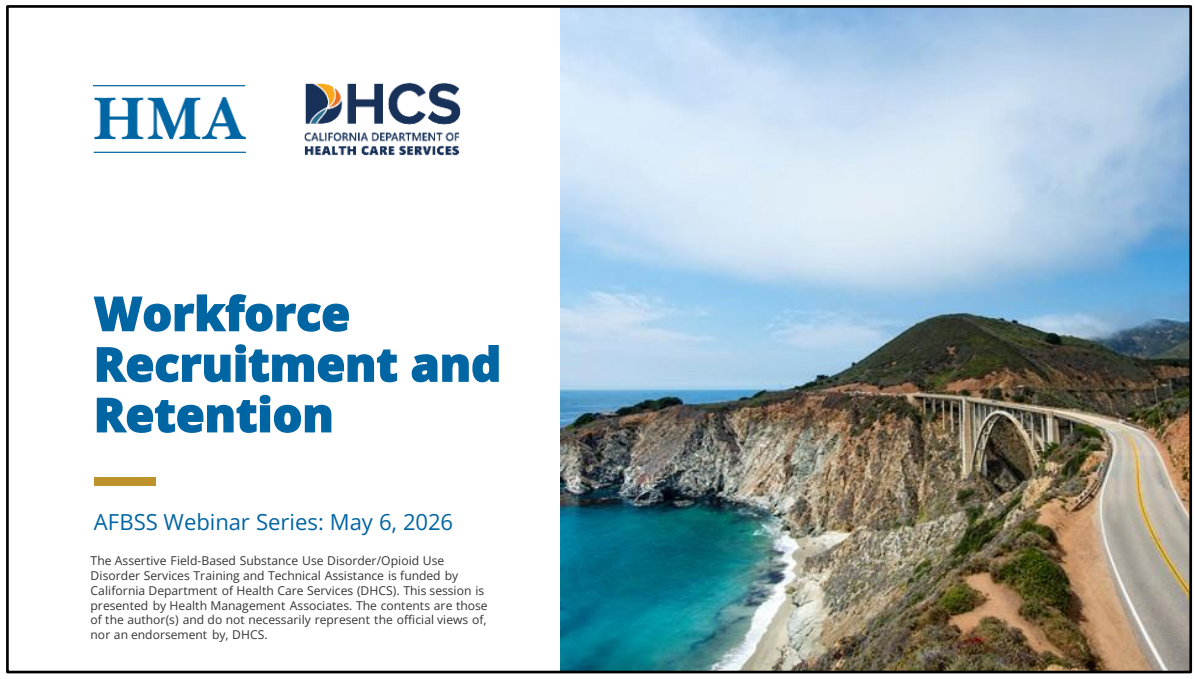

[Slide Image Description: This cover slide introduces the title of this webinar. It contains the logos for Health Management Associates.]

Disclaimer: This session is presented by Health Management Associates. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement by, California Department of Health Care Services.

Disclosures

Faculty	Nature of Commercial Interest
Karen Hill, PhD, MSN, ANP-C, BSN	Ms. Hill discloses that she is an employee of Health Management Associates, a national research and consulting firm providing technical assistance to a diverse group of health care clients.
Suzanne Daub, LCSW	Ms. Daub discloses that she is an employee of Health Management Associates, a national research and consulting firm providing technical assistance to a diverse group of health care clients.
Jeanene Smith, MD, MPH, CME Reviewer	Dr. Smith discloses that she is an employee of Health Management Associates, a national research and consulting firm providing technical assistance to a diverse group of health care clients.

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[Slide Image Description: This slide shows Continuing Education disclosures.]

- Karen Hill, PhD, MSN, ANP-C, BSN: Ms. Hill discloses that she is an employee of Health Management Associates, a national research and consulting firm providing technical assistance to a diverse group of health care clients.
- Suzanne Daub, LCSW: Ms. Daub discloses that she is an employee of Health Management Associates, a national research and consulting firm providing technical assistance to a diverse group of health care clients.
- Jeanene Smith, MD, MPH: Dr. Smith discloses that she is an employee of Health Management Associates, a national research and consulting firm providing technical assistance to a diverse group of health care clients.

Presenters

Suzanne Daub, LCSW
Principal
Health Management Associates

Karen Hill, PhD, MSN, ANP-C, BSN
Principal
Health Management Associates

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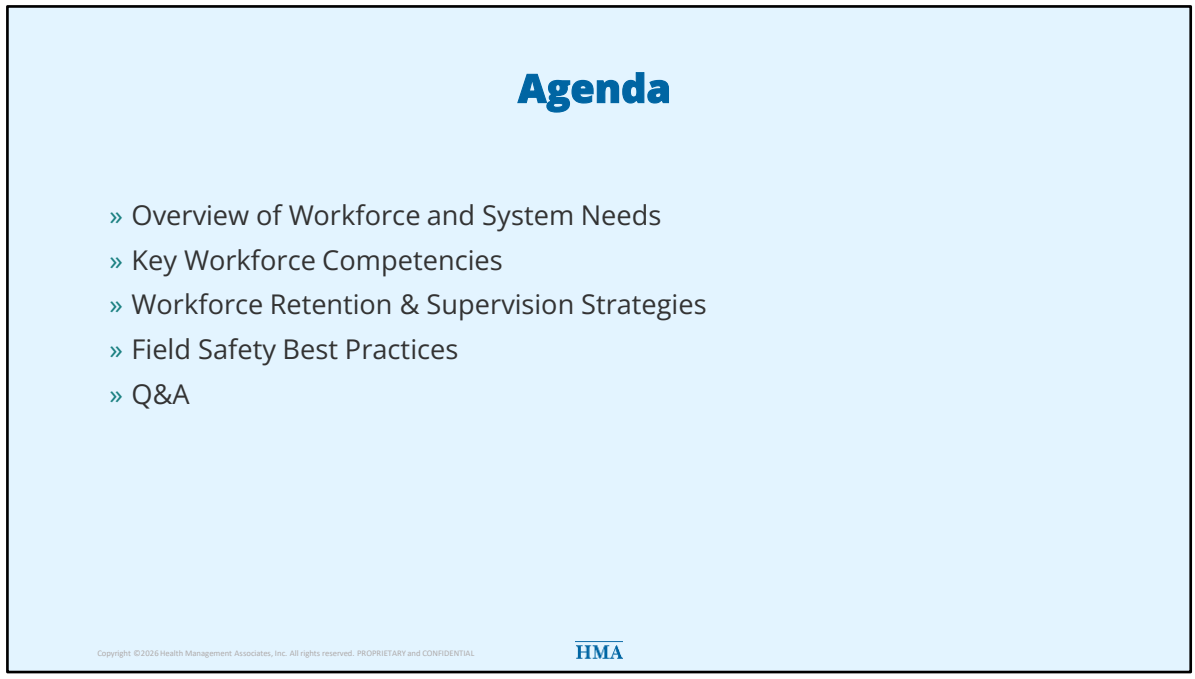
[Slide Image Description: This slide includes images of the presenters of this webinar on a light blue background.]

Suzanne Daub is a leading expert and nationally recognized trainer in integrated healthcare who knows how to help clients design, scale and evaluate behavioral integration into primary care and wellness culture. She is an energetic coach who believes building quality integrated systems of care means committing deeply to the people who deliver the work and empowering service users. Suzanne is best known for her creative leadership, which inspires those who serve vulnerable populations to embrace responsibility for transforming the way healthcare is delivered. She is passionate about a “no wrong door” approach to integrated care and works across systems to ensure that individuals and families get whole-person, recovery-oriented services regardless of where they seek help. She has published in the area of integrated care workforce development.

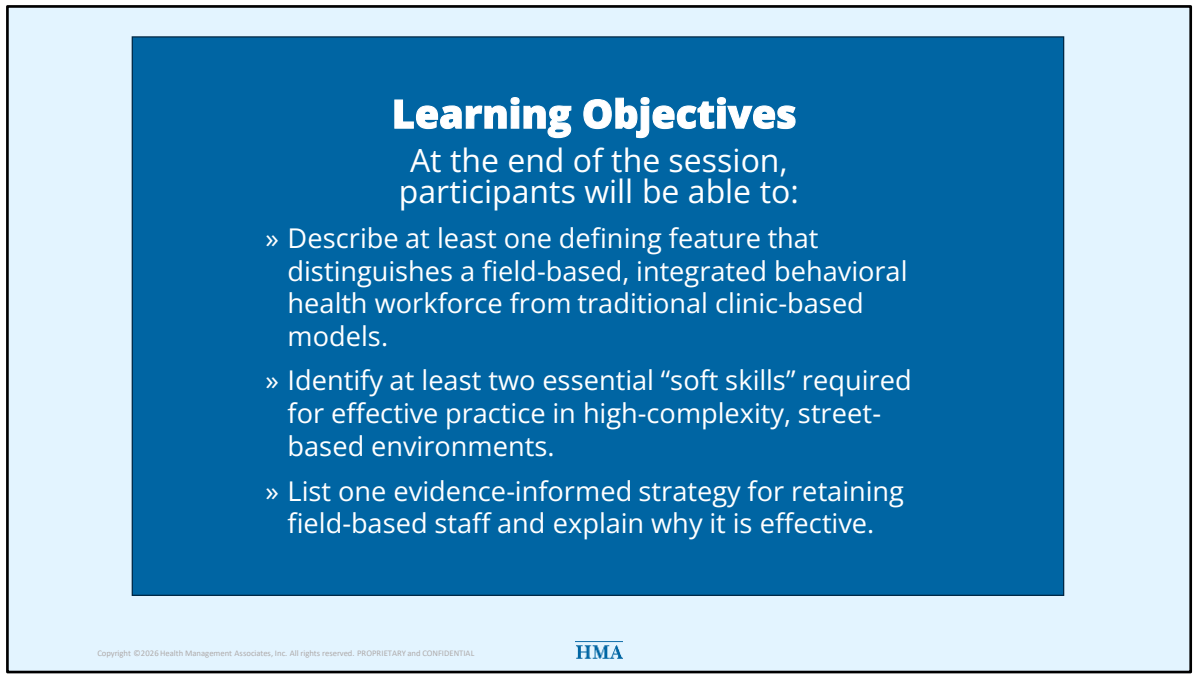
Karen Hill is a doctoral-prepared, board-certified advance practice registered nurse with a specialty in environmental and occupational health and clinical training in adult, adolescent and young adult health. An expert in workplace health and safety, Karen is exceptionally skilled in workforce assessment, engagement and development. Her clinical capabilities span primary care, acute care, outpatient care, home health care transitions, and trauma-informed systems of care. She is experienced in the social determinates of health and health disparities and community engagement of underserved populations.



[Slide Image Description: This slide shows the major sections of this webinar on a light blue background.]

The agenda for the presentation will include:

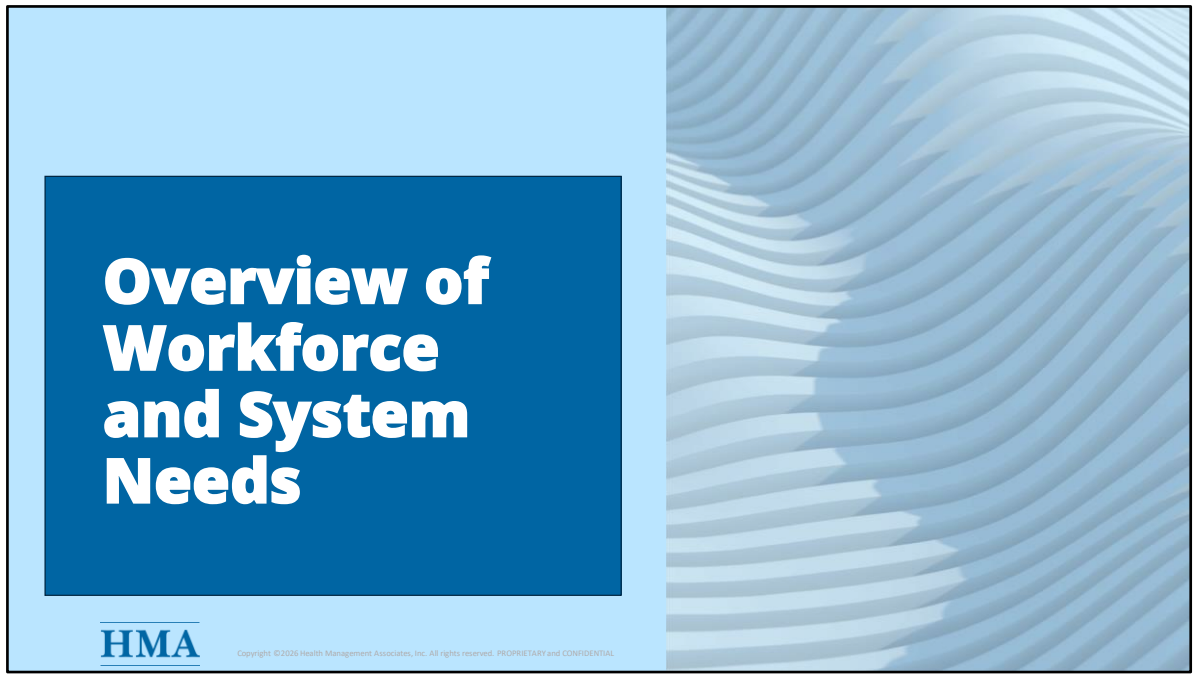
- Overview of Workforce and System Needs
- Key Workforce Competencies
- Workforce Retention & Supervision Strategies
- Field Safety Best Practices
- Q&A



[Slide Image Description: This slide shows the learning objectives for this webinar with a light blue background.]

At the end of the session, participants will be able to:

- Describe at least one defining feature that distinguishes a field-based, integrated behavioral health workforce from traditional clinic-based models.
- Identify at least two essential "soft skills" required for effective practice in high-complexity, street-based environments.
- List one evidence-informed strategy for retaining field-based staff and explore why it is effective.



[Slide Image Description: This is a section divider slide to indicate a major section of this webinar.]

This first section provides an overview of the workforce and system needs as they relate to the Behavioral Health Services Act (BHSA) and Behavioral Health Services and Supports (BHSS) goals and objectives. As we go through this, consider at your own site what policies or protocols most need to be modified or developed to support the AFBSS workforce.

Case Example: Community Services (CS) Clinic

- CS provides outpatient medication for opioid use disorder (MOUD), counseling and peer support services, telehealth, and referrals. CS has a 24-hour Opioid Treatment on Demand (OTOD) center.
- CS collaborates with under-resourced communities and provides essential education about effective opioid use disorder (OUD) treatment.
- CS targets ages 18 to 70 and has identified that female transitional aged youth (ages 16 – 25 years) are most likely to test positive for fentanyl.
- CS serves individuals across all biopsychosocial backgrounds and all racial and ethnic groups. Many CS patients are unhoused or precariously housed.

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[Slide Image Description: This slide shows presents a Community Services Clinic case outlining mobile opioid treatment, outreach, and workforce challenges. Image shows a group of people outside a community setting.]

Consider the fictional clinic Community Services and how they might use some or all of this material to address the development of their new program.

The case example is the Community Services Clinic (CS). CS provides evidence-based outpatient medication for opioid use disorder (MOUD), counseling and peer support services, telehealth, and referrals to community-based organizations and healthcare partners. CS has a 24-hour Opioid Treatment on Demand (OTOD) center. They are currently at American Society Addiction Medicine (ASAM) 1.7, medically monitored outpatient services Level of Care.

The mission is to collaborate with under-resourced communities and to provide essential education about effective opioid use disorder (OUD) treatment. CS targets ages 16 to 70. Using data, they have identified that female transitional aged[emerging adults-moving from adolescents to adulthood] youth are most likely to test positive for fentanyl. California's public behavioral health system (including county mental health plans and DHCS-aligned programs) consistently defines TAY as youth ages 16 through 25. CS serves individuals across all biopsychosocial backgrounds and all racial and ethnic groups, including people living with disabilities, pregnant persons, veterans, and re-entry individuals. Many CS patients are unhoused or precariously housed.

Disclaimer: This is a hypothetical case example. Any resemblance to an actual person is purely coincidental, including race, nationality, and gender.

Case Example: Community Services Clinic (CS)

- CS continues to face workforce challenges stemming from the pandemic and shifting socio-political change; pressures that are expected to continue.
- CS leadership is now charged with expanding services to reach individuals who require mobile field-based services and improve linkages with Open Access Clinic. The expansion will require staff to have new competencies and additional training to safely and effectively deliver services outside the "four walls" of the clinic.
- Consider how CS may develop a training and workforce stabilization plan.
- After reviewing staff, supervisor, manager, and leadership interviews and surveys, it is determined that the training should be focused on job competencies, workforce selection, training, and retention.

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[Slide Image Description: This slide shows outlines of Community Services Clinic case, workforce challenges, and expansion to mobile field-based services. Image depicts people gathered outside a building.]

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Consider how CS may develop a training and workforce stabilization plan.

After reviewing staff, supervisor, manager, and leadership interviews and surveys, it is determined that the training should be focused on job competencies, workforce selection, training, and retention.

Disclaimer: This is a hypothetical case example. Any resemblance to an actual person is purely coincidental, including race, nationality, and gender.

Traditional BH vs. AFBSS: Foundational Model Differences

	Traditional Behavioral Health Services	Assertive Field-Based Initiation for Substance Use Disorder Treatment Services
Service Model	• Office-based work, controlled environments	• Community-based, field-based, and mobile care
Engagement Philosophy	• Voluntary Compliance • Engagement through scheduled appointments, with missed visits handled administratively	• Engagement is intentional and persistent
View of Substance Use	• Abstinence	• Harm Reduction
Workforce Composition	• Primarily licensed clinicians • Clear role boundaries • Individual caseload ownership	• Multidisciplinary teams with complementary roles • Shared responsibility for engagement, continuity, and outcomes

SOURCE(S): California Department of Health Care Services, 2026.

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[Slide Image Description: This slide shows information about traditional BH vs. AFBSS with 15 colorful boxes.]

This slide examines the foundational differences between the models of substance use disorder (SUD) service delivery. In the column on the far left we have:

- Service model, or where care is provided.
- Engagement philosophy, how clients are engaged.
- View of Substance Use, the mental model of addiction. This is not absolute, but overwhelmingly an all or nothing point of view.
- Workforce composition, the providers rendering care.

Both models are in the business of helping clients who are experiencing SUD, yet the approach is very different. With Assertive Field-Based Initiation for Substance Use Disorder Treatment Services (AFBSS), the multidisciplinary team including individuals with lived experience take the services to where people are living in the community, provide services in the moment, and promote harm reduction. They actively seek clients that might need services and deliver them without judgment.

SOURCE(S): California Department of Health Care Services (DHCS), 2026.

Ideas in Action

» Given these differences, what stands out as most unique about the workforce needed to do this work well?

HMA

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[Slide Image Description: This is an Ideas in Action slide that provides an opportunity for participants to practice using the information. It contains a checkbox and an arrow.]

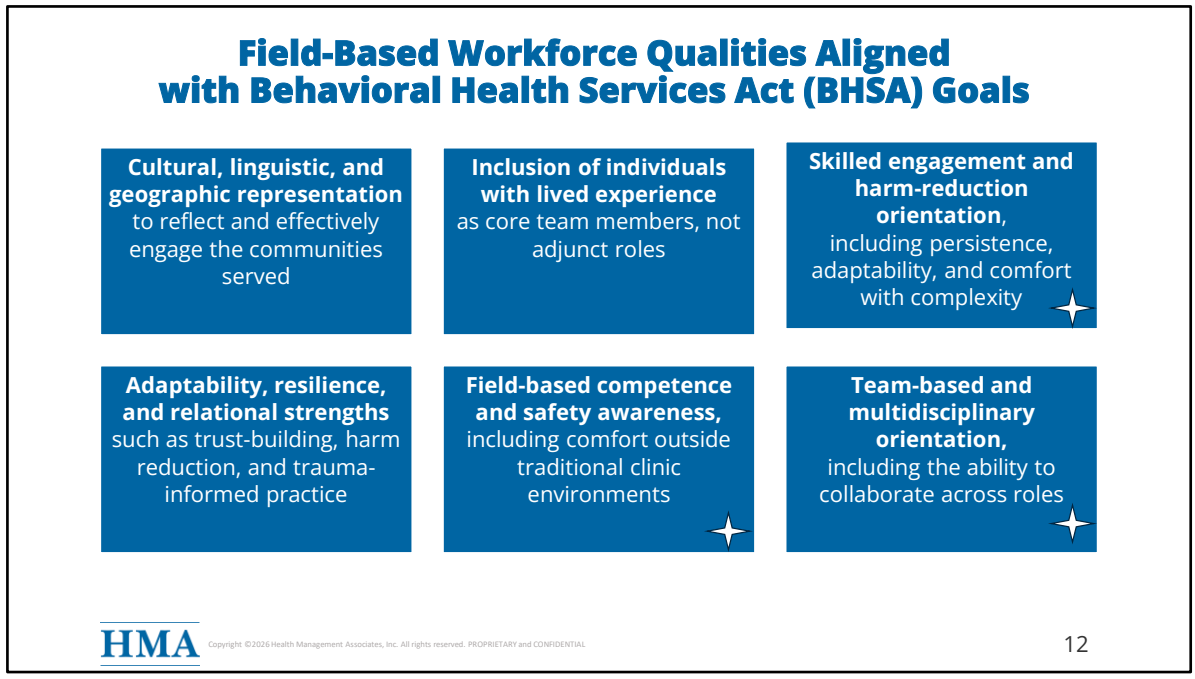
Community-based, field-based, and mobile care staff must be comfortable with engagement that is intentional and persistent. Even when potential clients are resistant, they keep showing up, offering lifesaving information to keep people safe until they may become ready with a goal of saving lives.

Field-based teams must have the following:

- Harm reduction skills
- Multidisciplinary teams with members who have complementary roles and skills, e.g., a deep understanding of the community and its people
- A shared responsibility for engagement, continuity, and outcomes
- Deep respect for the people they hope to collaborate with on the streets; street medicine staff must remember that they are in the clients' home, not the other way around
- An understanding of safety precautions and considerations
- The skills to work with individuals with persistent and ongoing trauma, keeping in mind trust, autonomy, and self efficacy has often been broken
- The ability to remain agile, ready to respond and act quickly

[Slide Image Description: This is a section divider slide to indicate a major section of this webinar.]

As you plan for the new program, it's important to take a close look at the hard and soft skill competencies needed for success in mobile, assertive, field-based work.



[Slide Image Description: This slide shows information about Field-Based Workforce Qualities Align With BHSA Goals with six colorful boxes.]

People who thrive in this work are steady, relational, persistent, and humble; comfortable with complexity; and committed to dignity, safety, and teamwork. AFBSS requires a flexible, multidisciplinary workforce with strong clinical and behavioral health skills, cultural and linguistic representation, lived experience, and familiarity with the communities served. Staff must be comfortable working outside traditional clinic settings and skilled in outreach, engagement, harm reduction, adaptability, and team-based care. These workforce qualities align with BHSA goals to expand access, reduce disparities, strengthen workforce diversity, and build capacity for community-based, field-delivered behavioral health and SUD services.

Statewide Behavioral Health Staffing Goals

- The behavioral health transformation is comprehensive and has developed opportunities to address the workforce deficits.
- The pandemic, inflation, gun violence, changing immigration policies, racism, environmental disasters, and war have led to an unprecedented need for mental and behavioral services.
- Statewide provider workforce gaps exist, and the gap widens if we consider professionals that are trained in substance use disorders (SUDs) and field-based services.
- DHCS wants a workforce that is diverse and multidisciplinary, includes lived experiences, has increased language capacity, and works to the top of their training and license.

SOURCE(S): California Department of Health Care Services, 2026; Weiner, 2022.

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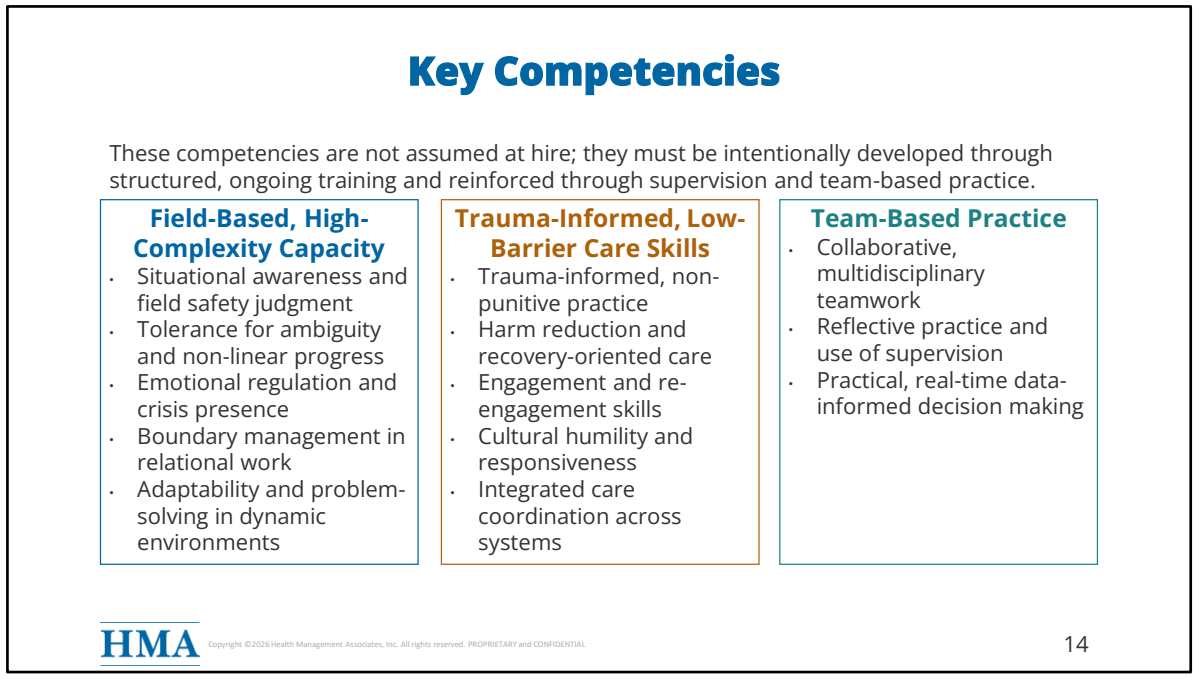
[Slide Image Description: This slide highlights statewide behavioral health staffing goals, workforce shortages, and need for diverse, multidisciplinary providers. Image shows a healthcare worker beside an ambulance.]

The demand for behavioral health services has grown dramatically in recent years, driven by the ongoing impact of the pandemic and other major social stressors affecting communities. At the same time, there are significant workforce shortages across the state, especially among providers trained in substance use disorders and field-based care. In response, the behavioral health transformation is creating new opportunities to strengthen the workforce by building multidisciplinary teams that are diverse, culturally and linguistically responsive, include people with lived experience, and allow staff to work to the top of their training and license.

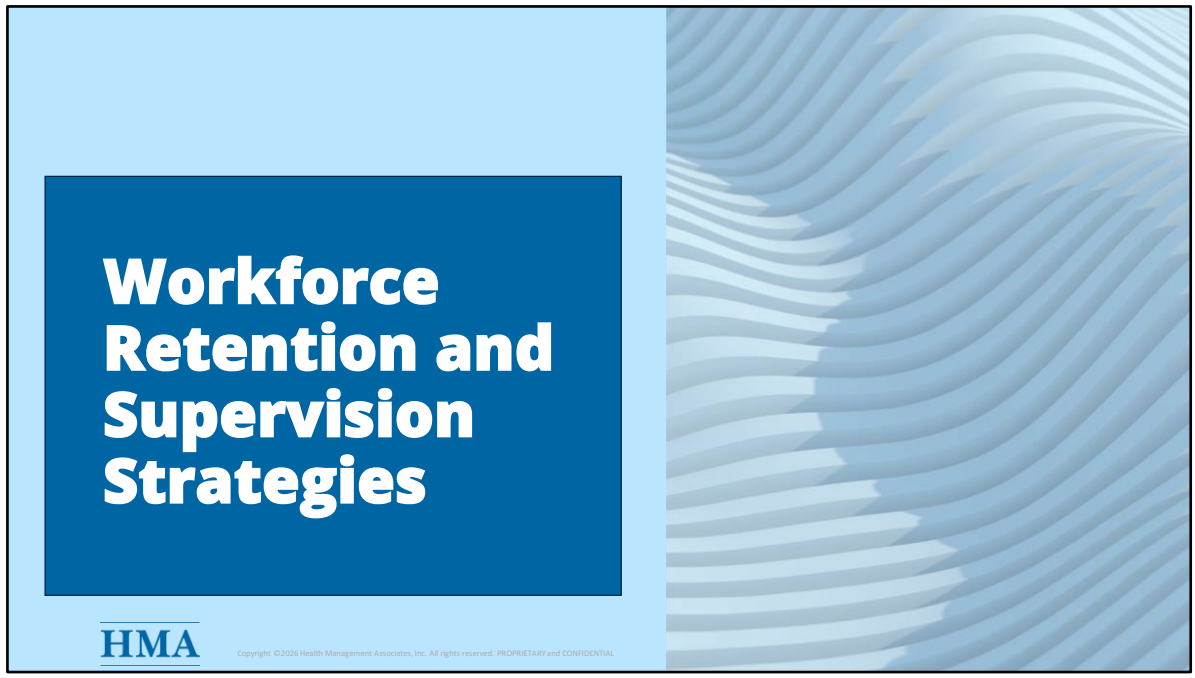
SOURCE(S): California Department of Health Care Services, 2026; Weiner, 2022.



[Slide Image Description: This slide shows key workforce competencies for field-based care, including high-complexity capacity, trauma-informed skills, and team-based practice in three colorful boxes.]

As we discussed, successful outreach workers are nonjudgmental, culturally responsive, and comfortable working in unpredictable, community-based environments. These skills are not simply expected at hire, they must be developed and strengthened over time through training, supervision, reflective practice, and team-based support. Here you see the key areas of competency:

- Comfort working in complex, fast-changing field environments
- Strong situational awareness, emotional regulation, and boundary management
- Trauma-informed, low-barrier, and harm reduction-oriented approaches to care
- Engagement and re-engagement skills for individuals who may be ambivalent about treatment
- Cultural humility and responsiveness to the communities served
- Ability to coordinate care across behavioral health, medical, housing, and social service systems
- Collaborative teamwork and real-time problem-solving in multidisciplinary settings
- Use of supervision, reflection, and data-informed decision making to support ongoing improvement



[Slide Image Description: This is a section divider slide to indicate a major section of this webinar.]

Now we will discuss how organizational leadership and supervision can provide support that will help reduce turnover.

Why Retention Is Challenging in This Work

- **Realities of Integrated, Field-Based Care**
  - High emotional and relational intensity
  - Exposure to trauma, crisis, and loss
  - Non-linear progress and complex barriers
  - Work that extends beyond traditional clinical settings
  - Unreasonable expectations of the work and the work challenges
- Burnout is not a personal failure; it is a system issue and an important risk to be addressed.
- Leadership and staff must prioritize using trauma informed care delivery and biopsychosocial care of the workforce to mitigate burnout.

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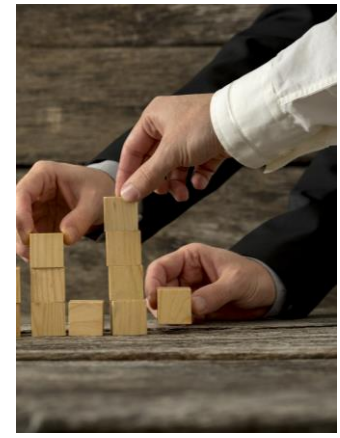
[Slide Image Description: This slide shows why retention is challenging in care, highlighting emotional intensity, trauma exposure, non-linear progress, and burnout as systemic issues. Image shows professionals meeting.]

Staff remain when they feel safe, effective, seen, and supported by leaders who understand the realities of the field. Retention depends on competitive wages, clear career pathways, manageable caseloads, recovery time after critical incidents, and structured, reflective supervision that integrates clinical guidance with emotional support. Together, these strategies create conditions for staff to grow, remain engaged, and do this work well over time.

Working in integrated, field-based care means managing high emotional stakes, crises, and trauma daily. Progress is rarely a straight line, and you will navigate complex, broken systems. Because this work happens outside traditional offices, it is deeply taxing. Remember: burnout is a systemic hazard, not a personal shortcoming. Leadership and staff must prioritize using trauma informed care delivery and biopsychosocial care of the workforce to mitigate burnout.

Infrastructure to Support Retention

- Provide specific training for supervisors in field coaching, complexity management, and providing staff emotional support.
  - E.g., Supervisors should go out in the field, receive training on coaching in the moment and role play how to provide emotional support for staff.
- Build multidisciplinary teams and recruit for engagement skills and lived experience, not only licensure.
- Establish field safety protocols and team-based visits with mobile documentation tools.
- Align HR and caseload expectations with outreach work and use simple data dashboards in team huddles.
- Train staff in street-based engagement and trauma-informed care (shadowing, reflective supervision groups).



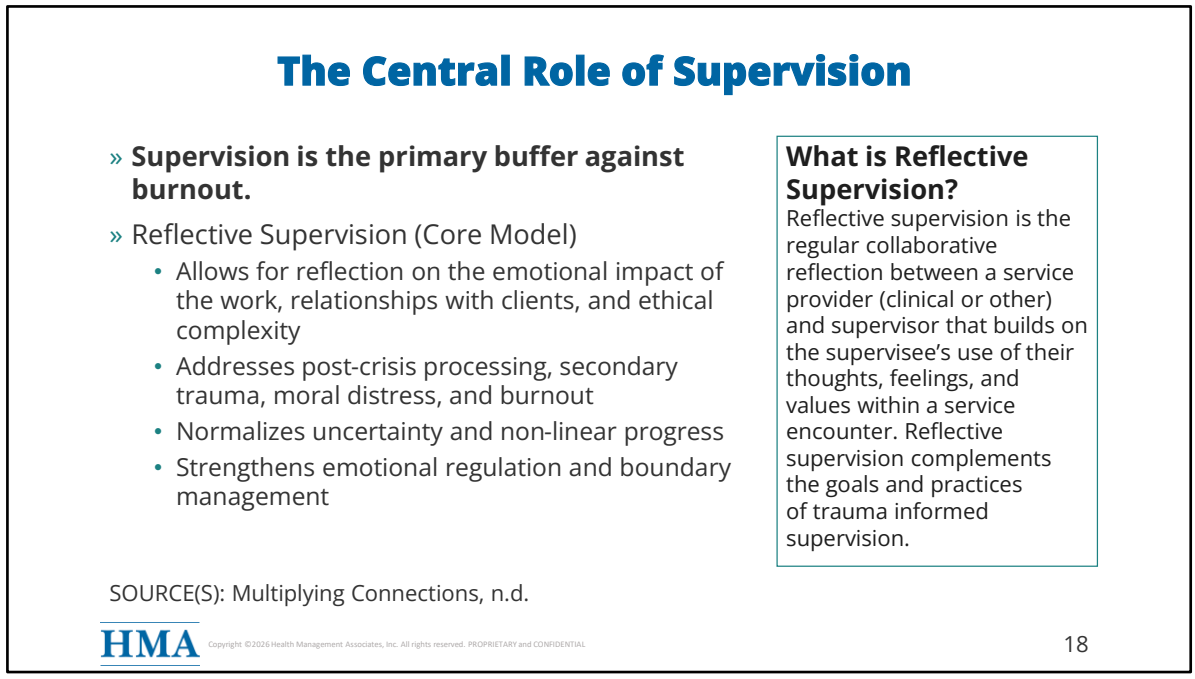
SOURCE(S): Hopper, E. K., et al., 2010; Miller, W. R., & Rollnick, S., 2012; Rushton, C. H., 2024.

[Slide Image Description: This slide shows outlines of infrastructure supports needed for field-based workforce success, including supervision, safety, HR systems, and resilience. Image shows hands stacking wooden blocks.]

Retention depends on more than hiring, it requires strong organizational support for field-based work. Here we see some key strategies including:

- Training supervisors in coaching, psychological safety, and managing staff stress and secondary trauma
- Hiring multidisciplinary teams with strong engagement skills and lived experience, not just licensure
- Supporting field safety through clear protocols, team support, and mobile tools
- Creating realistic workloads that account for outreach, travel, and emotional labor
- Providing ongoing training, shadowing, and reflective practice opportunities for staff

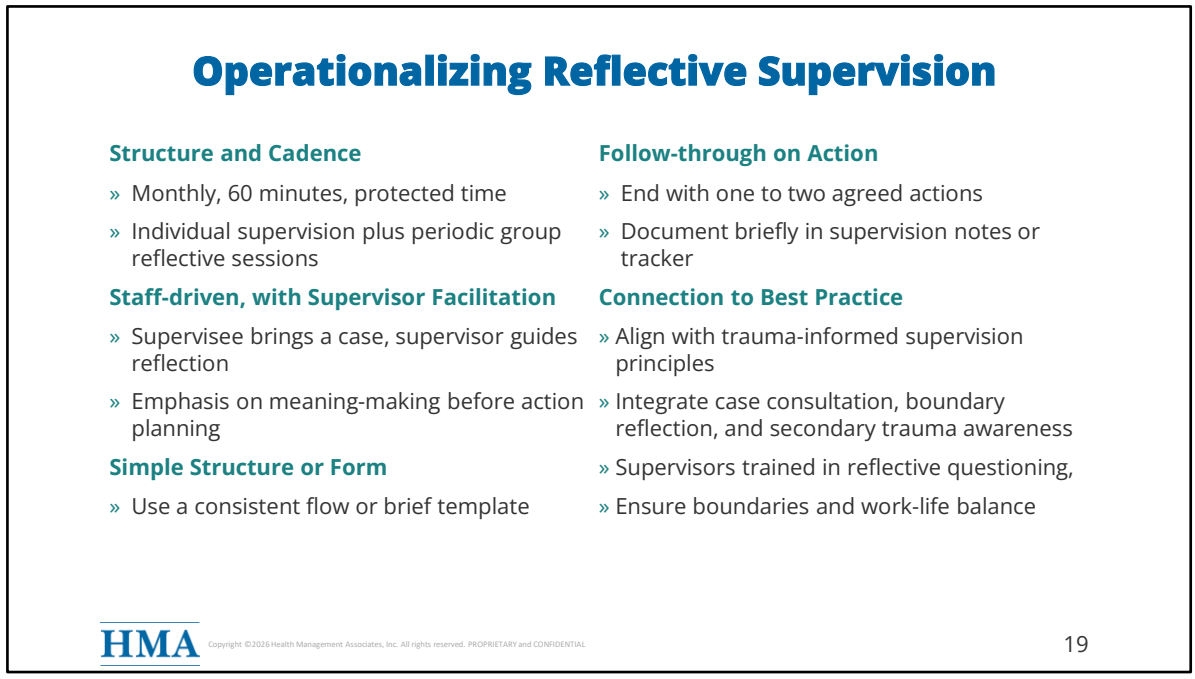
SOURCE(S): Hopper, E. K., et al., 2010; Miller, W. R., & Rollnick, S., 2012; Rushton, C. H., 2024.



[Slide Image Description: This slide shows supervision as buffer against burnout, introducing reflective supervision, emotional processing, and psychological safety.]

Strong supervision improves confidence, effectiveness, and retention. It is the primary buffer against burnout.
Strong supervision in field-based work is structured, consistent, and supportive. It should provide both clinical guidance and emotional support, helping staff learn, problem-solve, and feel safe raising concerns.
Reflective supervision, commonly used in trauma-exposed fields, creates space for staff to process difficult experiences, manage stress and secondary trauma, and navigate the uncertainty and complexity that often comes with outreach and engagement work.

SOURCE(S): Multiplying Connections, n.d.



[Slide Image Description: This slide lists opportunities to operationalize reflective supervision.]

Operationalizing Reflective Supervision:

- Reflective supervision works best when it is structured, consistent, and protected. Organizations should schedule regular supervision time, ideally monthly at minimum, with a mix of individual and group reflection opportunities.
- Sessions should focus on helping staff process challenging interactions, emotional impact, ethical tensions, and relationship dynamics before jumping into problem-solving. A simple structure can include discussing the situation, emotional reactions, client context, next steps, and needed supports.
- Reflective supervision should align with trauma-informed principles, support awareness of secondary trauma and boundaries, and reinforce healthy work-life balance, including taking time off, disconnecting after hours, and maintaining sustainable workloads.

Help Staff Stay and Grow

- **What sustains the workforce?**
  - Competitive wages and equitable compensation
  - Clear career pathways and opportunities for advancement
  - Manageable caseloads aligned with intensity of work
  - Time and support to recover after critical incidents
  - Team-based support and leaders who understand field realities
- When staff feel **safe, effective, seen, and supported**, they stay, grow, and do this work well over time.

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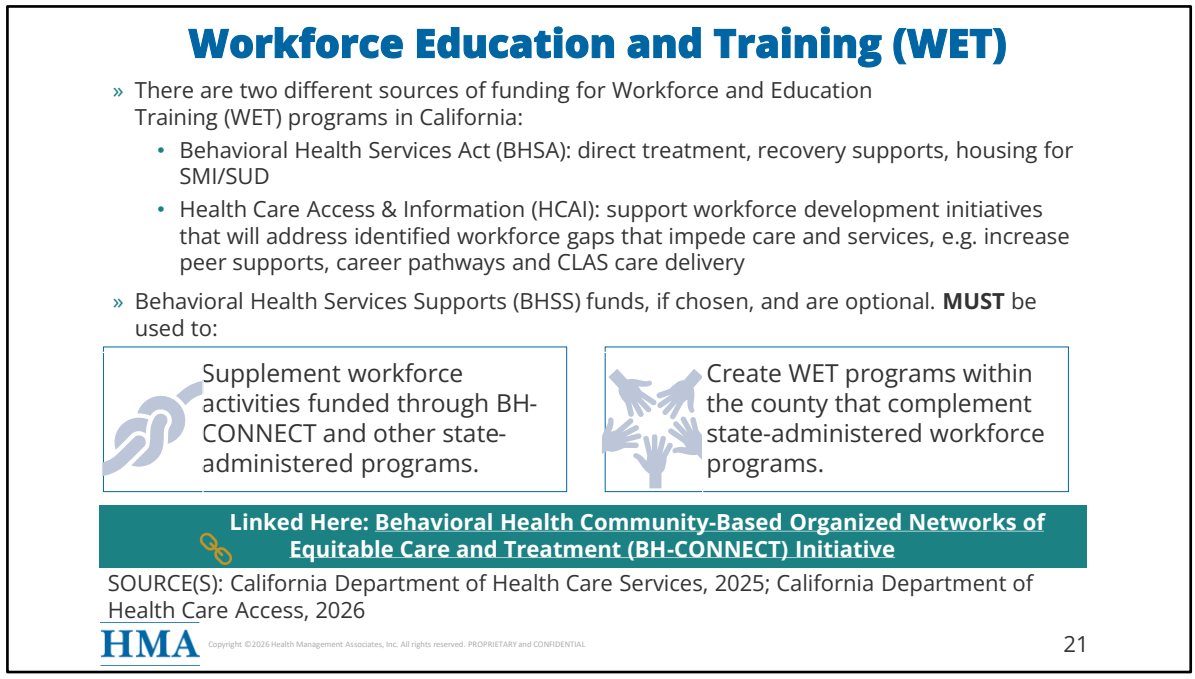
[Slide Image Description: This slide shows highlights strategies to sustain workforce growth, including equitable pay, career pathways, manageable caseloads, recovery support, and team-based leadership. Image shows colleagues in discussion.]

What Sustains the Workforce?
Sustaining a field-based workforce requires more than recruitment. Staff are more likely to stay when organizations offer competitive pay, manageable workloads, opportunities for growth, and time to recover after difficult situations. Strong team support, reflective supervision, and leaders who understand the realities of field work also matter. When staff feel supported, valued, and effective, they are more likely to remain engaged in the work over time.



[Slide Image Description: This slide shows Workforce Education and Training funding, purpose, and allowable uses under BHSA and Behavioral Health Services Supports (BHSS). Icons of a knot and hands represent structured programs and coordinated workforce development.]

There are two different sources of optional funding for Workforce and Education Training in California. They are BHSA and Health Care Access & Information (HCAI).
The Behavioral Health Services Act (BHSA) builds on the Mental Health Services Act (MHSA), which provided a component for Workforce Education and Training (WET) programs to address California's public mental health workforce challenges and addressed healthcare disparities that hinder access and utilization of services.

IMPORTANT: WET activities must supplement, but not duplicate, funding available through other state-administered workforce initiatives, including the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) workforce initiative administered by the Department of Health Care Access and Information (HCAI). Counties must

prioritize available BH-CONNECT and other state-administered workforce programs whenever possible

BHSA and Health Care Access and Information (HCAI):
The 2025 – 2030 WET Five-Year Plan emphasized supporting public mental health services to provide care at the lowest level of intensity and promote the use of non-licensed personnel throughout the care delivery system. For example: peer supports and career pathways, culturally linguistically aligned staff and those with lived experience.

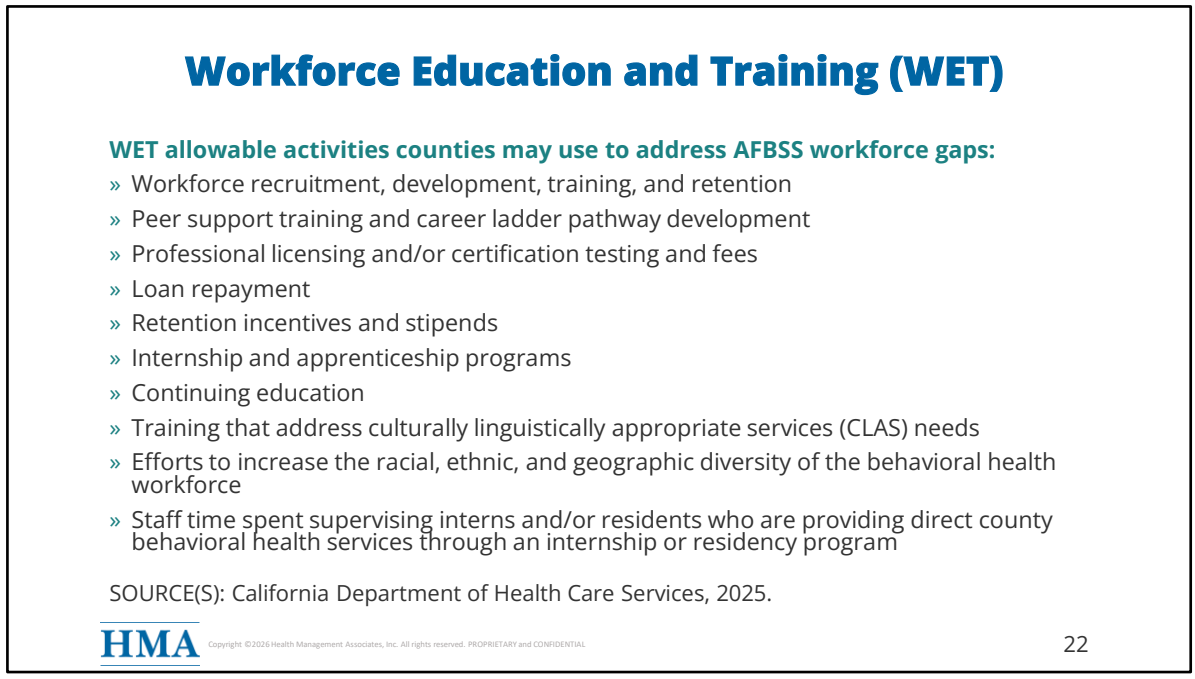
Per the BHSA, counties may use a portion of BHSS funds for WET. County providers employed or volunteering in the county behavioral health delivery system may participate in WET activities.
BHSA focuses on direct treatment and recovery supports for SMI/SUD and HCAI supports the workforce development initiatives.

WET funding compliments other funding such as the Behavioral Health Community Based Organized Networks of Equity Care and Treatment (BH-CONNECT), administered by the Department of Health Care Access and Information (HCAI). Counties must prioritize available BH-CONNECT and other state administered workforce funding programs when possible.

WET must supplement, not duplicate state administered workforce initiatives.

BHSS funds, if chosen and optional, MUST be used to:
- Supplement workforce activities funded through BH-CONNECT and other state-administered programs (e.g., stipends for childcare or transportation to supplement a retention bonus available through the BH-CONNECT workforce initiative).
- Create WET programs within the county that complement state-administered workforce programs.

SOURCE(S): California Department of Health Care Services, 2025; California Department of Health Care Access, 2026



[Slide Image Description: This slide shows Workforce Education and Training allowable activities.]

WET Allowable Activities:

- Workforce recruitment, development, training, and retention
- Professional licensing and/or certification testing and fees
- Loan repayment
- Retention incentives and stipends
- Internship and apprenticeship programs
- Continuing education
- Efforts to increase the racial, ethnic, and geographic diversity of the behavioral health workforce (e.g., individuals with lived experience)
- Staff time spent supervising interns and/or residents who are providing direct county behavioral health services through an internship or residency program

BHSS funds for WET activities may not be used to:

- Address the workforce recruitment and retention needs of systems other than the county behavioral health delivery system, such as criminal justice, social services, and other non-behavioral health systems, although county behavioral health may choose to partner with other systems in order to meet the intersecting needs of its clients.

- Pay for staff time spent providing direct county behavioral health services.
    - Employers must not be reimbursed for the time an employee takes from their duties to attend training.
- Off-set lost revenues that would have been generated by staff who participate in WET programs and/or activities.

SOURCE(S): California Department of Health Care Services, 2025.

Ideas in Action

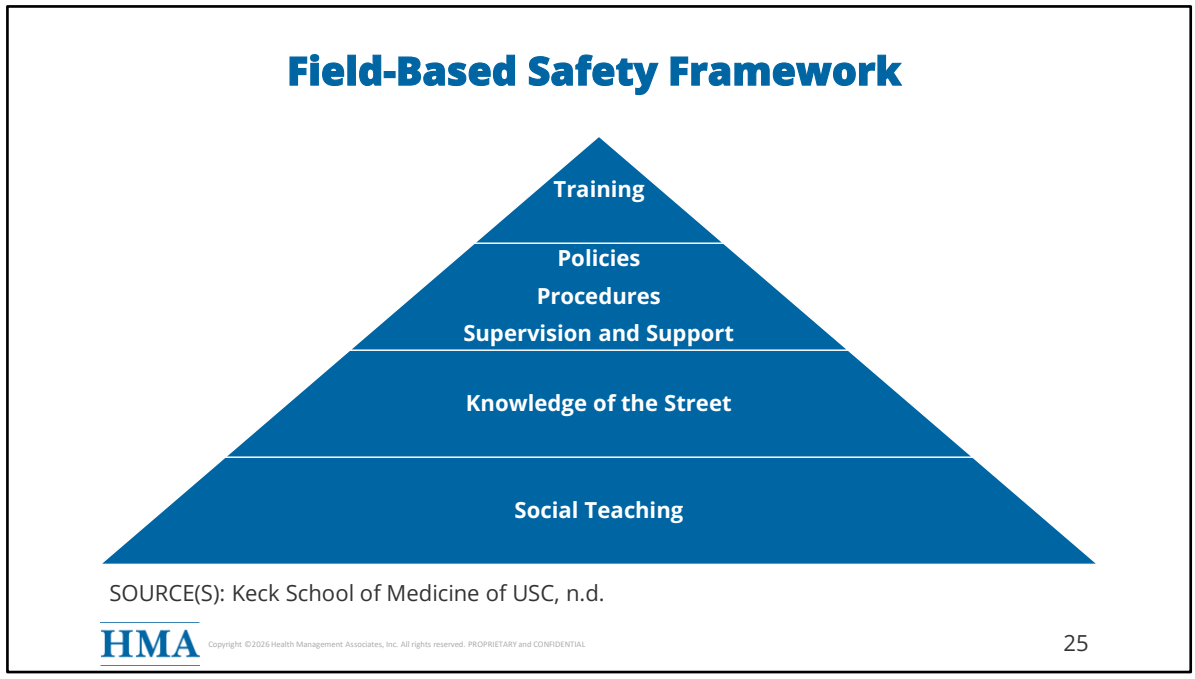
» What do your supervisors need to better support their teams?

[Slide Image Description: This is an Ideas in Action slide that provides an opportunity for participants to practice using the information. It contains a checkbox and an arrow.]

What do your supervisors need to better support their teams? Keep in mind key needs include training in remote supervision, robust safety protocols, enhanced tech-driven communication systems, and proactive burnout prevention for staff working in unpredictable environments.

[Slide Image Description: This is a section divider slide to indicate a major section of this webinar.]

Now we'll review workforce field safety.



[Slide Image Description: This slide shows a field-based safety framework emphasizing training, policies, supervision, street knowledge, and social teaching. Image illustrates a layered pyramid.]

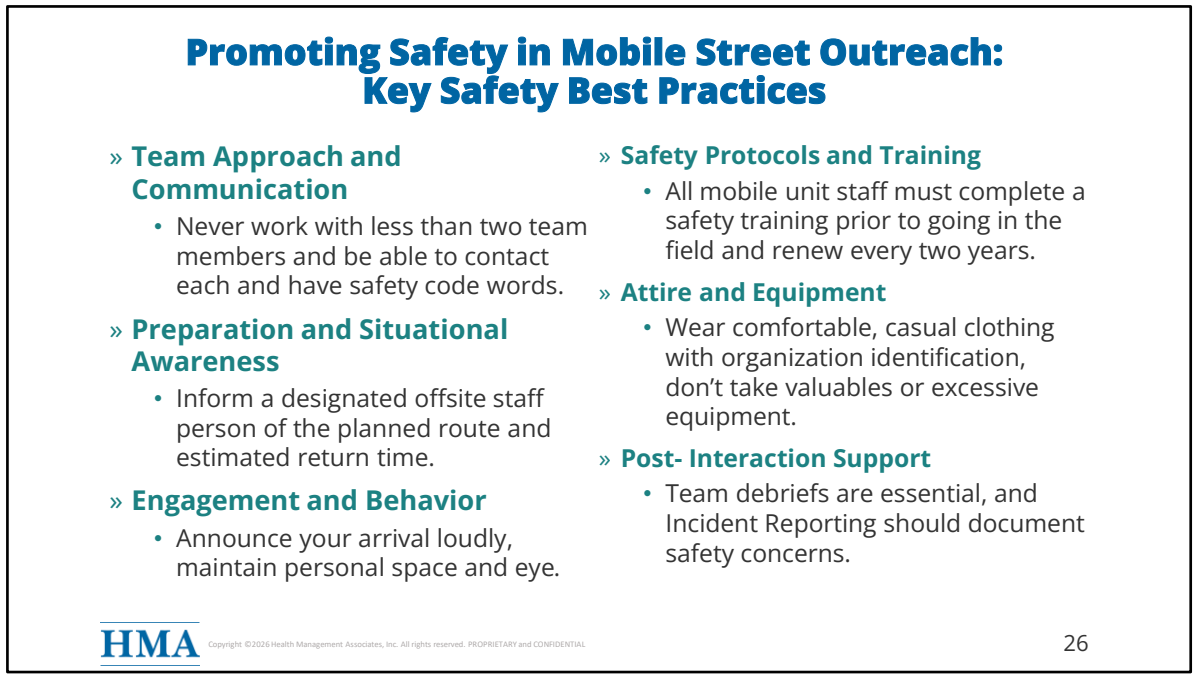
This is the pyramid that represents a foundation for safety assurance and can promote psychological and physical safety to field-based staff.

Field-based providers must be strong clinically, confident with diagnosis and treatment for themselves and for the client.

Team policies and procedures must reflect the environments they are working in and change as the circumstances change. Supervision and support are also key in the field.

“Street Credibility” is often provided by those are have lived experience and know the neighborhoods and cultural expectations though it can be learned through experience and openness.

Finally, all of the above result in social training and are manifested through practical application.



[Slide Image Description: This slide shows key safety best practices for mobile street outreach.]

Understand that ALL street outreach safety practices must be modified for each team. Safety First must be embedded into program design, not left to individual discretion. Safety and the required systems and protocols become cultural norms that can protect staff in the field and ensure that safety is core organizational value and the responsibility for everyone associated with the organization and the team.

Team Approach and Communication

- Always work in teams (two or more) and NEVER go alone. If possible, have at least one male.
- Have phones charged and share schedules with supervisor and other designated offsite staff. Check in throughout the day, via text or phone.
- Have a code word that when used it means to leave, no questions asked.

Preparation and Situational Awareness

- Know the neighborhood you are entering, check the current news to make

sure there have not been any negative issues in the area, e.g., recent violence.
- Always trust your instincts and avoid areas with unusual or unsafe activity. Also be mindful that the first day of the month and last day of the month can increase the chances of liability in the community, due to paychecks and more drug use, and at the end of the month people may feel desperate because they do not have the resources to use.
- Any deviation from the planned clinical locations or outreach routes must be reported to all mobile team members and the offsite designee immediately by the method pre-determined by the team. Acceptable methods of notification include phone call, text, and email. If a worker does not return to the mobile unit at the planned time and cannot be reached, the mobile team should notify the worker's emergency contact.

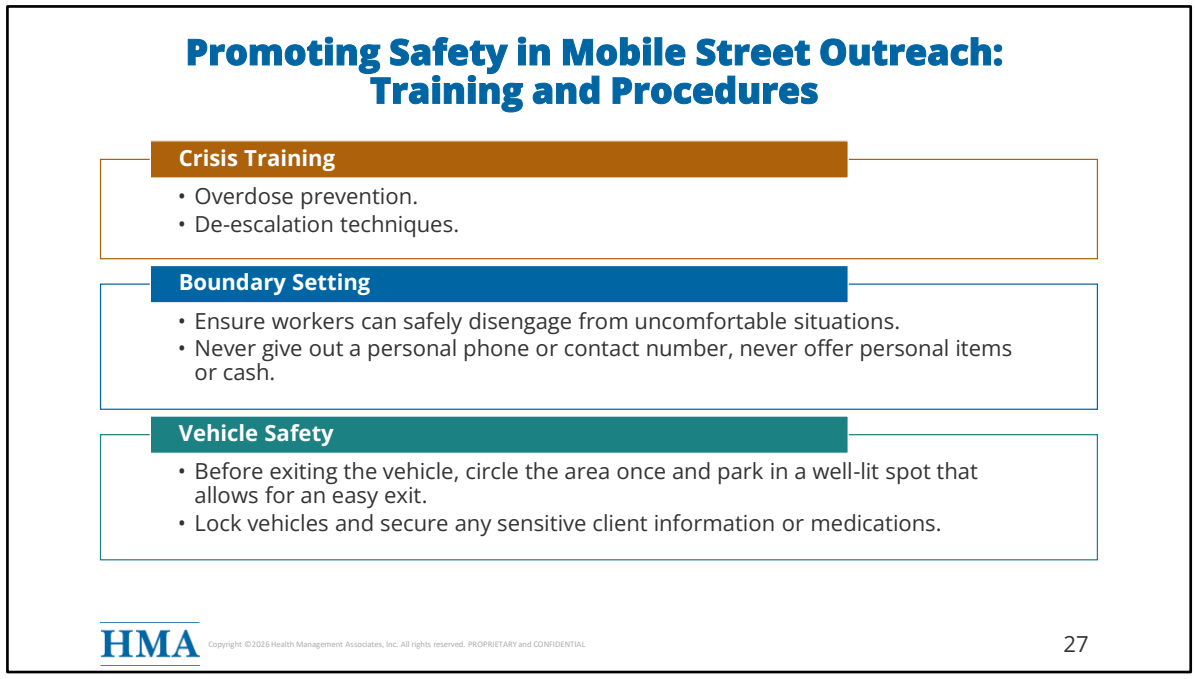
Engagement and Behavior
- Announce your arrival loudly (e.g., "Outreach Worker! May I approach?") to avoid startling residents.
- Maintain at least an arm's length of personal space and ensure you have a clear escape route. Avoid standing over clients; instead, crouch to their eye level.
- Approach clients with respect, pay attention to mood, affect, and behavior changes. Ask for permission. Use trauma informed approaches and motivational interviewing skills.
- Be trustworthy and honest. Never over promise or promise something you can't do. This is trauma informed care delivery.
- Ask permission prior to going into and encampment, tent or a place where clients are living.
- Always monitor situations and stay alert. The situation can change on a dime, and you must be able to react.

Safety Protocols and Training
- All workers who staff the mobile unit work must complete a safety training prior to going in the field and renew every two years.
- The training should include personal safety techniques, de-escalation techniques, risk assessment, non-violent crisis intervention and any other appropriate safety topics.

Attire and Equipment
- Always wear comfortable, casual clothing with agency identification, do not take valuables or excessive equipment, or weapons.
- Consider wearing identifiable, bright, or matching clothing, e.g., vests.

Post-Interaction Support

- Team debriefs are essential and even more important if there is a dangerous event.
- Incident Reporting should document any safety concerns or "near-miss" incidents to update the team’s risk assessment for future visits.
- Consider using a sample safety checklist or a specific de-escalation script for the outreach team.



[Slide Image Description: This slide shows training and procedures for mobile outreach in three colorful boxes.]

Safety must be embedded into program design, not left to individual discretion. It highlights the systems, protocols, and cultural norms required to protect staff in the field and ensure that safety is treated as a shared organizational responsibility.
Crisis training, boundary setting, and vehicle safety are important areas to start.

Consider the following examples:

- Crisis Response and De-escalation
    - Overdose Prevention: Implement harm reduction strategies, including providing naloxone and training to clients/staff.
    - De-escalation Techniques: Use calm, non-confrontational language, maintain personal space, and practice active listening to reduce tension.
    - Safety Disengagement: If a situation becomes unsafe, prioritize your safety by immediately disengaging, leaving the scene, and reporting the incident.

- Professional Boundary Setting
    - Contact Information: Never provide personal phone numbers, social media profiles, or home address to clients.
    - Financial and Personal Items: Never lend money, provide cash, or give personal items to clients.
    - Professionalism: Maintain clear, consistent boundaries to ensure a safe, therapeutic relationship.
- Vehicle and Situational Awareness
    - Parking and Exit Strategy: Park in well-lit, open areas that allow for a quick, unobstructed exit.
    - Environmental Check: Before exiting or entering your vehicle, survey the surroundings for potential hazards.
    - Securing Information: Lock all vehicles and ensure sensitive client information, medication, or valuables are secured out of sight.
- Safety Awareness
    - Trust Instincts: If a situation feels unsafe, leave immediately.
    - Universal Precautions: Treat every environment as potentially dangerous to maintain high alertness.

[Slide Image Description: This slide shows outlines on how supervisors promote safety in mobile street outreach.]

Preparedness and Communication

- Maintain an up-to-date emergency contact list for all personnel operating mobile units or conducting outreach.
- Ensure every worker has access to a functional cell phone—either agency-issued or personal.
- Install required safety applications on phones and provide training on their use.
    - The KATANA Safety app is a personal safety tool that connects staff instantly to trusted contacts and a 24/7 Response Center. It provides GPS tracking, emergency alerts, and one-touch actions such as sounding an alarm or requesting help. Designed for lone workers, it ensures rapid support in uncomfortable or high-risk situations. A patented quick-trigger device can activate alerts even when the phone is locked.

Safety Planning

- Collaboratively develop dynamic safety plans with staff.
- Update safety plans as conditions, risks, or operational factors change.

Response to Threats or Violent Incidents

- Provide an open, supportive environment for discussion following any threat or violent event.
- Attend to the needs of workers, coworkers, and affected clients or patients.
- Offer ample opportunities for debriefing and make trauma counseling available.
- Communicate incidents of threats or violence to all relevant staff members.

Incident Reporting and Follow-Up

- Document all incidents thoroughly in a written report.
- Immediately notify appropriate agency leadership or designated staff of serious incidents.
- Assess whether legal action may be necessary and initiate steps as appropriate.

Ideas in Action

» Consider a safety system you will adopt in implementing AFBSS.

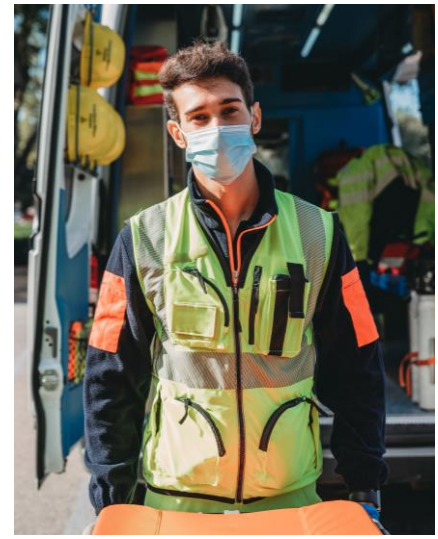
[Slide Image Description: This is an Ideas in Action slide that provides an opportunity for participants to practice using the information. It contains a checkbox and an arrow.]

CS Case Study:

1. Buddy System: Never conduct outreach alone; teams of two are the absolute minimum.
2. Code Words: Establish a predetermined code word to signal to teammates that you need to leave immediately without further question.
3. Route Planning and Tracking: Inform a designated offsite staff member of the planned route and estimated return time. Use GPS tracking or safety apps if one is available.
4. Safety Gear: Wear identifiable, bright, or matching clothing and official agency identification. Ensure mobile phones are fully charged.
5. Situational Awareness: Before exiting the vehicle, circle the area once and park in a well-lit spot that allows for an easy exit.
6. Respectful Approach: Announce your arrival loudly (e.g., "Outreach Worker! May I approach?") to avoid startling residents.
7. Positioning: Maintain at least an arm's length of personal space and ensure you have a clear escape route. Avoid standing over clients; instead, crouch to their eye level.

In Summary

- Field-based work requires multidisciplinary teams that work in collaboration with providers and CBOs that work inside the four walls.
- Field based teams take the care to the client.
- There are specific competencies and attributes that help them to be resilience in the field.
- Training, policies, procedures, knowledge of the street, and social teaching are essential for safety.
- Supervisors play a key role centering safety for field workers.



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[Slide Image Description: This slide shows bullets with next steps. It contains decorative arrows.]

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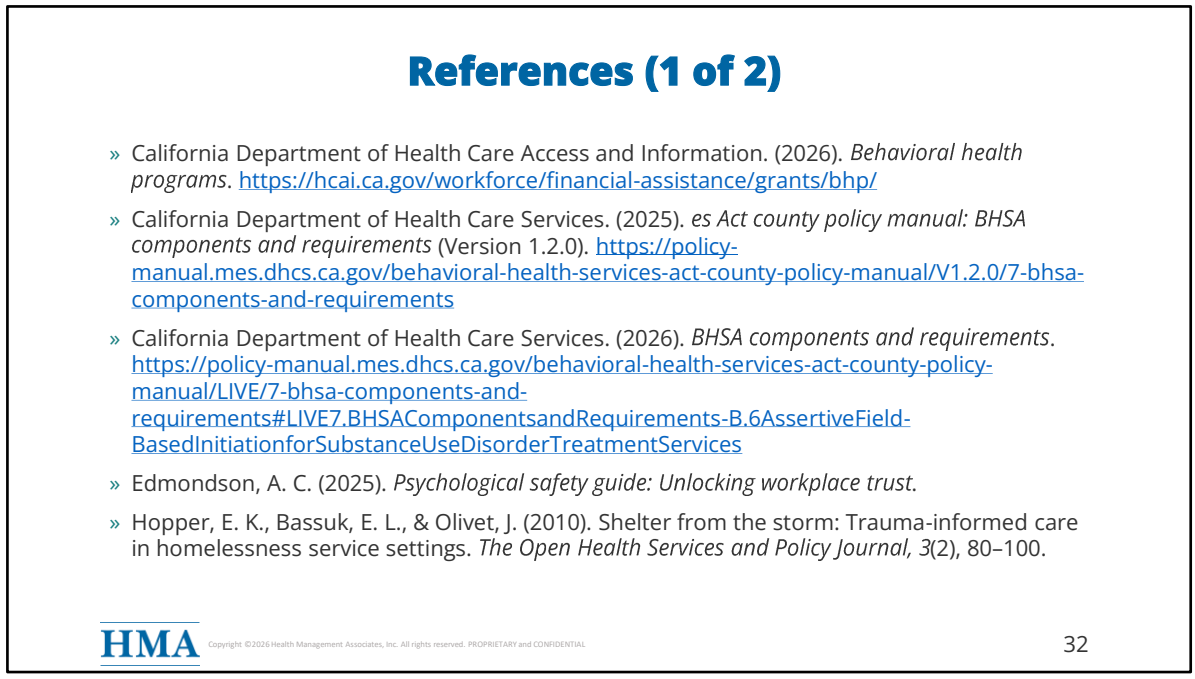
[Slide Image Description: This slide shows the AFBSS email address.]

We are here to support you and provide you with those opportunities to connect and hear about implementing AFBSS. Our email address is **info@afbsstraining.org**.



[Slide Image Description: This slide lists webinar resources.]

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