crisis hotlines, the community, and family members. The services include crisis screening, intervention, de-escalation services, and referrals to community resources.
5. Trusted Response Urgent Support Team (TRUST): 9-8-8
    a. The 9-8-8 crisis call center is available 24/7 and links to local crisis supports based on the caller's area-code. Operators at the call-center are trained in crisis response and can support callers over the phone, as well as by linking them to other appropriate crisis support services.
    b. Callers may ask for TRUST to come out and evaluate and support a person in crisis. This option is used to reduce contact with law enforcement when experiencing mental health crisis.
    c. Callers may also ask for MCRT or referral to IHOT through this hotline, or can be transferred to a navigator that can help the caller access a variety of MH resources.
6. 9-1-1: This emergency response number should be called when medical and/or law enforcement response is needed.

7. Other crisis hotlines for over the phone support:
    a. Trevor Project: 1-866-488-7386 or Text 'START' to 678-678
        i. This crisis line is geared toward LGBTQ+ youth, but may be used by anyone in crisis. More information at https://www.thetrevorproject.org/
    b. Trans Lifeline: (877) 565-8860
        i. This crisis line is geared toward Trangender, Non-Binary, and Gender Expansive folks, and provides peer support for the trans community that's been divested from police since day one. More information at https://translifeline.org/
    c. Crisis Text Line: Text HOME to 741741
        i. This crisis text line provides support when the person in crisis is unable or uncomfortable to talk out loud about their needs. Volunteer counselors respond to the texts in real time to support and de-escalate those in crisis. More information at https://www.crisistextline.org/
    d. RAINN: 800-656-HOPE (4673)
        i. RAINN (Rape, Abuse & Incest National Network) is the nation's largest anti-sexual violence organization. RAINN created and operates the National Sexual Assault Hotline in partnership with more than 1,000 local sexual assault service providers across the country and operates the DoD Safe Helpline for the Department of Defense. RAINN also carries out programs to prevent sexual violence, help survivors, and ensure that perpetrators are brought to justice. More information at https://www.rainn.org/
    e. National Domestic Violence Hotline: 800.799.SAFE (7233) or Text "START" to 88788
        i. Every contact to The Hotline is personal. Some people who reach out identify as survivors of abuse, some as concerned friends or family members, some as abusive partners seeking to change themselves. The Hotline advocates are here to listen without judgement and help you begin to address what's going on in your relationship. The Hotline services are always free and available 24/7. More information at https://www.thehotline.org/

Needs & Services Planning

Once sufficient assessment information has been gathered with the participant and their collaterals, that information should be consolidated into a Needs & Services plan (NSP) that will act as a roadmap for ongoing services and help determine readiness for discharge and completion of aftercare planning.

1. The CM is responsible for writing the NSP, however supporting staff should help the CM by providing assessment information and relevant context as needed.
2. The NSP includes the following:

   a. Needs - List of identified participant/collateral needs developed from the assessments and motivational interviewing completed with participant and/or collaterals.
      i. The template lists all categories of needs found on the SSM; however the CM only needs to enter information for the needs identified as high priority by the participant/collateral(s).
   b. Goals – CM shall develop goals for each identified need.
      i. These may be goals staff expect to reach by discharge from IHOT, or larger goals that will be only partially completed before being handed-off to participant's new providers during transfer to MH/SUTS program. When possible, the difference should be specified in the activities/support section.
      ii. These goals should be developed collaboratively with the participant and/or collaterals whenever possible and appropriate.
   c. Activities/Supports – List of steps that staff will take to address each of the identified needs and work toward completing goals.
   d. Who/How Frequent - Identifying which staff are responsible for each step and when/how often the step will be addressed.
   e. Signatures – The CM should sign the NSP to show completion of the document. The participant and CSS may also sign the document when appropriate (i.e. when the plan is being shared with the participant).
3. The target for completion of NSP is within 30 days of first contact with participant, however the CM may complete the NSP before or after this target date depending on circumstances of the case. Best practice is to complete the NSP as early as possible to ensure that there is a roadmap for the supporting staff as well as for the participant and their collaterals to follow throughout their time in the IHOT program.
4. IHOT staff should follow the NSP to work toward addressing all identified participant/collateral needs. Since participants are in the IHOT program for a short time (typically 120 days or less), there may be tasks IHOT staff are unable to complete before discharging/transferring the participant out of IHOT services; these tasks should be included on the aftercare plan along with appropriate resource information to help the participant, their collaterals, and/or their new treatment team complete the remaining tasks to meet the participants' needs and achieve their goals.

Service Timeline & Details

1. First contact attempts
   a. Staff shall make every effort to make first in-person contact with new referral within 3 business days.

   b. Assigned staff shall start making calls and following leads from the referral on the same day whenever possible, or next business day at the latest.
      i. Staff shall try the same number at least 3 times on different days and at different times before abandoning the lead.
   c. Staff shall make attempts to contact new referrals daily for the first 3 days, then 2x/week minimum until all leads are exhausted.
   d. Staff shall note the first attempts and successes with contacting both participant and their collaterals, this information will be recorded on the participant tracker.
2. Service dosage expectations
   a. For "average" participants – Staff should typically be meeting with participants 2x/week for approximately 1 hour per visit. The dosage then is 2 hours per week, and these hours can be distributed throughout each week in whatever way meets the needs of the participant.
   b. For "high needs" participants – For participants with acute mental health needs or safety issues that put them at increased risk, staff should meet the participants needs by meeting as frequently as required to help them maintain safety, up to 1x/day. However, these should be rare cases and staff should consult with CM and PM to determine appropriate dosage and next steps with participant. It is important to consider the strain that a high needs participant is putting on your ability to meet the needs of the rest of your caseload; consulting can help you balance these competing needs as well.
   c. For inactive participants – Best practice is to attempt to reach/develop new leads on inactive participants 1-2x/month; however this may be done more or less frequently depending on staff's capacity. Participants will be moved back to active status if/when any new leads are developed.
   d. For "lower needs" participants – Some participants are less willing to be engaged, are higher functioning, or otherwise need less frequent interactions. These participants should be contacted 1x/week on average.
   e. Case by case basis – The above dosage targets are all subject to variability; each participant's dosage will be managed on a case by case basis to ensure their needs are being met and that we are still able to serve everyone else on our caseloads adequately.
3. Discharging
   a. When participant refuses services – if staff receive a "hard no" from participant or repeated "soft no's" from participant at any time when IHOT services are offered, then the participant should immediately be discharged.
      i. Code as "Service Refusal"
         1. With no contact – if staff have been unable to find and contact the participant for the full duration of the program, the participant will be discharged on day 120 from intake.

ii. Code as “Discharged/Withdraw without all goals met” and “Whereabouts Unknown”.
    1. After participant AWOL – if staff have made contact with participant who agreed to IHOT services/continued contact from IHOT staff, but then lose contact with participant and are unable to find the participant again within the 120 days from intake, participant will be discharged on day 120.
iii. Code as “Discharged/Withdraw without all goals met” and “Whereabouts Unknown”.

b. When participant is incarcerated – if a participant is incarcerated at time of referral, or becomes incarcerated while in the IHOT program:
    i. Staff should attempt to determine the participant’s anticipated discharge date from jail.
        1. If relatively soon (i.e. there is enough time to potentially connect the client to other services within 120 days from participant intake into IHOT), then staff may continue to work with participant. Staff may move participant to inactive status while participant is incarcerated after consulting with CM and/or PM for confirmation and planning.
            a. Participant will be discharged when one of the above criteria i-iv or below criteria 2C is met.
        2. If not relatively soon, staff should contact the county team to request a transfer to their staff’s caseload, and/or discharge from our IHOT program.
            a. If discharging only, code as: “Administrative”, “Client does not meet program criteria”, and “Incarcerated”
            b. If transferring to county IHOT team, code as: “Administrative”, “Transfer to similar program”, and “Incarcerated”
        3. If unable to determine, consult with CM and/or PM to decide next steps (i.e. discharge, inactive status, or advocating for participant in court).
    ii. Staff should advocate for participant’s case to be moved to MH Court whenever appropriate. If participant has multiple cases, staff should advocate for all cases to be consolidated into MH court proceedings.
    iii. Staff should not offer recommendations for MH services for participant, especially if not asked.
    iv. If court staff (i.e. judge, public defender, etc.) ask IHOT staff for MH services recommendations, staff may only state that the participant’s eligibility for IHOT services also makes them eligible for FSP or higher

level of care, and that is the level of care we would advocate for at the call center.

v. Once participant is connected to MH court, they should be discharged as a successful graduation.
    1. Code discharge as: “Graduation”, “Clinician requested because goals met”, and check all appropriate connections/participant areas of improvement.
    2. You may not be able to connect with the participant directly to provide certificate of completion or other items. However, you may provide an aftercare plan to the public defender if appropriate.

vi. Staff should only attend participant court dates when:
    1. Staff need to gather more information about the client that can't be found elsewhere (med compliance, discharge timeline, etc.);
    2. Client may be discharged at the hearing, and in need of immediate support/linkage in order to meet basic needs;
    3. Staff need to advocate for the client to be connected to MH Tx court and/or have all their cases consolidated there; or
    4. Participant and/or their public defender have specifically asked IHOT staff to attend.

c. With ongoing contact but no successful linkage – If the participant has been engaging in IHOT services, but is unable or unwilling to make successful connection to MH/SUTS programs during the 120 days, then participant should be discharged. Consult with CM and PM to identify when it is no longer appropriate to keep serving a participant who has no intention of connecting to MH/SUTS programs and is not being successfully moved toward readiness.
    i. Code discharge as “Withdraw/Discharge without all goals met”, and “Goals partially met” if participant was successfully linked to any other useful community resources.

d. With successful graduation
    i. The goal is to make the connection as early as possible and within 120 days of intake.
    ii. However, it can happen at any time when client is ready to be connected to MH/SUTS program and has successfully engaged in approximately 2 sessions with new providers. We may request an extension if the client is close to making the connection at or after 120 days has passed in the IHOT program.
    iii. IHOT staff should facilitate a warm hand off of participant to new providers by:
    iv. Calling the call center with the client to provide support and advocate for the correct level of care for the participant.

v. Creating an aftercare plan with the participant that can be shared with the participant, their collaterals, and/or their new treatment team. This plan should include what steps need to be taken to address unmet participant needs, and steps to take to maintain current participant progress.
vi. Supporting the participant with attending the first few (approximately 1-3) sessions with new providers (including intake sessions, assessment sessions, therapy sessions, case management sessions, and/or psychiatrist/med management sessions) to help them engage with new providers successfully.
vii. The purpose of keeping a participant open in IHOT while they attend their first few sessions is to ensure they are engaging and can be successful in the program. The number of sessions attended with new providers is less important than the agreement among all providers and participant that participant is successfully engaging in the program.
viii. If it appears that the participant may be discharged from the new program due to difficulties engaging with the new providers, IHOT should keep the participant open and support the participant with engagement at the new program or transfer to a more appropriate program where the participant may have increased chance of success.
ix. IHOT staff should celebrate the participant's successful graduation from IHOT program with the participant by:
x. Providing the participant with a Certificate of Completion signed by IHOT PM.
xi. Giving the participant an incentive/gift such as a gift card or items that may support the participant in being successful moving forward.
xii. Promoting a sense of pride in the participant's accomplishment and hope in their future success in the new program.
xiii. Code discharge as: "Graduation", "Client requested because goals met", and check all appropriate connections/participant areas of improvement.

Case Management and Linkage

The heart of our work in IHOT is helping our participants get connected to any services available that meet their basic needs, help them prepare for engaging with MH/SUTS programs, and eventually to access those MH/SUTS programs when they are able to engage successfully. This includes identifying appropriate resources, providing information to participants/collaterals about those resources, helping to make the connection to those resources, advocating on behalf of the participant, and teaching the

participant and/or their collaterals how to advocate for themselves to get their needs met and be successful in linked programs.

Whenever supporting participants with making connections to community resources, we should provide the least amount of support needed to ensure the participant is successful in making the connection. This will allow the participant to do as much as possible for themselves, while still ensuring they are supported by our team and successful with their connection. We want to teach participants how to get their needs met independently and help them increase their autonomy, rather than to just do everything for them, which may keep them dependent on our systems of care. For higher functioning and independent participants, this may look like giving them contact information and a list of questions to ask and information to provide, then asking them to follow up before your next meeting where you will check in with them about how it went and troubleshoot any problems/barriers that came up. For lower functioning participants that need more support, this may look like making the call for or with them and doing most of the talking, or even providing transportation and in-person support for the service they are being linked to.

1. Mental Health services – When participants indicate readiness to engage in a behavioral health program, staff should support them with contacting the Santa Clara County Behavioral Health Hotline at 1-800-704-0900 and advocate for the participant to be connected to a program at the appropriate level of care.
    a. IHOT participants are automatically eligible for Full-Scope Partership (FSP) or Intensive FSP (IFSP) level of care
    b. Participants who are unhoused may be eligible for Assertive Community Treatment (ACT)
    c. Participants who are in need of MH care due to severe MH symptoms/diagnosis may be eligible for AOT program. Please consult with your Program Manager before making an AOT referral.
    d. Participants who are relatively stable in terms of MH symptoms and who are unwilling to accept a higher level of care, may advocate for an outpatient level of care.
    e. Staff should discuss the services provided and client expectations for different programs/levels of care that may be offered and help the participant understand the benefits and risks accepting or rejecting each program/level of care being offered.
2. Substance Use Treatment Services (SUTS) programs – If a participant is using/misusing substances and indicates readiness to engage in a SUTS program, staff should support them with contacting the Santa Clara County Behavioral Health Hotline at 1-800-704-0900 and advocate for the participant to be connected to a SUTS program at the appropriate level of care.

a. If a participant is requesting in-patient programming, staff should help them advocate for that level of care.
b. If only outpatient programs are being offered to the participant, staff should advocate with the call center representative and receiving SUTS program staff on behalf of the client, to identify barriers that may interfere with the participant's ability to engage in the program at an outpatient level.

3. Staff should also work with the participant to identify and try to reduce those barriers so that the participant has an increased chance of success with the outpatient SUTS program.
4. Staff may also need to link the participant to supplementary resources, including but not limited to:
    a. Alcoholics Anonymous (AA), Narcotics Anonymous (NA), or relevant sub-group (i.e. Crystal Meth Anonymous/CMA)
        1. Depending on the participant's drug of choice and demographics, a more targeted group may be available and more appropriate for the participant than a larger more generic AA/NA group.
        2. Staff should research which meetings are available and accessible for the participant and offer a variety of choices when linking to these kinds of peer-run meetings.
        3. Staff should encourage participants to try out different groups until they find one that is comfortable and meets their needs. Not all meetings are the same, the attendees and focus of the groups can vary widely and have a large impact on how the participant feels in the group. When a participant finds the right fit, these groups may help them to process the underlying issues that feed their addiction and to find the support they need to stay sober if that is their goal.
        4. Note that the main focus of these organizations is often to promote complete sobriety in the attendees. That works well for some folks who struggle with addiction, but doesn't work for everyone. If your participant does not want to make complete sobriety and ongoing abstinence their goal, this may not be the right fit for them. In these cases, consider harm reduction and other relevant resources instead.
    b. Recovery Café. Per their website at Recovery Cafe San Jose | Mission & Vision (recoverycafesj.org) :
        1. In this sanctuary from the streets, the Cafe helps participants develop tools and access other community resources for stabilizing recovery. Meaningful daily activities and a positive community are powerful forces that help break the patterns and challenges of addiction, unemployment and homelessness.
        2. Recovery Cafe San Jose is a place for:

a. Those who have been recently housed and want to stay on track with their goals
b. Those who complete residential treatment programs and need daily structure and support
c. Those living with a diagnosis who need community to combat isolation
d. Young adults dealing with the pressure to use substances to cope with life's challenges
e. Parents struggling with substance use who want to keep their families intact
f. People living on the street seeking to make steps toward recovery and stability
g. Those who are reentering the community from prison and seeking a sober and strong re-entry

c. Sobering Center – for short term (24 hours or less) support while sobering up, especially from alcohol.
d. Detoxification Programs – for short term (up to 2 weeks) inpatient detoxification support.
    1. Some long-term SUTS programs require clients to complete a detox program first, before they will complete intake into the long-term inpatient or outpatient program.
e. Sober Living Environment – for participants who are in recovery. This may be a good housing option for participants who are leaving detox and starting an outpatient SUTS program.
f. Crisis supports – If a participant is in crisis, it is our job to link them to the appropriate crisis supports and keep them as de-escalated as possible until those supports arrive. IHOT is a non-clinical program, so our staff should not be conducting full safety assessments or completing safety plans with participants in their moment of crisis. *IHOT staff does not have the authority to transport a person involuntarily to an emergency facility.* The list below includes some available crisis support options we can link our participants to and the services they may provide. (May need to remove the below list and put in a separate attachment for ease of updating – may do the same for SUTS supports)
    1. BWC Afterhours Support 408-278-2585
        a. This 24/7 crisis line is for all BWC clients and will be answered by our Contact Cares hotline volunteers. The volunteer will then contact the MH Division manager on call, and the manager will assign a clinician to respond within the hour.

   b. This hotline is for use when the participant needs support and evaluation for harm to self or others. If needed a 5150 can be made by this team in most instances.
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   b. Callers may ask for TRUST to come out and evaluate and support a person in crisis. This option is used to reduce contact with law enforcement when experiencing mental health crisis.
   c. Callers may also ask for MCRT or referral to IHOT through this hotline, or can be transferred to a navigator that can help the caller access a variety of MH resources.
4. 9-1-1: This emergency response number should be called when medical and/or law enforcement response is needed.
5. Other crisis hotlines for over the phone support:
   a. Trevor Project: 1-866-488-7386 or Text 'START' to 678-678
      i. This crisis line is geared toward LGBTQ+ youth, but may be used by anyone in crisis. More information at https://www.thetrevorproject.org/
   b. Trans Lifeline: (877) 565-8860

i. This crisis line is geared toward Trangender, Non-Binary, and Gender Expansive folks, and provides peer support for the trans community that's been divested from police since day one. More information at https://translifeline.org/

c. Crisis Text Line: Text HOME to 741741
   i. This crisis text line provides support when the person in crisis is unable or uncomfortable to talk out loud about their needs. Volunteer counselors respond to the texts in real time to support and de-escalate those in crisis. More information at https://www.crisistextline.org/

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   i. RAINN (Rape, Abuse & Incest National Network) is the nation's largest anti-sexual violence organization. RAINN created and operates the National Sexual Assault Hotline in partnership with more than 1,000 local sexual assault service providers across the country and operates the DoD Safe Helpline for the Department of Defense. RAINN also carries out programs to prevent sexual violence, help survivors, and ensure that perpetrators are brought to justice. More information at https://www.rainn.org/

e. National Domestic Violence Hotline: 800.799.SAFE (7233) or Text "START" to 88788
   i. Every contact to The Hotline is personal. Some people who reach out identify as survivors of abuse, some as concerned friends or family members, some as abusive partners seeking to change themselves. The Hotline advocates are here to listen without judgement and help you begin to address what's going on in your relationship. The Hotline services are always free and available 24/7. More information at https://www.thehotline.org/

5. Medical/dental evaluation and care – Staff should ensure that participants are correctly enrolled in MediCal and/or MediCare, and will provide assistance to helps uninsured participants to enroll.
   a. Staff should also help participants to identify their primary care doctor and encourage them to complete a medical evaluation if they haven't had one recently. Staff should continue to encourage and support participants with

engaging in preventative and maintenance health care while they are in our program.

b. Staff should also support participants with identifying their dental coverage, and accessing dental insurance if needed. Staff should support participants with identifying a dentist who will take their insurance and encourage participants to make regular dental appointments to maintain good dental health.
c. Staff should inquire with participants about their needs in these areas and provide the support that is required and requested for the individual participant. If participant refuses support in these areas, staff may use motivational interviewing techniques to attempt to move participants toward readiness to engage in medical and/or dental care, but should never force participants to engage in care against their will.

6. Housing/Shelter – When participants indicate housing needs, staff should make efforts to link participants with shelter and housing program options, including:
    a. Here4You hotline (408) 385-2400 – This is the main hotline that manages area shelters and can help match your participant to an open bed. Start by calling this hotline if your participant needs housing support, they may give you other options to try as well.
    b. VI-SPDAT (Service Priority Decision Assistance Tool) – all IHOT staff should be trained and certified to access HMIS and provide VI-SPDATs to individuals and families. Participants may also complete a VI-SPDAT at any shelter or with other outreach programs. IHOT Staff should ensure that any housing needy participant completes a VI-SPDAT as soon as possible, and keeps it updated with current information so that they are eligible for appropriate housing supports as they become available.
    c. Temporary Severe Weather Shelters (Warming Centers or Cooling Centers) – when there is severe weather the county often opens additional warming/cooling centers to help prevent injuries/deaths from the effects of the weather. Vulnerable participants should be provided with this information whenever severe weather alerts are announced to promote their safety.
    d. TAY Drop-In Center (DIC)/Respite – Transitional Aged Youth (up to age 25) may receive services from our BWC Drop-In Center and overnight respite. Staff should provide eligible participants with DIC contact information and make a warm connection whenever possible.
    e. Short-term crisis centers – If your participant is in a near crisis state (in terms of their mental health and suicidal thinking in particular) there may be more specific options available to help stabilize them and prevent interactions with EPS. These options include, but are not limited to: Momentum Crisis Stabilization Unit (24 hours or less stay), Blackbird House (2 weeks or less

stay), and Crisis Residential programs (2 week stay – may require 24 hour care referral).

f. Red-Cross – If participant housing is impacted by a man-made or natural disaster such as fire or flooding, Red Cross may have additional shelter options available to support them and staff should help participants research these options.

g. Flex-funds – Staff may use IHOT flex-funds to support with some housing needs with prior approval from Program Manager and/or Director of mental health services. All other programs and resources should be exhausted before flex-funds are used.

7. Other Basic needs – food, clothing, laundry, and hygiene
    a. Often times our participants are in need of basics and don't have the resources to get these needs met. IHOT staff should provide resource lists to participants who identify a basic need to help them meet those needs. These resources may include, but are not limited to: Food banks, clothing banks, laundry facilities, Dignity on Wheels and/or other showering/hygiene supports.
    b. We may also provide our participants with an outreach pack that includes some basic necessities including: first aid kit, socks, snacks, backpack, hygiene kit, etc.
8. Help with obtaining documentation such as birth certificate, photo identification, and/or social security card.
    a. Our participants frequently come to us without one or more pieces of their identification documentation, in these instances, IHOT staff should make efforts to connect participants to the resources necessary for them to obtain the document(s).
    b. Again, the level of support provided is determined by the participant's level of functioning. IHOT staff may provide the relevant information and allow participants to complete the steps to obtain their documents independently, or may accompany participants to the relevant offices and support them with completing the paperwork and speaking with the office staff to obtain their documents, or somewhere in-between, all depending on how much the participant can successfully do independently.
9. Help with mainstream benefit enrollment and renewal applications (SNAP, SSI, etc.)
    a. If participants demonstrate a need for benefit enrollment(s), IHOT staff should make efforts to connect participants to the resources necessary for them to obtain access to those benefits. Staff should tailor their level of support to the participant's level of independence (see section **g.ii** for examples).
    b. Some benefits require documentation from a doctor or psychiatrist; in these instances, IHOT staff may start the process with the participant, then hand it

off to the other provider with instructions on how to complete the process with/for the participant (this information may be included in the after-care plan being shared with new providers if appropriate).

10. Legal – If participants demonstrate need for legal support, IHOT staff should make efforts to connect participant with no/low cost legal resources such as Bay Area Legal Aid.
    a. If participant is already involved in criminal justice system, IHOT staff should attempt to connect with the participant's public defender and work with them to move all relevant cases to Mental Health Diversion court. See "Outreach Activities" section 4.d for more details.
11. Transportation – Participants often need help with transportation in order to meet their basic needs, attend medical/MH/SUTS appointments, and/or get to work. IHOT staff have some temporary supports they can provide participants throughout the duration of the participant's time in the program, however staff should always be looking for more long-term solutions that participants can continue to utilize after they graduate from IHOT. Temporary supports include:
    a. Monthly bus passes – The IHOT program gets a small number of monthly bus passes each month that can be provided to participants to help them meet transportation needs. These are also useful incentives to keep the participant engaged in services with IHOT.
    b. Bag of 5 bus tokens - The IHOT program also has access to a small number of Bus token bags (each bag contains 5 bus tokens) that can be provided to participants who have fewer transportation needs and don't require a monthly pass. These are also used to bridge participants between monthly passes, as it can take up to a week to provide them with a pass for the new month.
    c. Staff supports – IHOT Staff may, but are never required to, provide transportation to participants when safe and necessary to meet participant basic needs and/or connect them with MH/SUTS services successfully. We are NOT authorized to provide transport to participants for involuntary hospitalizations.
    d. Flex-funds for repairs and other transportation related needs – IHOT staff may also request flex-funds to help participants repair their own vehicles or for other transportation-related needs per approval of IHOT Program Manager and/or MH Division Director.
12. Advocacy – IHOT staff should advocate on behalf of participants to help ensure that their basic needs are met and that they are connected successfully to appropriate programs and services. Advocacy may take many forms including asking questions for clarity, encouraging providers to meet participant needs, voting/engaging in local politics to improve circumstances of participants/community members, and more.

13. Skill building – Staff should support participants with building skills as needed to help them successfully meet their basic needs and engage in MH/SUTS programs. Often this includes building skills around self-advocacy and independent living.
14. Health information - IHOT Staff should also make every effort to provide participants with appropriate health information, including information about harm reduction, STDs, HIV/AIDS, pregnancy prevention, COVID19 and prevention, and Monkey Pox along with prevention and vaccination programs. Staff should make efforts to stay informed about new community health risks, especially those that disproportionally impact unhoused and/or other marginalized communities, so that relevant information can be shared with participants in a timely manner.

Needs & Services Planning

Once sufficient assessment information has been gathered with the participant and their collaterals, that information should be consolidated into a Needs & Services plan (NSP) that will act as a roadmap for ongoing services and help determine readiness for discharge and completion of aftercare planning.

1. The CM is responsible for writing the NSP, however supporting staff should help the CM by providing assessment information and relevant context as needed.
2. The NSP should include the following:
    a. Needs - List of identified participant/collateral needs developed from the assessments and motivational interviewing completed with participant and/or collaterals.
        i. The template lists all categories of needs found on the SSM, the CM only needs to enter information for the needs identified as high priority by the participant/collateral(s).
    b. Goals – CM shall develop goals for each identified high priority need.
        i. These may be goals staff expect to reach by discharge from IHOT, or larger goals that will be only partially completed before being handed-off to participant's new providers during transfer to MH/SUTS program. When possible, the difference should be specified in the activities/support section.
        ii. These goals should be developed collaboratively with the participant and/or collaterals whenever possible and appropriate.
    c. Activities/Supports – List of steps that staff will take to address each of the identified needs and work toward completing goals.
    d. Who/How Frequent - Identifying which staff are responsible for each step and when/how often the step will be addressed.

e. Signatures – The CM should sign the NSP to show completion of the document. The participant and CSS may also sign the document when appropriate (i.e. when the plan is being shared with the participant).
    i. If the CM would like to keep the NSP as a living document while working with the participant, the electronic form may remain unsigned until just before discharge. However copies may be printed, signed and uploaded to the chart to show participant agreement throughout the process, especially when major changes occur.

3. The target for completion of NSP is within 30 days of first contact with participant, however the CM may complete the NSP before or after this target date depending on circumstances of the case. Best practice is to complete the NSP as early as possible to ensure that there is a roadmap for the supporting staff as well as for the participant and their collaterals to follow throughout their time in the IHOT program.
4. IHOT staff should follow the NSP to work toward addressing all identified participant/collateral needs. Since participants are in the IHOT program for a short time (typically 120 days or less), there may be tasks IHOT staff are unable to complete before discharging/transferring the participant out of IHOT services; these tasks should be included on the aftercare plan along with appropriate resources information to help the participant, their collaterals, and/or their new treatment team complete the remaining tasks to meet the participants' needs.

Documentation and Tracking

All service activities must be documented in the participant's chart and some additional information may need to be tracked in other documents/forms as well. The following are the most frequently used methods of documentation and tracking.

1. Progress Notes – Services provided to participants/collaterals are recorded in progress notes and should demonstrate what the provider did for the participant and how it helped the participant meet basic needs and/or engage in services. Progress notes:
    a. Must be written for every service provided. One note may be written for all services provided for a particular participant on a given day, or separate notes for each service may be written. If it's not in writing, it didn't happen; progress notes are our proof of service.
    b. Must be written and e-signed on the same day service is provided, or within 3 business days (where date of service is day 1).
        i. Late notes (written after 3 business days from date of service) must be identified with "Late Entry" in the introduction of the note and must also contain an appropriate explanation for why the note is late.
    c. Should be written following documentation guidelines found in Santa Clara County Documentation Manual and any other relevant BWC documentation policies.

d. Should only contain information about what the writer did during the session (do not include steps taken by other providers in the session) and from the writer's point of view only.
e. Should not contain any irrelevant or incriminating information. Adjust the level of detail so that your time billed is justified and the services rendered are apparent, but unnecessary details are omitted.
f. Should avoid jargon and judgements/subjective interpretations

2. Participant Tracker – This document was provided to us by the county to help them track the relevant information about each participant that they need to run reports and ensure the program is meeting goals and desired outcomes. It is very important to keep the document up to date and accurate so that reports pulled from the information are useful.
    a. The CM for each team is responsible for updating the participant tracker, but may request support from CSS/FA to complete the tracker for a particular participant.
        i. CSS/FA must update CM on a weekly basis at minimum to support CM's completion of the Participant Tracker.
        ii. CM must update the participant tracker 1x/month at minimum before day 3 of the following month.
        iii. The Participant tracker includes:
            a. Identifying information about the participant that can be found on their referral form
            b. Participant's contact information that may need to be updated throughout the participant's engagement in the IHOT program as the participant is located and/or moves.
            c. Successful and Attempted contacts with the participant and collaterals both via phone and in-person. These must be updated every time a contact attempt is made.
            d. Demographic information about the participant that may need to be assessed for and confirmed by IHOT staff.
            e. Discharge information that must be updated by staff completing the discharge. This includes: changing color code to red if unsuccessful or blue if successful graduation, entering discharge date, and entering reason for discharge.
        iv. The participant tracker should be as accurate and up to date as possible at any given time, but especially at the beginning of the month when it is shared with the county, so that reports pulled from the information are also accurate and informative.
    b. The Program Manager is responsible for sending a copy of the updated participant tracker to the County Contract Manager 1x/month on day 3-5 of the month.

3. Participant Chart
    a. Cost Center Open form completed and signed by staff opening participant in our HER system, AWARDS: This document should be completed at the same time as admission into the program while opening the participant in AWARDS.
    b. SSM & Assessments entered/uploaded by CSS/FA assigned to case: Assessments should be completed as early as possible after meeting with the participant. Assessments are to be entered in/uploaded to the participant's chart in AWARDS within 1 week of completion, and must be completed prior to discharge.
    c. Authorization to Release Information (ROIs) signed and uploaded for the participant's Emergency Contact and any other collaterals and community partners the participant agrees for us to work with and share information with. Staff should discuss what information is safe to share, and what not to share with each person they are signing an ROI for, and the appropriate boxes should be checked on the form to affirm the participant's desired communication.
        i. Staff may gather information from any community member about the participant without an ROI on file, however staff may not share information about the participant to any community member without a signed ROI. The only exception to this is when client is in crisis/a danger to self or others and staff are sharing with emergency providers, or when coordinating care with other identified members of the participant's treatment team. Information shared should always be done with the goal of helping the participant, no information should be shared if it is not to the benefit of the participant (i.e. no gossiping about the participant, even with other treatment team members).
        ii. ROIs are active for 1 year unless a shorter time is specified on the document, however the release can be revoked by the participant at any time, and staff should consistently check with participants about sharing information with others.
    d. Intake documents should be signed as soon as the staff are able to complete them with the participant, and are to be uploaded to the participant's chart within 1 week of signature.
        i. If a participant was located, but refused services, this should be documented in the chart as well.
        ii. See the IHOT Engagement and Intake Policy for further details.
    e. Referrals and other documents relevant to the participant's needs and goals should uploaded to the participant's chart in AWARDS within 1 week of completion, and must be uploaded prior to discharge. (i.e. applications for aid, relevant medical reports, etc.)
    f. In AWARDS the participant's Face Sheet contains contact and demographic information for the participant. The Face Sheet is to be updated by the client support specialist as the information is gathered and anytime there is a change

to this information, to ensure that it is always accurate. The face sheet should be reviewed and updated by the client support specialist one last time prior to discharge.

g. Progress notes are records of services provided to the participant and/or their collaterals, these notes should be entered and signed within 3 days of the services provided. The date of the service is day 1 and all business days for the agency are counted, regardless of the staff's individual work schedule.
    i. All IHOT billable services are written as Outreach notes
    ii. Non-billable services may be written as NB – MH Activity notes
    iii. All progress notes must be completed and signed for a participant before discharging the participant.
h. Needs & Service Plans (NSP) should be written within 30 days of the first contact with participant, or as soon as possible with the information available, and are to be uploaded to the participant's chart in AWARDS within 1 week of completion.
    i. If NSP is entered into AWARDS, it must be signed electronically prior to discharging the participant. However, the CM may leave the document unsigned electronically while working with the participant to allow for updates to the goals and staff action steps as needed. Paper copies of the NSP may be printed and signed with client after each change to document collaboration with participant on the NSP.
i. Aftercare plans are where staff document next steps for participant, contact information for any new providers the participant has been linked to, and remaining goals that new providers will help participant to accomplish after they are discharged from IHOT. An aftercare plan should be completed for any participant who was actively working with IHOT staff and did not AWOL before discharge. Aftercare plans should be uploaded to the participant's chart prior to discharging the participant.
j. Discharges cannot be completed until all other documents in the chart are uploaded, signed and complete. Discharge documentation should be completed within 1 week of the last session with the participant/collateral when participants are active, or within 1 week of day 120 in the program when participants are not active. Discharges should be completed and signed as soon as possible once the chart is complete and accurate.

4. Discharges
    a. Update discharge information for the participant in the participant tracker – include color coding, discharge date, discharge reason, updated contact attempts and successes, update demographic data, and updated contact info for accuracy and completion.
    b. Update lifelong connections in Face Sheet – BWC goal is 2 lifelong connections identified prior to discharge. Lifelong connections can include emergency

contacts, but should be a long-term natural support person in the participant's life, someone stable they can count on for some kind of support.

c. Review Face Sheet and make any updates needed for accuracy of contact and demographic information prior to discharge.
d. Complete and sign all progress notes and electronic chart documents, and upload all relevant paper documents to participant's chart prior to discharge.
e. Complete Discharge in AWARDS and e-sign the discharge form once the chart is complete and accurate.
f. Update weekly caseload/capacity tracker to show participant as discharged, so they may be removed from EPS alert list when PM sends weekly update to the EPS liaison.

5. Capacity & Weekly Caseload Update List
    a. The CM for each team is responsible for sending capacity information to PM each week. This will include the following:
        i. The number of Active participants each CSS has on their caseload,
        ii. The number of Inactive participants each CSS has on their caseload
            a. CSS/FA should discuss moving a participant to inactive with the CM and the choice to move participant to inactive should be made as a team once it is determined that all leads have been exhausted.
        iii. The number of New Referrals each CSS is requesting for the week
        iv. The above information for the FA when applicable
        v. A list of all participants separated into sections for Active, Inactive, and Discharged that will be shared with the EPS liaison.

        The PM will consolidate the information above from both CMs and send to the EPS liaison on a weekly basis, along with instructions to ensure all active and inactive clients are added to/included on the EPS alert list so that our staff is alerted when a participant is at EPS, and to remove participants listed in the discharge table from the alert list.

Documentation Due Dates

1. Progress notes – should be written within 3 business days from the date of service. The date of service counts as day 1 in this timeline. All progress notes for the month must be completed and signed by 3rd day of the following month so that billing for the month can be closed out on time.
    a. Progress notes written more than 3 days after the date of service must have "Late Entry" written in the introduction section of the note along with a valid reason for why the note is late.
2. Intake documents signed and uploaded

a. Intake documents should be reviewed with and signed by the participant as early as possible after first contact, and ideally at the first in-person meeting. If unable to get all documents signed on first meeting, staff should continue to attempt getting documents signed over each of the following weeks until all are completed.
b. If participant is only able to give verbal consent, staff should still record this on the document and upload it to the participant's chart.
c. Additional attempts to get an ink signature on intake documents from the participant should be made by staff until participant is discharged.
d. Signed documents shall be uploaded to the participant's chart by CSS within 1 week from completion, and all documents must be uploaded to participant's chart prior to discharge from the program.

3. Self-Sufficiency Matrix (SSM) & other assessments

    a. The initial SSM and other assessments should be started as early as possible with each participant. Ideally assessments would begin at the first meeting with participant and/or collaterals.
    b. SSM and other assessments should be completed within 30 days of first meeting with participant/collateral whenever possible.
    c. SSM should be completed again just prior to participant's discharge to demonstrate changes in their ability to get their basic needs met since starting the program.
    d. SSMs must be completed electronically in the AWARDS form. If completed with the participant on paper, the data must be transferred to the electronic form by CSS prior to participant's discharge at the latest. This transferring of data is not a billable service.

5. All other assessments shall be uploaded to the participant's chart by CSS within 1 week of completion, and must be uploaded prior to discharge.
6. Needs & Service Plans (NSP)
    a. NSP should be completed by the CM as soon as sufficient data has been collected through assessments. The goal is to complete the NSP within 30 days from first meeting with participant.
    b. NSP should be written collaboratively and shared with the participant whenever appropriate.
    c. NSP must be uploaded to participant's chart within 1 week of completion.
    d. NSPs will not be completed for participants who remain inactive unless it is appropriate to write one for their collaterals who are in contact with staff.
7. Discharge plans & documentation
    a. Aftercare plans should be written with/for the participant prior to their discharge session with IHOT staff.
    b. Aftercare plans should be shared with participant, collaterals, and/or new providers as appropriate for warm hand-off and participant success post-IHOT.

i. A different plan may be written for each of the involved parties from their own perspective if appropriate and necessary.
ii. Aftercare plans should include:
    1. Next steps for participant to meet their ongoing needs and successfully engage in MH/SUTS programs.
    2. Contact information for new providers and any other services participant may need to access on an ongoing basis or in the future (including how to re-connect with IHOT).
    3. Identified potential barriers to success with steps to address/overcome them.

c. Participants will be discharged at 120 days from intake, or when successfully connected to MH/SUTS program.
    i. Participants who have reached 120 days in the program, but are actively engaged and making progress toward goals may be extended until they are successfully connected and/or have their basic needs met. Participants may be discharged during an extension at any time if it becomes clear that they are no longer making progress toward their goals.
    ii. Participants may be discharged early if they refuse services or no longer meet IHOT eligibility criteria (i.e. they have moved out of the service area).
d. Discharge summary and related AWARDS documents should be completed within 1 week of participant's discharge session.
    i. Discharge summary cannot be started until all progress notes are written and signed for the participant. Other outstanding documents must also be uploaded to the participant's chart prior to starting the discharge summary.
    ii. If participant is being discharged due to no contact/AWOL from program, this should occur within 1 week from day 120 in program.

Warm Hand-offs

The first part of follow-up for a case is the warm hand-off to longer-term providers. Warm hand-offs should include the following:

3. IHOT Staff shall make contact with the new providers to explain our role in supporting the participant and define tasks for each provider to ensure the participant is successfully connected to and engaged with the new providers.
4. Staff should encourage participant to engage with new providers and use Motivational Interviewing strategies to increase the participant's chances of success in the new program.

5. Staff shall complete an aftercare plan with/for the participant and share with the new treatment team. This should include any goals that the participant identified, but has not been able to complete while in the IHOT program.
6. Staff shall support the participant with attending the first 1-3 sessions with new providers. This support can include scheduling help and reminders, transportation planning and help, or even accompanying the participant at the appointment (with permission from the participant and provider).
7. For more details regarding case closure and aftercare planning, see *IHOT Service Provision* Policy.

Discharge Process

See pages 39-42 for additional information about coding discharges. There is also additional information about discharges scattered throughout this document relevant to the particular section it is contained in. The following information is taken from a recent discharge process training.

Overview:

- The discharge process is just as big and important as the engagement and working phases are.
- We should be planning and discussing discharge with our participants and each other right from the beginning.
- Set the expectation with participants that we will be handing them off to new providers eventually.
- When writing NSP goals, keep in mind when we will consider them complete.
- Discharge phase begins once linkage to MH/SUTS program is initiated

Warm Handoff:

This is a team effort to ensure the participant is engaging with their new program, and that the new program has all the information they need to continue caring for the participant successfully.

This is also the phase where IHOT staff should start slowly backing off of the case and allowing new providers to take over more support for the participants.

Once you get confirmation of a participant's connection to a MH/SUTS program, you should start planning the warm hand-off and discharge phase with your team. This includes identifying the goals you will continue to support the participant with, and the goals you plan to hand-off to the new treatment team.

Warm Hand-offs may include the following:

- Introduce yourself and your participant to new providers
    - Accompany participant to intake appointments if appropriate
    - Coordinate care with new providers to clarify who will be supporting the participant with which tasks throughout the warm hand-off phase.
- Share aftercare plan, NSP, and other relevant documents with new providers.
- Share best practices/what worked well for us to engage the participant
- Identify and share a firm IHOT discharge date with the participant and their new providers so they know when you will be stepping away from the case.
- Start phasing yourself/IHOT out during the hand-off phase to allow space for the new providers to build rapport with the participant and engage them in the new program.

Exit Documentation:

This is the final documentation that must be completed by each team member prior to or during discharge.

This documentation happens on a specific timeline, where CSS/FA documentation must be completed before the CM can complete the discharge.

<u>CSS/FA must complete the following just prior to discharge:</u>

- Exit SSM with/for participant
- Complete all progress notes for participant.
- Complete final summary of services note – this is the final PN in the participant's chart indicating that the participant's case is being closed and no further outreach/support will be provided by our team.
    - This PN should contain an overview of the services we have provided to the participant throughout their engagement with IHOT.
    - Include names and contact information for new providers
    - Include the expected discharge date (that you have shared with participant and their new providers)
- Share final data with CM for participant tracker, including contact attempts and success numbers.
- Upload any remaining original documents to participant's chart, including aftercare plan.

<u>CM must complete the following during discharge:</u>

- Complete discharge in Awards after all PNs are complete, using information gathered from CSS and final summary of services PN.

    - Lets look at one in AWARDS together so everyone can see what is needed to complete this form

- Final update to participant tracker
- Schedule 90 follow-up call with new provider if successful graduation

Aftercare Planning:

Aftercare plans should be created for each client you connect with services. These plans help participants know who will continue supporting them going forward, how to overcome likely barriers they may face, and other information that may help them be successful post discharge.

Aftercare plans may also be shared with or created specifically for new providers or other collaterals who support the participant.

Aftercare plans should be written as a team, or at least with input from all members of the IHOT team working with the participant. Any team member can take the lead on writing the document and sharing it with the participant/collaterals.

<u>After-care plans should include the following:</u>

- MH/SUTS Provider contact information and role
- What other community and/or personal resources the participant can/will continue to utilize
- Barriers/challenges the participant may encounter and how to overcome them (refer back to resources and include how to access MH care if current program falls through)
- List of goals the participant is still working toward and who can help them with each one.
    - This may look like attaching an updated NSP to the aftercare plan.

We may create separate plans for providers and collaterals as need to share additional important information with them that will allow them to continue providing useful supports to the participant.

<u>Case Follow-up</u>

After a participant has been successfully connected to a new program and discharged from IHOT, there is a requirement to follow-up on the case after approximately 90 days. The process for following-up on a case includes:

2. When the participant is being discharged, staff should put an appointment on their calendar for 90 days from the discharge date to check up on the participant.

3. At around 90 days from discharge, one member of the IHOT team who worked with the participant should call the new providers (where the participant was connected) and ask the following questions:
    a. Is the participant still engaged in services there?
    b. How many times has client been to EPS since discharge?
    c. How many times has client been arrested/incarcerated since discharge?
    d. If client is not currently linked to services, do they have ongoing needs that IHOT may be able to support with?
    e. Staff should also gather information about the agency and provider they are speaking with, and note the date and time of the call.
4. Staff may also receive communications directly from participants who have been discharged (and/or their collaterals), and may ask the same questions of the participant to assess for their need to be re-opened in the IHOT program.
5. This service should be recorded in an outreach progress note under the IHOT Contact client name.
6. All follow-up information gathered should be shared with the Program Manager (PM) within 1 week of the call being made.
7. PM will consult with the County IHOT staff if needed and determine if a participant (who is no longer connected with a MH/SUTS program) will be re-opened in IHOT program.