Community Care Alliance

empowering people to build better lives

HIGHLIGHTS & OUTCOMES REPORT

FISCAL YEAR 2018

July 1, 2017 – June 30, 2018

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INTRODUCTION

DEAR FRIENDS AND COLLEAGUES:

It is my pleasure to share with you Community Care Alliance's Annual Highlights & Outcomes Report. The report itself provides you with a snapshot of one year's service to individuals, families and the local community. If you are not familiar with CCA there are a few things that are noteworthy in my opinion to include:

1. The breadth, depth and scope of services provided. This is not an accident in that we strive to customize what we do in a manner that will best assist our clients in achieving their desired outcomes. This is key to our organizational model to be comprehensive and provide the people we serve with "Extra Strength" services when the situation demands it.
2. People living at the poverty level endure trauma, disabilities and economic challenges that many people could not begin to comprehend. They are eager to work hard at moving their lives in a positive direction.
3. Our staff are expert in nurturing collaborative, non-judgmental relationships that facilitate tearing down "us and them" mindsets often nurtured in the popular culture.
4. The power of coordinated, customized community based services done well has a far greater positive impact on populations than traditional, narrow social services and therapeutic intervention.

If you look closely, you will note infants and toddlers meeting their developmental milestones while parents receive other supports to address mental health and addiction concerns, persons living with mental illness living independently and striving to meet their recovery goals, individuals with HIV/AIDS achieving medical stability and utilizing social supports to continue their progress, adults and youth becoming employed and attending post-secondary education/training, parents and children being reunited subsequent to placement in foster care, individuals struggling with Opioid and other substance use addiction learning to live and address daily challenges without drugs or alcohol.

I want to thank our staff and Board of Directors that are the unsung heroes reflected in this document. Community Care Alliance is mission driven before anything else and I would like to think we play a small role in making real Dr. Martin Luther King's vision of a Beloved Community that embraces and provides for the needs of everyone and not just those that are blessed with the privilege of their circumstances.

Sincerely,

Benedict F. Lessing, Jr., MSW

ACUTE SERVICES

MANAGER
Richard Crino, RN, QMHP—Vice President of Acute Services

EMERGENCY SERVICES

Open Access & Intake Services

MANAGERS
Kimberly Griffith, LICSW, QMHP—Co-Director/Emergency Services
Alicia Curran, LICSW, QMHP—Co-Director/Emergency Services

PROGRAM DESCRIPTION

Open Access & Intake Services is the agency's "front door" for accessing services. Through assessments and comprehensive screenings, experienced staff help individuals identify and prioritize their problems for treatment and make referrals to appropriate programs. Clients are engaged to focus on wellness and recovery at the outset.

OUTCOMES & ENGAGEMENT

Acute Services/Intake provides care coordination across of all Community Care Alliance programs. This program transfers clients to Adult Outpatient, Community Support and the Health Home teams as well as Healthy Transitions and the Center of Excellence programs.

- Completed 817 Bio-psychosocial Assessments and 406 Crisis Assessments, both in the community and at Community Care Alliance.

CLIENT STORY

"Larry" who is receiving outpatient and counseling services and has mobility issues, had reported to his Day Treatment provider that he was being taken advantage of by his roommates. The state became involved and police were sent out to his apartment to investigate his claim. In retaliation his belongings were thrown out on the street including vital information, such as his birth certificate, ID and medical cards. When Larry arrived at his apartment, he wasn't allowed in. Emergency Services (ES) was called as he was now homeless. ES coordinated an admission to the Acute Stabilization Unit (ASU) to meet the need of the crisis and for Larry's safety. The ASU, his CCA Outpatient Clinician, and ES coordinated a new plan for Larry to be admitted to a local nursing home for short term rehab and then step-down to an Assisted Living Facility in RI where he was able to live safely.

Acute Stabilization Unit

MANAGER

Tim Victorella, MSW, QMHP—Program Manager

The Acute Stabilization Unit (ASU) helps lower hospital and Emergency Department admissions by creating a safe trauma-informed care environment—24/7 stabilization, respite, medical care, case management, access to a medication prescriber, and the ability to find community resources to continue recovery after discharge. The ASU helps people experiencing a mental health or substance use crisis to develop better coping skills, create opportunities for personal growth, rebuild social/ community supports, and reduce every day stress through connections with basic needs programs.

Clients are encouraged to explore a more holistic approach while in treatment through activities, such as Tai Chi, guided meditation, health/wellness groups, and aromatherapy. Clients can use these activities to find harmony and balance to better their life.

OUTCOMES & ENGAGEMENT

- Admitted 970 individuals

Individuals come to the ASU to become more stable in their daily living situations. When discharged, clients leave with existing strengths enhanced, new coping mechanisms, survival skills, and resiliency.

The ASU offers a Zen room for relaxation. It gives clients the opportunity to unwind and meditate to help relieve stress and anxiety. Creative expressions, holistic health, mindfulness, and life skill groups are also available. We use these groups to not only engage clients in their treatment, but also to help them develop the skills needed to cope with their mental illness and maintain sobriety.

CLIENT STORY

"Mary" was referred from Behavioral Health Link, a new crisis treatment center, with anxiety and grief after losing a close family member. The ASU was able to keep her safe, assisted her in opening up about her grief, provided 1-1 support, and facilitated groups that assisted her in learning to cope with the stress in her life. Mary received support and a place to safely open up about her feelings. We were able to successfully assist her in connecting with other community resources and outpatient services within the CCA network.

QUOTES

"I love the ASU's ability to treat dually diagnosed patients. I have been struggling for years chasing sobriety. However, I have never addressed my mental health concerns. The entire team at the ASU was there for me when I needed help the most. The staff was patient and extremely compassionate during my detox and even more so afterwards. As a collective team they have helped me to finally understand my mental illness and gave me tools that I can use to help keep me sober." —Anonymous

"Thank you, ASU staff, for the warm welcome and compassion. It is staff like you that makes me hopeful and determined to have a successful recovery." —Anonymous

RISE TO RECOVERY

PARTIAL HOSPITALIZATION & INTENSIVE OUTPATIENT PROGRAMS

MANAGER

Francis Spicola, MA, LCDP—Program Manager

Intensive treatment for five days a week/five hours a day (Partial Hospitalization Program PHP); or three days a week/three hours a day (Intensive Outpatient Program IOP) for people, eighteen years or older, suffering with substance use and/or related mental health (MH) disorders. Requirements for admission are based on the American Society for Addiction Medicine (ASAM) assessment criteria and individuals are post any medical detox requirements. The program is a mixture of psycho-education, group and individual therapy and expressive art therapy, and individuals admitting to the IOP/PHP must be able to participate in such activities as well as be psychiatrically stable. Clients develop an individual Recovery Oriented System of Care plan with their team that may include wellness activities such as Acupuncture, Recovery Coaching, and Yoga classes.

OUTCOMES & ENGAGEMENT

- 145 individual clients treated
- 1900 billable treatment days, an approximate 10% increase over last year.
- 210 admissions (some clients admitted more than once)

The IOP/PHP has purposely developed relationships with local Suboxone providers. Since most Suboxone providers do not offer ASAM Level 2 forms of treatment, they have little recourse for treating clients if they relapsed and/or experienced a mental health crisis, which would often result in discontinuation of Suboxone. The CCA IOP and PHP is an alternative for clients receiving Suboxone from providers that allows them to remain on their medication.

- A 72% increase in treatment days for PHP/MH (non-substance-use primary mental health disorder) in the first half of fiscal year 2018 compared with same time period in 2017.
- Referrals from Suboxone providers increased by 300% for both IOP and the PHP programs.

Services at the IOP/PHP go well beyond individual and group counseling. The team also provides referrals for a multitude of programs and community resources, and offers case management such as sober housing, opiate overdose prevention (including Narcan for clients upon request), referrals for HIV testing, clothing vouchers and assistance in finding a primary care physician.

RESIDENTIAL SUBSTANCE USE TREATMENT PROGRAMS

MANAGER

David Thatcher, LCDP, LCDS, CCDS, ACDP—Program Manager

Adult males (18+) recovering from addiction live at either Wilson House or Jellison House. Each client works with clinical staff to develop a personalized treatment plan based on their individual needs. Recovery is an intensive process that may include a variety of different therapies, community resources and case management. Clients may also have co-occurring problems such as depressive disorders and/or PTSD and receive appropriate treatment. To stabilize daily living situations, staff help clients access essential services in the community. This includes primary care physicians, dental professionals, mental health providers, employment and housing assistance and medication assisted therapies. The program continues to refer and/or admit clients from the CCA Acute Stabilization Program and PHP/IOP Program. Support staff promote health, safety and consistency for residents who are unable to perform in less restrictive levels of care due to significant barriers. Each resident works actively with a certified counselor to assess and develop a personalized treatment plan based on the individual needs and motivation for change. Residents are educated about drug, alcohol and other co-occurring disorders and are exposed to different interventions including cognitive, behavioral and medication assisted therapies. Residents are encouraged to use staff, family and peer support to overcome crises and achieve long-term stability.

WILSON HOUSE AND JELLISON HOUSE

MANAGERS

David Lussier, CCSP, CADC, LCDP, LCDS, CCS—Team Manager Wilson House
Kieran Patry RCS, LCDP, CCSP—Team Manager Jellison House

OUTCOME & ENGAGEMENT

- 178 individual clients were served by SA Residential. 76 had stays of 60+ days
- 107 clients were served by Wilson House. 42 had stays of 60+ days
- 71 clients were served by Jellison House. 34 had stays of 60+ days

This program collaborates with multiple organizations in the State of Rhode Island to integrate clients into the community, improve daily living situations, and battle the opiate epidemic.

- Work with recent parolees to transition into society.
- Partner with CODAC for methadone/suboxone maintenance.
- Work with Providence In-Town Churches Associations to assist clients with SSI/SSDI applications.
- Refer clients to the CCA Pathways to Adulting, Independence, and Dignity (PAID) employment program.

- Provide a safe environment for clients through the 942-STOP grant. This grant provides 1 year of paid fees for eligible clients to have a safe place to live. The grant is used by multiple recovery housing agencies statewide.
- Provides five psychoeducational groups per weekday and three on weekend days. Three individual one-on-one counseling sessions per week. The Jellison House encourages clients to attend and participate in nightly 12 step recovery meetings as well as obtain a sponsor and home group.
- Resident were active and involved in many activities which promote present moment awareness and rebuild chemical reward systems. They participated in two fishing trips, played a friendly softball game against The Providence Center and had a bowling tournament.

CLIENT STORY

Growing up in northern RI, Josh had a normal childhood in a stable home. Like many teens, he began experimenting with alcohol and other drugs to lower inhibitions and bond with his peers. Josh was aware that certain members of his family struggled with their alcohol use but didn't give a whole lot of thought to the idea that he might be pre-disposed to a disorder. By the time he was in his early twenties binging on weekends evolved into a daily routine, which devastated his personal and professional relationships. Guilt, shame and inactivity ultimately led to a deep depression. In a matter of only a few short years this active, engaging young man found that he needed alcohol to maintain his mood and energy levels. When someone very close to him died, he began isolating himself and became more and more detached from his family and friends. He started missing work and eventually lost his job and his apartment. His life had become unmanageable due to his depression and drinking.

When he entered the Wilson House, Josh was withdrawn but quickly found his niche. To remove unnecessary distractions and provide space to plan and achieve his treatment goals, Josh made personal and professional sacrifices. He was open-minded in both groups and individual sessions and gained knowledge and insight into his disorders. He learned to use therapeutic techniques, which helped him address unhealthy, negative and addictive thinking patterns. He stopped self-medicating with drugs and alcohol and consulted with treatment professionals who helped him achieve medical and psychological stability. After completing residential treatment, Josh transitioned to the Mabel Anderson Sober House (on Wilson House campus). At this time, Josh has been drug and alcohol free for just over six months. He has gone back to work as a carpenter for a company owned by someone he met through his recovery network—a safe working environment that he appreciates. Josh continues to utilize CCA Psychiatric & Outpatient Services as part of his long-term recovery plan to maintain stability.

QUOTES

"I have been struggling with drugs and alcohol for a long time and always seem to do my best when I am at Wilson House working with the staff. I feel stable today and still use the skills they taught me to cope with cravings and stress." —David B.

"When I started treatment, my self-esteem was very low. Wilson House showed me how negative my thinking was and helped me change those thoughts to healthy, productive ones." —Vinny G.

CLIENT STORY

Brandon, who is 26 years old, was in the grips of Opioid addiction and had several near fatal overdoses before he was admitted to Jellison House in April 2018. Upon admission Brandon demonstrated signs and symptoms of severe anxiety and depression. He described himself as a "lost soul." He has since demonstrated tremendous growth in his recovery by obtaining a GED, joining 2 home groups, obtaining a sponsor, actively working the 12 steps of AA into his life and gaining employment.

Brandon successfully transitioned to Changes Recovery House through the 942-STOP grant. Brandon reports, "The house is comfortable safe and quiet." Brandon hopes that his current After Care Plan continues to be successful. Brandon has also completed the financial aid process for higher education. He is planning to attend the Community College of Rhode Island (CCRI) in 2019 once he is more acclimated to independent living. Brandon intends to complete all his general education courses before deciding on a major. Brandon says, "I at least want a Bachelor's degree in my chosen major."

QUOTES

"The Jellison House has changed my life for the better." —Brandon

"Brandon has greatly exceeded my expectations and I hope he strides for great heights in his future."—Albert Silva (Primary Counselor)

COMMUNITY INCIDENT RESPONSE, CONSULTATION & SUPPORT SERVICES

First Responder Support Services

MANAGER

Mackenzie Ramsay, BS—First Responder Program Coordinator

An Employee Assistance Program specifically created for police, fire, and EMS workers. This program assists employees with any personal or work-related problems that can or may impact job performance, health, and wellbeing. Our trained staff provide counseling, training, and crisis response services to all departments we serve, helping each individual explore ways to cope and develop resilience.

In addition to the EAP, our clinicians provide psychological support services to people in the community who have experienced traumatic events, as well as to police officers responding to individuals in crisis or critical incidents in the community.

OUTCOMES

- Served 11 police departments around Rhode Island
- Obtained two new police department contracts with Westerly and West Greenwich
- Provided 96 hours of counseling to police personnel and family members
- Conducted 52 hours of training to police departments: trainings included Peer Support, Debriefing Critical Incidents, and Crisis Responder Training.
- Provided 11 critical incident debriefings to police departments around Rhode Island
- Additionally, one of our clinicians completed 70hrs of ride along time with Woonsocket Police doing outreach and psychiatric intervention in the community.

COMMUNITY SUPPORT & RECOVERY SERVICES

MANAGER

Mary Dwyer, MS, M.Ed., APRN—Sr. Vice President of Community Support & Recovery Services

INTEGRATED HEALTH HOMES & ASSERTIVE COMMUNITY TREATMENT

MANAGER

Randi Case, MSW, LCSW—Co-Director
Kelly Kobani, BA, LCDP, CADC, CCSP—Co-Director
Susan Corkran, BS, RN—Director of Nurses

Community Support Program Teams (Teams 1-4 and ACT Team) focus on each client's individualized plan of recovery, wellness, and health self-management. The goal is to assist vulnerable individuals to live safely within the community and to reduce hospitalizations and institutional care.

OUTCOMES & ENGAGEMENT

- Served 949 Community Support Program Clients
  - 828 were enrolled in Integrated Health Homes
  - 176 were enrolled in Assertive Community Treatment

While IHH and ACT team members work to help a very needy population attain their goals of self-sufficiency, wellness and recovery by engaging the client in treatment, referral and care coordination, responding to psychiatric crises tends to be a large part of the day to day work. Over the past year, IHH and ACT teams have continued to identify preventive measures to engage a client prior to a crisis. When the crisis is not prevented the teams work to respond and support the client through the crisis. During this crisis management, teams work closely with Emergency Services, ASU, IOP, Housing and many other internal and community programs to assist the clients in need of additional services.

- As a result, CCA's Health home programs continue to see a decrease in number of clients experiencing a psychiatric hospitalization from 20% in FY2016, 14% in FY2017, and 12% in FY2018. Data provided through BHDDH shows CCA's Health Home as having one of the lowest psychiatric admissions across the state.

In addition to the existing IHH metrics that BHDDH has been monitoring, the program implemented one additional HEDIS measure as part of the preventative measures in addressing psychiatric hospital utilization. The measure is: follow-up post-ED visit for mental health issue within 7 days.

- The teams have been able to meet with about 90% of the clients within 7 days post discharge.

Despite having fewer clients in our Supported Employment services, there was an increase in the number of clients that were employed.

- Employment increased from 20% to 23%.

Staff meet the needs of our aging population with the goal of maintaining their ability to live in the community as long as possible.

- Over the past few years, the program has seen an increase in medical needs and complexities with our aging population.
- Discharge rates related to medical issues continue to be higher than at least 10 years ago, with nursing home placements at 6%, and deaths at 12%, many of which are due to medical causes.

As a health home provider, we focus on bringing in the necessary supports and assistance to meet clients' medical needs. The program has begun working with Tufts BehaveCare to help layer on a benefit for our IHH Tufts enrolled clients for in home medical assistance, triage, and coordination. Another program that we have outreached and have referred to is Program All-Inclusive Care for the Elderly (PACE), "a health plan for the aging population." Although, with PACE, a discharge to their care occurs, it allows for the client to continue living in the community while receiving a higher level of medical care.

- There has been an increase in the number of clients engaged in substance use treatment. With the opiate overdose epidemic in the state or RI, Substance Use Specialists work with this at-risk population and provide opiate overdose education and prevention, which also includes accessing Narcan.
- 53% of the co-occurring population engaged in substance use treatment.
- Over 50% of clients were diagnosed with a substance use condition (513 clients in FY 18)

Smoking rates among individuals with severe mental illness are significantly higher than in the general population.

- 60% of CSP clients identify as smokers.
- One clinician became certified as Tobacco Cessation specialist and started a new Tobacco Cessation group in November 2017, which 29 clients attended.

CLIENT STORY

Cheryl has some profound things to say. Among them, "It's okay to be different." Is Cheryl different? Well, she is the perfect elf! I mean this literally as Cheryl volunteers as an elf at the Polar Express. She demonstrated her tasks to me and plays the part so well. If only there was a full-time job that an elf could apply for! She would be perfect for it.

Cheryl walks to this seasonal gig because she doesn't have a car… in the cold, in the dark. She is committed to it and receives something for playing her part —a bag of popcorn, a bag, a salad to eat. She got the "golden ticket" for a free ride on the Comet Train. That makes it worth it.

At first Cheryl is nervous telling her story. She immediately tells me she wants to go to work. "I don't have very good confidence in myself, but by going to groups I'm learning to get out of my shell and

accept myself. I open up to everybody. The agency has helped me get my GED, go to college and graduate. But I didn't get a job. I tried very hard, it was overwhelming."

Cheryl has been coming to CCA for over 20 years. She says she tries to participate in every possible resource that she can. She joins in the Alive Peer Support Program, where she says, "They teach you to be free, and everyone accepts everything and everyone. You don't judge."

She loves the art groups at the Alive Program and the writing groups at the Wellness & Recovery Center. "You get to express yourself… talking, journaling." She has stories and poems. One of her favorites is "story dice" which gives topics to write about. "We talk about 'how was your week?' We try to help others who are sad in any way. We would change the mood to make the other person feel better and put our minds in a safe place."

"At CCA, I see a Peer Specialist, and my Case Manager, and I'm in a MUCH better place than I was twenty years ago when I first came here. The way I feel better with myself is helping others. For me to really help myself, I am learning to say no and put up boundaries. This is very hard, especially with my family. I wear two shirts, and I do take off one shirt to give to somebody." I ask, "Literally?" She says, "Really!"

"In Vocational, I'm learning to be on time, but with medications to help with sleep problems, sometimes it's hard. "I'm on top of the world when my medications are working. Myself and others, unfortunately, we decide we don't want to take our medications anymore because we are feeling great. But, it's trial and error and then we have to go back and build back up again." So, she admits that she's learned over time to stay on her medication. But, that it's not easy because it causes problems with eating right or boredom. "It messes with your head sometimes and family sometimes doesn't understand mental illness."

"What I've learned about mental illness is that stress is the main thing, and not having enough support systems at times. With all the information out there, you can't make your family understand even though you bring them the information. You can bring the horse to water…"

"I sometimes have to take a step back and work on myself. That's why I volunteer for the Polar Express." This is where I got the full demonstration with the perfect elf smile and elf voice and infectious excitement that kids would be enamored by.

After our interview, we are heading to the Wellness and Recovery Center where Cheryl is very much at home. I ask if she wants any help carrying her things. She says, "No! I'm an independent person. I'm a Momma. I'm a Memere." At the Center, she shows me the box of "Kindness Rocks" that she loves to make and some of her artwork.

MENTAL HEALTH PSYCHIATRIC REHABILITATIVE RESIDENCES

MANAGER

Kerri Berman, BA, CCSP, ALRA—Coordinator of Residential Services

MHPRR residential homes (Singleton, Sutherland, Tanguay, and Chicoine) provide transitional placement for those discharged from long-term hospitalization and requiring 24/7 support to develop skills needed to live independently. The program provides crisis management and wrap-around support, assisting clients in building a strong foundation of recovery, while reducing the need for inpatient psychiatric admissions. While mental health stability continues to be one of the main focuses of treatment, many residents have chronic medical issues that require medical intervention and coordination. Clients also receive other services at CCA and in the community. Strong family involvement is encouraged as it can be critical to the client's engagement in services.

OUTCOMES & ENGAGEMENT

The program continues to serve as a community option for clients transitioning from the hospital, or for clients who are experiencing mental health symptoms that have impacted their ability to care for themselves safely. Residents are connected with additional CCA services, including substance use treatment, vocational services, therapy and peer support.

- 50 clients lived in our residential homes
- 9 individual admissions in FY 2018; 5 from Eleanor Slater Hospital and 4 from community hospitals. The program was successful in re-integrating the clients back into a community setting safely with only 2 needing further hospitalizations.
- There were 10 discharges from the program, 4 of which were discharged to independent living. Another 2 were transferred from the group home setting to supervised apartments, resulting in a total of 6 clients transitioning to lower levels of care; an increase of 50%.

In recent years, the program has seen an increase of clients admitted into the program with legal involvement.

- 17 clients had a civil court certification, forensic agreement, or is a registered sex offender.
- Admitted the state's 1st NGRI (not guilty by reason of insanity) individual.

As a result, the multidisciplinary treatment team has gained experience and knowledge of coordinating treatment services with the court systems and has focused on finding more effective ways to engage clients in the treatment process. More social activities have been added on-site to increase peer support and engagement. Additional services such as medication education, therapeutic groups, family involvement, and staff training have also been found to be helpful.

THE WELLNESS & RECOVERY CENTER

MANAGERS

Laura Vear, MA, PC—Coordinator of Recovery Support Services

The Wellness & Recovery Center offers therapeutic, health and wellness and peer support groups to clients of CCA's Community Support Program and adult Outpatient Integrated Health Home. People can drop-in for the computer lab and Lucy's Place, a small café serving light fare for breakfast and lunch. Staff encourage personal growth within the relaxing and welcoming atmosphere of the Wellness and Recovery Center, a natural place for peer support and socialization, along with the treatment groups and peer recovery services.

OUTCOME & ENGAGEMENT

- 144 clients participate in at least one of the various groups offered
- 27 groups were offered (4 substance use, 11 psychotherapy, 12 health and wellness)
- Clients participated in 4,734 hours of activities

The Wellness and Recovery Center always strives to add new and innovative groups and activities to the schedule with special focus on meeting clients' needs and interests. One particular group, *Peace of Mind*, was offered for the 1st time in response to client's request for a group dedicated to clients living with psychosis. This group uses an integration of education, personal sharing, and coping techniques. The clients responded positively to the group, and within weeks of starting up the group has had consistent attendance of 6 clients.

QUOTES

"Wow there is a group for everything. I wish I would have time to go to every one of them."—Client

"The Wellness and Recovery Center is a very good place for people to go…You meet a lot of people, you interact with a lot of people, and they become your friends."—Client

ALIVE PEER SUPPORT PROGRAM

MANAGERS

Laura Vear, MA, PC—Coordinator of Recovery Support Services
Ashley Powers, CPRS—Peer Recovery Specialist/Program Manager

Alive is a peer supported social recovery program that provides both on-site and community group activities for individuals living with a mental illness and/or addiction.

OUTCOMES & ENGAGEMENT

- 90 members were active in the Alive Program

- The Alive program held a total of 189 activities, both on-site and in the community; 17 more activities offered than the previous year.
- Clients attended 1344 activities with an average attendance of 7 activities.

CCA continues to have one of the strongest Peer Support Programs in the state, offering individual and group options for Integrated Health Home and Assertive Community Treatment clients. CCA was awarded funding through Parent Support Network (PSN) for the 3rd year in a row to support the ALIVE program and expand peer services in the state. We partner with PSN to train and supervise new peer specialists. Laura Vear, Coordinator of Peer Recovery Services received the *Peer Recovery Specialist Supervisor of the Year Award* and has been a key figure in the state in developing a new Peer Specialist Supervisor training.

- 6 Peer Specialists provided 2147 individual contacts, providing 243 clients with Peer Support Services.
- 2 interns were placed at CCA to complete their Peer Specialist training as part of the PSN contract
- The program has embraced Peer Recovery Services, providing more activities and support groups such as Whole Health Action Management (WHAM) and soon will be offering Wellness Recovery Action Plan (WRAP), both peer recovery models.
- Alive received a scholarship from Shri Yoga studio, which allowed our clients to participate in this "innovative approach to movement-based yoga classes with community building, mindfulness and character education components built in," as defined by Shri Yoga studio in Pawtucket. Clients have really enjoyed this program and there has been consistent weekly attendance. Due to its success, Shri Studio has allowed expanded services to other CCA clients.

EVERGREEN ASSISTED LIVING

MANAGER

Emmy Jones, MA, NA—Administrator

Evergreen Assisted Living provides 24/7 monitoring of individuals with severe and persistent mental illness who struggle with activities of daily living. Most residents also receive services in the Community Support Program, receive BMI monitoring and intervention from the IHH and ACT Teams.

OUTCOMES & ENGAGEMENT

- Served 24 clients
- 6 new admissions mostly referred from CCA's Health Home program.

These clients were at-risk living in the community alone with many hospital and/or Emergency Department (ED) visits prior to admission. In the past couple of years there has been a greater emphasis on staff training geared towards crisis management and emergency response interventions. As a result, there has been more successful crisis management and psychiatric hospital diversion.

- ❖ Decreased the number of clients requiring a hospital level of care from 9 in FY17 to 5 in FY18.
- ❖ One client had 4 psychiatric hospitalizations and 9 ED visits in a 6-month period living in another assisted living program. Upon admission to Evergreen, the staff have been able to respond and support this client without the need for an ED visit or hospitalization.

The program continues to transition clients into the most appropriate level of care.

- ❖ 7 clients were discharged: 3 requiring a higher level of care with discharge to a nursing home; 3 transferred to another assisted living; and 1 to his own apartment in the community.

FAMILY WELL-BEING & PERMANENCY

MANAGER
Bridget Bennett, LICSW—Vice President of Family Well-Being & Permanency

CHILDREN'S BEHAVIORAL HEALTH SERVICES

MANAGER
Mary Turillo, LICSW—Director of Children & Youth Behavioral Health

CHILDREN'S OUTPATIENT SERVICES

MANAGER
Joelle Nelson, MA, LMHC, C—Program Coordinator

Provides a range of family-centered, trauma-informed, office-based, clinical services for children and families struggling with behavioral health issues. Professional clinicians are trained to address the needs of children of all ages with comprehensive assessment, treatment, and psychiatric services. Clients learn skills to manage symptoms of anxiety and depressive disorders, ADHD/ADD, substance use disorders, and many other issues. With all children, we collaborate closely with parents, teachers, other providers and caregivers, and use a range of therapeutic modalities, designed to meet the individual's needs.

OUTCOMES & ENGAGEMENT

- Served 671 children

CLIENT STORY

A now 18-year-old with a long history of treatment including psychiatric hospitalization and home-based services, was struggling in her foster home. Her grades were declining as well. With the support of her outpatient clinician, she was able to graduate on time and remain with her foster family. After graduation she enlisted in the military and has recently completed basic training. She remains strongly connected to her foster family.

ENHANCED OUTPATIENT SERVICES

MANAGER
Daniel Barbosa, LMHC—Team Manager

Enhanced Outpatient Services (EOS) provides intensive, community-based services for individuals in acute distress and at high-risk of harm to self or others.

OUTCOMES & ENGAGEMENT

- 281 children were served
- EOS staff have been early adopters of the MIRAH measurement-based assessment. In utilizing this tool, staff measure progress, resulting in enhanced levels of client/ family functioning.
- Group activities such as bowling, field day, game days, trips to the theatre, etc., allow us to enhance engagement whil providing opportunities for pre-social activities for the children/ youth in the program.

CLIENT STORY

BT is a 24-year-old woman with two young children. In 2015, she relinquished her two children to DCYF due to depressive symptoms including a suicide attempt. She started EOS, including therapy and case management services. BT obtained employment and stable housing and in 2018 one of the children was reunited with her. This boy had been hospitalized and displayed significant behavioral issues. He was placed at the CCA Viola Berard School and EOS staff provided support in the home. As his behavior stabilized, he was transitioned to Children's Outpatient Services. Later in 2018, BT's other child was returned to her care. At this time, EOS staff continue to provide support to the family to ensure that the children remain in their home and community.

QUOTE

"It's so gratifying to be able to see a family thrive."—EOS Staff

HEALTHY TRANSITIONS

MANAGERS

Tara McConkey, LICSW—Team Manager

Intensive, community-based services for youth ages 16-25 with serious mental health concerns, particularly due to the transition from adolescence to adulthood when facing new roles, responsibilities and expectations for independence. Multi-disciplinary team provides crisis assessment and stabilization and works together to assist participants with meeting personal goals for improving mental health and making successful transitions to adulthood.

OUTCOMES & ENGAGEMENT

Not only will participants be connected to their service providers, but they will also feel connected to other participants in the program. Participants create their own personalized treatment plan with the help of the team. They work with as many or as few members of the team as they choose.

- 66 young people were served
- More than half of the participants in Healthy Transitions are either working or enrolled in an educational program.

- Healthy Transitions utilizes the GPRA, a data collection tool developed by the Federal Government. In addition, the staff utilizes MIRAH to measure client progress.
- Healthy Transitions staff engage clients in a number of group activities centered around the arts and physical activities, as well.
- One participant has recently started a recovery support group.

CHILD WELFARE

MANAGER

Mark Cote, LMHC—Director of Child Welfare

FAMILY CARE COMMUNITY PARTNERSHIP

MANAGER

Patricia Corbett, LICSW—FCCP Northern Region Manager

The Family Care Community Partnership (FCCP) is a free statewide prevention program available to any family with a child under the age of 18. CCA is the lead agency of the Northern Region of the FCCP, partnering with CCAP. The FCCP helps families experiencing stress and in need of assistance to navigate services and community resources. FCCP engages with families using a wrap-around model; identifying family strengths and natural supports to develop a plan of change.

The Department of Children, Youth and Families (DCYF) has identified "Pivot to Prevention" as a major strategy and look to FCCPs to divert families from contact with or opening to the Department, or to assist families with initiating services that are required by the Department.

Families are often overwhelmed by chronic or acute stressors and are unsure how to proceed. The FCCP helps families understand risk and safety issues and plan for reducing stress.

OUTCOMES & ENGAGEMENT

There have been many changes this year including a new contract which began in May 2018. There is a greater focus of crisis stabilization and increased face to face contact with families. Statewide, FCCPs now have responsibility for Youth and Wayward diversion services. The DCYF "Pivot to Prevention" has increased efforts toward assessment and support of families to prevent them opening to DCYF.

- Opened 266 cases
- Approximately 72% of the families served met some or most of their wrap plan goals
- Approximately 6% of families opened with DCYF within 6 months of service with the FCCP.

FCCP seeks to connect with community resources to increase awareness and create partnerships. The program hosts or runs activities and groups for parents and youth such as parenting groups, classes and family events to promote skill building and positive family time. These different activities

support parents in their efforts to create a positive environment for their children, as well as to empower youth to make healthy decisions.

- Parenting classes were offered 2 times
- A Spanish support group was held on 7 occasions
- Held 2 Expungement Clinics.
- Family events included a trip to a local farm, a Fall Pumpkin Event and Family Bowling.
- Supported a summer Block Party, healthy cooking classes at a local organization and water safety courses at the YMCA

The FCCP has helped many families this year with connecting to resources, finding day care, improving educational services for their children, identifying improved living conditions and improved families' understanding of the needs of each of its members. Families that reach out to the police regarding filing a Wayward petition with the court when they feel that they have no other choice are now referred to the FCCP.

- Diverted more than 80% of youth from court involvement through connecting them to counseling, family team meetings, advocating in school and making referrals for social and recreational resources.

Northern RI Visitation Center

MANAGER

Kelli Li, MA—Manager of Integrated Permanency Support Services

NRIVC works with parents whose children are in out of home care due to abuse and/or neglect and are currently working towards reunification. Additionally, parents involved with NRIVC have an identified mental health and/or substance use concern. All NRIVC clients are referred by DCYF.

NRIVC supervises visits between birth parents and their children focusing on building parenting skills and enhancing the parent/child relationship. Additionally, NRIVC provides case management, recovery coaching, case coordination and recommendations to court in order to help parents overcome barriers to reunification or be part of the permanency plan for their children. NRIVC also assists with transportation of children to visits with their parents and provides home-based services to support the family after reunification.

NRIVC and Intensive Family Preservation now function as a continuum service, and families that reach reunification will continue work with their case manager, in their home setting in order to provide support and resources during transition.

OUTCOMES AND ENGAGEMENT

- 66 families were served

NRIVC continues to consistently collaborate with Adult General Outpatient, Treatment Foster Care, IOP, and PHP services. NRIVC and Intensive Family Preservation are in its second year of operating as a continuum service.

- 9 families that reunified utilized IFP services after reunification.

NRIVC utilizes the Family Advocacy and Support Tool (FAST) to collect data on each client's strengths and needs at Intake, every 90 days, then again at discharge.

- Data collected indicates that clients showed significant improvement in: child care skills, parental effectiveness, communicating, engagement in services, and financial stability, as well as management of their mental health/substance use needs.

Before beginning visitation through NRIVC, clients participate in a "engagement phase". Clients meet with our Engagement Specialist in order to ensure that they are receiving the appropriate services to fulfill requirements on their DCYF service plan. Our engagement specialist links clients with appropriate providers, while also connecting with providers that are currently in place. This process allows for NRIVC to take a team approach with our clients to ensure that all of their needs are being met.

QUOTE

"Our experience with DCYF through this whole ordeal was stressful at times. But with the help of my case manager it got better. My case manager helped us out a lot with support and feedback advice also parenting skills. She takes time out of her weekends to help us when we need her. She puts her clients first. It's been a long 18 months, but things are getting back on track for us with her help. We're looking forward to still have her working with us when we are reunited with our children. Thank you for all your help." —NRIVC Client

Intensive Family Preservation

MANAGER

Kathryn Landolfi, LCSW—Supervisor/Clinician

Intensive Family Preservation is a home-based program for families, funded by DCYF, providing intensive wraparound services for families in need of long-term stabilization to avert placement or assist with reunification.

OUTCOMES AND ENGAGEMENT

- IFP served 65 families.
- At the end of the year, 56 families maintained their children in the home, 5 families were reunified, and 4 families had their children removed from their home.

IFP runs a Parent Support Group that meets quarterly. Parents enjoy many activities during these groups (movies, bowling, jewelry making) while also making connections and building a support network with other parents.

- Participated in summer activities for children along with the EOS program.
- IFP and FCCP worked together to provide holiday gifts for non-Woonsocket residents and children not eligible for Adopt-a-Family.

CLIENT STORY

Dad engaged in IFP two months prior to the scheduled reunification with his two sons, ages 6 and 8. The children had been through several placements as Dad worked towards being financially stable enough to provide for all three of his children. Their mother was minimally involved in their lives. The six-year-old boy has a physical disability that requires services in order to manage him in the home and at school. He and his girlfriend's two-year-old son, who was in their care, had significant speech delays.

The couple had just moved into their own apartment in Woonsocket, but had already fallen behind on rent and was struggling to keep their home. Dad was working 50+ hours a week at an overnight job located over an hour away in order to earn enough money to pay their rent. His girlfriend was working at a Stop and Shop located in Providence. They would take busses and trains to get to their jobs every day, which added significant time to their commutes.

In order to reunify with his children, Dad participated in parenting classes, counseling sessions and other required activities in order to expedite bringing his children home. He enrolled his youngest son in Early Intervention and set up Home Based Therapeutic Services for his middle son in preparation for reunification.

After a long and difficult process, this father was able to reunify with his two sons. He has maintained them in his care since July 2017. They are happy to be home with their younger brother and in the care of their father. He exemplifies patience and understanding when dealing with his children and is a positive role model for fathers in similar situations.

NURTURING EARLY CONNECTIONS

MANAGER

Jeanne Rheume, LICSW—Program Coordinator

Nurturing Early Connections (NEC) serves families with children 0-2 years of age (average age 0-six months) who are involved in the Child Welfare system and in out of home placement. Staff provide increased supervised visitation for biological families, parenting skills and intensive case management with a goal of reunification and/or permanency for young children. We use an evidence-based parenting curriculum with families focusing primarily on child development and attachment and bonding.

OUTCOMES AND ENGAGEMENT

- Served 35 families
- 60% were first time parents; 50% placed in out of home care at birth and became involved with NEC within 3 months or less.
- 22 families received other CCA services, including adult mental health and substance use treatment, case management, Family Support Center, home visiting programs, Early Intervention, and Employment and Training programs (PAID).
- All 35 families saw their weekly visits with their babies increase by 100% (2-4 hours or more weekly) to increase attachment and bonding.
- Ten families successfully reunited within a 10-month period and are receiving after-care services with CCA's Intensive Family Preservation program.
- 50% of all families were reunited within a one-year period
    - Shortest length of out of home placement: 3months
    - Longest length of out of home placement: 15 months
    - 3 open adoptions
- 100% of families were exposed to chronic trauma (i.e., poverty, domestic violence, community violence) and had mental health issues that required clinical intervention.
- 90% parental substance abuse, and 37 % of babies were substance exposed at birth
- 37% of parents had a history of child welfare involvement when they were children
- 50% of babies were eligible and received Early Intervention services

CLIENT STORY

Karen's baby was placed into DCYF kinship care at birth due to mom's long history of mental health issues and trauma. With the assistance of our Nurturing Early Connections Program, she was able to receive increased visitation with her children, gain insight and information regarding child development and importance of attachment and bonding. She worked on her DCYF service plan, engaged with CCA Community Support Program to address her mental health concerns; received home visiting and parenting supports through the CCA Healthy Families America Program; obtaining housing through the CCA Supported Housing Program; and obtained basic needs assistance through the CCA Family Support center. Karen was reunited with her baby and is now working, attending all her and her child's appointments, and enjoying motherhood. Her daughter is meeting all her developmental milestones, and the family continues to receive support and information through our Intensive Family Preservation Program.

QUOTE

"I love this program, and without you all and everything you have done to support us I don't know where my family would be today." —NEC Client

Therapeutic Foster Care

MANAGER

Linda Harrod, LICSW—Program Manager

Therapeutic Foster Care (TFC) connects children that are exposed to abuse and neglect and are in the child welfare system with foster parents who provide a refuge in their home. A support team helps foster parents meet the emotional and behavioral needs of the children placed in their homes. Our goal for the children is permanency, and while reunification is what we seek for all children, permanency may end up being guardianship with a relative, or adoption.

OUTCOMES & ENGAGMENT

- 69 children were placed in TFC within 18 families
- 16 children received permanency either through returning to their parents who had completed their service plan or through adoption

With our small department of 2 clinicians and 4 case managers, we see our clients at least once a week unless they need more assistance. Staff attend school and provider meetings, court hearings, and any other meetings necessary to advocate for our client, the child. This may entail asking for more or fewer visits, depending on the need of the child, changing schools, or asking for more intensive counseling.

We provide activities for the children to engage with other children in the program as well as offer sibling visits when possible. We have outings for our foster parents and children throughout the year, such as the holiday party with Santa Claus, bowling event and a pizza party, and a summer barbecue.

CLIENT STORY

Three sisters were placed in one of our foster homes for over a year. The girls were free for adoption so the providers found a home that wanted to adopt them so they could stay together. Our foster parent helped facilitate the visits to make a smooth transition from the foster home to their adoptive home. The children were nervous and excited about the move and the foster parents did a wonderful job of helping the children transfer to the pre-adoptive family. The children have since been adopted and are doing well.

QUOTE

"It takes a village." —TFC Foster Parent

"One day at a time, sometimes just one minute at a time." —TFC Foster Parent

EARLY CHILDHOOD PROGRAMS

MANAGER
Darlene Magaw, MS—Family Support Director

EARLY INTERVENTION

MANAGER
Linda Majewski, M.Ed., MT-BC—Program Manager

Early Intervention is an infant-toddler home-based program regulated in Rhode Island by the Executive Office of Health & Human Services. The program serves eligible children from birth to 3 years of age to promote their growth and development. Qualified professionals work in partnership with the family to address children's developmental delays or functional skills levels that are likely to result in significant developmental problems, and certain other diagnosed conditions. Here at CCA, Early Intervention has provided nearly 50 years of service plan development, parent coaching, direct therapies (Speech, Physical, Occupational, Nursing and Nutrition), as well as innovative approaches like infant massage instruction and music therapy to reduce the impact of developmental delays and disabling conditions for children under three years of age.

OUTCOMES & ENGAGEMENT

- Served 588 children and their families.
    - Started with 227 and received 361 referrals.
- 311 children were evaluated for initial eligibility. One hundred twenty-two children graduated from EI into preschool programming and over half met their goals and were discharged without needing further special education services before age three.
- 96 % of EI families report they are mostly or completely satisfied that services have helped them to understand their child's unique strengths, needs and abilities.
- 96 % of families report their experience in Early Intervention has been very or extremely helpful in communicating their child's needs.
- EI has a service philosophy of providing intervention in the natural environment which for most infants and toddlers means the home or early care setting. Federal guidelines suggest 90% or better of all services should happen in the natural environment and CCA EI has been consistently above this 90 % target for many years.

CLIENT STORY

Leon was born to a mother in long term recovery and had characteristics of neonatal abstinence syndrome (NAS) due to exposure to methadone during pregnancy. Leon's mom and dad were well prepared before birth that Leon might have these symptoms. The Neonatal Intensive Care Unit that took care of Leon recommended a referral to Early Intervention. Our EI team met with the family shortly after hospital discharge and provided guidance related to feeding, positioning and ways to help Leon adjust to home life after several weeks in the NICU. The family identified needs ranging

from managing the cost of formula to finding the best swaddling position to help calm and comfort Leon during feedings. Leon's dad is his primary caregiver and mom is employed fulltime. Our EI team works closely with the family and their pediatrician to monitor weight and growth as well as other developmental milestones. We helped the family to apply for WIC over the phone in order to help make Leon's formula more affordable. Leon is now over 12 months old and continues to make good gains and steady progress in development. Leon's mom continues her recovery supports and Medicated Assisted Treatment (MAT) through a local clinic.

QUOTE

"The most important lesson I learned from the Early Intervention Program is to be patient and just do my best to incorporate speech activities into our daily routines."—Early Intervention Program Parent

First Connections

MANAGER

Darlene Magaw, MS—Family Support Director

First Connections is a family visiting program funded by Title 5 Maternal Child Health funds and Medicaid. CCA provides initial health assessment, maternal depression screening, and developmental screening for children under three and then short term, usually 2 – 6 visits, to identify and guide referrals to longer term services agreed to by the family. The CCA program serves cities and towns north and west of Providence. Providers are registered nurses, social workers or community health workers. Two of our providers are Certified Lactation Counselors to assist pregnant women and new moms plan and succeed with breastfeeding their infants.

Moms seen by First Connections are more likely to complete their 6 week post-partum OB/GYN visit. We also help to identify the signs of developmental concerns earlier and refer to Early Intervention in a timely fashion in keeping with the CDC campaign to "Learn the Signs – Act Early". Children screened early for developmental milestones and connected to Early Intervention are less likely to need further more costly interventions later in their schooling.

OUTCOMES & ENGAGEMENT

- Received 1568 referrals and were able to engage nearly 24% of those referred. Referrals from DCYF accounted for 219 of the total referrals.
- First Connections engaged 373 families and provided a total of 571 home/community visits.
- 98% of children received at least one developmental screening and 62 children were referred to Early Intervention.
- Screened 324 pregnant or new moms for depression and made referrals for further mental health assessment and treatment for 48 women.
- 230 guided referrals were made to other community supports, including WIC, SNAP, housing & heating assistance, and pediatric and postpartum care.

- Our specialized Peri-Natal Hepatitis B statewide program tracked the successful immunization of 50 additional children who were at risk for exposure to Hepatitis B transmission, however this program contract ended in February 2018.

QUOTE

"The nurse that visited our family was so helpful and knowledgeable about breastfeeding. She answered all my questions and visited again before I returned to work. She provided tips on pumping and storing my milk."

CLIENT STORY

A pregnant mother was referred by CCA's Family Care Community Partnership (FCCP). Her pregnancy was considered high risk due to diabetes. Also, her relationship with the father of the baby was not safe and a restraining order was completed with the help of the local DV advocate. Our FCCP provider focused on the needs of her 7 year old daughter who was having difficulties in school. Our First Connections provider focused on mom's well-being and consulted with her nurse-midwife throughout the pregnancy. Through our Cribs4Kids program, she was able to obtain a safe sleep crib for her new baby. First Connections provided sibling preparation materials that FCCP used to prepare her daughter for the new baby. Mom delivered a healthy boy and returned to work after her family medical leave. Her son is now 4 months old and meeting his developmental milestones. Her daughter is doing better in school this semester and enjoying her new little brother.

HEALTHY FAMILIES AMERICA

MANAGER

Gail McArthur, LICSW—Supervisor

Healthy Families America (HFA) provides prenatal and parenting support, case management and education. Families referred to HFA are either expecting or have a child under the age of three months. Family Assessment workers complete a Family Survey with the parent(s) that encompasses their own history of being parented as well as their beliefs and expectations for being a parent. Families receiving scores over 25 are enrolled with the understanding that the program is voluntary. Goal plans are developed based on family priorities from the interview/survey. Parent education and support is offered during weekly home visits. Periodic developmental screening is done to celebrate milestones or head off any developmental concerns that arise, and the evidence-based curriculum "Growing Great Kids" is used to guide families, as well.

OUTCOMES & ENGAGMENT

- Served 110 families.
- Completed 59 parent surveys.

- ❖ All families were screened for health indicators during pregnancy, including perinatal depression, use of tobacco, alcohol and other drugs, with referrals for further assessment made as appropriate.
- ❖ All of current children are up to date on their immunizations and have a consistent medical home.
- ❖ Families in HFA are more likely to be breastfeeding their infants at 6 months of age which is higher than the general population of breastfed babies. Two of our family support workers are Certified Lactation Counselors (CLC).
- ❖ 100% completed referrals to Early Intervention when screening suggested further assessment was needed.
- ❖ To reduce isolation, the team holds periodic social gatherings (at least 4 per year) including a Spring Safety Brunch, apple and pumpkin picking, a Born to Breastfeed gathering, trips to the zoo, Thanksgiving dinner, and photos with Santa, provided at no cost to families.
- ❖ Retention rates are generally good (we have 8 families whose children are graduating at age four this year) and we are continuing to explore strategies for successful initial engagement.

FAMILY SUPPORT

MANAGER

Darlene Magaw, MS—Family Support Director

THE FAMILY SUPPORT CENTER

MANAGER

Emidio Rosa—Supervisor

The Family Support Center (FSC) is a busy drop-in center and core Community Action Program service providing basic needs assessment, guided referrals, advocacy and financial assistance. FSC provides emergency food and clothing vouchers, utility and limited rental assistance to eligible individuals and families. FSC serves Woonsocket residents who meet income guidelines for specific services. Eligibility is income-based and depending on the funding source can range from below 200% of the federal poverty level (USDA Commodities) to below 300% (Good Neighbor Energy Assistance Fund).

Family Advocates make guided referrals to internal programs like financial literacy and employment programs, partnering with other agencies to determine eligibility for specialized resources like SNAP or National Grid affordable repayment plans. They provide affordable repayment plan negotiations with property owners and utility companies, as well. Staffers will engage with clients to advocate with landlords and/or utility companies when household bills fall behind; and depending on the circumstances that brought about arrearages, clients may have financial assistance paid on their behalf.

Prevention of homelessness is a core outcome of these supports – moving from crisis to stability and self-sufficiency is the goal for every client contact.

OUTCOMES & ENGAGEMENT

- Served 3823 households representing 6227 individuals.
- 7598 visitors signed in between July 2017 and June 2018.
- Served an additional 156 elderly/disabled household each month that were unable to travel to the FSC by delivering USDA commodities to congregate subsidized apartment complexes in the city. Due to elimination of funding for Emergency Food Assistance, our delivery program was ended in June 2018.
- Provided 2163 food vouchers and 1224 clothing vouchers.

A $17,000 grant for flexible rental assistance provided to CAP agencies from a donor to the Rhode Island Foundation allowed Family Advocates to assist families with a short term crisis that can be solved with less than $1000. An example of this is a temporary loss of income due to an injury not related to work or an expense that is paid in order to keep working (e.g., car repair) but impacts the households ability to pay the rent or mortgage. This grant was leveraged with other funds from various sources including faith-based missions.

- These funds prevented homelessness for 25 families representing 60 individuals who avoided entering the Shelter.
- Also partnered with United Way of RI and the Good Neighbor Energy Fund to provided utility assistance to 55 families who were facing shutoffs, thus preventing homelessness for 161 people in our community.
- A Community Development Block Grant for Woonsocket provided funds to assisted 19 families to move to more affordable housing and prevent homelessness.

QUOTE

"I'm so glad to finally have health insurance after many years of using the emergency room for pretty much everything. I have diabetes and want to get things under control before my health gets worse." — Client applying for insurance for the first time with our Navigator using the HealthSource RI portal.

CLIENT STORY

Marilyn is a mom with 3 young children under 8, one of whom was served by our Early Intervention program and graduated to pre-school services. Her husband had become more violent during their marriage and Marilyn found the courage to leave and sought help from the Family Support Center. Our family advocate helped identify domestic violence resources and crisis supports through the FCCP. Mom was able to move into safe housing and transfer her children to a new school in the community.

EDUCATIONAL SERVICES

MANAGER
Charles Stebbins, MA, LMHC—Program Director

VIOLA M BERARD EDUCATION CENTER

MANAGER
Kristen Moreau, MA, PC—Clinical Director

Individualized academic and therapeutic interventions are provided for at-risk children whose behavior and psychological difficulties impair their ability to learn in traditional school settings.

OUTCOMES & ENGAGEMENT

- 28 Students over the last year
- 5 Students have returned to the public school from our program over the past year

CLIENT STORY

A third grader presented with explosive behaviors in the classroom and became a Viola M Berard Education Center (VMB) student. He was unable to verbalize his feelings and had difficulty de-escalating when he was upset. During his time here, he actively participated in groups that worked on identifying feelings, working on the consistent use of coping strategies, empathy, and problem solving. This young student practiced the skills he was taught when he was in "good space" so that he was able to access them when he was struggling with his feelings and behaviors. The behaviors that referred him to Viola Berard decreased. He was able to advocate for himself and remain calm for longer durations of time, and accepted feedback without being argumentative. When there was a consequence for his actions, he was able to accept it. Due to his growth and progress, it was recommended that he return to the public school in the fall of 2018. During a follow up conversation with his mother, she reported that he was doing well and had adjusted.

QUOTE

"Every day is a new day." —VMB Teacher

VIOLA M BERARD BEHAVIOR INTERVENTION SERVICES

MANAGER
David Lamoureux—Coordinator of School Services

Behavior Interventionists are placed in public schools to assist administration in working with challenging students. Behavior Interventionists are a resource to teachers, providing suggestions about how to manage challenging behaviors. They also play a huge role in being students' biggest connection to the school.

OUTCOMES & ENGAGEMENT

- A Connections Survey showed that several students chose our Behavior Interventionist as their "go to" person if had any issues that affected their ability to function during the school day, revealing that Behavior Interventionists play an essential role in building a positive school culture for those students.
- Lowered the number of students needing out of district placement. Lowered the number of out of school suspensions.

ADULT BEHAVIORAL HEALTH SERVICES

MANAGER

Michelle Taylor, MS, CAGS, LMHC—Director of Outpatient, HIV Services & Opioid COE

General Outpatient Services

MANAGERS

Barbara Gloria, LMHC, CAGS, CCSP, PC—Team Manager, GOP
Christine Rathbun, MSW, LICSW—Team Manager, Team 5

General Outpatient Services (GOP) provides individual, group and family counseling by independently licensed clinicians using evidence-based practices, including Cognitive Behavioral Therapy (CBT), Dialectical Behavior Therapy (DBT), and Motivational Interviewing (MI). Psychiatry is available to those whose symptoms are best managed with medication.

OUTCOMES & ENGAGEMENT

- Served 1,767 clients:
  - 926 were admitted.
  - 783 were discharged.
  - 528 were treated for PTSD.
  - 620 received psychiatry services.
- Clients spend an average of 9 months in treatment.
- 65% of individuals have a co-occurring substance use diagnosis.
- Our appointment show rate has improved by 15%.

This year, the GOP Team has implemented the use of Measurement Based Care, an electronic assessment tool that allows clients to share how treatment is helping them, giving both the client and their therapist immediate feedback. This allows us to monitor progress and adjust treatment accordingly.

GOP Team 5 — Intensive Health Home

MANAGER

Christine Rathbun, MSW, LICSW—Team Manager

Comprehensive, multidisciplinary Health Home includes case management, counseling, nursing, psychiatry, peer support and vocational counseling. Clients receive assistance with a wide variety of needs in addition to their behavioral health needs, including chronic disease management, care coordination, activities of daily living, housing, education/employment, family support, and social engagement.

OUTCOMES & ENGAGEMENT

- Served 247 clients.
  - 50 were admitted.
  - 62 were discharged.
  - 129 were treated for PTSD.
  - 181 clients received psychiatry services. Clients spend an average of 16 months in treatment.
- 50% of individuals have a co-occurring substance use diagnosis.

Team 5 employs a person-centered approach designed to address each individual's unique needs. Stabilization of health is often the highest priority and that includes improving physical health, reducing and/or learning to cope with mental health symptoms, and achieving recovery from substance use. Harm reduction is often a first step along that path, especially when a client is not sure if he/she is ready to stop using substances completely. Housing may take precedence over these when a person is homeless or living in less than optimal conditions. Have a roof over one's head, obtaining a source of income, and having food in one's belly may be the most pressing concern. Once these are addressed, a person may now be ready to work on their health issues. Meaningful activity is important for all human beings. For some, this may mean paid employment, for others, it may be volunteering or engaging in an enjoyable activity, such as walking, crafting, or writing. Repairing and building strong relationships with loved ones, friends, and the community can have a powerful impact on improving someone's mood. Reunification with one's children is a joyous event that is always celebrated.

CLIENT STORY

Louise is a 60 year old woman who has been engaged in treatment for 5 years. She has a long trauma history, including being abusive to her own son and daughter, and eventually becoming estranged from them. She went through a period of being addicted to Adderall and then alcohol. She was experiencing deep anguish and shame about her relationship with her children and her past choices. She had very poor self-esteem and poor boundaries. Additionally, Louise had a great deal of shame about losing her job due to her angry behavior and inability to meet expectations. With a lot of hard work, Louise has made important changes in her behavior. Today she has relationships with both her

adult children and her grandchildren. She has good self-esteem, confidence and is grounded. She is abstinent for 2 years, happy, and has a positive outlook towards the future. Very recently, she returned to work in the same field and is grateful to have a second chance.

Center of Excellence for Opioid Addiction Treatment

MANAGER

Michelle Taylor, MS, CAGS, LMHC—Director of Outpatient, HIV Services & Opioid COE

The Center of Excellence for Opioid Addiction Treatment (COE) is a six-month program serving adults with Opioid Use Disorders using a multi-disciplinary team approach that includes co-occurring counseling, peer support, nursing, case management and psychiatry. Medication Assisted Treatment (MAT) options include buprenorphine (Suboxone) and naltrexone (Vivitrol). During the episode of care, individuals may be connected to other levels of care as needed, such as Detox, Intensive Outpatient Program, Partial Hospital Program or Residential Services. Clients are strongly encouraged to participate in peer recovery support through the Serenity Center, as well as other community supports, such as Narcotics Anonymous, Alcoholics Anonymous, and The Anchor Center.

OUTCOMES & ENGAGEMENT

Individuals sustain a prolonged period of abstinence, allowing them to repair relationships, restore their physical health and psychological well-being, return to work, be reunified with children who have been in DCYF custody, develop their spirituality, and resolve legal issues.

- 21 individuals have been served.
- All have received Narcan, the overdose-reversing medication that saves lives, along with instructions on how to use it.

Serenity Center

MANAGER

Stephen Risi, MSW, LICSW—Coordinator

The peer-run Serenity Center offers support services by certified Peer Recovery Specialists on Thursday and Friday evenings and Saturday and Sunday afternoons. Recovery groups include NA, AA, Families Coping with Addiction, and Medication Assisted Treatment Support Group. Social Activities promote development of a recovery support network.

OUTCOMES & ENGAGEMENT

Individuals engage in the array of services offered, drop-in, social events, self-help groups, and are supported in their recovery, remaining abstinent and developing the skills needed to live their life in a manner consistent with their own values and personal goals.

- 25 events were offered

- 129 individuals were active participants
  - 37 returned
  - 27 new participants
  - 65 unknown whether new or returning

HIV Support Services

MANAGER

Michelle Taylor, MS, CAGS, LMHC—Director of Outpatient, HIV Services & Opioid COE

HIV Support Services are provided at two locations, Agape Providence and Agape Woonsocket. The Agape centers are places where people living with HIV/AIDS come to socialize and learn about the progression of their disease and their role in staying healthy longer. Agape provides multiple services, such as case management and referrals, resources and advocacy, and promotes community awareness and prevention of the disease. Confidential, free testing is offered to members of the community.

Agape Woonsocket

MANAGER

Lorna Cohen, BA—Associate Director

In addition to the services described above, Agape Woonsocket offers a food pantry and personals closet where clients can "shop" for necessities. Clients have access to a variety of resources.

OUTCOMES & ENGAGEMENT

- 109 clients served. 38 received case management, and 71 for other services and activities.

In addition to receiving case management services which offer support and assistance in navigating the complicated medical and entitlement system, registered nutritionists from the RI Community Food Bank and AIDS Project RI are available to work with clients around preparing healthy meals for a healthy diet. Living a healthy lifestyle, which includes eating a healthy diet, empowers our clients to better manage their HIV disease. Members are encouraged to assist in preparing healthy meals for the drop-in Center with our Healthy Luncheon program.

- 86 households visited our food pantry 790 times.
  - These households had 96 family members; 86 adults and 10 children.
- Our pantry provided 3.5 days of food per visit for each household.
- Distributed 13,365 pounds of food.

Agape was awarded a Department of Health grant to promote the UNAIDS Goal for 90-90-90. The goal is that by 2020, 90% of all people living with HIV will know their HIV status; 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy; and 90% of all people receiving antiretroviral therapy will have viral suppression. With this funding, we have hired two part-

time Health Navigators who offer testing. Additionally, we provide van transportation to and from events. These include served meals, educational activities and healthy eating classes. A nurse is available weekly, to offer nutritional guidance and address other health issues. A Mental Health Counselor facilitates a coping skills group and provides individual support.

CLIENT STORY

Agape has been working with a 56-year-old woman who has been HIV+ for over 29 years. In addition to her HIV disease, she has been living with substance use and mental health issues, homelessness and has been resistant to staying engaged with the appropriate medical treatment. About 2 1/2 years ago, she expressed a desire to stop using. Her Agape case manager quickly referred her to Emergency Services where she had a stay at the Acute Stabilization Unit. Upon her discharge, she was followed by IOP. Her Agape case manager worked with her and HOPWA (Housing Opportunities for People with AIDS) to get her housed. She has reengaged with medical treatment and her viral load is now undetectable. In December, she will be moving into her own apartment, her first in over 3 years. She has also reunited with her children and grandchildren.

QUOTE

"I have been associated with Agape for a long-time now and without the help they have given me, I don't know where I would be. At first, I was so alone and lost and someone gave me a number to call. When I did, I expected someone to answer and be put on hold, but that didn't happen and finally there were faces to names. Kind, caring faces of people who really tried to help me. I can't begin to tell you how much I needed these people and their perspective on things. It's true, you can't do it alone and I thank God I didn't have to!" —Agape Woonsocket Client

AGAPE PROVIDENCE

MANAGER

Michelle Taylor, MS, CAGS, LMHC—Director of Outpatient, HIV Services & Opioid COE

Agape Providence serves individuals living with HIV/AIDS and co-occurring behavioral health issues. Services include a 12-bed transitional housing program for men. Outpatient services include mental health and substance use counseling, case management services, drop-in center, HIV & Hepatitis C testing, served meals, and nursing support/care coordination. A multi-disciplinary team comprised of nursing, case management, peer support, counseling, and psychiatry assist clients to develop an individualized one-on-one, strengths-based care plan. Through its partnership with RIC, Agape Providence hosts multi-disciplinary interns who support the full array of services, contributing to the development of a workforce that is well-prepared to support the unique needs of this population.

Financial support comes from a Ryan White Grant for those who are uninsured or underinsured, a CO-EXIST grant, and several other grants targeting this population.

OUTCOMES & ENGAGEMENT

- 35 individuals have been served since October 2017 when the program opened.
    - Average length of stay is 80 days.
- Of these, 23 men have benefitted from transitional housing.
- 12 participated in outpatient services and basic programming

Each client has an individualized treatment plan that addresses his unique needs with unique goals and outcomes.

- 7 clients achieved viral suppression since entering housing.
- 14 clients improved their overall health.
- 5 gained employment and 2 are participating in the PAID program.
- 1 currently going to CCRI and 1 is enrolled.
- Offered groups such as: psycho-educational, recovery-based, spiritual enhancement, mindfulness and meditation just to name a few. Some of the recovery-based groups have introduced client to 12-step recovery for the very first time and has actually helped them to achieve sobriety.

When clients move into transitional housing, they have often fallen out of care and are non-adherent to taking their HIV medications. Many have become very sick. Even with optimal treatment, HIV can cause chronic inflammation that takes a toll on the body. Also, individuals experience the typical conditions associated with aging.

Clients are helped with finding employment, permanent housing, and returning to school. Often this involves coordination with other agency programs, as well as connecting with community resources. These include detox, Residential substance treatment, hospital diversion, Intensive Outpatient Program, and Partial Hospital Program. AA/NA meetings are not only offered on site, but clients are assisted in attending these recovery groups in the community, as well. Clients are encouraged to attend social activities held by CCA's Serenity Center, our peer-run recovery center.

Community partners include The Miriam Hospital and Thundermist Health Center, both of which have infectious disease programs specializing in the treatment of HIV/AIDS. Both AIDS Care Ocean State (ACOS) and AIDS Project Rhode Island (APRI) share clients with The Agape Center.

CLIENT STORY

Addiction is one of those words I never thought I'd use to describe part of my life. After the untimely death of my parents, I thought I was all alone. Though I have my friends who I am enormously grateful for, I still felt all alone. So, to fill the void in my heart, I turned to drug use. It all started with the occasional weekend use, it soon became a short party on my day off. After a few years of that, it progressed into an everyday thing—before work to get me through the day. As a result of a few years of this I lost my job, new car, and a career in the medical field, which I enjoyed very much.

After all this downhill motion, my world came down in one large tumble. In the midst of it all, my inhibitions were lowered enough to where I made the worst decision of my life and I became HIV positive. After finding out I was positive, I lost all hope and willingness to live any longer. I refused to take any medication that was prescribed. In turn, I got really sick. My body began to shut down and I ended up in the hospital several times. Everything started to change for the better when I met the amazing people at the Agape Center. Being in rehab and finally moving into the Agape house gave me new hope. The wonderful group of people here treated me like a person and not an addict.

They helped with everything from a place to live, food, medical advice and other help I needed to get back on my feet. My advice to anyone living with HIV and a co-occurring disorder—contact The Agape Center in Providence and let them help you begin your new outlook on life. With the help of two amazing friends, Brian and Adam, I have learned that life is worth living. As well as staff at Agape, I give a huge thank you to Debbi, Cindy, Dave, Patty, Omaira, John, Scott, Walter and ERic. You all have done so much for me. I owe you all a great deal of gratitude. —Martin, an Agape Providence Client

QUOTE

"Before Agape, I was traveling through life on the dead-end road of addiction. Today I have a road map of opportunities with endless possibilities." —Agape Providence Client

HOUSING, WORKFORCE DEVELOPMENT, & BASIC NEEDS SERVICES

MANAGER

Nancy Paradee, MSW—Sr. Vice President of Housing, Workforce Development & Basic Needs

HOUSING

MANAGER

Judy Whitehead, BA, BS, ARM, LCDP, LCDS, CCDP—Director of Housing

Recovery Housing

Recovery Housing is a transitional housing program for men in early recovery. It serves as a bridge to reintegration into the community. For many participants this means obtaining employment, finding new meaningful, recovery-oriented activities, reuniting with family and other natural supports, and gaining the independent living skills to transfer into more permanent housing options. It is our goal to provide stability and supportive services to residents at a time when relapse potential is high in their early stages of recovery. We track outcomes upon discharge in the areas of housing and employment.

- 50 men were served in Woonsocket and Pawtucket
- 76% of participants had stable housing upon discharge, a 7% increase from last year. This included moving into their own apartments and moving in with family or friends
- 60% of participants were employed at the time of discharge, a 21% increase from the previous year
- 24% of participants were disabled and received SSI or SSDI benefits, a 5% decrease from last year
- 16% were either pending disability and/or looking for employment at the time of discharge, a minimal change from last year

QUOTE

"Without Birch Street Recovery House, I believe I would be back on the streets. The structure and support that the house has given me has shown me that a good life is possible without drugs. Thank You CCA for the opportunity to grow." —Joshua Rocha, Recovery House resident

Permanent Supported Housing:

- There are 84 scattered site units in Woonsocket and Providence that are owned by CCA and managed by Housing Opportunities Corporation (HOC). These housing sites provide permanent housing to over 100 people (singles and families).

- 59 households were served through several housing grants funded by the Department of Housing and Urban Development. This provided housing opportunities for 85 adults and children.

CLIENT STORY

Back in the day, I had been very successful in the car business and amassed a lot of money. My home was paid for, my kids were grown up, and I had a good relationship at home. I lost it all to drugs, particularly heroin. I was suffering with pain and my friend gave me a bag of heroin and I suddenly had no pain. In time my habit blossomed to about $20,000/month. I sold everything and spent all my money to get drugs. My wife left me and my kids lost all respect for me. I found myself homeless for about three years. During that time I got into treatment and stayed in shelters. I came to Burnside Apartments from the overflow shelter in Cranston.

Since coming to Burnside Apartments, I have re-connected with my kids and regained their respect. The responsibility of taking care of me and my apartment has improved my self-esteem and it sure beats homelessness. I am a richer man today than I was when I had a lot of money because I have a great relationship with each of my kids. —Dennis

Woonsocket Shelter

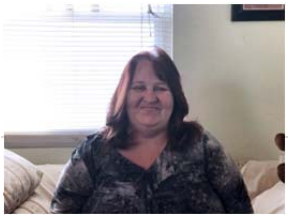
MANAGER

Bette Gallogly—Manager of Woonsocket Shelter & Homelessness Prevention Services

The Woonsocket Shelter provides emergency housing and case management support for single women and families with children who are homeless. In addition to emergency housing, residents are connected to programs to help them address their specific needs so they can transition to safe, permanent housing including: basic needs supports, employment and training, housing search assistance, GED support, financial literacy, mental health and substance use counseling, healthcare, early childhood services, programs for school-age children, and life skills training. The shelter is open 24 hours/day, 7 days a week and serves over 40 persons per night in the two shelter buildings.

- The shelter served 187 people comprised of single women and families.
- 90% of those exiting the shelter moved to permanent housing options. 30% of those exited the shelter in under 90 days.
- 30% of residents increased either their earned income or total income during their stay at the shelter.

CLIENT STORY



In 2012 a broken relationship left me, literally, out in the cold streets of Pawtucket. For a few years, I bounced around from shelter to shelter, psychiatric facilities to hospitals, and back to another shelter, with no

support. This…until I found the Woonsocket Family Shelter. I lived in the Woonsocket Shelter for one year, and then went into the Permanent Supportive Housing Program. There, I worked with a case manager who helped to identify community resources, and connected me with mental health counseling, basic needs, and other supportive services. Soon, I will be graduating from the program and getting my own apartment to begin living my life of independence.

"The Permanent Supportive Housing Program has helped me get through the roughest years of my life, and now I have hope for the future!"—Sandra

Rapid Re-Housing

MANAGER

Madeline Silva—Housing Services Supervisor

Rapid Re-Housing helps persons who are homeless move quickly into housing, thus minimizing the time they spend being homeless. Rapid Re-Housing assists people to obtain housing in an expedited manner, increase self-sufficiency, and remain housed. The Core Components of rapid re-housing are housing identification, rent and move-in assistance, and case management and supportive services. Rapid Re-Housing generally targets persons with low to moderate service needs.

- 39 households were served through this program for a total of 134 people (49 adults and 85 children)
- 48% of 39 participants successfully graduated the program and were able to either maintain the apartments on their own or transfer into other subsidized housing opportunities.
- 20% of participants increased their income during their involvement in the program.

QUOTE

"The Shelter staff and Community Care Alliance staff do a good job. As a Family, we felt at home. Blessings for all the employees and may God provide so you can continue to help families." —David, a former Woonsocket Shelter resident now with Rapid Rehousing

EMPLOYMENT & TRAINING PROGRAMS

MANAGER

Melissa Rouleau, BS—Director of Adult Education, Training and Assessment

Students have access to a wide-range of resources while attending Employment and Training programs, and/or obtaining a high school equivalency diploma, and improving literacy. Resources include Project Learn, work readiness training, vocational assessments, career interest and exploration, employer partnerships, supportive and non-supportive employment services, job coaching, individualized financial planning and financial literacy workshops, community-based work experiences, case management, expungement clinics, and Career Compass (a job club).

Assessments

Students, including those referred by the Office of Rehabilitation Services (ORS), receive vocational evaluations and community-based work experiences to assess manual dexterity, career interest, and vocational aptitude. These assessments range from aptitude testing, dexterity and physical stamina, career scope interest testing and community-based work experiences. The assessment process is critical to student success for program and employment placement.

Some Employment and Training students who are placed in jobs receive additional supports such as job coaching and retention to help ensure their success.

- 11 Situational Assessments
- 21 Non-supportive Job Development Participants
- 27 Non-supportive Job Placement Participants
- 8 Vocational Evaluations
- 2 Youth Pre-ETS Job Exploration Participants
- 2 Job retention/coaching Participants

Administrative Office Management Training Program

A 10-week program that consists of work readiness skills, resume and portfolio implementation, typing, business math, Microsoft Word and Excel, as well as routine administrative and clinical tasks to help keep offices running smoothly.

OUTCOMES & ENGAGEMENT

- Enrolled 14 students in the program.
- Eight students employed, three students transferred to our OJT program, three students took advantage of our supportive employment services.

Healthcare Reimbursement Specialist Training

Electronic Health Record Specialist trainees learn about medical terminology, electronic health records, medical reimbursement, and ICD-10, HCPCS, and CPT coding in a 10-week program for obtaining certification.

OUTCOMES & ENGAGEMENT

- Enrolled seven students in the program.
- 86% placement rate

Janitorial Training Program

Students perform routine cleaning duties to keep offices, clinics, restaurants, or other types of environments clean while being green. This program works with our local public and charter schools for work try outs and employment opportunities.

OUTCOMES & ENGAGEMENT

- Enrolled two students who also took advantage of our supportive and non-supportive employment services.
- One student is employed at a local school.

On The Job Training

Assist enrollees to find permanent jobs through direct placement or training subsidies for the employer. Participants must be RI Works (RIW) cash recipients.

OUTCOMES & ENGAGEMENT

- 9 students successfully completed the program and are now employed- a 100% placement rate.
- Numerous referrals could not become active due to homelessness, transportation, daycare issues, physical and mental health issues, and non-responsiveness to numerous contact efforts.

CLIENT STORY

I grew up living with my mother, my step-dad, and my younger sister in Pennsylvania. Tragically, when I was ten years old, my mother passed away one night in her sleep. Because I was still so young, I remained in the care of my step-dad, along with my sister.

I was 12 when my biological father decided to resurface, after having been absent for many years, and I had to go to court to resolve the issue of guardianship. It was up to me to decide whether I wanted to go live with him or stay with my step-dad. I chose to stay with my step-dad because of all the love and care he'd given to me.

While starting middle school at 13, I remember getting into a fight there one day after someone called my sister and me "orphans." I don't recall the hurt I felt then, but I do remember the principal asking me why I did it. I told him "it made me feel good!" From that point on, I started distancing myself from my usual friends and began to hang out with new ones. I met a young man I'll refer to as James. Well, James gave me lots of attention and a sense of belonging, something I had been chasing since my mom passed away. Sadly, I thought I had found everything I was looking for in James. I started spending all my time with him and I became interested in the things he did. Like James, I

started using drugs, and skipping school. I went from having straight "A's" on my report card to failing grades because of my absences.

One day, my step-dad received a letter in the mail, and we had to go back to court. This time it was because I decided I didn't need to be in school. The judge warned me that, if I didn't go to school, I would be sent away. I just laughed at him. I continued to skip school and eventually I really was sent away! (Years later, I found out that my being sent away was part of a huge scam called "KIDS FOR CASH," but that's a long story in itself!)

I enrolled in high school at a vocational school where I decided I wanted to take a course called "Health-Related Technology." I did well there and obtained my CNA license at the age of 16. I worked full time while still attending school, but quickly fell back into my old habits. My drug addiction had been in remission, but I picked back up as if I had **never** stopped using. I was constantly in trouble, and it seemed like I was caught in an endless, vicious cycle. My teachers were aware of what was going on, and they told me if I didn't go into rehab that I wasn't going to be able to graduate. I did what they suggested, and I ended up graduating with my class in 2007, but only by the skin of my teeth!

I always seemed capable of holding a job whether I was using drugs or not. This fact emboldened me, and I continued working to support my habit until the habit was more of a priority then my job. This was the lowest point in my life. I was a shell of a human being, not living as much as just existing. There must be a God, however, because right at that moment—the point where one more fix might well have landed me in the morgue—I found myself in the midst of a rough intervention. I had no choice but to allow "tough love" to help me kick drugs for good.

I moved from Philadelphia to the New York City area while progressing through several rehab step-down programs, culminating with entry into a transitional residence. The routine there of intense outpatient counseling five times a week, followed by nightly meetings, helped me to continue succeeding in the program; soon I had my own room and enjoyed more freedom. While participating in NA/AA, I met a fellow recovering addict. We turned out to be quite compatible, wanting the same things in life. A short time later, we had a baby boy together.

During this same period of time, I was inspired and mentored by a woman I met. She was very involved in her church, and I began volunteering there and at a food pantry. We even collaborated to help other recovering drug addicts and to assist at a summer day camp for kids who were at-risk and impoverished.

I relocated to Rhode Island at the beginning of 2015 and immediately enrolled in a local medical assistant (MA) program. The school never told me that I might have a difficult, if not impossible, task of finding a job because of my long struggle with drug abuse. By diligently applying myself to my studies, and remembering how far I'd come in kicking drugs, I was able to achieve the Dean's list throughout my entire enrollment. I graduated as a Medical Assistant on October 28th, 2015, and I knew my Mom would have been proud of me!

A few short weeks after my graduation, I was placed at Community Care Alliance (CCA), in Woonsocket, RI, through the Department of Human Services (DHS). I came into the On-The-Job-Training (OJT) program with an open mind and the willingness to allow someone to help me because I couldn't seem to get a job on my own. Days became weeks, and although I did have some interviews, nothing came of them. Depression and loss of hope began to creep in. Despite heroic efforts from both the DHS and CCA staffs to do their best for me, it seemed as though no organization was willing to take a chance and believe I was no longer the rebel of my past.

One day, I was looking at job leads in my email, and I applied for all of the medical assistant positions I could find. I received a call and went for an interview at a Suboxone and Pain Management clinic. They agreed to hire me, and I was so ecstatic at finally having a job that I didn't care what the rate of pay was! (As it so happens, it was quite fair.) I felt fortunate to have been put into the OJT program where I acquired the necessary tools for self-achievement. But the real blessing came shortly after that: CCA staff continued to work with me. They advocated for me and connected with employers shortly after my application was submitted. CCA posted a medical assistant position and soon after I received an interview and they offered me a full-time position at the agency! Imagine, working for the very people who believed in me the most!

I joined CCA as a Medical Assistant in March 2016, I was recently promoted to Medical Assistant Supervisor a year later. I love working with people and helping them. I really understand what they are going through, and it is very satisfying for me to see them progress in something that I, too, have overcome. My fiancé and I are currently renting a four-bedroom house, and my son—who is now almost three—has a new baby brother! —Former Student and Current CCA Employee

QUOTE

"My goal is to be an inspiration to my children and to others as I reinforce the belief that someone else's opinion should never define a person's worth." —Amanda August 2017

PROJECT LEARN

Project LEARN is an adult education literacy program for earning a General Equivalency Diploma (GED), or National External Diploma Program (NEDP) diploma. English as a Second Language (ESL) classes are offered, as well as the Wilson Reading System for students to improve reading and spelling skills, and those diagnosed with a language-based learning disability.

OUTCOMES & ENGAGEMENT

- Served 124 students
- 77 students participated in Project LEARN's adult basic education (ABE) class
- 47students participated in Project LEARN's English as a Second Language (ESL) class
- 48 students were North Star Digital Literacy certified
- 14 students gained employment
- 57 students retained employment

- 5 obtained their GED
- 6 students were dually enrolled in Project LEARN and an occupational skills training program.

Project LEARN students often participate in other CCA programs, such as The Harbour Youth Center, RI Works Partnership, and PAID. Having connected, comprehensive programs within CCA gives students access to resources that help remove existing barriers to employment and help students become self-sufficient.

Students often come to Project Learn with low self- esteem, low confidence, and low reading and math grade levels, but show improved self-esteem and confidence when measurable gains in skills are made in the classroom. Empowering our students through a contextualized curriculum and integrating resources helps keep students motivated.

Students are screened upon intake for all CCA programs and services. Students can take part in our financial literacy, essential skills and job readiness workshops. We integrate programs, so students can make the most of their educational experience.

QUOTES

"I can't believe I am working toward my High School Diploma at age 54." —Project Learn NEDP Student

RHODE ISLAND WORKS PARTNERSHIP PROGRAM

MANAGER

Renee Belanger, BSW—Rhode Island Works Team Leader

Funded by the Department of Human Services, the Rhode Island Works Partnership Program started on March 1st, 2018. This partnership consists of seven CAP agencies and Ser Jobs. The lead CAP agency is Comprehensive Community Action Program (CCAP). There are four components to this partnership that help clients become self-sufficient. Clients are assigned to a case manager where goals are implemented and monitored on a weekly basis. Goals may be modified or new goals may be added depending on the client's needs. Workshops are available to clients in order to increase their knowledge in financial literacy, essential employment and work readiness skills. Our adult resource room is available for these participants so that they can fill out housing applications, research training programs, childcare centers and for other employment or self-sufficiency means.

SUPPORT SERVICES

Allows our skilled case managers to assess and assist clients that are on cash assistance with barriers to education and employment such as transportation, childcare, housing, basic needs, physical health, mental health, financial literacy, and coordination of referrals, etc. Clients that complete the Support Services component move on to Vocational Education or the Work Preparation component of the RI Works program.

OUTCOMES & ENGAGEMENT

- An average of 35 clients was served monthly. (Data is based on May and June 2018 only)

TEEN AND FAMILY DEVELOPMENT

Teen and Family Development (TFD) allows case managers to assess and assist pregnant and parenting teens under 20 who receive state benefits and have barriers to education and employment such as transportation, childcare, housing, basic needs, physical health, mental health, financial literacy, coordination of referrals, etc. TFD case managers track attendance in high school and GED programs. They educate teens about sexual health and pregnancy prevention education through one-on-one conversation or through workshops.

OUTCOMES & ENGAGEMENT

- Served an average of 18 clients monthly. (Data is based on May and June 2018 only)
- Case managers in the TFD program continuously promote sexual health education and pregnancy prevention. During that time there were no repeat pregnancies.
- One TFD client obtained her High School Diploma and is now enrolled in a post-secondary educational program at Community College of Rhode Island.
- Clients are encouraged to participate in other programs such as our Pathways to Adulting, Independence and Dignity (PAID) program, adult basic education programs, financial literacy, and summer employment through CCA's Harbour Youth Center.

CLIENT STORY

I've been a part of Teen and Family Development for almost three years beginning in the prevention program. I got into the program due to running away and acting out when I was 14 years old. Since then my worker, Renee, turned me to the right path and has helped me with more than I can explain. I am now 16 years old and I am expecting a baby girl in April 2019. Renee has given me many tips and things to help me in my pregnancy and continues to help me whenever I need it—even if it's just to talk. She has taught me how to use my talking skills to get my point across instead of blowing up. This program has been very helpful to me and I am very pleased to say that I look forward to going forward with it.

VOCATIONAL EDUCATION

- Case managers assess and assist clients receiving cash benefits and have no prior training or work history, with opportunities to experience vocational trainings, adult basic education or English as a Second Language class, community-based work experiences, and essential skills and job readiness workshops.

OUTCOMES & ENGAGEMENT

- An average of 8 clients were served per month. (Data is based on May and June 2018 only)

- Participants obtain their GED or an industry recognized certification, attend a community-based work internship to gain work experience, or gain skills in an industry specific training program.

CLIENT STORY

Yaneliz Rodriguez turned 20 on Christmas Day! Her oldest boy, Christian, will turn 2 that day also! She says with a lovely smile that he was her gift. Yaneliz also has a one-year old, Giovanni.

Yaneliz overflows with gratitude for the opportunities she's been presented with after coming to Community Care Alliance. She is working very hard to be able to provide a stable home, and is a role model for teen mothers everywhere.

Yaneliz speaks highly of our Teen and Family Development program where she is counseled on resources and guided through next steps. She has gone to the CCA Family Support Center for diapers and food assistance; and has brightened her boys' holiday with Adopt-A-Family.

Over a year ago, having a place to live was her first priority. Yaneliz and her babies lived in our Shelter for six months and took part in the program to qualify for Rapid-Rehousing. Recently she obtained her own apartment in public housing.

This summer she also took part in Youth Summer Jobs at the CCA Harbour Youth Center. She loved her job working with young children at the middle school.

We met at the YWCA where she attends the GED/PIP Program (Parenting in Progress) and her children attend daycare with transportation provided. She wants to receive her diploma since leaving high school in the eleventh grade with an eye toward becoming a police officer.

"I thank them so much—Renee, Patty, Elizabeth… If it wasn't for them, I wouldn't know what to do. They helped me with jobs, school, kids resources, family events, day-care, transportation, receiving donated gift cards and food baskets. They check up on me and ask me how I'm doing. They made me feel like I am somebody. They said, 'Here are your opportunities.' I just have to go do them. I'm not going to give up. Thanks to CCA, they showed me what I can do."

"I'm on the right track. I'm doing this for my kids. That's my goal. I want them to know that—yes, I got pregnant at a young age; but that's not an excuse to stop. I want to show them that no matter what gets in your way, you can still graduate. You can still go for you goals. Don't give up. A lot of things got in my way, but my kids need to see what I did."

MONEY SENSE

MANAGER

Donna Andreozzi, M.Ed., MA—Money Sense Coordinator

Funded by United Way, Money Sense financial literacy workshops are integrated with our Employment and Training programs. Clients are guided to establish financial goals, such as paying off lenders, improving credit scores, increasing net worth, opening and maintaining a bank account. Additionally, Money Sense offers training on available tools and resources that support front-line Case Managers, enhancing their ability to work with clients whose finances influence their life circumstances.

OUTCOMES AND ENGAGEMENT

- Served 642 individuals
- 66 Money Sense clients reported following their budgets several months after participating in individual financial coaching or group workshops.
- Of those who reported having debt upon entering the program, 25% were able to reduce it. Another 22% who desired to raise their credit scores did so.

Even the smallest of changes can literally add up. For example, when clients track their expenses they see where the money goes and then better determine where they want their money to go. From this analysis, participants become more aware of their habits. Many change their spending habits for the better due to this newfound awareness. Perhaps for the first time in their lives, these positive changes allow clients to experience success when handling money.

CLIENT STORY

A RI Works client who attended recent Money Sense workshops reported that she was able to save for an emergency fund. Over the course of a few months, the client accumulated $450. She eventually needed that money to fix her car.

Although she was briefly saddened to part with her savings, the client reported that she was happy to have the money when she needed it for its intended purpose. She was encouraged to learn that she was able to start a new habit of saving money. Her confidence increased because of that success, allowing her to think that it is possible to repeat her habits and accumulate more money for other goals.

THE HARBOUR YOUTH CENTER

MANAGER

Stump Evans, AA—Youth Services Manager

The Harbour Youth Center serves youth and young adults ages 14-24. Participants can engage in a variety of services that include workforce development, academic supports, leadership training, and entrepreneurial mentorship. All services are free and provided in a safe, supportive environment.

OUTCOMES & ENGAGEMENT

The Harbour provides a multitude of classes, work-based learning opportunities and supports to help our clients achieve their academic, employment or life goals. We offer classes in leadership, entrepreneurship, social media, choosing your career path, conflict resolution, boat building and more. We also offer the opportunity for hands-on workplace learning to practice the classroom skills in a real-world environment while earning wages.

- Served 450 participants
- 7 participants built a boat by hand through the RI Marine Trades Association and The Herreschoff Museum.
- 24 young adults successfully completed the PAID program with 19 finding permanent employment, and 5 enrolling in industry training classes.
- 90 youth successfully completed a 6-week summer jobs program in a variety of key industry sectors including construction, culinary, digital archiving, graphic design, education, business management and more.
- 200 youth participants received some level of career readiness education, support or training.
- 50 youth received GED, academic and post-secondary planning services.
- 400 youth participated in Youth Center events and received support services from Youth Center staff.

QUOTE

"The staff at the youth center believed in me without judgment for my work gap or my arrest record. They gave me the support, encouragement and skills to succeed and I am so grateful for their help. I just needed a chance, and that's what I got. I learned that it's possible to keep going even when you're at your lowest." —Natasha, PAID graduate

CLIENT STORY

When Natasha applied for the PAID program in September, she was feeling lost and unsure of how to get back into the working world. As a single mother who had spent the last four years unemployed due to medical issues, she didn't know where to begin, especially following a brief period of incarceration in the spring and subsequent court proceedings. She was worried that no program would take her and would judge her prematurely.

Once accepted into the PAID program, she dove into the classes and job shadows while juggling full-time GED classes and parenting responsibilities. Through the program, Natasha confirmed that her long-term passion is to be a nurse, but was curious about youth work and education as well. PAID placed Natasha with Connecting for Children and Families (CCF) in the After School Program at the middle school for a two-week job-shadow opportunity. Staff at CCF were so impressed with Natasha that they began talking to her about roles she could take on following her two week experience.

When the PAID program ended, a staffing restructure resulted in a Program Assistant position becoming available, which was the same role Natasha was shadowing. This full-time position was offered to Natasha. She is now not only responsible for the logistics of the program, but also in charge of running Teen Outreach in the middle school and high school and providing a safe environment for youth to talk about home, sexuality, bullying, and empowerment. Although Natasha is still interested in pursuing a career in nursing, she absolutely loves working with middle school and high school aged youth, and is gaining invaluable experience while continuing to attend GED classes. More importantly she found her self-confidence again and is showing her amazing daughter just how strong her mom really is! Natasha took an opportunity and turned it into a career, family stability and a chance to move her and her daughter's life forward in spite of difficult life challenges.