Community Care Alliance

empowering people
to build better lives

Outcomes & Highlights

Fiscal Year 2016

July 1, 2015-June 30, 2016

www.CommunityCareRI.org

Introduction

This year was a special year for Community Care Alliance as we celebrated our 125th anniversary! Even though our name is only two years old, the agency is the culmination of several mergers over the last 125 years, as we've grown in order to advance collaborative partnerships and carry out our goals to better serve the specific needs of vulnerable people.

Our employees carry on a rich tradition of caring for community needs that began in the 1890s when we provided children's daycare for parents working in Woonsocket mills—to the present day, with over 50 distinct programs serving approximately 15,000 people from several cities and towns in northern Rhode Island and across the state.

While the challenges people face today are more complex, poverty can often be linked as the root cause, just as it was 125 years ago, impacting housing, childcare, health, employment, mental health, family permanency, effective parenting, education, nutrition, and emotional well-being. At the same time the challenges of human services agencies are myriad, affected by changing policies, funding, managed care coordinators, best practice directives, partnerships and collaborations. Through all the underlying working gears of an agency this size, our first concern is with helping the people who come through our doors to regain a sound footing and overcome those issues they are facing.

Following is a brief summary of program activities and outcomes for FY2016 to highlight the work that we do to help people build better lives and address the most critical community needs.

Key

- Client Engagement
- Outcomes

Positives

The best way to illustrate our outcomes is to tell the life changing stories of our clients. Frank was happy to talk with us and share his experience at Community Care Alliance. He was served by several of our programs as he progressed through his recovery.

Frank's Story

The first thing that impresses me when I meet Frank is how sincere he is—and, how happy he is to have changed his life as it could have ended very differently. He begins over eight years ago when he says, "I had a very unstable living situation. I was using substances at the time. That was the time I hurt myself, I tried killing myself and was just at a low, low point in my life." He's been sober a little over three years now, so his journey has been long and arduous.

Frank was working as a registered nurse, but was unable to keep it all together. "In 1996 I went to school to be a nurse and graduated very high in my class. I was working at a nursing home, but was experiencing psychiatric symptoms. I was seeing things, and had paranoia. My job ended when I left at lunch to go get drugs and never came back to work."

Frank lost his career, his home, and was court ordered to come to services at Community Care Alliance, which was NRI Community Services at the time.

"I came here about eight years ago. I saw Amy Skurka first, who did my Intake. I always remember her because she was so helpful. I was using heroin, crack, alcohol." At that time, Frank started seeing one of our psychiatrists who prescribed Suboxone.

He speaks with great respect for all the people at CCA who have helped him, naming each and every one—not wanting to miss anyone. The turning point for Frank, however, was his stay at Wilson House about four years ago. He had one brief relapse since then, but now is committed to his sobriety.

"Right now, I'm balancing a lot of things, which is amazing because I was all over the place before. I was homeless at points, not following through with my meds. Using on and off… more on than off."

"Jess Shannon was my caseworker for a long time. That helped because I needed some consistency in my life. She helped me a lot. I was getting help, but I wasn't really ready to receive it. About four years ago, my girlfriend died as a direct result of heroin use, and then her brother died in a car accident. It was one of the lowest points I had been in in a long time. I was in and out of the hospital three times and had been at the Acute Stablization Unit (ASU). When I was at the ASU someone suggested that I go to Wilson House, and I didn't really want to go, but I did."

"From Wilson House I went to Jackson House [CCA sober house] where I had a relapse. I ended up getting kicked out of the sober house. But, my relapse was brief, and it was a good thing because I became more solid in my sobriety. I really want to do this. I started going to more groups… I attended Sally's group and a medication assisted therapy group. Sally's group has always helped me. Kelly's group, Josh's group. Even at my lowest points, this place helped me; it held me together till I could get to the point where I wanted help."

Frank went back to school right after his stay at Jackson House. "I really decided that I wanted to be sober, and I never wanted to be on disability. I feel really stable. I'm engaged now."

Frank says he isn't interested in his nursing career anymore and is currently studying computer engineering at CCRI. He becomes animated when talking about his new career path. "I'm doing an internship at a place in Peacedale, and I LOVE it there. People are so great to work with there. They are so friendly and everyone gets along. And everyone is so helpful there, it's amazing." When I mention that it would be great to turn that internship into a permanent opportunity, he says, "I pray, I hope that I could. That would be so wonderful." So far he has all A's and one semester left in the spring, and is thinking of transferring credits to a four-year program from there. He is also engaged to be married.

When asked about where he sees himself in the future, Frank says, "Wherever God brings me. Hopefully everything will come together. I'll get a job in programming. We'll get married in May."

—Colleen Joubert, Director of Communications & Development

Mission

We support individuals and families in their efforts to meet economic, social and emotional challenges and enhance their well-being.

Vision

Through programs, advocacy and collaboration, people are empowered to discover their potential and live as engaged citizens, free of stigma, within a thriving community.

Community Support & Recovery Services

Community Support Program (CSP)

The Community Support Program (CSP) works with adults with long-term needs associated with severe and persistent mental illness who at times may be hospitalized due to the nature of their illness. Given the treatment and supports provided, the goal is to assist CSP clients to live safely and optimally within the community and to divert from hospitalization or need for higher levels of care.

- CSP served 1100 adults living in the northern part of RI diagnosed with a severe and persistent mental illness, including MHPRR clients (see Mental Health Psychiatric Rehabilitation Residences below).
- The program has helped 80% of the clients remain out of the hospital with only 225 out of 1101 clients requiring a psychiatric hospitalization throughout the course of the year.
- Of those hospitalized, 96% did not experience a repeat hospitalization given the post discharge support and treatment provided.

Health Homes

Layered within CSP, Health Home (HH) services are provided, which include a focus on medical care coordination, wellness activities, ongoing health education and transition of care. HH teams focus on identifying chronic health conditions and risk factors, providing health education, performing vitals screening, and coordinating with medical providers. In addition, there is one Assertive Community Treatment Team (ACT) that serves clients with complex issues, providing on average double the service hours per month for each client. With state changes to the Health Home team model, there were new outcomes metrics instated in the first two quarters of this program, starting on January 1, 2016. The teams met all the outcome targets. These changes and changes to funding also resulted in enhancements to Peer Recovery Services.

- Completed 99% of the Daily Living Assessments, collected 92% of BMIs, and discharged under 10% of the client population due to non-treatment adherence.
- A 36% decrease in the number of clients that were closed or discharged due to lost to contact or refusing treatment. Additionally, many more remained engaged through the transfer process with a 29% increase in client discharges that were successfully transferred to another provider to promote continuity of care.
- A 10% decrease in the number of smokers. In FY 2015, 750 of the clients identified themselves as smokers and in FY 2016, 678 of the clients identified as smokers.
- While it has been difficult for many CMHOs to employ certified peer specialists, CCA has been able to increase the number of Peer Specialists from 3 to 6 staff.
- The program has provided Peer Recovery Services to 144 clients—a 128% increase from the previous year and almost doubling the number of contacts from 731 in FY 2015 to 1235 in FY 2016.
- ACT served about 100 clients/month.

Mental Health/Psychiatric Rehabilitative Residences (MHPRR)

The MHPRR program consists of 41 beds across 4 different residential programs (2 group homes and 2 supervised apartments). Besides on-site support and treatment, clients benefit from the full array of services that the agency offers. As mental illness impacts the entire family, the program strives to engage families in treatment to provide support and help the family members, as well as the client, to cope and build healthier relationships.

- Averaged 96.8% occupancy serving a total of 45 clients.
- Gained 3 new admissions; 2 of which were admitted from long-term hospitalizations and 1 that had been in the ACI for over a year.
- Thirty of the 45 clients participated in groups and activities at CCA Wellness and Recovery Center, 20 participated in Psychotherapy and/or Substance Use counseling, and 6 clients engaged in Peer support services.
- Out of 45 clients served, 33 client's families were involved in the client's care. Staff maintained regular contact with these families helping to coordinate visits and strengthen relationships.

Wellness & Recovery Center

A focal point of recovery, hope and empowerment for adult clients of CCA, the Wellness & Recovery Center offers a place to go that encourages peer support and personal growth. Master's Level Clinicians provide a diverse array of weekly therapeutic groups at the center, including dialectical behavioral therapy, cognitive behavioral therapy, and expressive therapy. Substance Use Specialists including 1 dual licensed clinician provides co-occurring group treatment. In addition, a variety of specialty health education groups are held to promote health and wellness; this includes smoking cessation, nutrition, fitness and exercise, and diabetes education groups.

Inside the center, there is a newly updated computer lab for social networking, career development, and community resources. Lucy's Place, an eatery serving light fare for breakfast and lunch, encourages peer support and natural connections. Therapy dogs are often available for unconditional acceptance and support.

- Twenty-seven groups were offered; 12 psychotherapy groups, 3 co-occurring groups, 12 Health and Wellness groups.
- 4,977 duplicated group participants across the various groups; a total of 202 unduplicated clients (202 clients participated in 4,977 groups).
- 35% increase in the computer lab utilization (duplicated count) from 814 in FY 2015 to 1099 in FY 2016.
- 27% increase in the number of clients (duplicated count) that frequented Lucy's Place from 2545 in FY 2015 to 3228 in FY 2016.
- A total of 7 clinicians were mentored and supervised through the Wellness & Recovery Center as they obtained their license as Mental Health Professionals.

At the Alive Peer Support Program fundraising event

Alive Peer Support

The Alive Program is a supportive social program for people living with mental illness and/or addiction. Alive operates in the evenings and weekends when clinical support is less likely to be available. This peer-run support program provides social activities on evenings and weekends to adults living with mental illness and/or addictions.

- 182 activities were held (in-house and community) with average attendance of 8 participants.

> *"I'm more friendly, reaching out to others. I'm adamant about my recovery. I want to keep doing good, working with CCA."*
>
> —Jamie

Jamie came to CCA in 2012, living in an MHPRR group home and entering CSP. She has utilized the different services available within the program, at the agency and in the community She is well informed and well connected with local resources and always eager to share this knowledge with her peers. She is a volunteer with NAMI and gets a lot out of giving back. She now lives independently in the community with supports through her CSP Health Home.

Acute Services/Emergency Services

Emergency Services (ES) provides 24/7 crisis intervention, hospital diversion, crisis stabilization and referrals to a higher level of care, including inpatient psychiatric treatment and detoxification, for people experiencing a psychiatric and/or substance abuse emergency. The ES team serves adults who are active in other Community Care Alliance programs, as well as new clients who call for services or are referred by their primary care provider, emergency rooms, family, elder care agencies, and the police. If a minor is in need of emergency services, they are immediately connected to our Child and Family Services department who will assess the child/adolescent for ongoing services or a higher level of care.

During this fiscal year, CCA initiated a contract with Thundermist Health Center (THC) to provide on-site emergency psychiatric triage services to patients of THC starting in October, 2016. THC patients who do not have a behavioral health care provider now have easy access to services provided by CCA, including the Intake department, emergency intervention to avoid hospitalization, or admission to our Acute Stabilization Unit.

In August of 2015, the contract CCA had with Landmark Medical Center to provide on-site emergency room psychiatric triage evaluations ended. In order to ensure continuity of care for our clients seen in the emergency room, we developed an interagency referral form and process. This enables CCA staff to know when an active client was seen at Landmark and the outcome. In addition, this process helps Landmark identify and refer new clients to CCA who are in need of either emergency intervention or ongoing treatment.

- 512 crisis evaluations and follow-up crisis intervention services were completed in the office and in the community.
- Prior to contract termination, 95 crisis evaluations were completed in the month of July at Landmark Medical Center.
- 91 clients were diverted from psychiatric inpatient hospitalization and admitted to the Acute Stabilization Unit.
- In addition to providing crisis intervention services, staff completed 91 evaluations on residents in nursing homes.

Acute Stabilization Unit (ASU)

Offers 24/7 on-site crisis stabilization and counseling and diversion services to reduce reliance on psychiatric hospitalizations and/or as a step down from hospitalization. The ASU has 13 beds in a residential setting located in North Kingstown, RI. Clients participate in individual and group counseling, as well as a nursing assessment and access to a psychiatric prescriber.

- 1,539 individuals were treated at the ASU. More than half of these individuals were referred by hospitals, allowing the least restrictive environment for those experiencing a behavioral health crisis.
- 77 individuals were sent to the Acute Stabilization Unit from Wilson House, a long-term substance abuse residential treatment facility. In order to establish a continuum of care, ASU referred many more individuals (both active and new clients) to Wilson House.
- 253 referrals were facilitated by Community Care Alliance programs and providers.

Rise to Recovery

Provides trauma-informed treatment for adults suffering with substance use and/or related mental health disorders. Individuals are assessed and, if deemed appropriate, are admitted to either the Intensive Outpatient Program for three days a week at three hours a day; or Partial Hospitalization Program for five days a week at five hours a day. The programs provide group therapy, education groups, individual counseling, and referrals for follow up care, case management, and family engagement. In addition, PHP clients are assessed by a psychiatric provider who can provide medication if needed and monitor progress while the client is enrolled in the program. Opiate overdose prevention groups are offered in an effort to stem the tide of the opioid epidemic.

- 266 individuals were served. The IOP had 221 admissions and the PHP had 45 admissions. This is a 270% increase in admissions overall compared to the previous year.

A Client Story

A 58 year old gentleman (name withheld) was referred to ASU from a local emergency room. He was feeling depressed and suicidal after relapsing on alcohol. When first arriving at the ASU, this man was irritable, never making eye contact, and did not engage with staff or treatment. ASU staff soon found out that he had multiple medical conditions complicating his detox and recovery. After speaking with his nurse and therapist, he began to open up, and agreed to receive medical treatment for the first time in many years. He quickly regained strength, had a better outlook, and was totally engaged in his treatment at ASU. Most importantly, he gained strength emotionally—smiling and discussing sober living options for his future.

Upon discharge this man reported that he enjoyed the holistic approach the ASU has to offer, including the morning smoothies, pet therapy, mindfulness meditative exercises, and the constant use of music to alleviate anxiety. He expressed positive feelings of being "at home" while at the ASU.

"They helped me find ways to make things work for me. They treated me with great respect"—Rise to Recovery Client

The ASU offers a peaceful environment completely different from a hospital setting.

Wilson House Campus

The Wilson House Campus in Pawtucket encompasses several options for people with chemical dependency. A 16 bed (males only) residential substance abuse treatment facility offers the opportunity to focus completely on recovery in a home-like atmosphere. The highly structured program emphasizes relapse prevention, and offers supportive services that can become a part of the client's safety net after discharge. Two bedrooms on the third floor provide sober living space. Additionally, men and women can participate in Intensive Outpatient and General Outpatient Programs at this location. When mental health issues are identified, the Wilson House staff works with its partner ASU (Acute Stabilization Unit) to assess and start or change medication when needed.

- Provided residential services to 91 clients resulting in 47 successful completions.
- Prevented 77 hospitalizations by utilizing the ASU to help stabilize a person prior to admission into Wilson House, or any other service on Campus. In the past the client would need to be medically cleared by a hospital prior to their admission.
- All clients who have successfully completed the Wilson House program have transitioned into sober housing or some form of safe and sober living arrangements. Not one person who has completed had to transition to a shelter or the street.
- Clients identified with significant opiate addiction issues are provided with Narcan kits at the time of their discharge.
- At least 5 of these kits were used in an overdose situation. If the client did not have these kits there is a high probability they could have died.

"The Wilson House showed me how to live life without the need to use drugs or alcohol." —John H.

"My son had been through 5 different residential treatment facilities and it wasn't until he completed the Wilson House Program, that I was able to truly see change. I have my son back because of the Wilson House." —Mrs. C.

Wilson House is a program of Community Care Alliance, located in Pawtucket Rhode Island

Donald's Story

Donald is a 61 year old single man who worked as a machinist for over 25 years. He lived a "normal" life with his wife and two children for many years. What was not "normal" in his life was daily drinking for over 45 years. He was known by his family and peers as a functional alcoholic.

He spent some time in detox toward the end of his drinking but always returned to the same old behaviors within a short period of time. Finally, when estranged from his wife and his children were grown, Donald was homeless. In 2014 Donald decided to take a different path in life. After completing detox Donald entered treatment at Wilson House and successfully completed the program.

Donald acknowledged that he still had a long road ahead of him. He was agreeable to step down to the next level of care and began working on his recovery with our Intensive Outpatient Program (IOP) while living in sober housing. After completion of IOP Donald decided it was in his best interest to attend weekly counseling while moving forward in his life and looking for work.

Donald's journey was not easy; however he has been successful with the continuity of care that was provided. Donald is currently working full-time, living in sober housing, and stays connected with his ex-wife and kids. He continues his sobriety with his sober supports.

Northern/Western Prisoner Reentry Council

Serves individuals 90 days prior to release from the ACI and up to 60 days post-discharge, with the intention of facilitating successful transition back into the community and preventing recidivism. Discharge Planners work with individuals who are being released from each of the ACI's long-term facilities – Minimum, Medium, Maximum and the Women's facility.

- 428 ex-offenders were served in total; 211 in Woonsocket, 127 in Cranston, and 90 in Pawtucket.
- 340 clients were male; 88 were female.
- Individuals received assistance with each of the following :
  documents - 39%
  SNAP - 33%
  clothing - 40%
  SSI/SSDI -11%
  housing - 12%
  connection to natural supports - 22%
  mental health services - 50%
  substance use services -87%
  medical services - 17%
  sex offender treatment - 66%
  domestic violence counseling - 30%
- Staff received training in Motivational Interviewing, an evidence-based practice designed to recognize ambivalence to change and to move individuals along the continuum of readiness to change.
- CCA is now completing assessments on-site at the Woonsocket Probation and Parole office to increase follow-through for individuals who are either court-ordered or voluntarily seeking treatment.

"You can always show up at the Wilson House campus and expect to be treated with respect and dignity. The staff on campus always put clients first." —Tom B.

"The Wilson house is the home of second, third, chances. They [staff] had faith is me when I had lost all faith." —Robert S.

A Client Story

Two months prior to his release from the ACI, Justin Gordon, our discharge planner, began working closely with Sam (name changed for privacy) . Sam was committed to creating a new life for himself and to leaving his recent experiences behind him. An advantage for him was that he has two degrees from Johnson and Wales University and has worked at some of Rhode Island's most prestigious restaurants as an executive sous chef. Justin helped him to create a resume that was forwarded to the Rhode Island Department of Labor and Training. Following an interview, Sam was approved for the Roadmap to Reentry program. As expected , he was very well qualified for multiple positions the DLT had to offer. While still incarcerated, Sam was interviewed for a position at a pizza restaurant. Upon his release, he was able to start at the restaurant immediately. On his own, Sam secured a second job refurbishing a hotel in Warwick.

Another barrier that Sam had to overcome was housing. Although he has a significant other who was living in the community with her son, the apartment was not big enough for the three of them. Justin assisted Sam to conduct a computer search and to contact several landlords. With help of his significant other and Justin, Sam was able to find a larger apartment. Sam and his family moved in the weekend of his release. Additionally, Justin helped to connect Sam with substance abuse counseling, food stamp assistance, a furniture voucher for his new apartment, couples counseling, and parenting classes in the community. Sam informed Justin that "you have helped me more than anyone ever has, and I could not thank you enough."

"Wilson house gave me the skills and the tools needed to be successful at recovery." —John D.

Community Incident Response, Consultation & Support Team

Team members provide outreach and public education/consultation activities through liaison relationships with local police departments, school systems, health centers, family service organizations, substance abuse treatment agencies and community mental health organizations. Several contracted training activities are facilitated in partnership with the Substance Use and Mental Health Leadership Council of RI, and the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals. Team members are trained to provide psychological support services to community residents and their families as well as to specialty populations such as first responders, correction officers and military personnel involved in traumatic events. Acute services staff also provide employee assistance, consultation and training services to public sector organizations and their employees to minimize the risk of workplace violence, to mediate on the job conflicts and to promote optimal team functioning. Group psychological first aid and post incident debriefings are also provided per request.

- Program staff implemented a clinician ride-along program and a role call informational training series to contracted departments in an effort to enhance patrol officers awareness of behavioral health issues.
- The program added 3 new law enforcement agencies to its consultation and employee assistance program element; Brown University, Cranston police department and the Cumberland police department.
- Provided a 4 hour crisis response training for the FBI-sponsored New England Hostage Negotiators Conference.
- Facilitated with police peer support officers 10 critical incident support debriefings/group support sessions for police officers involved in critical incident events from various police departments throughout RI. Team members also continued to provide ongoing assessment and counseling services for police officers in need of mental health support services.

Housing, Workforce Development, & HIV Support Services

Employment & Training Program (EMTR)

Occupational skills trainings include ten-week Administrative Office Management (AOM) and Healthcare Reimbursement Specialist (HRS) classes, and a four-week Janitorial (JAN) class. Certified Nursing Assistant (CNA) training is also offered several times a year through a partnership led by the Health Care Training Collaborative (HCTC) and with Saint Antoine Residence, a nursing and assisted living facility located in North Smithfield.

Classes include Career Prep, a two-week series of lessons designed to equip students with up-to-the-minute resumes, soft-skill enhancement, and interviewing techniques. In addition, students participate in weekly sessions that offer mock interviews, presentations from outside employers, and techniques for getting the most out of attending job fairs. Students also learn the basics of financial literacy, including sensible budgeting, banking tools, and credit repair through several workshops known as Money Sense (available to all CCA clients).

Some of our students, especially those referred by the Office of Rehabilitation Services, receive Vocational Evaluations and Situational Assessments to assess manual dexterity, career interest, and vocational aptitude. Some EMTR students who are placed in jobs receive supportive employment services to help ensure their success.

Another component of EMTR is On-The-Job-Training (OJT), a program that assists enrollees to find permanent jobs either through direct placement or training subsidy for the employer. Participants must be RIWorks cash recipients.

Jerry's Story

My name is Jerry. For me, financial stability had always been non-existent; dead end jobs led to dead end jobs, which ultimately led to debt and evictions. While my debt grew larger, my window for change seemed to be getting smaller; I knew I needed change but did not know the path to take to get there.

- 34 clients enrolled in HRS, AOM and JAN classes.
- 29 successfully graduated with credentials in customer service, coding and billing and/or electronic health records.
- Job placement rates were 50% for JAN, 60% for AOM and 89% for HRS.
- 65 clients were enrolled in the OJT program
- 34 students left OJT due to lack of childcare, lack of transportation, employment or non-responsiveness.
- 31 clients completed OJT, with 21 placed successfully, a 70% placement rate for OJT.
- 26 vocational evaluations and 1 situational assessment were completed.
- 16 non-supportive employment and 6 supportive employment job development services were rendered with funding from the Office of Rehabilitation Services.

One day, during conversation, a family friend asked me if I had ever thought of a career change. I hadn't.

"I'm 40 years old," I thought to myself. "I'm just too old for a career change."

She was not convinced that my age should get in the way of a successful future and so together, we looked to find a program that fit my needs.

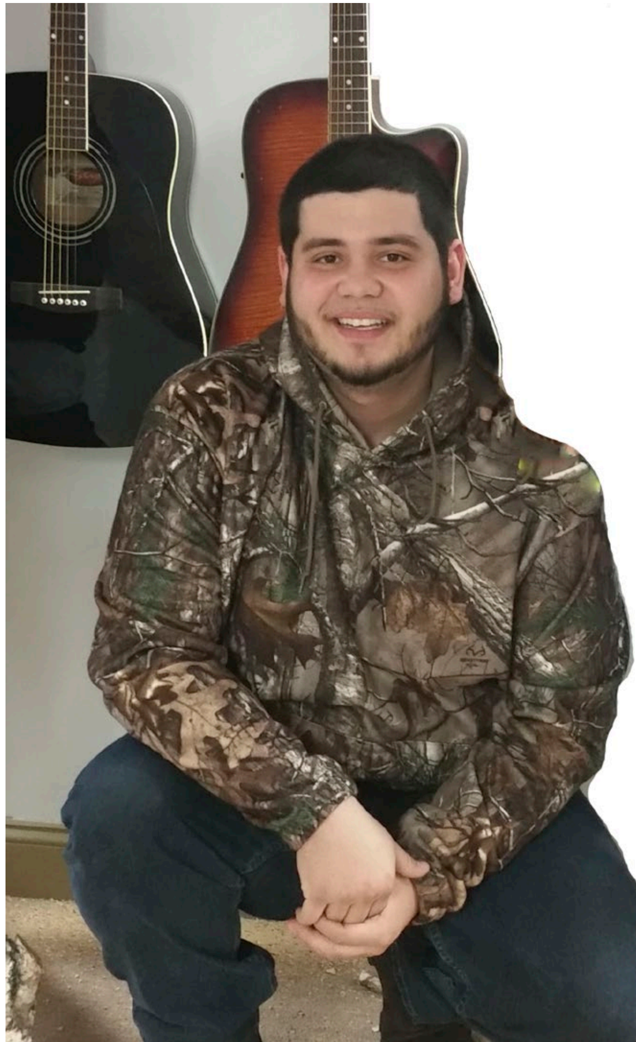
The Employment and Training Center (EMTR) had many opportunities for me and I felt that it was where I could truly succeed. Before I knew it, I was a student enrolled in their Healthcare Reimbursement Specialist Program. I could feel myself moving towards positive, meaningful change.

About three weeks into the program, as part of the course, students were offered an opportunity to attend a job fair with the EMTR staff for a hands-on experience. At first, I declined because I felt like I needed to focus more on my coursework, but as the day approached, I decided to just go. At the time, I did not realize how important this piece of the program would be to my success.

That day, using my resume developed in class, I was able to confidently approach multiple employers and discuss my skills and qualifications. Shortly after the job fair, one of those employers contacted me requesting an interview with their site manager who offered me a job.

Now a graduate and an employed citizen, I have a more positive view of my future and a better attitude about my career change. Thank you Employment and Training staff for all of your support.

—Jerry



The Harbour Youthworks 411 Center

This drop-in center for youth and young adults between the ages of 14-24 in the Northern RI Region provides career exploration, job readiness, employment, academic skill building, college preparation, leadership development and access to computer lab. Every client is assigned a case manager and fills out an Individual Service Strategy to set goals for the upcoming year of engagement.

- Over 100 youth between the ages of 14-24 participated in the Summer Youth Employment Program.
- Three-fourths of those students returned to school, employment or both upon completion.
- Over 500 youth received services ranging from academic supports, employment skills training, leadership skills and or social/emotional supports.
- Every year since 2010, the youth center has increased participation, employment and employment retention, participant wage gain, industry credentials and post-secondary acceptance by our youth and young adults.
- This year, we are also the highest performing YouthWorks411 Center in the Greater RI Region.

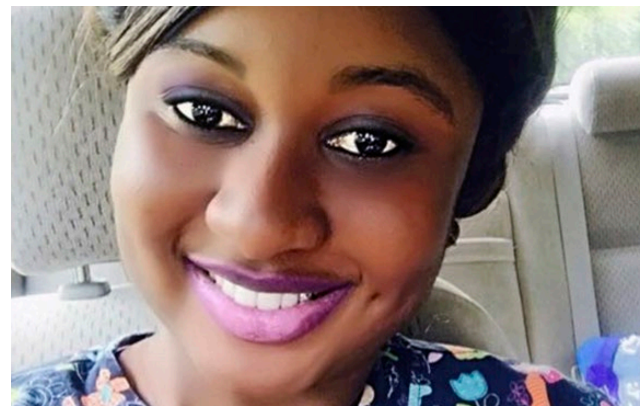
Geneva's Story

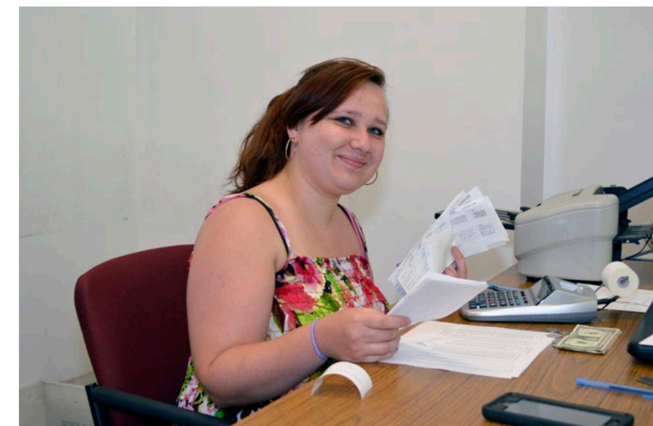
Since I was young I knew I wanted to be in the medical field. I helped my family take care of my grandfather and when he passed away I made up my mind to become a nurse to help others that could be going through the same situation that my family experienced.

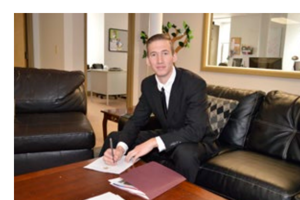
I first became involved with the Youth Center when I turned 16. I would go down to the office whenever I had free time or needed someone to talk to and actually be listened to. I dropped out of high school very young believing I could just get a good paying job and not have to worry about school. I was mistaken, I tried several times to enroll in the CNA program through Community Care Alliance but I was too young and not stable enough to pass the screening. Shortly, I became pregnant with my first son, I decided to take GED classes at the Youth Center in order to advance academically, but I also needed to work. With the help of the staff at the Youth Center, I got a job at a local gas station. It was not a good job and I was not treated with respect but it was a job that helped make ends meet. I worked there for 2 years and I then became pregnant with my daughter. Throughout all of these trials I continued to work with the Youth Center in job training and academic skills.

It took a lot to realize that I needed to push myself harder and make a lot of sacrifices to advance in life. I tried once again to be a part of the CNA program and with the support of the Youth Center, I was able to get into the program. I graduated the CNA program and was offered employment at a local nursing home. I am very proud of myself and I know my grandparent would be proud of me. I am advancing in my life in the profession I love; most important I am now able to spend time with my children. I am part of the WIOA program which has given me the opportunity to have a paid internship supporting me in my passion for the medical field. I now know I would like to be an RN and become a positive role model to the other youth in my community and to my children.

Building our future and their dreams







Woonsocket Shelter

The shelter serves 20 families and 8 single women at a given time that are in need of housing to stabilize their situation. This is not a night to night shelter, but a "shelter residence program" that provides an individual bedroom for each family in an apartment where they share a kitchen, bathroom and living room with other families. Residents sign an agreement to work toward housing. Nearly all families access at least one other CCA program that improves their coping mechanisms and likelihood of being a good tenant in future housing. Life skills classes are mandatory and include time management, conflict resolution, housing search, job search, bullying, adjusting to community living and home management. Families with children in school access an after school program that includes tutoring by a professional teacher and the availability of a school counselor to work with families to facilitate McKinney-Vento rights for homeless children. Family activities included Christmas carol sing-a-long, cook-outs, a holiday party, a Thanksgiving buffet, participation in the Adopt-a-Family program. This year, renovations were made in the indoor playroom and outside playground through the Blue Cross Blue Shield, Blue Across Rhode Island Campaign volunteers.

- 180 people went through the shelter from 77 households.
- 143 people transitioned to other housing as follows:
  22 went to market rent apartments
  19 went to housing with rental subsidies
  4 went to permanent supportive housing programs
  27 moved to transitional housing programs
  60 moved in permanently with family members or friends
- 25 adults completed financial literacy class.
- 33 adults used mental health counseling services offered by CCA.
- 6 children used mental health services offered by CCA.
- 6 adults used substance abuse counseling services.
- 6 mothers utilized Healthy Families America.
- 14 families connected with FCCP services offered by CCA.
- 3 families made use of the CCA Stabilization Unit.
- 4 individuals connected with the HIV+ services at CCA's Agape Center.
- 5 individuals connected with The Harbour Youth Center at CCA.
- 34 families used the Family Support Center for food and/or personal care items.
- 8 adults completed employment and training classes.
- 47 families used Adopt-a-Family for holiday gifts.
- 16 families participated in the after-school program.

A Client Story

After being evicted from her apartment for not paying the rent, a pregnant woman and her two children came to the Shelter. They were able to improve their situation dramatically by taking advantage of many of our programs while they were at the Shelter. The children were enrolled in school and connected to Head Start, and an after-school program. The mother was referred to Healthy Families America, a CCA program for families under age three and expectant mothers and engaged in mental health counseling through CCA. She also participated in a relationships group offered by Sojourner House at the Shelter. During their stay, the Family Support Center was a source for food and basic needs for her family.

After assessments, the family received further stabilizing supports from the Northern Rhode Island Family Care Community Partnership run by CCA. The mother completed a financial literacy class, as well as training at the CCA Employment and Training Center as a Healthcare Reimbursement Specialist. She completed work on her GED through Project Learn and is currently looking for a job.

A new baby was born to this family while they resided in the Shelter. After five months at the Shelter, this family obtained housing through the Woonsocket Housing Authority.

"The staff here helped me to understand I needed to be responsible for what I did and that helped me get some housing help."

—Transitional Housing Program Client

Transitional Housing

Serves parents between 18-24 with their children by providing them up to 24 months in the shelter to acquire life skills in budgeting, cooking, job search as well as acquire employment and completed high school diplomas. If the participant obtains housing prior to the 24 months they can be followed in the community to complete their allotted time.

- Of 76 individuals (22 families) housed, 54 moved forward from the program. The following moves were made:
  13 went to market rent apartments
  24 went to subsidized apartments
  2 went to permanent supportive housing
  13 went to live permanently with families or friends
  2 left without giving any destination
- The average time in the program for the 22 families was 5. 5 months to get housing.

The Woonsocket Shelter

"Without this apartment I don't know where I would be."

—Burnside Client

Permanent Supportive Housing at Burnside

Located in Woonsocket, Burnside provides housing and supportive services to disabled, chronically homeless men with mental health and substance use problems.

- Nine men currently live at Burnside
- All residents completed a Financial Literacy class, and Life Skills classes; case management services, and referrals to additional services were utilized.
- 4 were served by the CCA Community Support Program.
- 2 residents were involved with our Rise to Recovery Program.
- 2 receive services at CCA's Outpatient Program.

A Client Story

A man, who had attended the Harvest Community Church in the city, was referred to CCA by Pretrial Services with a long-standing addiction to alcohol. He went into recovery, and within two years stayed sober, cleared up his court case, worked out his outstanding debt with Woonsocket Housing and entered his own housing.

—As told by Housing Manager

Adding personal touches to the shared living space makes this place home.

The Agape Center

The Agape Center provides a safe, supportive, non-judgmental environment for clients with HIV/AIDS to address their unique needs, especially regarding medical, mental health, and family responsibilities. This program includes case management, housing, and support groups, and additional services, such as educational/informational presentations, a client advisory committee, weekly luncheons, holiday family dinners, and access to the food pantry and personal care center. Clients may also participate in special interest activities and field trips with peers.

291 clients were served, with 69 receiving case management services.

- 17,446 pounds of food was distributed to 89 households consisting of 121 adults and 28 children from the Agape food pantry.
- 1, 552 pounds of personal care items and household goods was received by 74 households, which consisted of 97 adults and 16 children.

Remembering the personalities of those who've passed on from HIV/AIDS is the basis for Anna's workshop. This quilt was created for an Agape Center client.

- 9 case management clients received housing from our HOPWA (Housing Opportunities for People With HIV/AIDS) program and all attended More for Your Money, another CCA program.
- 12 clients were referred for mental health services, Intensive Outpatient (IOP) or the Acute Stabilization Unit (ASU).
- 16 were successfully re-engaged with either infectious disease primary care or dental services.

"Agape has always felt like home and in the words of Dorothy, "there is no place like home."

—Agape Center Client

Housing Opportunities for People with AIDS

This Agape Permanent Supportive Housing program provides safe, affordable housing to individuals with HIV/AIDS while they stabilize medically and use the supportive services available to them. They work with case managers from The Agape Center and a HOPWA Housing Coordinator to access any needed support services and work toward being able to move into subsidized community housing.

"This apartment gave me hope that I can live a good life. These people helped me."

—HOPWA Client

- The program housed 19 clients this year with 6 moving on from the program.
- 2 moved to market rent apartments, 1 moved in with family members, one left for long term hospitalization and one was incarcerated.
- 3 accessed CCA substance abuse counseling
- 2 are served by our Community Support Program
- 3 used Family Support Center for basic needs
- 1 utilized CCA's Acute Stabilization Unit
- 4 completed financial literacy classes
- 13 accessed Agape food pantry
- 13 accessed Agape personal care closet
- 15 received case management services from the Agape Center
- 2 completed employment and training courses
- 1 completed credit counseling through The Financial Opportunity Center

Recovery Housing

Serves as a transitional housing program for men in early recovery, and a bridge to reintegration into the community. For many participants this means obtaining more permanent housing, obtaining employment, and reuniting with family and other natural supports as they progress in their recovery. 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.

- 78 men were served in the program.
- The average length of stay was 5 months.
- 12 veterans were served at Capitol Hill through a contract with the Providence VA Medical Center. The majority of these veterans had PTSD and addiction issues.
- 75% of participants obtained stable housing when they left recovery housing.
- 56% of participants were employed at the time of discharge.
- 29% of participants were disabled and received SSI or SSDI benefits.
- 15% were either pending disability and/or looking for employment at the time of discharge.

"Recovery Housing saved my life. I am now in a sober and safe environment. I am held accountable for my choices and actions. I have close to two years sobriety and I am very active in my recovery and giving back to my peer and in the community. I am now looking for permanent housing. Thanks to the services and help that I have received I have a fighting chance. One day at a time"

—Dave, Recovery Housing resident

Assisted Living (Evergreen)

Residents receive assistance with medication administration, meals, laundry, prompts with Activities of Daily Living (ADLs) and coordination with external healthcare appointments. Due to the long-term care needs of Evergreen residents, there is minimal turnover at this site.

- 29 people lived at Evergreen Assisted Living

"Evergreen has helped me a lot. I feel I have a better personality. I'm so much more stabilized living here. I've been here a year and a half and my medication is working good. I like living here. I'm never alone."

—Kathleen, Evergreen resident

Supported Independent Living

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 are able to provide permanent housing to over 100 people (singles and families).

- Biweekly monthly meetings occur between CCA and HOC to address any housing related issues and increase support services to the tenants as needed.

"I absolutely love my apartment and all the services I have received at CCA. I no longer have to live on the streets, or couch surf, or stay in the shelter. I now can take care of my son and myself and know we are both safe. I was always treated with respect and dignity at CCA and they always listen to what I had to say. They never brought up my past mistakes and encourage me to look forward. I'm so blessed."

— Tess, Independent Living Tenant

"I was released from prison and I didn't want to ever go back. With the help of my caseworker I realized I need to do something different if I wanted different results. I called CCA and asked about going into sober housing. This house has helped change my life. For the first time in 14 years my wife tells me how proud she is of me and that I'm a good husband and father. I'm proud of the man I'm trying to become. Thank you CCA. There is no stopping me!"

—Ricardo, Recovery Housing Resident

Family Well-Being & Permanency

Holidays are difficult for many of our clients. Because of the generosity of many organizations in the community, CCA is able to help. Here, the Blackstone Middle School Basketball Team helps distribute Thanksgiving Food donations.

Family Support Center

A core Community Action Program service providing basic needs assessment, guided referrals, advocacy and financial assistance to Woonsocket residents who meet income guidelines for specific services. New clients receive a comprehensive assessment of household resources and after reviewing priorities together with our Family Advocate, they identify the referrals or services most needed to address immediate concerns. Staffers engage with clients to advocate with landlords and/or utility companies when household bills fall behind. Depending on the circumstances that brought about arrearages, clients may have financial assistance paid on their behalf.

- Served 3219 households representing over 5500 individuals.
- Prevented homelessness to 1 family by providing utility assistance.
- Provided short term rental assistance for 219 families representing 635 individuals who avoided entering the emergency shelter.
- Rapid Rehousing Funding provided financial assistance, referrals to employment/job training and individualized coaching for becoming a responsible tenant for 8 families who successfully graduated after 3 – 8 months of assistance to maintain their own apartments after being homeless.

Holiday Program & Milk Fund

CCA administers the applications for the Adopt-a-Family program and the Milk Fund; and distributes holiday food baskets during the holidays for families in need.

- Processed 959 applications for Adopt-a-Family, which provided 1972 Woonsocket children with holiday gifts and clothes from donors in the community.
- 497 holiday food baskets were distributed.
- The Milk Fund served an average of 244 households with 1,223 half gallons per month.

Volunteer Income Tax Assistance Program

Provides free tax preparation for low to moderate income individuals and families.

- 1050 tax returns prepared
- Over $1.5 million in refunds were returned to the community, with over $565,000 from Earned Income Tax Credits.

General Outpatient Program

Master's level or independently licensed staff serve adults with mental health and co-occurring substance use issues in the General Outpatient Program (GOP) in an office-based setting. Utilizing an array of evidence-based practices (EBP) in both individual and group modalities treatment may include cognitive behavioral therapy, dialectal behavior therapy, motivational interviewing and more. Psychiatric assessment and medication management are offered to clients who have the most severe symptoms.

Staff work closely with other agency programs to coordinate families' needs and to assist clients to access basic needs, employment services, housing, and higher levels of care as needed. There is close coordination with other external providers, including but not limited to: DCYF, Probation and Parole, area hospitals, Thundermist and other area PCPs and medical providers.

- Served 1,677 clients
- 923 were admitted
- 894 were discharged
- 461 clients were treated for PTSD
- 395 clients received psychiatry services
- Clients spend an average of 8 months in treatment.
- 60% have a co-occurring substance use diagnosis.

David's Story

"Do I want to live like that again?"

David used to "live like that"—that being intoxicated daily with resulting job losses and homelessness. He started using alcohol at the age of 10. "I was shy, afraid… people made fun of me. I felt stupid because I couldn't learn." David now reads the local newspaper every day at the library, though he says, "I still have to read something a few times to get it."

David left school in the 11th grade to work in mills and in construction. He is well aware of the price he paid using alcohol and other substances all those years and the effect on relationships, jobs, and housing. He married at age 40, but was incarcerated 2 weeks later "for something stupid, probably related to drinking." When he was released after a few months, he learned that his wife had left him. "My whole life fell apart because of the drinking. I lost my apartments, jobs…." One of his girlfriends died from an apparent overdose. David also used substances,"everything,"during that time. He had several admissions to the ASU and was in Wilson House. He had some short periods of sobriety when in facilities, "prison, rehab, Edgehill," but would relapse after a few months. "It would start with one beer. I figured I could have ***one****." This became a pattern for him. He speaks of drinking more so as not to become ill. "They call it a 'get well' drink in the morning. I used drinking and drugs as an escape."*

He eventually entered into Adult Outpatient Services but would not show for his appointments due to intoxication. In mid-May, 2015, he came into an appointment and was ready to make a change. He was referred for detox at Roger Williams Hospital. From there, he went to the ASU, then to the Intensive Outpatient Program at CCA. He began meeting with his therapist again, returned to AA meetings, and was able to obtain a room in one of CCA's sober houses. He has lived there ever since and has remained sober for the past 18 months, one of his longest periods of sobriety. He is currently waiting to hear about a subsidized apartment.

"You can't just say you're gonna quit… you gotta surrender to it." David explained that this means admitting that you are powerless over alcohol. He is often tempted by his old friends but this is when he asks that question, "Do I want to live like that again? That keeps me straight." Other strategies that help: "staying at home, going to the gym, going to meetings." He particularly likes going to the gym daily where he has tried some classes such as Zumba. "I like the pool and the hot tub."

Another bonus to his sobriety is that his relationship with his father has improved. When he was drinking, his father would lock the door and not answer David's phone calls. "Now he welcomes me and he evens calls me and asks me to come over. He even gives me a ride home so I don't have to take the bus."

One more bonus: His great big smile. When he first came to the center the front desk used to be uncomfortable due to him being so grumpy and not wanting to wait his turn.

He now takes so much pride in his appearance, always well groomed and now gets his hair cut every few weeks. "I'm getting new teeth in December!"

—As told by Barbara Gloria, Case Manager

Children's Behavioral Health

Children's Behavioral Health serves clients aged three through adulthood with mild to severe emotional disturbance or serious mental illness and co-occurring disorders in several levels of care. Programs utilize a team approach with services provided by a master's-level and independently licensed clinicians, case managers and a child and adolescent psychiatrist. Therapeutic Integrations Specialists from our Kids Connect program are placed in multiple local preschool/daycare settings in order to maintain stable placement for children with behavioral health challenges. The Healthy Transitions Team includes clinicians, case managers with specialties in education and employment, substance use and wrap around practice as well as a nurse and psychiatrist.

Our work in Children's Behavioral Health has been further informed by our use of the Adverse Childhood Experiences measure. A simple measure, completed by the client or caregiver, quantifies the number of traumatic events in the lives of our clients. The use of this scale both with clients and guardians has reinforced our need for all of our services to be trauma informed. It further highlights the benefits of working with parents to enhance their level of understanding of the impact of these childhood experiences on their own functioning as well as on the behavior of their children.

Our treatment across all programs is trauma informed, strengths based and family focused. We utilize a variety of evidence based/evidence informed practices including motivational interviewing, cognitive behavioral therapy and positive behavioral interventions. Staff work closely with schools, Department of Children Youth and Families (DCYF), Family Care Community Partnership (FCCP), other CCA teams, as well as other provider agencies to ensure that services to families are coordinated and comprehensive.

Healthy Transitions

The launch of our Healthy Transitions team in the fall of 2015 has been an exciting and challenging venture for Children's Behavioral Health. This team which is partially funded by a SAMSHA grant serves young people age 16-25 with serious behavioral health challenges. Our two priority populations are young people experiencing their first episode of psychosis and those transitioning out of the Child Welfare System. In collaboration with BHDDH and DCYF, the Healthy Transitions teams at CCA and the Kent Center will inform policy regarding effective practices for this unique population. The goal of the program is to assist participants to successfully move into adulthood with a focus on employment and education.

This team is co-located in the Harbour Youth Center thus providing access to employment/education services as well as opportunities for participants to engage in pro-social activities with their peers.

"After several years of work with clients in DCYF custody, I saw an intense need for helping professionals focusing on the 'aging out' population. The unique nature of Healthy Transitions and its accessibility for this population allows for the flexibility that maximizes the therapeutic relationship."
—Brandon St. Pierre, Healthy Transitions Clinician

- Served 335 children and their families in the Community Based Program
- Served 737 children in the Outpatient Program
- half way to our goal of 60 clients in Healthy Transitions.
- Our Kids Connect program was able to preserve the preschool/childcare placement of 69 children ages 3-6 allowing their parents to seek or maintain employment.

First Connections & Perinatal Hepatitis B Prevention Program

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. We serve all of the cities and towns north and west of Providence. Our specialized Perinatal Hepatitis B Prevention Program is statewide. Providers are registered nurses, social workers or community health workers. Five of our current providers are Certified Lactation Counselors to assist pregnant women and new moms plan and succeed with breastfeeding their infants.

- Received over 1600 referrals.
- Engaged 396 families.
- 99% of children received at least one developmental screening.
- 79 children were appropriately referred to Early Intervention.
- Screened over 300 pregnant or new moms for depression and made referrals for further mental health assessment and treatment for 48 women.
- Made over 500 guided referrals (from both First Connections and Perinatal Hep B Prevention Program) to other community supports including WIC, SNAP, housing & heating assistance, as well as pediatric and postpartum care.
- Tracked the successful immunization of over 100 additional children who were at risk for exposure to Hepatitis B transmission.

"We've seen that Moms seen by First Connections are more likely to complete their 6 week post-partum OB/GYN visit and children screened early for developmental milestones and connected to Early Intervention are less likely to need further more costly interventions later in their schooling."
—Darlene Magaw, Director of Family Support Services

This Early Intervention Program family enjoyed the Annual EI Fun Day.

Early Intervention

Early Intervention is an infant/toddler home-based program regulated in Rhode Island by the Executive Office of Health & Human Services. It had its beginnings with the passage of the Federal Individuals with Disabilities Act of 1972 and provides the most appropriate and least restrictive family-centered support for children and families eligible for these services. Here at CCA, Early Intervention has provided over 45 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.

- Started with 265 active children and added an additional 244 through eligibility determination during the 12 month period—total served 509.
- 350 children were evaluated for initial eligibility
- 163 children transitioned to further preschool services in their community.
- 165 children graduated from EI into preschool programs.
- Half met their goals and were discharged without needing further special education services before age three.

"EI providers are knowledgeable and have helpful suggestions about how I can teach my child every day the things he needs to catch up with in his development. I've also learned that each child is different and to be patient - my son will learn at his own pace."
—Early Intervention Program Parent

Healthy Families America (HFA)

Families referred to HFA are either pregnant or have a child under the age of three months. Family Assessment Workers complete a Family Survey with parent(s) that procures their history of being parented, as well as their beliefs and expectations for parenting their own child. Depending on their score, families are enrolled with the understanding that our 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 and guided by the evidence-based curriculum, Growing Great Kids. Periodic developmental screening is done to celebrate milestones as well as head off any developmental concerns that arise.

- 105 families received prenatal and parenting support, case management and education.
- 81% attained six month retention.
- Trained 7 of 8 staff on the evidenced-based curriculum for addressing mild depressive symptoms, Mother & Babies.
- 100% of participating families were screened for health indicators during pregnancy, including perinatal depression, use of tobacco, alcohol and other drugs, resulting in referrals for further assessments, as appropriate.
- 100% of children served are up to date on their immunizations and have a consistent medical home.
- Families in CCA's HFA reported fewer injuries and visits to the ER than the general population of infants and toddlers, based on data from Prevent Child Abuse America.
- HFA was accredited by Prevent Child Abuse America for meeting Best Practice Standards in program operations, supervision and training.
- Our Team participated in the HV COIIN, a national quality improvement effort to standardize our perinatal screening and tracking of referrals of elevated depression scores. Selected team members also participated in Motivation Interviewing Coaching and program improvement in partnership with a consultant from Bradley Hospital.

First Connections, Emily Marek and Jeiza Munoz, and Healthy Families America, Tamara Castonguay, recently passed their certification exams to become Certified Lactation Counselors.

Youth Success

Youth Success engages teens living in Woonsocket who are pregnant and/or parenting (including dads), with the goal of improving their educational attainment (e.g., GED or HS diploma) and preparation for being self-sufficient adults, including employment preparation and life skills training. They also receive education about pregnancy, preventing subsequent pregnancies, and STD prevention. Case managers use an evidence-based curriculum, Casey Life Skills, to guide service plan development and individualize coaching of life skills. This program is funded with TANF dollars from the Department of Human Services to reduce dependency on public cash assistance and improve employment outcomes for young parents.

- Served 38 teens.
- 3 received their HS diploma, 19 obtained employment and there were no repeat pregnancies.
- All 38 clients served were assessed and had service plans in place within 60 days of first contact.
- Case managers made 218 home visits and 125 community visits (school, office, etc.).

Northern RI Visitation Center (NRIVC)

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 has consistently had a wait list to serve 8-12 families. NRIVC has built strong relationships with DCYF workers and supervisors in region IV and is a respected child welfare provider in the family court system.

- 68 families were served.
- 61 started visitation on site.
- 3 were reunified the previous year.
- 29 are still working towards reunification at year end.
- 19 reunifications occurred and 32 children obtaining permanency.
- Doubled capacity to serve families over the last two years.

"You are the only one who really took the time to get to know me."

—NRIVC Parent

Treatment Foster Care

Serves children who are entered into the Child Welfare System for a variety of reasons; mainly from child abuse or neglect, or less commonly due to educational neglect where the parents have not sent children to school. These children are placed in the care of our agency within foster families through DCYF. Our goal for the children is for permanency. While all children enter TFC with the goal of reunification, permanency can mean different things—reunification with parents; guardianship with a relative; or adoption, in some cases.

- Served 60 children, 31 boys and 29 girls;
  14 — 0-3 years old
  12 — 4-5 years old
  16 — 6-8 years old
  12 — 9-12 years old
  6 —12-18 years old
- 2 children were asked to leave their foster home due to aggressive behaviors.
- 2 children stepped down because they no longer needed the level of service.
- 8 children were reunified with their parent(s).
- 7 children were placed in pre-adoptive homes.
- 6 children found permanency with kinship families.

Northern RI Visitation Center Success Story

This family's story is all too common and illustrates the scope of work done to reunify families. A single Mom was referred to NRIVC by DCYF after her children were removed due to reports of concerns of neglect. Staff helped Mom build parenting skills and utilize appropriate language with her two children during visits at the NRIVC site. To reduce family stress and worry about basic commodity needs, visitation staff helped Mom obtain supplies needed for her children. They also worked with Mom to build self-advocacy and communication skills so she could communicate effectively with her DCYF worker. To ensure that the family received coordinated care, the Visitation Center team communicated regularly with other CCA programs that were working with the family, including Healthy Families America and the Community Support Program. Her two children were reunified with her after she had time to adjust to a new baby who went home with her from the hospital. The work of our staff continued after the family's reunification to assist Mom in addressing stressors and coordinate with all programs involved.

—Ivy Medeiros, Director of Child Welfare, Family Wellbeing and Permanency

Family Care Community Partnership (FCCP)

Our clients consist of families with children under the age of 18 years old, who are at risk of child abuse or neglect, or have a child with a serious emotional disturbance/behavioral issues. A key to our wraparound practice with families is for the families to have voice and choice in their own goals. Through the process of family team meetings, our staff assist families to advocate for their needs and develop goals, using a strengths based approach.

In addition, FCCP has a number of outreach events through the year, including parent support groups and family events. At these events, we give information about child safety and well-being. This year we were able to give out safety latches for kitchen cabinets, time-out instructions with a sand timer, and coloring books about topics such as Good Touch/Bad Touch, Police Officers Care, and Say No to Strangers. One popular item at events is the Rice Bowl, a sensory bowl where children can reach in and sift through the scented rice to promote a calming effect.

"FCCP helped my family, they can help yours too" is used in a statewide public awareness campaign to help parents know that there is help for them.

- The total number of referrals was 347, with 52% coming from DCYF and 48% coming from our community of providers, including mental health agencies, hospitals, schools, and other providers.
- Served 302 active cases in our northern RI Region.
- Of those cases, less than 10% of the families opened to the Department of Children Youth and Families, consistent with numbers from previous years.
- Fifty percent of our families actively participated in their wraparound plans, meeting at least some or most of their goals by the time they closed with FCCP.

Russell, pictured here with his daughters. We helped Russell when his daughter, who is developmentally disabled, was suddenly placed into his care. Russell didn't know how to manage his daughter's needs, and received guidance through the process of getting the medical and educational services needed, so that his daughter is able to thrive and he is able to continue working.

Viola M. Berard School

Students enrolled in the Viola Berard School are given daily supports both clinically and behaviorally. Students are taught pro-social behavior throughout the day so that they may self-regulate their behavior. Weekly clinical groups are also part of the school day. These groups are designed to help students identify their feelings and how it relates to their behaviors. They can then be taught positive coping strategies that can be reinforced throughout the day by school staff.

- 25 Students were served through our Out of District Program, as well as the 45 Day Assessment and Stabilization Program.
- In our Out of District Placement:
  Two students transitioned back to their high school, and one student transitioned back to their elementary school.
  One Woonsocket student transferred to a more restrictive school setting
- From the 45 day Assessment and Stabilization Program, 9 Woonsocket students were served.
  Of those students:
  4 returned to their Woonsocket school upon completion of assessment
  2 students remained in the Viola Berard School and slotted into Out of District Placement
  2 students discharged from program by district due to absenteeism (attempted home outreach unsuccessful by VMB and CCA).