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SERVICE PLAN

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MISSION & VALUES

Mental Health Services for Homeless Persons, Inc., dba FrontLine Service, provides behavioral health services in Cuyahoga County, Ohio, for more than 30,000 children and adults each year. Founded in 1988 to serve adults experiencing severe mental illness and homelessness, FrontLine Service now provides outreach, mental health assessment, and diverse clinical interventions for children and adults through homeless assistance, crisis, and trauma programs. FrontLine Service is a not-for-profit, 501(c)(3) corporation, a contract agency of the Alcohol, Drug Addiction and Mental Health Services (ADAMHS) Board of Cuyahoga County, and a partner agency of United Way Services of Greater Cleveland.

FrontLine Service is certified by the Ohio Department of Mental Health and Addiction Services (OhioMHAS) to provide the numerous mental health services, including but not limited to; Case Management, Crisis Intervention Mental Health, Assessment, Behavioral Health Counseling and Therapy, Mental Health Assessment, Behavioral Health Hotline, Employment, Community Psychiatric Supportive Treatment, Therapeutic Behavioral Services, Psychosocial Rehabilitation, Evaluation and Management, Referral & Information and Other Mental Health Services.

One of FrontLine’s service locations is a Licensed Class 1 Residential Facilities—the James L. Stricklin Crisis Stabilization Unit. FrontLine Service is accredited by the American Association of Suicidology (since 2003) and by the Commission on Accreditation of Rehabilitation Facilities (CARF), consistently receiving 3-year accreditation awards from CARF since 2006.

The FrontLine Service leadership team supports and implements the agency mission statement, as approved by the Board of Trustees. FrontLine Service offers 24-hour professional services for children and adults in Cuyahoga County experiencing trauma or psychiatric crisis. The goals of these services are to help the person resolve the crisis, reduce, and manage subjective distress, and gain competence in new coping skills to forestall recurrence of the crisis. FrontLine Service also provides services to families in crisis, to protect children from harm and from removal from their families. FrontLine Service provides services to families who experience loss due to violence. FrontLine Service provides a continuum of services for those who are homeless, or at risk of becoming homeless, many of whom have a disability. Through participation in these services, clients achieve safe and permanent housing, and learn how to live with independence and dignity through the effective management of their health and recovery.

MISSION STATEMENT

Reaching out to adults and children in Northeast Ohio to end homelessness, prevent suicide, resolve behavioral health crises and overcome trauma.

In offering services, FrontLine Service staff members respect the choices and perceived needs of clients, and encourage participation of the person’s natural support system, if so desired, or create supports where few currently exist. Services are attentive to clients’ ethnic characteristics and cultural beliefs. Services support clients’ freedom to choose among alternative interventions unless the protection of safety requires emergency hospitalization. Service recommendations promote delivery of services in the least restrictive setting appropriate to the person’s needs and available resources,

preferably in the person's natural environment, if possible. Services are not restricted or denied to any adult or child solely based on their status or involvement in the justice system.

FrontLine operates from a trauma-informed philosophy of care. Staff are educated about the impact of trauma on the lives of persons served, and all persons served at FrontLine are trauma survivors. This treatment improvement protocol enhances the therapeutic relationship between the client and the worker, permits the client to feel safe and empowered, and encourages the worker to identify his or her own self-care needs and plan for resilience.

FrontLine recognizes that our work in the area of cultural competency and diversity is broad and inclusive of all groups, to include those who have experienced oppression because of sexism, heterosexism, ableism, classism, ageism, and anti-Semitism. The majority of those we serve are persons of color and experience oppression because of their race. FrontLine is committed to focusing efforts on fighting racism, within and outside of our organization. Since January 2020 the leadership team has undertaken experiential and educational activities, and discussion groups and opportunities, expanded to include all staff within the organization. The vision statement which defines who we want to be as an organization, in the next five years is as follows:

FrontLine Service is a driving force in creating an anti-racist community. Everyone we work and collaborate with supports this transformation in their policies, practices, and actions. We hold each other accountable to this vision. We utilize an anti-racist lens in all organizational decisions, as we work to achieve representation of our community at all levels of our agency. FrontLine is a safe and brave space. Staff and those we serve experience success regardless of their race and can be their authentic selves. Their voices inform program and agency decisions. As members of the broader community, we are each responsible for upholding this vision.

FrontLine's 2026 Strategic Direction:

- FrontLine will identify and respond to community needs and social issues to produce a measurable impact on the community's wellbeing. We will collaborate with our partners to provide trauma-informed, client-centered services.
- FrontLine will be highly regarded nationally for our development and implementation of evidence-based practices and will be a leader in our advocacy and education endeavors.
- As an employer of choice whose effective recruitment and retention programs result in an engaged workforce, FrontLine will be a financially vibrant organization and a trusted steward of community resources.

Our values as a non-profit, charitable organization are to promote the well-being of the common good through:

- Belief in the capacity of clients to direct their recovery.
- Anti-racism, cultural diversity, equity, inclusion and cultural competence
- Use of services and treatments having evidence of effectiveness.
- Protection of Client Rights
- Community collaboration to achieve continuity of care.

- Principled leadership
- Sound governance
- Financial accountability and responsible use of resources
- Systematic collection, reporting, analysis and use of outcome data.
- Adherence to professionally qualified standards of service
- Complying with all applicable federal and state laws

PROGRAMS AND SERVICES

FrontLine Service works with behavioral health providers, planners, advocates, and service recipients to develop resources as well as increased awareness and knowledge of the issues pertaining to persons with mental health needs and co-occurring substance use disorders. Agency staff members participate in community-based efforts to identify gaps in the community's service delivery system and improve behavioral health services in Cuyahoga County. Efforts to develop joint activities with other service providers have resulted in easier access to services for clients and the development of innovative programs.

FrontLine Service operates Coordinated Intake which is the gatekeeper to all persons seeking Emergency Housing in Cuyahoga County. FrontLine provides a broad range of services to homeless and disabled adults including rapid re-housing, mediation and diversion programs for individuals and families seeking shelter, as well as services for disabled men and women within the City of Cleveland's emergency shelters. Outreach workers assist individuals who are homeless, not yet connected with traditional community behavioral health services, and those who are homeless with substance use disorders. Additionally, an emergency housing program is available for homeless men and women who want to work.

Transitional housing, permanent supported housing and independent living in the community are all potential housing options for clients once they leave the shelters. Some clients may also need to stay in a Residential Treatment Program before they can be successful in their own apartments. Staff may also assist other clients with placement into group homes.

FrontLine clients who are homeless will have a primary staff person assigned to them to coordinate services. Clients may be assigned to a specific team, i.e., the Integrated Dual Disorder Treatment team, Bridges to Housing, a Forensic Team, and/or the psychotherapy team. If they are housed in permanent supportive housing, the client will be assigned to that specific site's treatment team.

FrontLine restructured programming in 2016 and created a "Youth and Family Services" site where various programs that work with children and families are housed. One of these programs serves young people in their transition to the adult service system. Another works closely with high barrier families to achieve housing stability and address mental health needs within the family.

Crisis Services provides 24-hour hotline, referral & information, and crisis intervention services to children and adults throughout the County. This program has been successful in reducing inpatient

psychiatric hospital utilization, and in improving the linkage of persons to ongoing mental health services after resolution of the crisis. The Crisis Stabilization Unit is a 15-bed Licensed Residential Facility where clients who are experiencing an acute mental health crisis can voluntarily stay for 7-10 days (about 1 and a half weeks) and participate in treatment groups, socialization activities and medication monitoring to regain their stability. The Police Co-Responder team responds to crises in the community alongside local law enforcement officers.

Trauma Services works closely with the local police department who refer children who have been traumatized by domestic violence and other violent events to the Children Who Witness Violence Program. Additionally, in collaboration with the Cleveland Police Department and the Witness Victim Center, the Traumatic Loss Response Team is a project that has allowed FrontLine Service to offer crisis intervention and case management services to persons who have experienced a loss due to violence. The Defending Childhood program provides assessments to children to determine which may require a referral/linkage for ongoing, more intensive services from one of the Child- Serving agencies in the greater Cleveland area.

Additional details about FrontLine's programs and services follow:

EMERGENCY HOUSING & SERVICES

COORDINATED INTAKE & DIVERSION	
<p>Service Description</p>	<p>Coordinated Intake is the front door for all homeless services in the Cuyahoga County Continuum of Care. All participating agencies in the continuum must receive their referrals via Coordinated Intake.</p> <p>Every person and/or family seeking emergency shelter in Cuyahoga County is assessed by Coordinated Intake & Diversion staff to determine if an immediate intervention might prevent the episode of homelessness. Interventions include family reunification, landlord-tenant mediation, and/or community referrals.</p> <p>If a shelter stay cannot be prevented, the family or individual is assessed for appropriate shelter placement and a referral is made. Additional recommendations for service needs are made based on information attained during the assessment. These recommendations are documented on the housing recommendation form which is given to the individual/family to present at the shelter.</p> <p>When diversion is not an option, this centralized system of coordinating emergency housing in Cuyahoga County permits individuals to be assessed and linked quickly and directly to the most appropriate service, i.e., transitional programming or to one of the emergency shelters in the city.</p> <p>Shelter options for families are limited therefore the Coordinated Intake team will maintain a wait list when necessary.</p>
<p>Days, Hours of Operation</p>	<p>Coordinated Intake operates five days a week at 1736 Superior Avenue, in the Bishop Cosgrove Building. Services are provided by phone at 216.674.6700. The hours are Monday through Friday, 8am – 8p.</p> <p>On weekends and holidays, individuals needing emergency housing can go to their respective emergency shelter—men to the 2100 Lakeside men’s shelter, and women to the Norma Herr Women’s Center at E. 22nd and Payne.</p> <p>Families and individuals can call 2-1-1; FrontLine staff are on call and will provide diversion services if possible.</p>
<p>Needs & Characteristics of Population Served</p>	<p>Individuals and families seeking emergency shelter in Cuyahoga County.</p>

Goals & Scope of Service	<p>The overall goal of Coordinated Intake is to assess homelessness, divert, when possible, certify the homelessness and manage the referral process to the appropriate shelter and housing resources.</p> <p>100% of clients receiving services from Coordinated Intake will be entered into the Homeless Management Information System (HMIS).</p> <p>15% of those seeking shelter will be diverted.</p>
Necessary Referrals/ Formal Affiliations	Coordinated Intake works directly with all Continuum of Care funded programs in Cuyahoga County. Daily communication between Coordinated Intake staff and staff of these participating agencies ensures that Coordinated Intake staff are aware of existing and upcoming vacancies.

RAPID REHOUSING	
Service Description	<p>The Rapid Rehousing (RRH) program at Frontline Service is designed to provide short-term case management aimed at ensuring housing stability. The average duration of service is twelve months. Staff meet with participants a minimum of once a month.</p> <p>The staff meet with the client to complete a Housing Stabilization Review. This review includes status of utilities, furniture, food, continued employment, adherence to a budget, and other needed community resources. New Housing Stabilization Goals are developed to address any barriers. At least one meeting is conducted at the participants' new residence where a visual inspection will be conducted.</p> <p>Staff will remain in contact with clients as needs dictate. Contact may be via telephone or in- person visits. The focus is on resolving any identified barriers. Staff interventions can include education around budgeting and adhering to lease requirements, advocacy, and external referrals. Often, advocacy is related to property owner/tenant issues. External referrals can include employment, furniture resources, local food pantries, behavioral health, and health related needs.</p> <p>To provide RRH services, FrontLine Service staff work collaboratively with Eden Inc. who is the fiduciary manager of the program. Eden provides all referrals; participants are already housed upon receipt of referral.</p>
Days, Hours of Operation	<p>Monday –Friday 8:30am to 5pm</p> <p>After hours services are available as needed until 8:00pm</p>
Needs & Characteristics of Population Served	<ol style="list-style-type: none"> 1) Homeless, single young adults, adults and families of Cuyahoga County 2) Sufficient income to sustain on-going rent payments. 3) Possess skills required to live independently.
Goals & Scope of Service	<ul style="list-style-type: none"> ● 95% of referrals received will maintain permanent housing for the duration of service provision. ● 90% of participants will report satisfaction with services received.

Necessary Referrals/ Formal Affiliations	EDEN, Inc.
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SHELTER-BASED CASE MANAGEMENT	
Service Description	<u>Gateway Services at 2100 Lakeside Men's Shelter</u> FrontLine staff work with the residents living in the Gateway Services community of the 2100 Lakeside emergency shelter for men. The residents served by the case management staff of Gateway Services have severe mental illness, mental retardation/developmental disabilities, physical handicaps, medical disabilities (including those with HIV/AIDS), substance use disorders and include those people classified as frail and/or elderly. The targeted population is historically known to be difficult to engage in treatment and services. These case managers will refer residents to PATH or to Integrated Behavioral Health Services (IBHS). Gateway prioritizes access and applications to Housing First program via the Chronically Homeless Prioritization Process for Permanent Supportive Housing.
Days, Hours of Operation	The emergency shelter operates 24 hours a day, seven days a week. The case management services are available during typical business hours (8:00 am to 5:00 pm) with limited evening availability as needed.
Needs & Characteristics of Population Served	Individuals who are homeless have a wide range of needs and characteristics. The Housing Needs Assessment will assist with identifying some of these needs and barriers to housing, including, of course, housing assistance, and the following: alcohol and drug treatment, medical and/or psychiatric services, entitlements, job training or other support services.
Goals & Scope of Service	The primary goal of case management programs is to link residents with housing, psychiatric and physical health services, and to link those who are eligible for additional services to those community resources and services. An additional goal for residents in the Gateway program is to provide a safe community within the larger men's shelter for those more vulnerable individuals. 50% of those engaged will be placed in housing within 90 days (about 3 months).
Necessary Referrals/ Formal Affiliations	Coordinated Intake The Office of Homeless Services FrontLine's PATH and IBHS programs Lutheran Metropolitan Ministry (operator of 2100 Lakeside Men's Shelter)

TEMPORARY HOUSING: NORTH POINT	
Service Description	<p>North Point Temporary Housing was developed in response to the need for Cuyahoga County and the City of Cleveland to provide overflow emergency shelter to unaccompanied men and women. The program is based on the belief that the problem of homelessness is a combination of the lack of affordable housing and poverty. The services provided at this program are targeted to address those issues. Program participants are from Cuyahoga County's Coordinated Intake, 2100 Lakeside Emergency Men's Shelter or Norma Herr Women's Center.</p> <p>North Point Temporary Housing is an innovative approach to providing an environment more conducive to achieving permanent housing than provided by traditional emergency shelters. By providing semi-private rooms, access to phones, access to intensive services on-site including rapid job placement and retention services, along with short-term rental subsidy, participants are able to quickly achieve self-sufficiency. Additionally, North Point Temporary Housing now provides intensive case management and targeted services to young adults ages 18-24 to eliminate the cycle of homelessness for this population.</p>
Days, Hours of Operation	North Point is a 24/7 residential facility. Unless a resident is working third shift, he or she is expected to be out working or seeking employment or engaged in work study/preparation activities during the day.
Needs & Characteristics of Population Served	The target population is unaccompanied men and women who are 18 years and older and who are able and willing to become gainfully employed and want to achieve permanent housing. North Point believes that for this target population, if income can be increased, people can achieve and maintain permanent housing with limited support.
Goals & Scope of Service	<p>North Point service goals:</p> <ul style="list-style-type: none"> • 60% of incoming participants that are unemployed will achieve gainful full-time employment of sufficient amount to remain permanently housed and meet basic needs prior to exit. • 50% of participants will achieve permanent housing. • 60% of program participants that have achieved gainful employment and permanent housing upon release will not return to shelter within one year of release.
Necessary Referrals/ Formal Affiliations	North Point residents are referred from Coordinated Intake, 2100 Lakeside Men's Shelter or the Norma Herr Women's Center.

PROGRAMS & SERVICES for those who are HOMELESS or HOUSED.

INTAKE & ASSESSMENT SERVICES	
<p>Service Description</p>	<p>Intake/screening activities may occur when a potential client calls or walks into the office seeking services. Formal referrals may come from the criminal justice system, hospitals, other social service agencies, etc. Staff will review the eligibility criteria for the various programs, i.e., homelessness and mental illness for IBHS, and the potential client will be instructed on what to do next (schedule an assessment).</p> <p>The Integrated Diagnostic Assessment is an intensive clinical evaluation of an individual and is always completed face-to-face with the client. A thorough understanding of the client achieved by completion of the diagnostic assessment is essential to the formulation of an achievable and effective treatment plan. Staff also obtains a description of the person's cognitive and behavioral functioning at the time of assessment, a description of the strengths and capabilities of the person assessed, employment information, and a physical health assessment when indicated. Diagnostic assessment services include the completion of an initial psychiatric evaluation unless the initial diagnostic assessment determines that the client does not have a mental health need and is ineligible for service.</p> <p>An integrated diagnostic assessment is completed prior to the initiation of any other mental health service apart from crisis intervention or Evaluation and Management services in emergency situations. For new clients, the integrated diagnostic assessments are performed at our main location, 1744 Payne Avenue. In rare situations, assessments can be conducted off-site (homeless shelters, The Crisis Stabilization Unit, etc.).</p> <p>FrontLine Service utilizes bi-lingual agency staff or contracts with appropriate service providers for clients who cannot communicate easily in English or who are hearing impaired.</p>
<p>Days, Hours of Operation</p>	<p>Diagnostic assessment services are available from 9:00 a.m. – 12:00 p.m., 1:00 p.m. - 4:00 p.m., Monday through Friday. Assessments may be scheduled or conducted on a first come, first-serve walk-in basis.</p> <p>Licensed FrontLine staff complete diagnostic assessments in a confidential, secure office environment.</p>
<p>Needs & Characteristics of Population Served</p>	<p>The majority of the people walking in the front door of FrontLine are referred from Coordinated Intake or emergency shelters because they are homeless and have been identified as having some type of mental health issue. Many are also trauma survivors and have substance use disorders. Some have already been engaged with our PATH or homeless outreach workers.</p>

<p>Goals & Scope of Service</p>	<p>The primary goals of the Integrated Diagnostic Assessment are:</p> <ul style="list-style-type: none"> • To gather enough current and historical bio-psycho-social information to determine if an individual seeking services is eligible for services. • To identify and prioritize problems and needs to be addressed during service delivery. • To make treatment recommendations based on the (provisional) diagnosis and other findings of that assessment. • All clients will receive a Diagnostic assessment within 24 hours of the screening. 100% of walk-ins will be seen by an intake coordinator or counselor that day to determine next steps.
<p>Necessary Referrals/ Formal Affiliations</p>	<p>If persons seeking services with FrontLine are not found to be eligible for services, assessment staff will refer the client to more appropriate services. Counseling may be available even if the client is deemed ineligible for any other FrontLine services. Entities referring potential clients to FrontLine are numerous and may include but are not limited to the following types of programs and services: shelters, hospitals, community outreach programs, drop-in centers, jails, prisons, other behavioral health centers.</p>

OUTREACH PROGRAMS	
Service Description	<p><u><i>Projects for Assistance in Transition from Homelessness (PATH)</i></u> Funded by the Ohio Department of Mental Health and Addiction Services (ODMHAS), the PATH program (Projects for Assistance in Transition from Homelessness) remains committed to serving homeless individuals who have been resistant to accepting services and are seriously mentally disabled. The PATH and other outreach programs coordinate efforts to maximize the number of homeless persons contacted in the community. These service hours help to make outreach services more available to clients. PATH staff work to engage those who have been resistant to traditional mental health services by meeting them in their natural environment, including the street, homeless camps, drop-in centers, under bridges or near abandoned buildings where they are sleeping. PATH staff offer practical assistance with basic needs, like food, blankets, clothing, and water.</p> <p><u><i>AOD Outreach</i></u> Outreach workers also engage those who are struggling primarily with a substance abuse issue who do not have a severe mental health disability and attempt to engage them and then refer them to treatment programs.</p> <p>Both Outreach Programs will assist their clients with obtaining any benefits they may be entitled to, securing appropriate shelter/housing, obtaining necessary diagnostic services and ongoing evaluation and management services with a psychiatrist and nurse, improving hygiene and daily living skills, and obtaining substance abuse treatment, when needed. PATH also begins to introduce the idea of the client transitioning to a more traditional IBHS program where they will receive ongoing services.</p>
Days, Hours of Operation	Outreach staff work Monday – Friday from 8:00 a.m. until 8:30 p.m. with flexibility to work earlier or later hours as needed, and they are available on-call.
Needs & Characteristics of Population Served	The outreach population is comprised of individuals who are homeless and have been resistant to accepting services, and who are seriously mentally disabled and/or have serious substance use disorders. Some of these individuals live in the City’s homeless camps, under bridges, in shelters, on the streets, in bus shelters, or abandoned buildings.
Goals & Scope of Service	<p>The primary goal for the PATH program is Engagement. Once engaged, some clients are willing to enter treatment, and some will be transitioned to the IBHS program. Some clients will stay with PATH until they are linked to necessary services and/or housed.</p> <p>Goals:</p> <ul style="list-style-type: none"> • 700 contacts will be made per grant year. • 532 clients will be enrolled per grant year. • 399 clients will be linked to mental health treatment per grant year.

	<ul style="list-style-type: none"> • 40% of clients served will have some type of benefits/entitlements upon discharge from the program. <p>The primary goal of the AOD Outreach program is linkage: Clients are linked to substance abuse treatment, benefits/entitlements, primary care providers, counseling and mental health treatment as needed.</p> <p>Goals:</p> <ul style="list-style-type: none"> • 25% of clients served are enrolled in AOD (Alcohol and Other Drugs) treatment in the community. • 35% of clients served will be linked to mental health treatment in the community. • 35% of clients served will be linked to primary care in the community. 10% of clients served will be linked to counseling.
Necessary Referrals/ Formal Affiliations	This “grass-roots” outreach program works best because of the considerable number of informal affiliations the outreach staff have developed with community-based programs, drop-in centers, shelters, neighborhood churches, emergency rooms, etc. Referrals received from concerned community members (courts, hospitals, police, local business owners, family members, etc.).

BRIDGES TO HOUSING – A CRITICAL TIME INTERVENTION PROGRAM	
Service Description	<p>The Bridges to Housing program provides supportive services to Young Adults (18-24) that reside at the North Point facility, Young Adults at any other emergency shelter in the County, and Young Adults who are homeless on the streets. Achieving permanent housing is the primary goal for these program participants. The program is funded by an Emergency Solutions Grant from the Cuyahoga County Office of Homeless Services and services are billed to Medicaid.</p> <p>The expected outcome is to increase the number of homeless Young Adult individuals placed in permanent housing with access to recovery supports and other behavioral health services. The intent of Bridges to Housing is to outreach, engage and link to services and permanent housing utilizing screening tools and evidence-based practices to end the cycle of homelessness for these individuals. Bridges to Housing focuses on outreach and engagement, connection to permanent housing and the implementation of the following evidence-based practices: Critical Time Intervention (CTI); Housing First; Motivational Interviewing; Harm Reduction; and Trauma-Informed Care. Program participants are assisted with securing identification and supporting documentation, applying for SSI/SSDI benefits when appropriate, completing housing applications, and coordinating medical and mental health appointments.</p>

	<p>Staff also help program participants plan and coordinate their moves and provide follow-up support once program participants have accessed permanent housing by utilizing the Critical Time Intervention model. CTI is a time-limited model for assisting vulnerable populations through major life transitions. Intensive services begin while the person served is still in North Point, other shelters, or the streets to provide continuity of care throughout the transition to housing. Once housed, independent living skills, employment, money management, mental health linkage and community integration are the focus of treatment. After the transition has been successfully navigated, CTI services are tapered and transitioned to traditional community providers. The typical timeframe is nine months and has three distinct phases. Phase one, labeled “transition to the community,” consists of the Bridges Case Managers providing intense support and assessing the available community resources. In phase two, termed “tryout,” the participant is encouraged to embrace and “try out” the plan for services and natural supports developed in phase 1. Phase three, or “transfer of care,” is focused on completing the transition of services to communities and traditional service providers. The transfer of care is gradual so that the participant does not feel abandoned when the Bridges Case Managers terminates the service.</p> <p>The project will serve at least 100 Young Adult individuals during each fiscal year and at least 65% of these individuals will achieve permanent housing placements.</p>
Days, Hours of Operation	Regular business hours for this program are Monday through Friday, 8:30 a.m. – 5:00 p.m. with availability during the evenings until 8:00 pm and 24/7 Crisis availability.
Needs & Characteristics of Population Served	Individuals who are homeless Young Adults (18-24) and have insufficient supports, serious mental health problems, trauma histories, foster care histories, and/or substance use disorders require many supports to transition successfully from the streets and/or shelters to housing.
Goals & Scope of Service	<p>Moving through time-limited, structured phases, staff work intensively with formerly homeless Young Adult individuals in collaboration with their community and traditional service providers to assist the participant in achieving a successful transition to permanent housing.</p> <p>Additional goals of the program include:</p> <ul style="list-style-type: none"> • Increase housing stability and decrease recurrent homelessness; 90% of clients that are housed will maintain housing upon discharge. • Decrease the number of homeless Young Adult individuals in shelters and on the streets; 65% of those opened in the program will achieve permanent housing.
Necessary Referrals/ Formal Affiliations	North Point, YWCA, A Place for Me, LMM (Lutheran Metropolitan Ministries), Coordinated Intake, Bellefaire Missing and Homeless Youth, Care Alliance Outreach and EDEN (Emerald Development and Economic Network) are all important affiliates’ referral sources.

INTEGRATED BEHAVIORAL HEALTH SERVICES and INTEGRATED DUAL DISORDER TREATMENT (IDDT) PROGRAM

<p>Service Description</p>	<p>Traditional case management (CPST) (Community Psychiatric Supportive Treatment)) has been replaced by a combination of Psychotherapy, Therapeutic Behavioral Services and Psycho-Social Rehabilitation. These are the basis of service provision to clients on the Integrated Dual Disorder Treatment Team (IDDT), Forensic Team, and Housing First/Supportive Housing Teams.</p> <ul style="list-style-type: none"> • Psychotherapy uses principles, methods and procedures of counseling that assist the clients in identifying and resolving personal, social, vocational, intrapersonal, and interpersonal concerns. • Therapeutic Behavioral Services are goal-directed supports and solution-focused interventions intended to achieve identified goals or objectives as set forth in the individual’s treatment plan. Services focus on teaching, not doing, to increase self-sufficiency which is consistent with The Recovery Model. • Psychosocial rehabilitation is comprised of individual face-to-face interventions for the purpose of rehabilitative skills building, the personal development of environmental and recovery supports considered essential in improving a person’s functioning, learning skills to promote the person’s self-access to necessary services and in creating environments that promote recovery and support the emotional and functional improvement of the individual. <p>IBHS teams utilize several evidence-based practices as appropriate: Principles of IDDT, Harm Reduction, Motivational Interviewing, Trauma Informed Care, Housing First. IDDT is an evidence-based practice which is effective for persons who have a severe and persistent mental illness and a substance use disorder. The IDDT model is based on a progressive staging process where the treatment team identifies which stage of change the client is in, and then applies the treatment intervention strategies that directly correspond to that specific stage. The IDDT Stages of Treatment include Pre-Engagement, Engagement, Early Persuasion, Late Persuasion, Early Active Treatment, Late Active Treatment, Relapse Prevention and Remission. Motivational interviewing, also an evidence- based practice, is one of the primary intervention methods utilized in IDDT and a variety of other programs.</p> <p>Forensic programs and Housing First/Supportive Housing Teams are described in greater detail later in this document.</p> <p>Service provision is client centered and client driven. IBHS staff work with clients to build rapport and trust, often outreaching clients to keep them engaged in services. IBHS staff assist clients in learning the skills needed to reach their self-defined goals. Highly collaborative in nature, the IBHS program depends not only on the client for input and collaboration, but on other appropriate service providers in the community to provide a comprehensive array of services. It is the intent of the IBHS program to</p>
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facilitate each client's experience of their own successes and to build on these successes for optimal recovery.

IBHS serves one of the most vulnerable populations of persons with mental illness: those who are homeless. Among these individuals are those who are dually diagnosed with a substance use disorder and/or other mental disability. IBHS provides an array of intensive services delivered by a community-based team of service providers including case managers, social workers, psychotherapists, peer-support specialists, nurses, advanced nurse practitioners and psychiatrists. Services and support are focused on the individual's ability to succeed in the community; to identify and access services needed to achieve optimal independence and to show improvement in overall functioning. IBHS services include monitoring and assessment of the individualized needs of each client. Services are primarily community based and are provided in locations that meet the needs of the clients.

IBHS staff members develop an Individualized Treatment Plan (ITP) with each client within five face-to-face sessions of service provision or 30 days (about 4 and a half weeks) after admission, whichever is longest. Goals and objectives are, to the extent possible, expressed in the client's own words, and start at the level at which the client can successfully accomplish them. IBHS staff assist clients in linkage to services and resources to meet their goals and achieve independence, as identified in their ITP. FrontLine Service encourages involvement of family and/or significant others whenever clients wish to involve their families as natural supports in the treatment planning process. The client, staff, and appropriate clinical managers review the client's goals and objectives whenever clinically indicated, at a minimum every 180 days (about 6 months) and make changes in the treatment plan as indicated by the review.

Because most of the clients come to the agency without income or insurance, IBHS staff assists clients in applying for all entitlements, including disability assistance, Medicaid or Medicare, Supplemental Security Income, and veteran's benefits. When appropriate, staff assist clients with finding an organization or an individual to become their representative payee for Social Security entitlements. In these situations, the staff is available to assist the client with developing more efficient budgeting skills and will help the client work towards more self-sufficiency in this area. It is a goal for the client to develop the skills needed for independent management of income, if possible. Staff also assist the client in securing community services through other providers, including healthcare, financial, vocational/training services, or social support groups.

Equally important is the role that IBHS staff plays in providing education and supporting clients' development. Staff providing services must have a working knowledge of services, resources and support systems that are appropriate to the needs of the client. Staff educate clients about the resources and support available to them in their own community and how to access them. Every client is familiarized with how to access crisis intervention services. Other resources include pre-vocational/training opportunities, social groups/activities, and self-help groups. Staff

	<p>work with clients to identify skills which need to be strengthened (I.e., personal hygiene, budgeting, meal planning and preparation, housekeeping, transportation by bus) provide assistance and reinforcement as the client’s skills develop. The client and IBHS staff may coordinate efforts with other appropriate service providers in the community, as documented on the client’s ITP.</p> <p>IBHS staff work closely with clients to assist them in identifying housing options that are appropriate to their abilities and preferences. Because many FrontLine Service clients are homeless and in need of permanent housing at the time of initial contact, additional support services are provided through the agency’s Housing Coordinator and EDEN Inc., our partner organization.</p> <p>FrontLine’s PATH, Outreach, or Crisis Services may transfer clients to the IBHS program. The transfer of services from one FrontLine Service program to another is carefully coordinated and includes the participation of the client, the appropriate Program Managers, the staff who provided initial services to the client, and the newly assigned direct service worker. Coordination of service provision between FrontLine Service programs during this process is less disruptive to the client and minimizes the risk of losing the client during the transition period.</p> <p>Group services are an additional service modality utilized by FrontLine Service. In keeping with its traditional role, group services offer clients the opportunity to acquire and practice the social and organizational skills useful in obtaining needed resources.</p> <p>Information gathered during the screening and assessment process is utilized to determine not only eligibility, but the urgency of the client's needs and ensures that those most in need have priority to IBHS services. For eligible individuals, services may be provided by a Psychotherapist, TBS and/or PSR worker. Psychotherapist or TBS worker are primary.</p>
Days, Hours of Operation	<p>IBHS services are available 24 hours per day, 7 days per week.</p> <p>Clients and family members can directly contact the TBS, psychotherapist or PSR providers at the 1744 Payne Avenue location Monday through Friday, from 9:00 a.m. to 5:00 p.m. During holidays and at other times, calls to the agency's administrative office are forwarded to the 24-hour Mobile Crisis Team, who contact staff to provide after-hours services, when needed.</p>
Needs & Characteristics of Population Served	<p>Eligible individuals are adults who are homeless or at imminent risk of becoming homeless, have a severe mental disability, are a Cuyahoga County resident, are unlinked with any other mental health agency (closed in other mental health agencies for at least 6 months) and agree to receive services. Eligibility requires that IBHS be a service that is medically necessary for the diagnosis or treatment of the illness and without which the person can be expected to suffer prolonged, increased, or new morbidity or impaired function.</p>
Goals & Scope of Service	<p>Specific goals that are measured include the following:</p> <ul style="list-style-type: none"> • 75% of IBHS clients will secure housing (independent, family/friends, group home, sober living, rooming house, etc.)

	<ul style="list-style-type: none"> • 85% will obtain or maintain eligible benefits, including health care, food stamps. • 65% of clients will obtain Primary Physical health care. • 75% will obtain or maintain a source of steady income which may be Social Security, Disability benefits, or employment.
Necessary Referrals/ Formal Affiliations	Coordinated Intake, walk-in, Mobile Crisis, other community mental agencies such as Recovery Resources, Connections, The Centers, Care Alliance, shelters, and hospitals are sources of referrals for new clients.

FORENSIC PROGRAMS	
Service Description	<p>FrontLine works collaboratively with several community partners to provide forensic services to its population. Some of the funding streams may have changed over the years, but the history and major focus of these programs has remained the same. The agency's Information & Referral Service staff are instrumental in the identification and linkage of those individuals who need these forensic services. The I&R staff, a service of the Mobile Crisis Department, receives forensic referrals from the Ohio Department of Mental Health and Addiction Services of inmates from the Ohio Department of Referral and Corrections facilities who will soon be released and need mental health linkage.</p> <p>Once potential clients or consumers are identified, staff of the various Forensic programs will engage potential clients and provide case management services utilizing the interventions of Therapeutic Behavioral Services and in some cases Psychosocial Rehabilitation.</p> <p><u><i>Returning Home Ohio (RHO)</i></u> A collaboration of the Corporation for Supportive Housing and the Ohio Department of Rehabilitation and Correction (ODRC), targeting adults returning home to Ohio from federal prison (typically prisons in Ohio) that provides housing assistance in the form of permanent supportive housing subsidies administered by Eden, Inc., tenant assistance, as well as support services such as mental health or housing case management and housing retention. The expectation is that the individuals in this program will become self-sufficient so that the vouchers can be awarded to new individuals on a continual basis. Currently there are 40 available vouchers for Cuyahoga County.</p> <p><u><i>Women's Forensic Team</i></u> A re-entry program aimed at reducing recidivism for women in Cuyahoga County jails who are at risk of homelessness. This program offers support services including a range of case management services, group therapy, peer support, supported employment, and psychiatry as needed. This program utilizes elements from the IDDT model, like Motivational Interviewing and focuses on intensive case</p>

	<p>management with linkage to benefits and other services, including access to another evidence-based program—Supported Employment. Grant funded through the ADAMHS board.</p> <p><u>Community Transition Program (CTP)</u> A re-entry program funded by OHMAS in an effort to extend substance use and mental health services to all Ohio counties for clients exiting federal prison as of July 1, 2016.</p> <p><u>Eden-Community Transition Program through Corporation for Supportive Housing (Eden-CTP)</u> A housing case management program that is linked with the previously described Community Transition Program. Community Transition Program participants who have received a housing subsidy through the program, and are housed, will be referred to Frontline for housing case management, enhancing community supports, encouraging engagement in pro-social activities, and to assess ongoing behavioral health needs. The Corporation for Supportive Housing established a contract with Eden for housing services, and Eden has partnered with Frontline to offer services to 65 individuals in Permanent Supportive Housing, 50 individuals in Rapid Re-Housing, and 5 individuals in Recovery Housing over the course of the grant period—January 1st, 2018, through June 30th, 2019.</p> <p><u>General Forensics/ Mentally Disordered Offenders (MDO)</u> A program designed for clients who meet Frontline Service agency criteria (severely mentally ill and currently homeless) who are actively involved in the court system—and in particular, the Mental Health and Developmental Disabilities Court of the Cuyahoga County Common Pleas Court. The program offers case management and coordination with the courts, as well as linkage to psychiatry, psychotherapy, and peer support services as needed.</p> <p><u>Returning Home Cuyahoga (RHC)</u> A collaboration among the Cuyahoga County Corrections Planning Board, The ADAMHS Board of Cuyahoga County, the Mental Health and Developmental Disabilities Court of the Cuyahoga County Common Pleas Court, EDEN Inc., and FrontLine Service. This program is designed to serve pre- and post-trial individuals, on probation, who are high utilizers of the corrections, hospital, and homeless systems, with the goal of reducing recidivism by establishing and maintaining independent housing and intensive wrap-around services. The program provides housing assistance in the form of permanent supportive housing subsidies administered by Eden, Inc., tenant assistance, as well as support services such as mental health or housing case management and housing retention. This is a pilot program and currently there are 15 vouchers available for this population.</p>
Days, Hours of Operation	Monday through Friday, 8:30 a.m. to 5:00 p.m. After hours, consumers can use the Mobile Crisis Hotline for psychiatric emergencies.
Needs & Characteristics	<u>RHO:</u>

<p>of Population Served</p>	<ul style="list-style-type: none"> • Adults returning home to Cuyahoga County. • Currently incarcerated or Within 120 days (about 4 months) of release from prison • Either have <i>Serious Mental Illness (Axis I) or HIV+</i> • Homeless or at risk of Homelessness <p><u>Women's Forensic Team:</u></p> <ul style="list-style-type: none"> • Adult women who are currently incarcerated at Cuyahoga County Jail, Cuyahoga City jails, Northeast Pre-Release Center or within 30 days (about 4 and a half weeks) of release from those institutions. • Have <i>both</i> Serious Mental Illness (Axis I) <i>and</i> a substance use disorder or history of significant use. • Homeless or At Risk of Homelessness <p><u>CTP:</u></p> <ul style="list-style-type: none"> • Adults exiting prison in Ohio. • Client received some type of chemical dependency treatment while incarcerated and have a substance use disorder. • Client must be currently incarcerated <i>or</i> in the community <i>and</i> on parole to be considered eligible for referral. <p><u>General Forensics/MDO:</u></p> <ul style="list-style-type: none"> • Adults who are involved in the muni-docket, MHDD, or mental health probation through Cuyahoga County. • Must meet agency criteria. <p><u>Eden-Community Transition Program</u></p> <ul style="list-style-type: none"> • The client is linked with Eden and has been housed through the CTP housing benefit. • Client meets the CTP- criteria. <p><u>Returning Home Cuyahoga</u></p> <ul style="list-style-type: none"> • Adults who are part of the Mental Health and Developmental Disabilities Court Docket • Must have a Severe and Persistent Mental Illness • High utilization of psychiatric hospitals/EDs, shelter system, and frequent or lengthy incarcerations
<p>Goals & Scope of Service</p>	<p><u>RHO:</u></p> <ul style="list-style-type: none"> • 80% will remain housed in the RHO (Returning Home Ohio) program or exit for a clearly positive reason. • 80% will maintain or increase public benefits (food stamps, general assistance, Medicaid, Medicare) • 65% will receive income (SSI, SSDI, employment)

	<p><u>Women's Forensic Team:</u></p> <ul style="list-style-type: none"> • 25% of those clients linked to employment services will become employed. • 85% of those linked to housing services will secure housing. • 85% of those eligible for healthcare will gain access to healthcare benefits prior to exiting the program. <p><u>CTP:</u></p> <ul style="list-style-type: none"> • 60% of referrals will be engaged in services. <p><u>General Forensics/MDO:</u></p> <ul style="list-style-type: none"> • Of those who need housing, 50% will secure stable housing within 120 days (about 4 months) • 80% will maintain or increase public benefits (food stamps, general assistance, Medicaid, Medicare) • <p><u>Eden Community Transition Program</u></p> <ul style="list-style-type: none"> • 80% of CTP clients will remain housed in CTP or exit the program for positive reasons. • 65% of CTP clients will increase their housing during the quarterly review period. <p><u>Returning Home Cuyahoga</u></p> <ul style="list-style-type: none"> • Serve 15 individuals annually (pilot program)
<p>Necessary Referrals/ Formal Affiliations</p>	<p><u>RHO:</u></p> <ul style="list-style-type: none"> • ODRC primarily • Parole officers sometimes • Community referrals (FLS Intake/Coordinated Intake/Self-Referral) <p><u>Women's Forensic Team:</u></p> <ul style="list-style-type: none"> • Cuyahoga County Jail psych, Cuyahoga County mental health docket, FLS forensic liaison, public defenders, victim's witness advocates, self-referral while incarcerated. • Community referrals (FLS Intake, Coordinated Intake). Fewer referrals come from the community d/t the small window that we can admit clients post release (30 days (about 4 and a half weeks)) <p><u>CTP:</u></p> <ul style="list-style-type: none"> • If a client is on parole, their parole officer must make the referral. (Frontline cannot make the referral) <p><u>General Forensics/MDO:</u></p> <ul style="list-style-type: none"> • FLS Intake primary referral source • Mental Health Docket/FLS Jail Liaison

	<p><u>Eden-Community Transition Program</u></p> <ul style="list-style-type: none"> • Eden Inc. refers clients as they become housed. <p><u>Returning Home Cuyahoga</u></p> <ul style="list-style-type: none"> • Mental Health and Developmental Disabilities (MHDD) Docket probation officers primarily • Public Defenders, Jail Liaisons, Case Managers, Jail Mental Health Staff
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SAFE HAVEN I & III	
Service Description	The Safe Havens offer residents services based on the psychosocial rehabilitation of service delivery, also known as the Clubhouse model, which is an evidence-based practice that focuses on the strengths and abilities of each individual, which fosters independent functioning and fulfillment of societal roles, assuming that growth and recovery is a process that continuously occurs throughout each individual's life. The Safe Havens provide individuals experiencing mental illness with services and opportunities to live meaningfully within their communities and aim to strengthen and increase the social networks of these individuals by providing an environment that promotes a sense of community and belonging through peer support. Through the Clubhouse model, clients work side by side with program staff to learn new skills (meal preparation, housekeeping, hygiene, etc.), follow a daily routine, and resolve problems. Research suggests individuals that are served under the Clubhouse model experience reduced symptoms of mental illness and enhanced recovery outcomes, and most of the Safe Haven residents achieve significant gains within their first few months of program participation (medication adherence, decrease in high-risk behaviors, decrease in hospitalizations/ED utilization).
Days, Hours of Operation	The Safe Havens are staffed 365/24/7, and clinical staff are available on-call after business hours.
Needs & Characteristics of Population Served	<p>Each client's treatment is individualized based on his/her needs, abilities, preferences, and strengths. Emphasis is placed on recovery.</p> <p>The target population for the Safe Haven programs is single adults with a history of homelessness who have not been successful in less supportive housing. Residents must have a severe mental illness such as schizophrenia, schizoaffective disorder, bipolar disorder, or another severe mood/psychotic disorder, and they can have a co-occurring substance use disorder as well.</p> <p>Residents can receive case management, individual counseling, group counseling, life skills services, and medical services (at FLS's main location) by participating in the Safe Haven program.</p>
Goals & Scope of Service	The overall goal is to provide residents with the tools needed for mental health stability. To achieve these overarching goals, staff work with clients on:

	<ul style="list-style-type: none"> • Improving skills needed to manage medical needs. • Improving personal living skills • Improving domestic living skills • Improving community living skills • Increased integration into the community through improved social skills • Improved ability to access needed community resources. • Improved symptoms awareness and management of mental illness • Improved management of substance abuse problems • Increased involvement in meaningful activities <p>More specific program goals include the following:</p> <ul style="list-style-type: none"> • 95% decrease in psychiatric ER (Emergency Room) visits/inpatient admissions during program participation. • Individual improvement in symptom distress scores on the Ohio SCALES • 10% reduction in legal recidivism over course of program participation.
Necessary Referrals/ Formal Affiliations	Alcohol, Drug Abuse and Mental Health Services Board of Cuyahoga County Cuyahoga County Coordinated Intake EDEN, Inc.

PERMANENT SUPPORTIVE HOUSING (PSH) – HOUSING FIRST	
Service Description	The Permanent Supportive Housing (PSH) program serves single adults and families who meet the HUD definition of chronic homelessness, and who have a qualifying disability (substance use disorder or mental illness). Participants are identified and placed through the county’s Coordinated Intake system. The PSH program provides accessible, safe, affordable housing based on the principles of <u>Housing First</u> , which is the belief that housing is a human right and there should not be pre-conditions to obtain permanent housing other than a willingness to be housed and abide by lease requirements. Permanent supportive housing is provided to eligible adults and families in both community settings, such as independently owned apartments or houses, as well as designated PSH apartment buildings located throughout the city of Cleveland.
Days, Hours of Operation	PSH staff are available on-site during business hours, and there is a designated on-call person after business hours and on the weekends/holidays. You can also call the Mobile Crisis Team for assistance with mental health crises 24/7 at 216-623-6888.
Needs & Characteristics of Population Served	High barrier individuals who meet the HUD definition of homelessness are identified through street outreach and prioritized for placement in a PSH via a ranking system that factors days of homelessness, client’s preferences, and their Vulnerability Index Score. Eligible participants come from the street, locations not meant for human habitation, shelters, safe havens or fleeing domestic violence. Residents of PSH typically have multi-system barriers, including severe mental illness and substance use disorders, criminal justice involvement, chronic health conditions, and unemployment.
Goals & Scope of Service	Case management, psychotherapy, group therapy, life skills, physical healthcare, (via local healthcare partners) and psychiatric/nursing services are available to residents of PSH. The program provides social service support; however, participation in services is not required to maintain housing. Services are delivered in alignment with evidence-based practices, such as Motivational Interviewing, Harm Reduction, and Trauma Informed Care. Participants develop individualized goals that could include housing, health, employment, inter-personal relationships, reducing or abstaining from substances, maintaining psychiatric stability, etc. Goals for PSH – Housing First: <ul style="list-style-type: none"> • Budget report of how client assistance was distributed and number of clients served • Budget report of how client laundry assistance was distributed and number of clients served. • Summary of activities provider, number of residents who participate in social/recreational activities.
Necessary Referrals/ Formal Affiliations	Cuyahoga County Coordinated Intake EDEN, Inc.

SUPPORTED EMPLOYMENT PROGRAM

Service Description	<p>FrontLine Service’s Supported Employment (SE) program applies the principles of Individual Placement and Support (IPS); an evidence-based practice to meet the employment and educational needs of ‘Housing First’ residents. Supported Employment helps consumers find and maintain competitive jobs and/or educational opportunities in their communities. Supported Employment services are integrated with Community Psychiatric Support Treatment (CPST) and/or Case Management services at each site, in addition to other support services, at varying levels of intensity.</p> <p>There are eight core principles that make the SE model different from vocational rehabilitation programs. The principles are briefly described below. Research has demonstrated that these principles produce positive consumer outcomes and improved program and service-system outcomes.</p> <ol style="list-style-type: none"> 1. Focus on Competitive Employment: Agencies providing IPS services are committed to competitive employment as an attainable goal for people with serious mental illness seeking employment. 2. Eligibility Based on Client Choice: People are not excluded based on readiness, diagnoses, symptoms, substance use history, psychiatric hospitalizations, homelessness, level of disability, or legal system involvement. 3. Integration of Rehabilitation and Mental Health Services: IPS (Individualized Placement and Support) programs are tightly integrated with mental health treatment teams. 4. Attention to Consumer Preferences: Services are based on each person’s preferences and choices, rather than providers’ judgments. 5. Personalized Benefits Counseling: Employment specialists help people obtain personalized, understandable, and accurate information about their Social Security, Medicaid, and other government entitlements. 6. Rapid Job Search: IPS programs use a rapid job search approach to help job seekers obtain jobs directly, rather than providing lengthy pre-employment assessment, training, and counseling. 7. Systematic Job Development: Employment specialists systematically visit employers, who are selected based on job seeker preferences, to learn about their business needs and hiring preferences. 8. Time-Unlimited and Individualized Support: Job supports are individualized and continue for as long as each worker wants and needs the support.
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Description:

FrontLine Service provides intensive employment and/or educational services to assist people seeking employment and/or educational opportunities in choosing, obtaining, and retaining competitive employment and /or educational opportunities in the community via FrontLine Service’s Supported Employment Program. Services and support are focused on the individual’s ability to achieve their employment and/or educational goal(s); to identify and access services needed to achieve optimal independence; and to show improvement in overall functioning. Services are community-based and provided at times and in locations that meet the needs of the clients. All services are provided in a manner that promotes the dignity and privacy of the persons served, that is not unduly disruptive, and takes into consideration the individual’s cultural beliefs, values, and practices.

Target Population, Eligibility & Assignment of Primary Worker:

FrontLine Service receives funding from HUD and other stakeholders to operate a Supported Employment program for persons residing in one of our ‘Housing First’ programs. Residents of the ‘Housing First’ programs are those who have experienced homelessness and will have what HUD defines as a ‘disabling condition.’ The disabling conditions will have been of long term and continuing duration and will significantly impede the residents’ abilities to live independently.

A referral to the Supported Employment program can be completed by a client or a third party. Clients residing in a FrontLine Service Housing First program are made aware of FrontLine Service’s employment services via flyers, posters in common settings, and discussions with providers. The client’s Individualized Service Plan (ISP) should reflect the client’s desire to receive services from the Supported Employment program to achieve their individualized employment and/or educational goals. The referral is then forwarded to the Supported Employment Program Manager who assigns an Employment Specialist to work collaboratively with that individual. Clients have the option of receiving services from another Employment Specialist if they believe that their needs would be better met by another provider. The assigned Employment Specialist conducts an immediate interview to identify individual needs at initial contact, determine whether the agency can provide the services needed. Exclusion criteria for Supported Employment services: the individual is not residing in one of the targeted ‘Housing First’ programs or the individual does not accept services.

Supported Employment services are provided at the following ‘Housing First’ sites:

- Emerald Commons, Madison Avenue
- Downtown Superior Apartments, Downtown area
- Liberty at St. Clair, Glenville area
- South Pointe, Tremont area
- Edgewood Manor, Broadway area
- Greenbridge I/II, E.75th/Euclid Ave.
- The Winton, W. 95th/Lorain
- Buckeye

	<ul style="list-style-type: none"> • Union-Miles • West Village on Detroit • Harper’s Pointe • Scattered Sites • Young Adult Program, Scattered Sites in Cuyahoga County • Families in Housing, Scattered Sites in Cuyahoga County
Days, Hours of Operation	<p>Employment Specialists typically work 8 a.m. – 4:30 p.m., Monday through Friday. They can flex their time to accommodate client needs, i.e., when a client has an early or later job interview, when meeting with employers, or with the employee on the job.</p>
Needs & Characteristics of Population Served	<p>The only eligibility requirement is the individual is a client of FrontLine Service, receiving housing support/case management services and has expressed a desire to work.</p>
Goals & Scope of Service	<p>Employment planning is a crucial component of the Supported Employment services. The Employment Specialist is responsible for developing and implementing the Individualized Employment Plan (IEP). Supported Employment staff and the client collaborate to develop a comprehensive IEP as soon as clinically prudent. Clients take an active role in the development of the IEP, including sharing strengths, needs, and service expectations, which are then documented in the client’s own words. The IEP also includes strategies for work/school place accommodations, if necessary, as well as interventions to overcome other barriers to employment or education. Participation in the development of the IEP provides the client with a structured set of service expectations and personal goals.</p> <p>Job exploration entails the employment specialist meeting with the participant to explore ambivalence related to pursuing employment and/or educational opportunities; referrals to increase the participants awareness of how work will impact their benefits; and exploration of diverse types of employment, volunteer, or educational opportunities. Job search skills training involves the consumer meeting with their Employment Specialist to become more knowledgeable and skilled in areas pertinent to achieving a successful job search and placement.</p> <p>Job Development services are provided to assist clients with finding and obtaining employment. Employment Specialists meet with clients to complete applications, talk to employers in the community, and participate in job interviews. The Employment Specialist also meets with employers, independently, to facilitate lasting relationships in order to learn about the employer and provide workplace recommendations for clients.</p> <p>Job retention services/Job Supports involve the employment specialist being consistently ready to assist consumers who are placed in competitive employment to enhance job adjustment and retention. Once clients are placed in employment and when appropriate, the Employment Specialist ensures that the new employee has received all necessary information to be oriented to the job. Job retention services/Job Supports may also include on-site job coaching/Job-Site Training on behalf of the client when appropriate and with client consent.</p>

	The Supported Employment team serves approximately 135 clients per calendar year.
Necessary Referrals/ Formal Affiliations	Staff can refer clients, or they can self-refer.

BEHAVIORAL HEALTH PSYCHOTHERAPY	
Service Description	<p>Behavioral Health (BH) counseling and psychotherapy services are face-to-face services provided for individuals and groups in a time-limited, structured manner to help clients achieve mutually defined goals. These services are not site-specific and are provided in agency offices, or in a community setting that affords private and confidential service delivery. BH Counseling and psychotherapy services may address mental, emotional/behavioral, trauma-related or substance use disorders.</p> <p>When the client is a child or adolescent, these face-to-face services may also be provided to a family member, parent, guardian or significant other when the intended outcome is improved functioning of the child or adolescent. Timely collateral contacts with family members, parents, or guardians, and/or other agencies/providers are ensured. Psychotherapy is provided to children and adolescents through the agency's trauma services, which are detailed in separate sections.</p> <p>Behavioral health counseling and therapy services are identified in the Individual Service Plan(s) of the client.</p> <p>Behavioral health counseling and psychotherapy services may be particularly valuable for children and adolescents who have experienced traumatic events, and who are referred to the Children Who Witness Violence program (a program within the Trauma Services Department). Results of research studies indicate that behavioral health counseling and therapy services for these children may help them to achieve an adaptive understanding of the violence that was witnessed, address the distressing symptoms of anxiety, conduct or mood disorders that frequently result from exposure to violence, preclude deterioration in academic and social functioning, and preclude the development of generalized maladaptive beliefs.</p> <p>Most of the adult clients who are engaged in psychotherapy have been dually diagnosed with mental health and substance use disorders. A majority of the agency's psychotherapy clients also exhibit symptoms consistent with past traumatic experiences.</p>
Days, Hours of Operation	<p>Counseling/psychotherapy is most often available by appointment only, typically occurs Monday through Friday between 9 a.m. and 5 p.m., and may occur outside of regular business hours if needed, i.e., to work around someone's employment schedule.</p> <p>Both individual and group counseling services may be provided.</p>

Needs & Characteristics of Population Served	As above, the needs and characteristics of the population vary. Adults, children, and adolescents are eligible to receive this service, which is available within many FrontLine programs.
Goals & Scope of Service	Goals are individualized, focused on the treatment of the mental illness or emotional disturbance, substance use disorder, or trauma, and documented in the ISP (Individualized service Plan). BH (Behavioral Health) counseling and therapy services may address mental, emotional/behavioral, trauma-related or substance use disorders. Common psychotherapy goals include learning about mental health symptoms and diagnoses; learning coping skills to improve symptom management; reducing harmful behaviors; improving interpersonal skills to strengthen relationships; improving coping to manage anger and aggressive behaviors; coping skills to obtain/sustain abstinence from substances, etc. When the person served is a child or adolescent and the intended outcome is improved functioning of the individual, the interaction may also be with the significant others involved with the individual. A goal attainment scale is presently being evaluated and considered to collect outcome data for psychotherapy.
Necessary Referrals/ Formal Affiliations	Referrals to psychotherapy may be made during an initial assessment or when the client identifies that they would like to participate in psychotherapy.

YOUTH & FAMILY SERVICES

SUPPORTIVE HOUSING FOR FAMILIES (SHF)	
Service Description	FrontLine Service has a long-standing history of aiding in reducing homelessness with families in Cuyahoga County. Supportive Housing for Families (SHF) was developed after FrontLine recognized a need to provide a different type of program for families that were struggling with homelessness. The Supportive Housing for Families program serves families that are homeless or housing unstable and have at least one family member that has a mental illness and/or problems with substance use. In this program, each person in the family is offered individual and family counseling and case management services in their home by a Family Support Specialist.
Days, Hours of Operation	Regular business hours for this program are Monday through Friday, 9:00– 5:30 p.m. with after hour availability when warranted and 24/7 Crisis availability.

Needs & Characteristics of Population Served	The Supportive Housing for Families program serves families that are homeless or housing unstable and have at least one family member that has a mental illness and/or problems with substance use.
Goals & Scope of Service	<p>Each Family Support Specialist is licensed and can provide counseling and case management services to clients within the SHF program.</p> <p>The SHF program seeks to end family homelessness in Cuyahoga County, one family at a time. Outcomes include but are not limited to:</p> <ul style="list-style-type: none"> • 100% of families will be offered mental health assessment and treatment. • 100% of families engaged will increase or maintain mainstream benefits. • 30% of families will obtain or increase employment status.
Necessary Referrals/ Formal Affiliations	EDEN Day One Family Foundation

SUPPORTIVE SERVICES FOR VETERANS' FAMILIES	
Service Description	<p>This program is designed to prevent homelessness and increase housing options for homeless Veterans and their families. Case managers provide supportive services, access to community-based mental health and substance abuse services, and linkage to benefits for Veterans in Cuyahoga, Lake and Ashtabula Counties. Additionally, FrontLine Services subcontracts with Great Lakes Community Action Partners (GLCAP) to provide these services to homeless and at-risk Veterans in 10 northwestern Ohio counties for Ohio's Balance of State. The Supportive Services for Veteran Families (SSVF) program focuses on quick access to services to prevent homelessness when possible and to ensure quick access to affordable housing to ensure that the homeless episode is brief and non-reoccurring.</p> <p>FrontLine Service provides goal-oriented and individualized support focusing on improved self-sufficiency for Veterans and their families through assessment, planning, linkage, advocacy, coordination, and monitoring activities. FrontLine's (SSVF) program provides outreach, case management, assistance with obtaining Veteran Administration and other public benefits, temporary financial assistance as well as other supportive services to very low-income, homeless Veterans and Veteran families in the community. In addition to serving Veteran families who are homeless, this program also serves Veteran families who are imminently at risk of becoming homeless. Supportive services for Veterans and Veteran families who are homeless or at-risk of homelessness are focused on quickly regaining stability in permanent housing after experiencing a housing crisis or homelessness. To best serve the Veteran in these areas, FrontLine Service has partnered with EDEN, Inc., Northeast Ohio Coalition for the Homeless (NEOCH) and GLCAP.</p>

	<p>FrontLine Service’s partnerships are critical to the success of the SSVF program. Utilizing a Landlord Recruitment and Retention Specialist the partnership with EDEN, Inc. provides SSVF staff with a group of property owners with affordable, suitable housing based on family size and income as well as location preference. EDEN’s Landlord Recruitment and Retention Specialist works closely with many property owners that have quality housing in the Cleveland area. This relationship often is instrumental in ensuring that the property owner works diligently to have units ready and available for SSVF program participants to move in quickly. Additionally, the Landlord Recruitment and Retention Specialist is qualified to conduct Housing Quality Standards inspections, further ensuring that these low-income Veteran families are obtaining quality housing. The partnership with GLCAP has enabled FrontLine Service to support the extension of the SSVF program services to several northwestern Ohio counties that did not have much needed services to address Veteran homelessness.</p> <p>FrontLine Service’s SSVF program is a leader in the Continuum of Care’s effort to end Veteran Homelessness. This program’s staff track all homeless Veterans in the county and facilitates weekly meetings of all Veteran providers to ensure that all Veterans experiencing homelessness have immediate access to emergency shelter, housing, and services.</p> <p>Annually, the SSVF program will serve at least 575 Veteran/Veteran Families, providing both Rapid Rehousing and Homeless Prevention services. The percentage of households receiving each service will be determined according to community needs. All Veteran/Veteran Families enrolled in SSVF will be linked to appropriate Veteran and/or community resources.</p>
Days, Hours of Operation	Monday – Friday, 8 a.m. – 5:30p.m. with crisis services available 24/7.
Needs & Characteristics of Population Served	In addition to serving Veteran families who are homeless, this program also serves Veteran families who are imminently at risk of becoming homeless.
Goals & Scope of Service	<p>Engaging 575 homeless Veterans each year</p> <p>Assisting 75% of program participants exit program with stable housing.</p> <p>Linking 70% of program participants to VA resources upon exit.</p>
Necessary Referrals/ Formal Affiliations	<p>Department of Veterans Affairs</p> <p>EDEN</p> <p>Northeast Ohio Coalition for the Homeless (NEOCH)</p> <p>Great Lakes Community Action Partners (GLCAP)</p>

CRISIS & TRAUMA SERVICES

REFERRAL & INFORMATION	
Service Description	<p>Referral and Information services are responses, usually by telephone, to inquiries from people about services in the community. Referral and Information services are conducted when the determination of service needs in the initial call or service request reveals that the person is not in crisis. The caller is provided with information about shelter, housing, legal services, community mental health centers, support groups, mental disorders, etc.</p> <p>A regularly updated Community Resource Directory, which includes information about the array of health and social services offered in Cuyahoga County, is available to all crisis staff members and is used when offering referral and information services.</p> <p>FrontLine Service uses the term “linkage” to refer to a specialized application of referral and information services, in which a person is referred to appropriate services at an ADAMHS Board-funded agency. Linkage services consist of helping the person to:</p> <ol style="list-style-type: none"> (1) Identify the services requested and/or needed. (2) Determine the eligibility for ADAMHS (Addiction and Mental Health Services) Board contract agencies. (3) Understand the range of services available from ADAMHS Board contract agencies. (4) Select an ADAMHS Board-funded agency that will best meet his or her needs; and, (5) Arrange an intake appointment with the selected agency. <p><u>Role in the Cuyahoga County Diversion Center Initiative</u></p> <p>As part of the Cuyahoga County Diversion Center initiative, Law Enforcement Officers, family, friends and individuals seeking help will be able to access assistance through our Crisis Call Center Helpline by dialing 216-623-6888. We have added 5 staff members to the Crisis Call Center, essentially one person on each shift 7 days per week to handle the increased call volume.</p> <p>When an officer, family, friend or individual seeking services contacts the Call-In Helpline, call center staff will be able to provide guidance and information regarding where they might access services for the person they are interacting with/themselves. Call center staff may request to speak directly to the individual that the officer has encountered, to obtain additional information. Following interaction with the caller and individual, the Call Center staff will provide a recommendation to the office, which may include:</p>

	<ul style="list-style-type: none"> • The individual remaining in the community. Call Center staff would connect the individual to community behavioral health services, the officer would allow the individual to return to their home and, with the assistance of FrontLine, follow up with those appointed services. • The Officer accompanying the individual to the Diversion Center, for assessment and appropriate linkage to treatment and services. • Dispatching additional assistance to the officer and individual, which may be a member of FrontLine’s trauma or crisis team. • Hospitalization. That the individual physical and or mental condition necessitates more intensive services. <p>The Call-In Helpline staff will be unlicensed, degreed staff who will receive a minimum of 40 hours of training prior to answering the Helpline which will include but not be limited to: comprehensive understanding of the Diversion Center philosophy, protocol and operations, St. Vincent’s Psychiatric ED (23-hour Observation), basic understanding of police protocol as well as full array of community resources. Additionally, each staff person will receive training in trauma-informed care, client centered services, suicide risk assessment and safety planning.</p> <p>Call-In Helpline staff are able to access a licensed clinician immediately who will be able to offer a brief telehealth assessment, when necessary. This type of assessment is clinical in nature and may be utilized to support an individual remaining in the community and receiving services at a later date.</p>
Days, Hours of Operation	Referral and information services are available twenty-four hours per day, seven days a week.
Needs & Characteristics of Population Served	Cuyahoga County Residents seeking non-crisis assistance, typically in the form of questions about a wide variety of community services.
Goals & Scope of Service	The primary goal of this service is to refer all callers to the most appropriate behavioral health service that is offered in the County.
Necessary Referrals/ Formal Affiliations	ADAMHS Board 2-1-1

MOBILE CRISIS TEAM and CHILDREN’S RESPONSE TEAM	
Service Description	<p><u>Philosophy:</u></p> <p>The mobile teams maintain a philosophy of referring patients to the least restrictive setting and to maintaining individuals in the community whenever possible. Many patients in mental health crisis are referred to outpatient care or other alternative settings. Whenever appropriate, patients receive follow-up visits by the MCT/CRT staff to stabilize the crisis.</p>

Description:

The Adult Mobile Crisis and Child Response Teams provide a full range of evaluation, intervention, referral, and disposition services for adults, adolescents and children who are experiencing a mental health crisis. Crisis services are provided at any location within Cuyahoga County where the individual is experiencing the crisis. These services are a process of assessing a client's experiences, mental status, psychosocial functioning, resources, strengths, and situation, and employing that assessment to select, plan, and deliver a systematic sequence of interventions to assure the client's safety and health, to help the client reduce and manage subjective distress, to help the client develop and use effective coping skills, and to help the client gain competence in new coping skills in order to forestall recurrence of the crisis. For each contact received, crisis staff complete a screening of individual needs at initial contact and an individualized plan for delivery of crisis intervention, or other services deemed appropriate to the client's needs. This plan is utilized to identify and document specific service recommendations for the client.

In practice, effective crisis intervention consists of a sequence of assessments and interventions that assist a client in resolving crisis situations and subjective distress. Crisis intervention services are face-to-face or telephone responses to a crisis experienced by an individual, significant other, or community system. Crisis assessment services are a component of the crisis intervention, and are an intensive, face-to-face, clinical evaluation of the individual. Although clinical evaluation is a component of crisis intervention services, the clinical evaluation of crisis assessment services is more thorough, and includes domains of an individual's functioning (e.g., community interests, health behaviors, leisure activities) that are not assessed during crisis intervention services. Clinical disposition decisions are based on information provided during the crisis assessment process.

The Child Response Team works closely with the Mobile Response and Stabilization Services (MRSS) team, operated by Bellefaire. MRSS is a comprehensive program that provides crisis de-escalation, stabilization and linkage services available to youth ages 0 to 20 and their families. MRSS staff meet with youth and families in person wherever they are to provide intensive services to address emotional and/or behavioral issues that require intervention. The CRT and MRSS strive to seamlessly coordinate care to maximize community services available to children/youth in Cuyahoga County who are experiencing distress or a crisis.

A vital component of both crisis programs operated by FrontLine is the linking of the person in crisis with other service providers in the community to develop the support necessary to address future life stressors and avert additional crisis. MCT Mobile Crisis Team maintains a resource directory and a current listing of available emergency shelters.

Services include:

- Immediate telephone response

- Hotline and Referral and Information services
- Mobile Crisis outreach capability
- Comprehensive mental health assessment
- Short-term crisis intervention
- Follow-up services
- Pharmacologic assessment and management
- Disaster response and counseling
- Immediate referrals to the full continuum of acute psychiatric and addictions services
- Online Emotional Support (“chatting” and texting)

Crisis services are provided 24 hours a day, 7 days a week, and take place at any location within Cuyahoga County, including hospitals, schools, places of employment, as well as on-site. A crisis intervention specialist or a team of specialists, depending on the nature of the mental health crisis, delivers crisis services. Individuals providing these services are qualified, behavioral health practitioners, as required by the Ohio Department of Mental Health and Addiction Services (OHIO MHAS). The MCT team consists of licensed mental health clinicians: social workers, counselors, nurses, psychiatrists, and others who have been trained to provide these services. The FrontLine Service Medical Director is available by cell phone 24 hours a day, 7 days a week, for consultation with MCT staff. All providers of crisis services are knowledgeable of crisis intervention techniques, the appropriate use of community resources and procedures for involuntary hospitalization. In addition, crisis staff must be currently trained in First Aid, CPR and Non-Violent Crisis Intervention techniques.

FrontLine Service collaborates with hospitals, mental health agencies, schools, and numerous other community providers to complete assessments, develop treatment plans, coordinate necessary support, and arrange follow-up services for the person experiencing the crisis. The team participates in a county-wide Psychiatric Emergency Provider meeting hosted by the ADAMHS Board which serves to bring together representatives of the hospital emergency departments and the publicly funded crisis services to coordinate care between these two systems. FrontLine Service also collaborates with specific hospitals and ADAMHS Board-affiliated agencies to access targeted crisis services with funds provided by the ADAMHS Board. We “voucher” these services either because the client is uninsured and otherwise would not be able to access the indicated treatment level of care or because these partner agencies offer residential crisis stabilization services, a service FrontLine does not provide for children and adolescents.

Staff members from the Mobile Crisis Team provide Crisis Chat, an Online Emotional Support (OES) program, Monday through Friday from 3:00 p.m. until 8:00 p.m. Crisis Chat and Crisis Text are offered 24/7 nationally. OES Specialists are Crisis Intervention Specialists who have received additional training in online

emotional support. During the crisis Chat contact, staff greet the Visitor, listen to their presenting concerns, identify the current problem/issue, assess the current state of mind of the Visitor, conduct a suicide risk assessment, identify resources, create a safety plan, and review next steps before ending the contact. The anonymity of OES services is prioritized and the primary expectation at the conclusion of the service is that the Visitor has been offered an opportunity to discuss whatever issue they need/want, that they understand how to get back in touch with OES services should they need to in the future and that they feel comfortable doing so. The National Suicide Prevention Lifeline number is also always provided to OES Visitors.

Service Modality:

The primary treatment modality of crisis services is a “short term,” strategic, cognitive, and solution-focused model to provide brief, yet intensive intervention to individuals in a mental health crisis. The principal objective of crisis services is to assist individuals in returning to a baseline level of functioning, prevent harm to self or others and assist in connecting them to both informal (e.g.: personal and social) supports as well as formal resources (e.g.: community-based services) to facilitate their ongoing support on a long-term basis. Crisis staff encourages individuals’ families and/or significant others to participate, with the client’s consent, as specified in the FrontLine Service Use and Disclosure of Personal Health Information policy.

Mobile Crisis Outreach

Mobile Crisis outreach services are provided through a team of qualified professionals that respond and intervene when the patient is experiencing a mental health crisis in the community. The mobile outreach team is trained to assess the crisis and to stabilize the individual in the community. Evaluations take place in homes, residential centers, detoxification programs, jails, shelters, police stations, schools, and other community settings. The outreach team also accompanies the police to emergency evaluations. The team is committed to maintaining clients in the community and to diverting them from more restrictive settings whenever possible.

Crisis Stabilization Beds

FrontLine Service assumed operations of our Crisis Stabilization Unit, formerly operated by another ADAMHS-contracted community mental health center, in May 2012. The MCT can access these 15 beds, when necessary, to continue to evaluate and divert a client from an inpatient setting. The MCT provides the comprehensive assessment necessary for admission and works in collaboration with the manager of the Crisis Stabilization unit to identify the needs of the individual. For individuals who receive case management services in the community, MCT will contact that provider to advise them of the placement and necessity for follow-up. Individuals

who are unlinked to community resources are provided linkage and referral services through MCT, complete a treatment plan and disposition plan. This treatment option helps to stabilize the individual and move toward crisis resolution in a modality that does not require a more restrictive setting.

Authorization for Inpatient Services

The MCT has been identified by the ADAMHS Board as the entity responsible for authorization of admission for inpatient services of Cuyahoga County residents at Northcoast Behavioral Healthcare Services. In addition, the MCT can authorize transfer from private hospital emergency departments to the Board-funded Psychiatric Emergency Services program. While this service option is employed sparingly, it is a critical component to the continuum of crisis services that the MCT provides.

Services Authorized by Child Response Team (CRT)

Children who participate in mental health crisis intervention services through our Child Response Team may require services we do not provide to fully resolve their crisis or decrease the likelihood of a reemergence of their crisis. These services, provided by other organizations in our county, include crisis stabilization services and inpatient behavioral health admission. When an intermediate level of care is indicated to address a child's mental health crisis (regardless of insurance status), the CRT (Child Response Team) has exclusive access to a total of 23 crisis stabilization beds (funded by ADAMHS Board & NEO Collaborative) which are operated by Applewood, Bellefaire and Ohio Guidestone. The CRT are able to refer clients to these crisis beds for short term stabilization services within residential treatment programs. For *uninsured* CRT clients requiring an inpatient behavioral health level of care, FrontLine acts as the fiscal agent, authorizing (or "vouchering") the service. CRT staff facilitate admission to either Cleveland Clinic Foundation's Fairview Hospital or Windsor-Laurelwood Hospital. For hospital level of care, we initially authorize three days of inpatient services and authorize additional days as needed to address the crisis needs of the child/adolescent. The ADAMHS Board of Cuyahoga County reimburses these organizations for these services.

Special Population:

MCT provides services to children and adolescents who are experiencing a serious emotional disturbance or psychiatric crisis. The landmark 1999 Report of the Surgeon General on Evidence Based and Best Practices (Page 178 – 9), specifies that the provision of crisis services to children and adolescents through mobile crisis teams, intensive in-home services, short-term or emergency hospitalization and residential placement have all proven effective in addressing crises. These services include evaluation and assessment, crisis intervention and stabilization, and follow-up planning. Programs intervene immediately and are available 24 hours a day, 7 days a week.

How Caseloads are Built and Maintained:

Each person who is assessed by the MCT is assigned a primary worker. This person provides many services including linking the client to an appropriate on-going service provider and is responsible for ensuring all necessary documentation is completed. Because the Mobile Crisis Team operates 24 hours per day, 7 days per week, there are times when another crisis staff member, assigned by the program manager/supervisor, will provide crisis intervention services to a client who is assigned to another staff person. A client's case remains open until the client is no longer in need of crisis intervention services, requests that their case be closed, is hospitalized, or successfully linked to another on-going service provider. Program Management staff assist crisis workers in determining when a client's case meets the threshold for termination. (It should be noted that when MCT is unable to link a client to an on-going provider in a timely fashion, they may continue to provide services to that client if it has been determined that the discontinuation of our services will result in a recurrence of a mental health crisis).

The average caseload for staff providing crisis services to adults is between 7 – 10 cases; for staff providing crisis services to children, the caseload is between 5 – 8 cases. A client may remain active with MCT for 3 – 5 weeks. In extreme cases, MCT has maintained some cases longer while trying to secure the most appropriate linkage to ongoing services. Clients are seldom reassigned a new primary staff person. To keep caseloads at a manageable level, staff with a higher number of cases, or cases requiring more intensive services are given fewer new case assignments.

Location of Crisis Intervention Services:

Crisis Intervention Services are community-based and are provided at any location in Cuyahoga County. The Adult Mobile Crisis and Child Response Team operates out of the FrontLine Service Main Office, 1744 Payne Avenue, Cleveland, Ohio.

Because community interventions are a component of crisis services, FrontLine Service leases two cars for use by our crisis intervention teams. MCT workers are provided with workspace, phones, computers, and office supplies needed to provide services. In addition, MCT staff conducting crisis intervention services in the community are provided with a cell phone. Interview rooms are available to meet with clients privately in the office and contain furniture that is easily accessible to children of varying ages as well as age-appropriate therapeutic and play toys. Psychiatrists and nurses have private offices to provide care to clients.

Hotline Services:

Hotline Services are FrontLine Service's twenty-four-hours-per-day, seven-days-per-week capability to respond to telephone calls made to the agency for crisis assistance. The person may or may not be a client of the agency. Hotline services are brief, supportive, verbal interventions that satisfactorily address the individual's crisis. These interventions may or may not lead to face-to-face mental health assessment, crisis assessment, and/or crisis services.

Hotline services are meant to be brief interventions, lasting less than thirty minutes. The goals of engagement are to:

1. Help the person understand the nature of the current crisis situation.
2. Explore ways in which the person might resolve the situation and reduce his or her subjective distress by utilizing strengths and supports; and,
3. Help the person develop a plan for getting additional help, if needed.

If these goals cannot be achieved during the conversation, then additional crisis services are indicated, and the focus of the intervention shifts to arranging these services. Frequent or repetitive requests for hotline services and the hotline service encounters that exceed 60 minutes, are generally an indication that face-to-face crisis services are indicated.

Staff members who provide crisis intervention mental health services also provide hotline service and referral and information services, thus ensuring coordination among these three services. Hotline service providers also coordinate their work with Cuyahoga County's emergency service systems, by taking referrals from members of the county's police, fire, and emergency medical systems, and by requesting that they join our staff in providing crisis intervention mental health services when needed to ensure client safety and health. MCT staff members who provide hotline service also take referrals for the agency's Trauma and other behavioral health services and refer clients to behavioral health services offered by other contract agencies of the ADAMHS Board.

Crisis Intervention Mental Health Services:

Crisis intervention mental health services are face-to-face responses to a crisis experienced by an individual, significant other, or community system. Face-to-face crisis intervention mental health services are available 24 hours a day, seven days a week. In practice, effective crisis intervention consists of a sequence of assessments and interventions that assist a client to resolve crisis situations and subjective distress. The process includes assessing a client's experiences, mental status, psychosocial functioning, resources, strengths, and situation, and utilizing these findings to select, plan, and deliver a systematic sequence of interventions to facilitate the client's safety or health, help the client reduce or manage subjective distress, and use effective coping skills to forestall recurrence of the crisis. Crisis intervention and crisis assessment services are performed, at the client's residence, at another site of the client's choice, at another service or treatment facility, or at

	<p>the FrontLine Service office. Crisis intervention mental health services are available to any adult or child in Cuyahoga County.</p> <p>Staff members perform crisis assessment services and crisis intervention mental health services under the direction and supervision of the Program Managers. Staff members who perform crisis intervention mental health services collaborate with FrontLine Service’s integrated behavioral health staff and with the community behavioral health service providers at other contract agencies of the ADAMHS Board. Crisis intervention mental health service providers also coordinate with Cuyahoga County's emergency service systems by taking referrals from members of the county's police, fire, and emergency medical systems and by requesting emergency service personnel accompany MCT in providing crisis intervention mental health services as needed to ensure client health safety.</p> <p><u><i>Police/Mental Health Co-Responder Program</i></u></p> <p>In partnership with the Cleveland Division of Police, a crisis staff person from FrontLine Service will partner with a CIT trained law enforcement officer to respond to crisis calls received via Cleveland Division of Police Dispatch for mental health related crisis in the community. The crisis specialist in collaboration with the CIT officer will engage and respond to the person’s needs, provide assessment and triage to the least restrictive options in the community. The Co Responder Team will provide follow up on crisis calls from other officers within their assigned police district as well as engage high utilizers of service in order to decrease the need for public safety assistance. Frontline Services would be assigned to the 1st, 2nd and 3rd Police Districts. Crisis Specialist along with CIT officers will work collaboratively with other aspects of public safety such as EMS and dispatch in order to reduce the high utilizers of service by proving ongoing monitoring and support. These Co-Responder teams will work to reduce the use of emergency rooms and jails and link people to services, reduce the number of calls for service to public safety and increase collaboration and problem solving between the law enforcement and behavioral health system.</p>
Days, Hours of Operation	Services provided by the Mobile Crisis Team, Hotline, Referral and Information, and Crisis Intervention services, are available 24 hours per day, 7 days a week.
Needs & Characteristics of Population Served	Any adult or child experiencing a current or developing mental health crisis in Cuyahoga County is eligible for crisis services. Many of these individuals have experienced long-standing mental health challenges, exposure to trauma, co-occurring substance abuse issues, chronic medical illness, suicidal/homicidal ideations, forensic involvement, and other personal/systemic obstacles. MCT staff have been trained in crisis intervention services, Non-Violent Crisis Intervention, First Aid, CPR, and are knowledgeable of the wide variety of community services and resources that are accessible to individuals in crisis. The MCT staff that completes the initial crisis assessment is assigned as the primary worker. The primary worker is responsible for coordinating with other FrontLine Service and/or community providers to identify the most appropriate and accessible services and resources for each client.

Goals & Scope of Service	<p>The Mobile Crisis Team has been designated by the ADAMHS Board's Emergency Crisis Plan as the organization in Cuyahoga County that will fulfill the following goals:</p> <ul style="list-style-type: none"> • Provide crisis intervention mental health services to children and adults in a mental health crisis at locations throughout Cuyahoga County. • Conduct crisis assessments at locations throughout Cuyahoga County, to assure the least-restrictive placement for those thought to need psychiatric hospitalization. • Operate the County's Suicide Hotline. • Authorize admission to the inpatient services of Northcoast Behavioral Healthcare System (NBHS). • Authorize transfers of individuals from private hospital emergency departments to the Board-funded emergency services of the Saint Vincent Charity Medical Center Psychiatric Emergency Department (PED) when needed. • Access Board-funded services such as in-home therapeutic services, crisis stabilization and inpatient behavioral health admission for children and adolescents; and, • Link new clients with Board-funded behavioral health counseling and therapy and community behavioral health program services. <p>AMCT-specific program goals include:</p> <ul style="list-style-type: none"> • To answer incoming calls on the hotline as quickly as possible: The Crisis Team staff will answer 95% of incoming calls to the Crisis Hotline within 60 seconds or less. • To respond as quickly as possible to requests for a face-to-face Crisis Assessment Face-to-face crisis assessments should be initiated, on average, within 3 hours of the time the assessment was requested. • Following a Crisis Assessment, divert individuals to the least restrictive treatment option. The Crisis Team will divert 50%^ of individuals assessed in the emergency department away from hospitalization to a more appropriate level of care.
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	<p>CRT Specific program goals include:</p> <ul style="list-style-type: none"> • Answer incoming calls to the hotline regarding children/adolescents as quickly as possible. <p>95% of incoming calls to the Crisis Hotline about children/adolescents are answered within 60 seconds or less.</p> <ul style="list-style-type: none"> • Respond as quickly as possible to requests for a child/adolescent face-to-face Crisis Assessment <p>Face-to-face crisis assessments should be initiated, on average, within 3 hours of the time the assessment was requested.</p> <ul style="list-style-type: none"> • Following a Crisis Assessment of a child/adolescent, assure that they are linked to a provider for ongoing services. <p>Following a face-to-face Crisis Assessment, 80% of clients will be linked to a provider or relinked to their current provider.</p>
Necessary Referrals/Formal Affiliations	<ul style="list-style-type: none"> • Cuyahoga County Hospital Emergency Departments • Northcoast Behavioral Healthcare System • American Association of Suicidology • National Suicide Prevention Lifeline • Crisis Text Line – Contact USA

HOSPITAL FOLLOW-UP PROGRAM (Hope Link)	
Service Description	<p>The Hospital Follow-up Program, called “Hope Link” works to expand access to follow up services for individuals that are no longer in an active crisis but have been identified as being at risk of dying by suicide as they transition from a hospital setting to the community. The project’s goals are 1. Reduce the suicide rate in Cuyahoga County by 10% for each year of the grant period (as measured per 100,000 from information provided by the Medical Examiner) by utilizing the Air Traffic Control model to expand access to follow-up services; 2. Expand communication channels, enhance call oversight and provide immediate client feedback.</p> <p><u>Description:</u> The Hope Link Program provides follow-up calls to individuals discharged from a hospital or other crisis program who have been identified as being a risk for suicide. Staff from the Hope Link program reach out to each person quickly during their transition from one level of care to another to provide support and assistance with linkage to an on-going provider.</p>

	<p>When a referral is received the Crisis Follow-Up Specialist will:</p> <ol style="list-style-type: none"> 1. Reach out to each person referred within 24 hours of receiving referral. 2. During the call, he/she will: <ul style="list-style-type: none"> • Reassess for suicidality using the Columbia Suicide Severity Rating Scale (C-SSRS). • Develop a safety plan with each person that is consistent with the level of risk assessed. • Provide referral information and assistance with a warm hand off to an on-going service provider as needed. • Review schedule of future follow-up calls, the follow-up calls are scheduled in FrontLine’s EHR. 3. Calls will stop once the person has successfully linked to a provider or requests that staff stop calling. Clients will be closed after 5 unanswered calls, but a follow-up letter will be mailed. 4. Staff will reach out again at 90 days, 6 months and 1 year following the initial referral. <p><u>Service Modality:</u> The Hope Link Program utilize crisis / trauma interventions and intensive case management services to address the immediate emotional and practical needs that family members are faced with in the aftermath of a homicide or other type of traumatic death. Services include phone only interactions with the individual and /or essential others, and collaboration with other appropriate service providers to meet essential needs. Services are client-oriented and need-responsive.</p> <p><u>How Caseloads are Built and Maintained:</u> Hope Link staff do not have caseloads but are assigned individuals to contact by the Hope Link Program Manager. The frequency of subsequent follow-up calls is largely driven by the level of need as well as what family members request. The higher the perceived risk, the more frequently the person will be called. If a person is determined to be in crisis, they will be referred to other services such as the Mobile Crisis Team. All contacts with clients are documented and maintained in the client’s record.</p> <p><u>Location of Hospital Follow-up Program:</u> The Hope Link Program services are provided by phone so most staff at in their homes when they receive our follow-up calls. The Hope Link program is located at FrontLine Service’s Main office building, 1744 Payne Avenue.</p>
Days, Hours of Operation	The Hope Link Program services are available to families 7 days a week. Staff members are available for scheduled follow-up calls typically between the hours of 9:00 a.m. to 7:0 p.m. Referrals to the program can be made 24 hours a day, 7 days a week via Hope Link’s fax line.
Needs & Characteristics of	<u>Target Population, Eligibility and Assignment of Primary Worker:</u>

<p>Population Served</p>	<p>The Hope Link Program accepts referrals for any hospital or crisis service in Cuyahoga County. Any individual who is being discharged from a hospital inpatient unit or emergency department or crisis program who has been identified as being at risk of suicide is eligible. The Hope Link Program accepts referrals for both children and adults. Within 24 hours of a referral, a staff person will be assigned to make the initial follow-up call. The Program Manager will determine the appropriate follow-up call schedule after the initial contact is made.</p> <p><i>Special Population:</i> Both children and adults who have been determined to be at risk for suicide can be referred to the Hope Link Program. Hope Link aims to provide accessible, comprehensive, culturally competent services to all members of a family referred to the program. Services are provided by phone, text or other electronic messaging platforms.</p>
<p>Goals & Scope of Service</p>	<p>Hope Link will reduce the suicide rate in Cuyahoga County by 10% for each year of the grant period by utilizing the Air Traffic Control model to expand access to follow-up services.</p> <ul style="list-style-type: none"> • Expand access to follow-up care by providing trauma responsive follow-up services for every child and adult discharged from inpatient behavioral health units at hospitals or crisis stabilization facilities, the state psychiatric hospital, or any of the 16 emergency departments following an evaluation of suicidal ideas and conduct, and those who may not receive immediate behavioral health treatment but were referred by members of law enforcement or the Crisis Call Center for follow-up services. • FrontLine will continue to collaborate with the local State Psychiatric Hospital, the Cleveland Division of Police, and the Ohio Suicide Prevention Foundation while adding in new stakeholders to ensure data sharing across all community partners. As the single point of contact for the County, FrontLine will facilitate opportunities for at least 25 local organizations in collaborating, coordinating, or sharing resources with other organizations as a result of this grant.
<p>Necessary Referrals/Formal Affiliations</p>	<p>Cleveland Clinic affiliated Hospitals University Hospital affiliated Hospitals Metro General Hospital Northcoast Behavioral Health System</p>

PRISON LINKAGE PROGRAM	
Service Description	<p>The Prison Linkage Program partners with The Ohio Department of Mental Health and Addiction Services’ (OhioMHAS) Community Linkage Social Worker (CLSW) staff to assist adult offenders in Ohio Department of Rehabilitation and Correction (ODRC) prisons and juvenile offenders at Ohio Department of Youth Services (ODYS) facilities by providing qualifying offenders with appointments and referrals to support services that promote successful re-integration into the community after discharge, such as housing and health care services.</p> <p>The OhioMHAS Community Linkage Program strives to aid all offenders with severe and persistent mental illness in their mental health recovery and stability by providing high quality, holistic and timely continuity of care services upon entering and leaving prison.</p> <p><u>Description:</u> The Prison Linkage Program provides linkage appointments for on-going behavioral health services for individuals being released from ODRC and ODYS facilities to Cuyahoga County. When a referral is made to the Prison Linkage Program, our staff will arrange for an appointment typically within 72 hours of the individuals’ schedule arrival back to Cuyahoga County. We then will reach out to the individual or agency to confirm that the appointment was kept. If it was kept, the case is closed. If we are informed that the appointment was not kept, our staff will reach out to the individual and make attempts to reschedule the appointment. These attempts will continue until the appointment is completed, the client refuses to continue working with us, or we lose contact with the individual.</p> <p><u>Service Modality:</u> The services of the Prison Linkage Program include phone only interactions with the individual and /or essential others, and collaboration with other appropriate service providers to meet essential needs. Services are client–oriented and need–responsive.</p> <p><u>Location of the Prison Linkage Program:</u> The Prison Linkage Program provides services by phone, which is at times done remotely from the staff person’s home. But when they are in the office, they are located at FrontLine Service’s Main office building, 1744 Payne Avenue.</p>
Days, Hours of Operation	The Prison Linkage Program provides linkage services Monday-Friday, typically between the hours of 9:00 a.m. to 5:30pm.
Needs & Characteristics of Population Served	<p><u>Target Population, Eligibility and Assignment of Primary Worker:</u> The Prison Linkage Program accepts referrals for any ODRC or ODYS facility that is releasing a person with behavioral health issues back to Cuyahoga County.</p>

	<p>hospital or crisis service in Cuyahoga County. The Prison Linkage Program accepts referrals for both youth as well as adults.</p> <p><i>Special Population:</i> Both youth and adults who have been determined to be eligible for Community Linkage services can be referred to the Prison Linkage Program. The Prison Linkage Program aims to provide accessible, comprehensive, culturally competent services to each client served by this program. Services can be provided by phone, text, or other electronic messaging platforms.</p>
Goals & Scope of Service	<p>The Prison Linkage Program facilitates the continuity of mental health care for persons entering or leaving the prison system by assisting in policy development, sharing of information, identifying, and addressing needs, monitoring outcomes, and providing problem-solving assistance. This will promote reduced recidivism rates for persons with mental illness who are leaving the prison system and reduce the number of persons incarcerated due to their illness.</p> <p>Goals:</p> <ul style="list-style-type: none"> • Provide continuity of mental health care for offenders entering or leaving an ODRC prison who are identified with serious and persistent mental illness (SPMI). • Provide continuity of mental health care for youthful offenders entering or leaving an ODYS facility who are identified as being on the mental health caseload. • Reduce recidivism of persons with mental illness who are involved in the criminal justice system. • Reduce de-compensation rates of released offenders to increase chances at recovery and successful reintegration. • Facilitate problem solving between the corrections and mental health systems and offenders related to accessing community mental health services. • Enhance public safety by arranging post-release mental health services, recovery supports and benefits. <p>SPECIFIC GOALS include:</p> <ul style="list-style-type: none"> • 100% of individuals referred to the program are given a linkage appointment • 80% of the behavioral health appointments are scheduled within 72 hours of the client’s arrival in Cuyahoga County. <p>We were able to confirm that 65% of individuals ultimately linked with the behavioral health agency to which they were referred.</p>
Necessary Referrals/Formal Affiliations	The Ohio Department of Mental Health and Addiction Services’ (OhioMHAS)

CRISIS STABILIZATION UNIT – a Licensed Residential Facility

Service
Description

The Crisis Stabilization Unit offers a 15-bed intensive, short-term treatment alternative to an inpatient psychiatric hospitalization. The program provides treatment for people experiencing a psychiatric crisis. The program is designed to serve people who are 18 years or older and have symptoms of a serious mental illness. The expected length of stay is 5-7 days.

Program Objectives:

The objectives of the Crisis Stabilization Unit treatment program are the reduction of symptoms, the resolution of crisis, and the rapid reintegration of the client back into the community.

Admission Criteria:

- 18 years of age or older
- Admission is voluntary.
- Mental illness is the primary problem.
- Cuyahoga County resident
- The individual is experiencing an acute psychiatric crisis and cannot be effectively treated in a less restrictive treatment setting.
- Individuals must be willing to participate in the treatment planning process and implementation to be considered appropriate for admission.

Clients must be independent in the care of any medical condition/need. Crisis unit nurses can provide basic nursing interventions to assist the clients. Medical conditions that are not stable will not be accepted. This includes clients who lack the capacity to manage their health problems, which as a result pose a risk to self and others. If there is any question/concern that the condition is not stable, medical clearance must be obtained prior to the admission. A nurse will review each referral on a case-by-case basis to determine if it meets the above criteria.

A medical evaluation *may* be necessary:

- If a client has diabetes, high blood pressure, cardiac history, or a disease process that requires medication and the client does not have this medication, or if values are out of range of acceptable norms as determined by the CSU physician.
- If a client reports regular drug/alcohol use and is at risk for withdrawal from an addictive substance.
- If a client looks visibly ill or has significant physical complaints.

Clients who are experiencing suicidal thoughts or have made a non-life-threatening suicide attempt or gesture can be considered appropriate for admission. Most clients who have made a life-threatening suicide attempt will not be appropriate for admission. Any individual who has committed an injurious act to her/himself, others, or property, but who is no longer presenting an immediate risk, can be considered for admission on a case-by-case basis.

The Crisis Unit will accept referrals that fall into the category of SA/MI (substance abuse/mental illness) with the understanding that the CSU does not serve SA only. If after 24 hours, the crisis staff determines the client is SA only, the referral source will be diligently asked to assist the crisis stabilization unit in making appropriate referrals.

The crisis unit will not accept anyone demonstrating symptoms of being grossly under the influence of substance(s). This includes, but is not limited to, slurred speech, unstable gait, agitated state, unstable level of consciousness. Medical clearance must be obtained if a client reports regular drug/ETOH use and is at risk for withdrawal from an addictive substance. *No client in active acute medical detox will be accepted.* The CSU (Crisis Stabilization Unit) will not accept clients who have used Phencyclidine (PCP) in the last 72 hours (about 3 days) or are still showing signs of agitation.

Hospital step-downs will be accepted from inpatient psychiatric units, when they need further observation, medication stabilization, or transition from inpatient to the community. Clients need to have linkage to a Community Mental Health Center and a housing plan unless other agreements have been made with the discharging hospital and the crisis stabilization unit.

- A psychiatric evaluation prior to being admitted will be necessary: If a client is off medications for a considerable time and exhibits psychotic symptoms.
- If it seems that medication will be necessary, and the Crisis Unit psychiatrist will not be available for more than 24 hours the Crisis Unit will accept clients without medications on a case-by-case basis.
- For private hospital ERs in Cuyahoga County that do not staff ER psychiatrists, evaluations from medical doctors will be accepted in lieu of a psychiatric evaluation.

Those in need may come for treatment on their own initiative or may be referred by others including the Adult Mobile Crisis Team, Community Mental Health Centers, and from area hospitals.

A multi-disciplinary team of mental health professionals including psychiatrists, mental health nurses, social workers, and crisis specialist provides treatment. A psychiatrist is available on-site Monday, Wednesday, and Friday mornings and by

	<p>phone as needed. Social Workers are on site 7 days a week on 1st and 2nd shifts. Nursing staff are on site 24 hours/day, seven days/week.</p> <p>The program emphasizes respect for the individual, use of client strengths, and voluntary consent and participation in treatment.</p> <p><u>Admission:</u></p> <p>All admissions are voluntary. Upon admission, each person is given a description of the services offered, the risks and benefits of these services, clients’ rights, rules of safety, behavior expectations, and guidelines to services and programs. People will be assigned rooms based on their functioning and needs. Privacy issues are program priorities. Program participants are free to leave the building at any time, to attend personal business. However, residents are asked to sign in and out of the program so staff may continue to coordinate treatment and monitor progress. All clients are expected to be back on the unit by 8:00 pm daily.</p> <p><u>Assessment & Treatment:</u></p> <p>Upon admission, people will receive a crisis assessment. A psychiatrist will evaluate most of the individuals admitted to the program. Medication compliance will be encouraged and monitored. Individual counseling, group services, liaison, and discharge planning will be provided. Individual needs will dictate the intensity of treatment and the provision of any ancillary services.</p> <p>For individuals with case managers in the community, the case manager will be contacted and required to participate in all aspects of their treatment. Treatment and discharge planning will be coordinated with existing service providers and support figures, depending on individual needs and wishes, to implement an immediate comprehensive treatment and discharge plan.</p> <p><u>Discharge:</u></p> <p>The length of stay for each individual will be determined together with the treatment team. Individuals are considered ready for discharge when their symptoms are reduced and manageable, their functioning has improved, and they appear behaviorally stable and feel ready to leave. The average length of stay is seven days.</p> <p>Discharge planning will include linkage with existing or new community support services, depending on individual’s needs, and existing support networks, residents without suitable living arrangements will be assisted in securing appropriate services.</p>
Days, Hours of Operation	The Crisis Stabilization Unit is available 24 hours a day, 7 days a week.
Needs & Characteristics of	As described above, the Crisis Stabilization Unit offers a 15-bed intensive, short-term treatment alternative to an inpatient psychiatric hospitalization for people

Population Served	experiencing a psychiatric crisis. The program is designed to serve people who are 18 years or older and have symptoms of a serious mental illness. The expected length of stay is 5-7 days.
Goals & Scope of Service	<p>The program is designed to provide an intensive therapeutic milieu conducive to reducing acute symptoms, promoting stabilization, and improving functioning. Crisis intervention includes the use of strengths and the promotion of skills for managing psychiatric symptoms and increasing coping and functioning. Treatment also includes coordination and linkage with community service providers. In addition, the milieu is designed to reduce stress with the encouragement of opportunities for relaxation, recreation, and socialization in an atmosphere of respect, support, and hope.</p> <p>Specific CSU Goals:</p> <ul style="list-style-type: none"> • 80% of clients admitted to the CSU complete their treatment as determined by the CSU Treatment Team. • 80% of clients are successfully linked to services upon discharge. • 90% of clients served are satisfied with the services they receive there.
Necessary Referrals/Formal Affiliations	Cleveland Clinic, University Hospitals, St. Vincent Charity Hospital, Metro Hospital. Community Mental Health Providers such as Recovery Resources, The Centers, Connections, Murtis Taylor, etc.

CHILDREN WHO WITNESS VIOLENCE	
Service Description	<p>The CWWV program offers immediate home-based trauma assessment and crisis intervention services and support services for children, newborn to 17 years, and their families, who have witnessed violence in their own homes. Services are available throughout Cleveland’s 5 Police Districts and in the communities of Euclid, Lakewood, Maple Heights, Beachwood, CMHA and Glenwillow. Multiple service modalities and trauma informed interventions are utilized to address the family’s immediate needs, increase the safety, improve the functioning of the family unit, and assist families by providing advocacy services in the various systems that they interface with including legal, child welfare, and housing.</p> <p>If an immediate outreach is requested the CWWV clinical staff members will attempt to stabilize the crisis utilizing Psychological First Aid and then developing a safety plan. Over the course of following visits staff will offer and then complete a comprehensive diagnostic assessment, provide short-term individual and/or family trauma counseling services and with the consent of the child’s parent or guardian, secure other community resources appropriate to the child and family’s needs.</p>

If contacted after the crisis is stabilized, the development of the comprehensive assessment is the focus of consequent visits. CWWV staff work closely with the family to ensure that the child witness is connected with all appropriate systems before ending their involvement.

The CWWV philosophy is that the provision of immediate intervention to children who have witnessed violence in their own homes is critical. Domestic violence deeply impacts children of all ages. Infants exposed to violence can develop insecure attachments to their caregivers due to the violence in the home infant's physical development can be impacted resulting in failure to thrive. Preschool children in violent homes may regress developmentally and suffer sleep disturbances, including nightmares. School-age children who witness domestic violence may exhibit a range of psychological responses and behaviors: including depression, anxiety, and aggression toward peers. Adolescents and teens who have grown up in violent homes are at risk leaving home pre-maturely, drug and alcohol experimentation and involvement in juvenile justice system.

Immediate age-appropriate intervention and non-crisis linkage to community-based providers for on-going services provides the child (ren) and their family with a means of mitigating the impact of the trauma on individuals and the family unit.

Piloted in 1999, the CWWV program at FrontLine Service offers such services as crisis intervention, diagnostic trauma-informed assessments, evaluation, and management if seen by a FrontLine psychiatric provider, behavioral health counseling and therapy, as well as support services.

Each family referred to the CWWV program is assigned a primary clinician. This person is a licensed service provider in the state of Ohio and will provide the majority of services, including linking the client to all appropriate on-going service providers, and is responsible for ensuring that all appropriate activities, (i.e., completion of requested diagnostic services, coordination with other services providers) pertaining to the client are completed and documented. There may be times when it is necessary for another staff member to provide services, due to schedule conflicts.

It is the primary clinician's responsibility to ensure that all services provided within and outside of the agency are done so in a coordinated, collaborative manner. All services provided to or on behalf of a CWWV client are documented in the client record on an on-going basis. Supervision with CWWV Program Managers includes a review of these records to ensure that documentation is completed in a timely manner.

CWWV clinicians are provided with workspace, phones, computers, and office supplies needed to provide services. In addition, CWWV staff conducting services in the community are provided with a cell phone and a laptop computer. Interview rooms are available to meet with clients privately at the office and contain furniture that is easily accessible to children of varying ages. Psychiatric services are available

with a FrontLine Service Psychiatrist. In addition, counseling services are provided in private, confidential offices.

CWWV utilizes the following evidence-based practices:

Psychological First Aid (PFA): The evidenced-informed model of PFA will be used to provide services to families and children in assisting them in the immediate aftermath of trauma. PFA is a well-researched model which assists traumatized individuals to manage the period directly following the incident and has effectively been utilized in the CWWV program since its inception.

Child and Family Traumatic Stress Intervention (CFTSI): Frontline clinicians will utilize CFTSI concepts/interventions to decrease post-traumatic stress reactions and onset of PTSD by increasing communication and family support. CFTSI is a brief (5-8 session) evidenced based early intervention for children ages 7 to 18 years old that reduces traumatic stress reactions and the onset of PTSD. The CFTSI intervention is implemented within 30-45 days (about 1 and a half months) following the traumatic event or the disclosure of physical or sexual abuse.

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT (Trauma Focused Cognitive Behavioral Therapy)) (Cohen et al., 2004): which is a psychotherapeutic intervention designed to help children, youth, and their parents overcome the negative effects of traumatic life events such as child sexual or physical abuse; traumatic loss of a loved one; domestic, school, or community violence.

TF-CBT is characterized by the National Child Traumatic Stress Network (NCTSN) as a well-supported, efficacious treatment. It targets symptoms of posttraumatic stress disorder (PTSD), which often co-occurs with depression and behavior problems. The intervention also addresses issues commonly experienced by traumatized children, such as poor self-esteem, difficulty trusting others, mood instability, and self-injurious behavior, including substance use. TF-CBT with some adaptations will work effectively with our urban families experiencing domestic violence. The program was designed to provide services for children 3 to 18 years of age and their parents.

TF-CBT has been recognized by the Substance Abuse and Mental Health Services Administration and the U.S. Department of Health and Human Services as a “Model Program.” TF-CBT has been classified by the Institute of Medicine (IOM) as “Selective and Indicated.”

The intensity of service provision may vary considerably among a caseload, depending upon the client’s needs. Staff assess, on an on-going basis, the client’s need for services and adjust them accordingly. Cases may remain open only briefly, or for 2 – 3 months, and will only be closed following linkage to another service provider, at the request of the client, or if a determination has been made that there is no need for additional services. The CWWV Program Manager meets with CWWV staff weekly, to provide clinical supervision, at that time individual cases are

	<p>reviewed, along with service provision and plans. The Program Manager makes recommendations for continuation or termination of services.</p> <p>CWWV services are community based and provided in homes, hospitals, other organizations, as well as the CWWV office. The CWWV program is located at FrontLine Service’s Youth & Family Services site, at 1701 Payne Avenue. The specially designed children’s lobby area, furniture, and equipment, to include age-appropriate toys and activities, are configured to accommodate children at various ages.</p>
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TRAUMATIC LOSS RESPONSE TEAM (TLRT)	
<p>Service Description</p>	<p>TLRT provides comprehensive intensive case management assistance including practical and emotional support services to adults and children impacted by homicide and other types of traumatic loss. The team is available 24/7 for immediate on scene response for all homicides that occur in Cleveland and the suburbs in Cuyahoga County. TLRT staff provide crisis intervention services to the co-victims and assist families in completing a needs assessment which identifies the immediate needs and assist with coordination and advocacy to ensure access to resources. Clinicians also provide psychoeducation on the impact of traumatic loss and inform and practice with the clients, trauma informed coping skills that address the acute symptoms of trauma and loss. TLRT is also designed to increase communication between community partners in order to provide effective, trauma-informed collaboration of services.</p> <p><u>Description:</u></p> <p>The Traumatic Loss Response Collaborative is a collaboration of agencies and programs that serve co-victims of homicide. The Homicide Unit of the Cleveland Division of Police, suburban police departments, hospitals, and the Department of Children and Family Services make referrals to TLRT by contacting FrontLine Service’s 24-hour crisis line to request assistance for the family or witness. TLRT provides immediate response 24/7 when requested and will attempt to engage the family in services within 24 hours. TLRT also coordinates with the Witness Victim Service Center to address criminal justice system advocacy. TLRT also works closely with the Cuyahoga County Medical Examiner’s Office.</p> <p>TLRT focuses on the immediate crisis needs and provides intensive case management for the co-victims. These services include but are not limited to assistance with making funeral arrangements, applying for Victims of Crime Compensation, assistance with information on addressing issues of estates of loved ones, applying for, and accessing death benefits and life insurance, facilitating filings for custody of children, etc. TLRT also addresses the mental health needs associated with traumatic loss through Psychological First Aid and the provision of psychoeducation on coping skills to manage acute symptoms associated with trauma exposure and grief. Mental health assessments are also provided to determine</p>

appropriate ongoing treatment and therapy. FrontLine's TLRT has one therapist available who provides community-based Cognitive Behavioral Therapy.

TLRT also provides family members of unsolved homicides with additional support by providing a clinician who acts as a liaison to the Homicide Detectives in the Cleveland Division of Police. This position is designed to focus on the families who are awaiting resolution to the criminal case by acting as the liaison between detectives and family members, updates are sought from the assigned detectives to provide to families awaiting additional information, the TLRT clinician contacts family members on important dates and times of year. Staff are available to provide emotional support when families make contact with the Homicide Division.

Service Modality:

TLRT services utilize crisis / trauma interventions and intensive case management services to address the immediate emotional and practical needs that family members are faced with in the aftermath of a homicide or other type of traumatic death. Services include face to face interaction with the individual and /or essential others, telephone contact with the individual and/ or essential others, and collaboration with other appropriate service providers to meet essential needs. Services are client-oriented and need-responsive and are based on the principles of Psychological First Aid, an evidence informed practice that demonstrates effective interventions for first responders to traumatic incidents. Clinicians are available to respond to new referrals 24 hours a day. One therapist is available to provide ongoing Cognitive Behavioral Therapy to adults or children.

How Caseloads are Built and Maintained:

Cases are assigned to TLRT staff immediately by Program Managers. Initially, the family member listed as being the person notified of the decedent's death by Homicide detectives is opened as the client for purposes of tracking the referral. Upon meeting with family, it is determined which members require individual services, warranting their own case to be opened. It is not always possible for the assigned worker to be the same person that provides the immediate response, but continuity of workers is stressed for families in crisis. The TLRT program staffs 5 crisis clinicians and one therapist. Some families request, and require, time intensive level of care so caseloads are monitored based on level of need and frequency of contact with the families. The frequency of contact is largely driven by the level of need as well as what family members request. Some co-victims require daily contact in the immediate aftermath of the violent incident, while others with more native support needs can be addressed by monthly phone "check-ins." The regular practice is for cases to remain open for the first 90 days (about 3 months) after a death, so at minimum, a monthly check in can occur. If there are no specific identified needs at the 90-day point, the case may be closed but the assigned clinician will contact the co-victim again at 6 months and a year after the loss. The therapist maintains a caseload of approximately 15 clients. All contacts with clients are documented and maintained in the client's record.

	<p><u>Location of TLRT Services:</u> TLRT services are community based and provided in homes, as well as the TLRT office. The TLRT program is located at FrontLine Service’s Youth and Families Services building, 1701 Payne Avenue.</p>
<p>Days, Hours of Operation</p>	<p>TLRT services are available to families 24 hours a day, 7 days a week. Staff is available for scheduled follow-up appointments between the hours of 8:00 a.m. to 6:30 p.m., Monday through Friday. Nights and weekends are staffed by on-call availability of Trauma staff. All staff within TLRT services are committed to a significant amount of flexibility in their schedule to accommodate the needs of families whenever possible. Referrals to the program can be made 24 hours a day, 7 days a week via FrontLine Service’s crisis and hotline number, 216-623-6888.</p>
<p>Needs & Characteristics of Population Served</p>	<p><u>Target Population, Eligibility and Assignment of Primary Worker:</u> TLRT accepts referrals for any immediate family members of a homicide victim when the incident occurred in Cuyahoga County. Other types of traumatic death will be accepted as well if there is an acute need for intervention. The Cleveland Homicide Detectives refer all new homicides for immediate response, but services can also be offered to family members that detectives identify as still having significant needs, even if time has passed since the loss. TLRT accepts referrals on both children and adults. A primary worker is assigned within 24 hours of receiving the referral. Whenever possible, the clinician that provides an immediate response becomes the primary worker assigned to follow the case. When this is not possible due to caseload constraints, the initial worker will link the family to the assigned worker to ensure a fluid transition between workers.</p> <p><u>Special Population:</u> Both children and adults who have experienced a loss due to violence can be referred to the Traumatic Loss Response Team. TLRT aims to provide accessible, comprehensive, culturally competent services to all members of a family referred to the program. Services are home, or community based but can be provided in the office as well. The appropriate environment for intervention is largely determined by clients with consideration for privacy, comfort, and safety.</p>
<p>Goals & Scope of Service</p>	<p>TLRT will meet the complex needs of children and adults throughout Cuyahoga County who have witnessed or whose families have experienced homicide or other types of traumatic death.</p> <ul style="list-style-type: none"> • TLRT will respond to every referral and begin outreach within 24 hours of receiving a referral for 100% of those referred to provide our initial crisis intervention services. • TLRT will provide face to face visits for 75% of those requesting services within 72 hours of the referral. • The TLRT staff will successfully engage families in services offered by the TLRT program and link those in need to on-going services for 85% of the referrals.

Necessary Referrals/Formal Affiliations	<p>Cleveland Homicide Unit Cleveland Division of Police All Police Departments of Cuyahoga County Cuyahoga County Witness Victim Service Center Cuyahoga County Department of Children and Family Services</p>
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DEFENDING CHILDHOOD INITIATIVE

Service Description	<p>Cuyahoga County was one of eight sites that received funding through the US Attorney General Eric Holder’s Defending Childhood Initiative (DCI) for 5 years. At the conclusion of the federal monies Cuyahoga County Department of Justice Affairs provided the necessary funds to continue the necessary work of the project. The goals of the DCI are to prevent exposure to violence, mitigate the negative impacts of exposure when it does occur, and develop knowledge and spread awareness about the issue. Researchers at the Begun Center for Violence Prevention and Education at Case Western Reserve University were part of this collaborative effort, they provided planning, data, and evaluation support. The role of the DCI program staff at FrontLine Service is to provide trauma informed screening and assessments for all children referred to the DCI, and then link the child to the most appropriate agency. This linkage is based on the agency/program that can provide the child with the most appropriate trauma-informed intervention, driven by the results of the assessment.</p> <p>Defending Childhood staff also are trained in the trauma informed intervention TF-CBT. Trauma Focused Cognitive Behavioral Therapy is a trauma informed evidence-based practice supported by research to utilize with children who experience physical or sexual abuse.</p>
Days, Hours of Operation	<p>Referrals from the Defending Childhood Network are accepted by phone, fax, and in person. During business hours phone calls are received in FrontLine’s Trauma Services Department at (216) 361-8640. A DCI staff person will gather pertinent information from these calls to determine whether a crisis response is necessary. After conferring with the Program Manager, staff will contact the family within 6 hours or 24 hours, depending upon the disposition of the case. A team will be dispatched to the home for families who cannot be reached by phone.</p> <p>During evening and weekend hours, calls will be forwarded to our 24-hour Mobile Crisis line at (216) 623-6888. The Mobile Crisis Team Program Manager will triage referrals to determine if the call is a crisis or non-crisis in nature. If the referral necessitates a crisis response, the on-call Trauma Services Manager will be contacted immediately. Staff will contact the individual/family to develop an appropriate plan of action and to schedule an appointment at the client/referent’s earliest convenience. Non-emergent referrals will be contacted within 24 hours from receipt of referral.</p>

	<p>The Defending Childhood Initiative will also play a part in the developing Child Advocacy Center providing screening, assessment and TF-CBT to children who come to the center seeking services after being sexually abused.</p>
<p>Needs & Characteristics of Population Served</p>	<p>Most children and youth exposed to violence are never identified, assessed, or treated. Exposure to violence, particularly multiple exposures, interferes with the emotional, social, and cognitive development of children. Without intervention, the negative impact may remain for a lifetime. To advance the county’s goal to “empower the general public and child-serving agencies to prevent violence and to identify and intervene when children are exposed to violence in their homes, schools, and communities,” the Defending Child Initiative provides a centralized intake and assessment center that will identify youth exposed to violence, connect them to services and provide appropriate follow-up.</p> <p>The County’s Child Trauma Services Network delivers evidence-based services and promising practices to promote the safety of individuals and families and mobilize the community to act against violence in Cuyahoga County. The development of the centralized assessment function works to help the county both prevent and lessen the negative cognitive, social, and emotional consequences that come with ongoing exposure to violence.</p>
<p>Goals & Scope of Service</p>	<p>The purpose of Defending Childhood is to develop a system of planning and service delivery that will effectively reduce childhood exposure to violence and its negative impact on individuals, families, and communities. To reach this goal, the County is committed to implementing prevention activities to reduce the incidence of violence and identifying and helping youth who are already negatively affected by their exposure to violence. The end goal is to reduce the associated trauma caused by this exposure and to build resilience in youth.</p> <p><u>Scope of service:</u></p> <ul style="list-style-type: none"> • Provide 24/7 central intake services. • Receive and process referrals according to established guidelines. • Provide evidence-based crisis services in homes, as needed. • Provide trauma based clinical assessment services for families referred through the Defending Childhood Network • Engage and assist children/families in access treatment to reduce the negative consequences of exposure to violence and the resulting trauma. • Interface with national and local evaluation teams and utilize data systems to collect and provide required data.

	<ul style="list-style-type: none"> • Maximize utilization of Medicaid funds, complying with all requirements. • Collaborate and coordinate services with Defending Childhood agencies to ensure efficient and effective service delivery. • Attend all required training, as defined by Defending Childhood. • Maintain existing capacity to provide mobile assessments in the community. • Establish and maintain compassion fatigue support groups for program staff. • Collaborate closely with the developing Child Advocacy Center to provide appropriate screening, assessment, and treatment.
Necessary Referrals/ Formal Affiliations	Cuyahoga County Department of Children and Family Services Other Cuyahoga County Child-Serving agencies

SUPPORTING CHILDREN-TRAUMA SYSTEMS THERAPY PROGRAM (TST)	
Service Description	<p>The Supporting Children-Trauma Systems Therapy Program provides screening, assessment and treatment of children/adolescents impacted by the loss of a parent or guardian to a fatal opioid overdose. The TST staff provide initial screening services to children/adolescents for trauma exposure and assist families to identify needs and provide coordination and advocacy to ensure access to resources. If the child or adolescent is experiencing problematic behaviors and emotions, then a linkage appointment is facilitated to the TST therapist, and they will receive evidence-based Trauma Systems Therapy services that address the symptoms and behaviors related to exposure to trauma and loss.</p> <p><u>Description:</u> The Supporting Children- Trauma Systems Therapy program is a collaboration of agencies that serve children/adolescents who have lost a parent or guardian to a fatal opioid overdose. The Heroin-Involved Death Investigations Unit of the Cleveland Division of Police, the Cuyahoga County Medical Examiner’s Office and the Division of Children and Family Services make referrals to Supporting Children TST by submitting a referral form electronically or by contacting FrontLine Service’s 24-hour crisis line to request assistance for the child.</p> <p>Supporting Children-TST focuses on the outreach and engagement of children/adolescents and their families after a loss of a parent or guardian to a fatal opioid overdose. Once contact is made the Family Engagement specialists offers an initial appointment to provide support and explain the program. A follow up screening session occurs utilizing the Trauma Symptom Checklist (TSCC) to screen for trauma symptoms. If the screening determines the child is experiencing problematic behaviors and emotions, then a linkage appointment is facilitated to the</p>

TST therapist. If the child does not meet threshold for trauma symptomology but has other needs for services then referrals will be made to other appropriate community resources.

The TST therapist will implement evidence-based Trauma Systems Therapy services that address the symptoms and behaviors related to the child/adolescent's exposure to trauma and loss. The TST therapist will use the Trauma Systems Therapy Assessment Form to record information about the child and family that will be used to develop an effective TST treatment plan. A TST Assessment has two outputs: an understanding of when/why the child shifts to survival states and the capacity of the child's social environment to support the child to self-regulate. The intersection of these two outputs is the foundation of the TST model to determine what phase of treatment to begin with and what the interventions will address: Safety-Focused, Regulation-Focused, or Beyond Trauma. The TST Treatment Agreement Letter is then developed between the TST therapist, child/adolescent and caregiver that is signed and becomes the guide for therapy services.

Service Modality:

Supporting Children- TST services provide trauma screening, assessment and therapy services to address the problematic behaviors and emotions a child/adolescent is experiencing in the aftermath of the death of a parent or guardian to a fatal opioid overdose. Services include face to face interaction with the individual and /or essential others, telephone contact with the individual and/ or essential others, and collaboration with other appropriate service providers to meet essential needs. Services are client-oriented and needs-responsive and are based on the principles of Trauma Systems Therapy, an evidence-based, trauma informed therapeutic intervention.

How Caseloads are Built and Maintained:

Cases are assigned to TST staff by Program Director/Program Manager. Initially, the child/adolescents listed as losing a parent or guardian to a fatal opioid overdose are opened as the client for purposes of tracking the referral. Upon meeting with family, it is determined which members require individual services. The Supporting Children-TST program staffs 1 Family Engagement Specialist and 2 TST therapists. Caseloads are monitored based on level of need and frequency of contact with the families. The Family Engagement specialist caseload is determined on outreach and engagement of the referrals received. Once a child has been screened and meets criteria for Trauma Systems Therapy, they will be linked to one of the TST therapists. The TST therapists will maintain a caseload of approximately 12 clients. Depending on what phase of therapy they are in the child/adolescent will have twice a week sessions or weekly sessions. All contacts with clients are documented and maintained in the client's record.

Location of Supporting Children-TST Services:

Supporting Children-TST services are community based and provided in homes, as well as the office, or other community-based locations (school, library). The Supporting Children-TST program is located at FrontLine Service's Youth and Families Services building, 1701 Payne Avenue.

Days, Hours of Operation	Supporting Children-TST staff work a flexible schedule to accommodate the needs of families whenever possible. Services are available to families for scheduled appointments between the hours of 8:30 a.m. to 6:30 p.m., Monday through Friday. Nights and weekends are staffed by on-call availability of Trauma staff if a crisis response is needed.
Needs & Characteristics of Population Served	<p><u>Target Population, Eligibility and Assignment of Primary Worker:</u> Supporting Children-TST accepts referrals for children and adolescents ages 5-17 if they have lost a parent or guardian to a fatal opioid overdose in Cuyahoga County.</p> <p>The TST Family Engagement specialist is assigned and begins outreaching within 48 hours of receiving the referral. Once engagement begins the child/adolescent will be screened for TST services and if meet criteria will be linked to the TST therapist. When this is not possible due to caseload constraints, the Family Engagement Specialist will maintain bi-weekly contact with client & family and will determine if linkage to other services is necessary.</p> <p><u>Special Population:</u> Children ages 5-17 who have experienced a loss of a parent or guardian due to a fatal opioid overdose can be referred to the Supporting Children-TST program. Supporting Children-TST aims to provide accessible, comprehensive, culturally competent services to the children/adolescents referred to the program. Services are home, or community based but can be provided in the office as well. The appropriate environment for intervention is largely determined by clients with consideration for privacy, comfort, and safety.</p>
Goals & Scope of Service	<p>Supporting Children-TST will meet the complex needs of children and adolescents ages 5-17 throughout Cuyahoga County who have lost a parent or guardian to a fatal opioid overdose.</p> <ul style="list-style-type: none"> Supporting Children-TST will respond to every referral and begin outreach within 48 hours.
Necessary Referrals/Formal Affiliations	<p>Cleveland Division of Police Heroin-Involved Death Investigation Unit Cuyahoga County Medical Examiner's Office Cuyahoga County Division of Children and Family Services</p>

CHILDREN OF INCARCERATED PARENTS	
Service Description	<p>The Alcohol, Drug Addiction, and Mental Health Services (ADAMHS) Board of Cuyahoga County in collaboration with Oriana House, Inc. (OHI), Salvation Army, and Frontline Service Inc., expanded and implemented a multi-faceted program for incarcerated parents, their children, and the custodial parents/caregivers through supports, strategies, and activities that foster positive family engagement, reduce violence and recidivism, and promote safe facilities, homes, and communities.</p> <p>Service Area: The Healthy Families Program will operate in Cuyahoga County, Ohio where Cleveland is the major city.</p>
Days, Hours of Operation	Monday – Friday, 9 – 5:30
Needs and Characteristics	The target populations served are Cuyahoga County children, custodial parents/caregivers and 1) male incarcerated parents sentenced for felony offenses

of Population Served	to Oriana House, Inc.'s (OHI) McDonnell Center Community Based Correctional Facility (CBCF) and 2) female parents that are inmates from the Ohio prisons under transitional control to OHI and Salvation Army Halfway Houses in Cleveland, Ohio.
Goals & Scope of Service	The objectives of the Healthy Families Program are to: 1) Create a safe, child/family-friendly environment in the identified correctional facilities through policy and procedural changes; physical space, furniture, and equipment modifications; and staff training; 2) Implement regular and meaningful services and activities to strengthen the relationships between incarcerated parents, their children, and the custodial parents/caregivers while addressing the individual needs of each family member; 3) Conduct a process and short-term outcome evaluation.
Necessary Referrals and Formal Affiliations	Oriana Housing Inc. Salvation Army Family Builders

MEDICAL SERVICES

EVALUATION AND MANAGEMENT	
Service Description	<p>Evaluation and Management (E&M) services are provided to agency clients by the Medical Director, Associate Medical Director, advanced practice nurses, psychiatrists, and nurses. E&M services include the prescribing of medications and ongoing evaluation based on clinical acuity to assess the efficacy of the medication, explore, and reduce barriers to adherence, explore alternatives for treatment and assess for side effects or adverse reactions. Providers of E&M services will meet face-to-face or via telehealth with each individual client receiving these services. When the client is prescribed medication that must be administered by injection, an agency nurse or an agency prescriber will provide this service.</p> <p>For clients receiving psychotropic medication, the prescriber will meet with the client a minimum of once every 90 days (about 3 months) to review the effectiveness of treatment and side effects of medication. Exceptions regarding the interval of follow-up may be made by prescribers based on the client's stage of recovery and client preference. All clients prescribed medication will receive education regarding the purpose of the medication, its intended effects, side effects and alternatives. Education on medication will also be provided to family members as appropriate. Clients have the right to decline medication and services are not contingent upon acceptance of medications. Prescribers will continue to engage clients in collaboration with the multidisciplinary team for ongoing evaluation of symptoms, supportive psychotherapy, and exploration of barriers to and alternatives for treatment.</p> <p>Clients receiving psychotropic medications will have a complete psychiatric evaluation upon initiation of evaluation and management services at the agency or upon return to services after an interval of 3yrs. Comprehensive evaluation may be repeated at the discretion of the prescriber when clinically indicated. Clients receiving antipsychotic medication will have an AIMS (Abnormal Involuntary Movement Scale) evaluation at least once per year. FrontLine Service assists clients in obtaining Medicaid so that they may obtain services. FrontLine Service's prescribers will provide sample medications when available, or order medications for eligible clients through the Central Pharmacy program. Additionally, when appropriate, FrontLine staff assist clients in obtaining free medication via the Patient Assistance Programs of the pharmaceutical companies.</p> <p>To further assist clients with their ability to secure their prescriptions, FrontLine Service has partnered with Genoa Pharmacy. Genoa operates a pharmacy location at the main FrontLine office to allow for direct communication and prescription coordination between FrontLine, the pharmacy, and the client. In addition, Genoa is also able to mail the medication to the client's home provided the client can provide a current mailing address.</p>

Days, Hours of Operation	The clinic operates Monday through Friday from 9 a.m. – 5 p.m., with an hour break from 12:00 pm to 1:00 pm.
Needs & Characteristics of Population Served	E&M Services are available to all FrontLine clients who would benefit from this service. Broad characteristics of the population served include but are not limited to severe and persistent mental illness, trauma survivorship, substantial medical comorbidity, poverty, homelessness, substance use disorders, and psychiatric crises.
Goals & Scope of Service	<p>The primary goal of this service is to support and facilitate the process of recovery for persons being served. The philosophy of treatment is based on Trauma Informed engagement and motivational interviewing to promote and maintain positive change. Treatment modalities include comprehensive bio-psycho-social evaluation and evidence-based diagnosis and treatment. A dynamic, ongoing collaboration with the person being served facilitates progress in recovery using the tools of pharmacologic management and supportive psychotherapy.</p> <ul style="list-style-type: none"> • 100% of psychiatric evaluations will be scheduled within 2 weeks of client request. • 100% of hospital discharges will be seen by a nurse or prescriber within 24-48 hours (about 2 days). • 100% of walk-ins will be seen by a nurse or prescriber that day to determine next steps. • 100% of PSH residents requesting health assessments will receive that service in 2021. • Begin to offer health management nursing groups at each PSH site in 2021.
Necessary Referrals/ Formal Affiliations	The clinic provides services to individuals receiving PATH services, Case Management services, Integrated Behavioral Health Services and Crisis services.

INTEGRATED BEHAVIORAL HEALTH/PRIMARY CARE	
Service Description	<p>FrontLine Service, in collaboration with Care Alliance, a Federally Qualified Health Center, has established an Integrated Behavioral Health/Primary Care (IBHPC) program. This IBHPC meets the behavioral health and general medical or physical concerns of the clients served. Care Alliance’s primary care staff meet with current clients of FrontLine Service in either the FrontLine Service Clinic.</p> <p>The following services are provided internally by members of the Integrated Care team, which is comprised of staff from both Care Alliance and Frontline Service:</p> <ul style="list-style-type: none"> • Comprehensive care management, including but not limited to: <ul style="list-style-type: none"> o Triage based on acuity.

	<ul style="list-style-type: none"> o Assessment of service needs/Reassessments o Identification of gaps in treatment o Development of an integrated person-centered plan o Implementation of the person-centered plan o Assignment of health team roles and responsibilities o Arranging for and ensuring access to primary care and other healthcare services needed. o Appointment scheduling o Monitoring of critical chronic disease indicators o Development of Crisis and Contingency Plan o Development of Communication Plan • Comprehensive transitional care and follow up, including: <ul style="list-style-type: none"> o Discharge/Transition Planning o Ensuring that healthcare and treatment information is appropriately shared with all providers involved in the care of the person served, including treatment history, current medications, identified treatment needs/gaps, and support needed for successful transitions between treatment settings. o Providing follow up and medication reconciliation upon discharge from hospitalization. • Individual and family support services, including <ul style="list-style-type: none"> o Education regarding concerns applicable to the person served. o Education or training in self-management of chronic diseases o When possible and allowed, interaction with family members and/or significant others to identify any potential impact(s) of disease(s) of the person served on the family unit; offer education or training in response to identified concerns.
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Days, Hours of Operation	The Integrated Care Clinic is held on-site at the 1744 Payne Avenue location 2 half days a week. Site visits to the individual permanent supportive housing buildings are provided based on clinical indications.
Needs & Characteristics of Population Served	Integrated care is provided to current adult clients of the two partner organizations who have a severe and persistent mental illness (SPMI), and who could benefit from integrated physical and mental health care.
Goals & Scope of Service	<p>The Integrated Care Team promotes wellness, resiliency, and recovery. They teach patients about the interactions between their mental and physical health as well as the self-management skills the patients need to manage both their mental health and medical concerns and conditions. For example, patients with diabetes and schizophrenia learn to recognize and understand how the medications they take for both conditions interact with each other and how to best manage both chronic, long-term conditions. Health promotion is currently focused on individual patients. The goal is to provide groups that encourage a peer support model of recovery.</p> <p>Broad program goals include the following:</p> <ul style="list-style-type: none"> • Linkage with Primary Provider • Reduce ER Utilization • Improve health surrounding diabetes, hypertension, and obesity. • Decrease social isolation and assist clients in building networks to better address health needs.
Necessary Referrals/ Formal Affiliations	Referrals to the Integrated Care Team are made by the client's CPST worker or prescriber.

MEDIATION & CONFLICT RESOLUTION SERVICES

CLEVELAND MEDIATION CENTER (CMC)	
Service Description	<p>Community Mediation Program- Mediate conflicts between neighbors, property owners and tenants, and family members, between service providers and clients, and within organizations and businesses.</p> <p>Eviction Prevention- Assist tenants at risk of losing their housing in filling out paperwork to apply for rental assistance and mediate with their landlord to prevent eviction and loss of housing.</p> <p>Shelter Diversion Program- Provide shelter diversion services at Coordinated Intake and at the Cuyahoga County Jail to help individuals and families seeking homeless shelter services and homeless or housing insecure inmates exiting jail find safe, appropriate housing, and avoid entering shelter.</p> <p>Re-Entry Program- Provide mediation at the Community Based Correctional Facility between clients and their family members.</p> <p>Shelter Mediation Program- Mediate between homeless shelter staff and shelter residents so that residents exit to permanent housing instead of homelessness.</p> <p>Training- Provide mediation, diversion, and conflict resolution training to community members.</p>
Days, Hours of Operation	9AM-5PM Monday-Friday
Needs & Characteristics of Population Served	<p>Community Mediation and Training- Serve all community members in Northeast Ohio in conflict and in need of mediation or conflict resolution skills.</p> <p>Shelter Diversion- individuals and families that are homeless.</p> <p>Jail Shelter Diversion- individuals being released from the Cuyahoga County Jail</p> <p>Re-Entry Mediation- Clients at the Community Based Correctional Facility and their family members.</p>
Goals & Scope of Service	Cleveland Mediation Center promotes constructive conflict resolution to facilitate dialogue, stop evictions, prevent homelessness, and train those who wish to mediate.
Necessary Referrals/ Formal Affiliations	<p>Community Mediation, Eviction Prevention Mediation, and Training- Call 216-621-1919 to refer. Services are open to all community members.</p> <p>Shelter Diversion- May be accessed through Coordinated Intake for those seeking shelter and the Cuyahoga County Probation Department for those in jail.</p>

ACCESSING SERVICES

LOCATIONS

The main offices of FrontLine Service are located in downtown Cleveland and are easily accessible through numerous public transportation routes. FrontLine Service is located at 1744 Payne Avenue, Cleveland, Ohio 44114. The phone number is (216) 623-6555. The Integrated Behavioral Health Services (IBHS) programs, the Mobile Crisis Team, the Child Trauma Services, PATH, Forensics, Bridges to Housing, and the Outreach Teams operate from this site. The agency office is open to clients and visitors from 9:00 a.m. to 12:00 p.m. and 1:00 p.m. to 5:00 p.m., Monday through Friday. Crisis Intervention, Hotline, and Referral and Information services are available 24 hours per day, 7 days per week. The phone number to access these services is (216) 623-6888. PATH and Outreach staffing is staggered so that coverage is often available between 8 a.m. to 8:30 p.m. several days each week. While each program targets different segments of the homeless population, they work in collaboration to ensure that clients are receiving services that will address their specific needs.

Accessing Services

- A. Locations
- B. Availability
- C. Linkage and Scheduling
- D. Information and Education
- E. Choice
- F. Cultural Competence

AVAILABILITY

FrontLine Service provides numerous services to persons in Cuyahoga County and remains committed to making these services accessible and available. IBHS services are available 24 hours per day, 7 days per week. Clients and family members can directly contact the assigned IBHS provider at 1744 Payne Ave. on Monday through Friday, from 9 a.m. to 5:30 p.m. During holidays and at other times, calls to the agency's primary telephone number are forwarded to the 24-hour Mobile Crisis Team, who contact IBHS staff members to provide after-hours services, when needed. Hotline, Referral & Information services, and Face-to-Face Crisis Intervention are available 24 hours a day, 7 days a week.

LINKAGE AND SCHEDULING

FrontLine Service has focused a considerable amount of attention on providing services to clients in a place and at a time that is convenient to the client. Most of the programs we operate focus on providing services to clients in their natural environment. Service facilities are in areas that are central to many clients being served.

Ongoing monitoring and review of the utilization of psychiatric time has resulted in FrontLine Service increasing the number of recouped hours from cancelled or missed appointments, thereby increasing the availability of doctor appointments for other FrontLine Service clients. Clients who do not have an appointment but are experiencing psychiatric distress are seen by the psychiatrist that day for emergency assessment or Evaluation and Management services. Nurses are also available to triage clients for emergent psychiatric or physical health issues.

IBHS services are available to clients through scheduling, or on a walk-in basis when an unexpected situation or need arises. Scheduling of IBHS services is highly dependent upon when the client agrees to be seen, thereby assuring client convenience.

INFORMATION AND EDUCATION

Information about available services is a critical component of service accessibility. Numerous documents describing agency services are available to potential clients: agency brochures, the FrontLine Service Individual Treatment Plan, Consent to Treatment form, and the Client Rights Handbook. Agency brochures are distributed to maximize information/education about services offered. Outreach teams visit bus shelters, abandoned buildings and cars, meal sites, churches, and other places where homeless persons frequent to reach as many potential consumers as possible. The IBHS teams provide information on agency services to callers as well as information on other community services if our services are not appropriate.

In addition, Referral and Information staff provide education about and prompt access to the community support and behavioral health counseling and therapy services offered by all contract agencies of the ADAMHS Board. Senior Crisis Services staff actively participates in providing training to Law Enforcement bodies such as police departments, police dispatchers, and other service providers such as EMS (Emergency Medical Service) staff and the Red Cross Emergency Service Volunteers.

CHOICE

FrontLine Service is a strong advocate for consumer choice. In addition to educating clients about the services available to them at FrontLine Service, staff also advise clients about other services available within the community. Frequently, clients will have contact with these providers as a result of the advocacy of their FrontLine Service worker. In situations where a client feels that they would work better with a different worker, a transfer is completed. Clients can contribute to the decision about whom they will work with at FrontLine Service. Client choice is a contributing factor in this decision, although not a singular one. From time to time, decisions may have to be made based on availability of staff.

Clients work closely with their worker to develop treatment plans that are individualized to the needs and goal choices of the client. Provision of one service is not contingent upon the client's acceptance of another service. Assignment of crisis staff is contingent on their work schedule. In most instances, the MCT Program Manager assigns cases to the staff as it relates to their strengths and abilities to respond to the crisis call. In cases that require a Spanish-speaking staff person, the MCT Program have several staff available to assist with providing services to these clients.

CULTURAL COMPETENCE

FrontLine Service provides culturally competent assessment and treatment services to persons of diverse cultural and ethnic backgrounds, and we have developed innovative programs that are responsive to the cultural values of our community. More than half of all individuals served by FrontLine Service programs are African American, Hispanic, or Asian. Our policies prohibit discrimination against any person or group based on race, ethnicity, age, color, religion, sex, national origin, sexual orientation, gender expression, physical or mental handicap, developmental disability,

genetic information, or HIV status. We abide by a Cultural Competency Plan, an Affirmative Action Plan, and a comprehensive Performance Improvement Plan. Our policies direct and support the provision of services in a culturally competent and sensitive manner.

To support culturally competent service delivery, we require that all staff members participate annually in training specific to cultural competence, diversity, equity, inclusion and anti-racism. For those providing direct services, training may include education on the effects of psychiatric interventions and psychotropic medications on ethnic minority persons; issues related to differential diagnosis of ethnic minority persons and vernacular language patterns of ethnic minority persons. In addition, our medical staff members are required to have completed training on medication issues for children, elderly, minority populations and persons with a severe mental disability or emotional disturbance.

FrontLine Service is a driving force in creating an anti-racist community. Everyone we work and collaborate with supports this transformation in their policies, practices, and actions. We hold each other accountable to this vision. We utilize an anti-racist lens in all organizational decisions, as we work to achieve representation of our community at all levels of our agency. FrontLine is a safe and brave space. Staff and those we serve experience success regardless of their race and can be their authentic selves. Their voices inform program and agency decisions. As members of the broader community, we are each responsible for upholding this vision.

FrontLine Service has sought opportunities to provide psychotherapy and supportive services to individuals of various subcultures. In support of this mission, we maintain a service contract with CyraCom, the leading provider of language interpretation services to healthcare. CyraCom is a Joint Commission certified national agency providing interpretation via phone, video, mobile app, or written text, that allows FrontLine to bridge the communication gap in real time (24/7, 365 days (about 12 months)/year) in over 200 languages. In addition to CyraCom being U.S. based and HIPAA compliant, the certified interpreters receive over 120 hours (about 5 days) of initial training, including medical terminology, anatomy, and physiology.

FrontLine continually seeks innovative and strategic ways in which to reach out and engage those in need.

SERVICE LOCATION LISTING

1. Main Office / Administration – FrontLine

1744 Payne Ave.
Cleveland, Ohio 44114

2. 1701 Payne - Child and Family Services

1701 Payne Avenue
Cleveland, Ohio 44114

3. Coordinated Intake/SSVF

Bishop Cosgrove Center
1736 Superior Avenue 2nd & 3rd Floor
Cleveland, Ohio 44114

4. Buckeye

11529 Buckeye Road
Cleveland, Ohio 44104

5. Downtown Superior Apartments

1850 Superior Avenue
Cleveland, Ohio 44114

6. Edgewood Park Manor

3215 East 55th Street
Cleveland, Ohio 44127

7. Emerald Commons

1976 West 79th Street
Cleveland, Ohio 44102

8. Gateway

2100 Lakeside Avenue
Cleveland, Ohio 44114

9. Greenbridge I

7515 Euclid Avenue
Cleveland, Ohio 44103

10. Greenbridge II

7609 Euclid Avenue
Cleveland, Ohio 44103

11. Harpers Point

3873 West 25th Street
Cleveland, Ohio 44109

12. James L. Stricklin Crisis Stabilization Unit

1315 Detroit Avenue
Cleveland, Ohio 44102

13. Liberty at Saint Clair

10004 Saint Clair Avenue
Cleveland, Ohio 44108

14. North Point

1550 Superior Avenue
Cleveland, Ohio 44114

15. Harper's Pointe

3875 W. 25th St.,
Cleveland, OH 44109

16. Safe Haven I

7408 Broadway Avenue
Cleveland, Ohio 44105

17. Safe Haven III

1701 Brainard Avenue
Cleveland, Ohio 44109

18. South Point

3323 West 25th Street
Cleveland, Ohio 44109

19. The Winton

9431 Lorain Avenue
Cleveland, Ohio 44102

20. Union Miles

4175 East 131st Street
Cleveland, Ohio 44105

21. West Village

8301 Detroit Avenue
Cleveland, Ohio 44102

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