HIGHLIGHTS & OUTCOMES REPORT

FISCAL YEAR 2019

July 1, 2018 – June 30, 2019

Project Opportunity Instructor, Lucas Pralle, with students in the classroom.

When measurable skill gains are made, we see clients’ self-esteem and confidence improve so students can make the most of their educational experience.
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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

Our Adult Intake Department provides comprehensive screening and assessment services to residents in the Northern RI area. It is one of CCA’s key points of entry to treatment, enabling clients to access the vast array of services offered throughout the agency. The assessment process that takes place at Intake serves to identify and prioritize the needs of the client, and to refer them to the program best suited to meet those needs. These referrals are informed by the goals and motivations of the service recipient, with the focus on their wellness and recovery.

OUTCOMES & ENGAGEMENT

In the past year, Emergency Services has increased coordination with our local police departments to better serve the members of our community. These efforts have involved establishing routine “ride-alongs” by which an ES clinician accompanies a police officer on their shift, providing clinical assistance when appropriate. This has resulted in increased police awareness of the concerns and contributing factors of behavioral health when working with individuals in crisis.

In addition to this, Emergency Services has recently implemented a new Mobile Crisis Program, which operates after-hours and on weekends. In this program model, Qualified Mental Health Professionals (QMHP) coordinate directly with police and EMS, responding to behavioral health crises in the community. The purpose of this initiative is to identify individuals at risk and refer those individuals to an appropriate level of care. In doing so, Mobile Crisis Clinicians emphasize diversion from Emergency Departments and Psychiatric Hospital Units. Due to these efforts, program coordinators have identified an increase in both after-hours and daytime referrals, suggesting that more community members are being met with a continuum of care that better fits their behavioral health needs.

The emphasis of the Emergency Services department on coordination with local police and EMS has proven to be an effective means of increasing access and visibility around ES assessment and referral services. With continued collaboration, the long-term objective is to not only increase client engagement, but to avoid unnecessary Police/Fire/EMS contact in behavioral health crises by introducing clients to a more appropriate continuum of care.
The Intake department completed 1092 Biopsychosocial Assessments through Open Access an increase of 25% over last fiscal year.

Emergency Services clinicians conducted 408 crisis assessments (both in the community and at CCA)

The Mobile Crisis Program engaged in 36 client contacts in its first month of operation (May 2019)

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**BH-Link**

**MANAGER**

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

BH-Link is a comprehensive crisis unit, intended to serve those individuals (18+) who are experiencing mental health and/or substance use related crises by providing a community-based, 24/7 hotline and triage center. BH-Link provides immediate access to clients seeking services, ensures stability, provides seamless transfer to ongoing care, and reduces unnecessary use of hospital-based services. The vision of this program is to deliver better, more cost-effective behavioral healthcare in Rhode Island.

Primary Components:

BH-Link Hotline (414-LINK; 414-5465) – a one-stop, statewide 24/7 call-in center that connects people to appropriate care and resources when they, or someone they care about, is experiencing a behavioral health crisis.

BH-Link Triage Center – a 24/7 community-based walk-in/drop-off facility, where clinicians provide people with immediate emergency behavioral health support and connect them to long-term care and recovery services.

**OUTCOMES & ENGAGEMENT**

Since opening on November 14th, 2018, BH-Link has created a calm and welcoming environment meant to provide an alternative to the overstimulating atmosphere of hospital-based emergency departments.

- 1,347 total face-to-face assessments
- 49% of total face-to-face assessments were self-referrals
- 2,914 total crisis calls

When walking into BH-Link, clients are greeted by warm staff and shown to a quiet and softly lit treatment space where they have access to a private pod, designed for their comfort, including a reclining chair, television, and serene artwork.

Beyond the difference in atmosphere, BH-Link has demonstrated reduced wait times, faster referrals, smoother transitions, and reduced healthcare costs. In addition, the program provides crisis phone services, alternative transportation options, Narcan distribution, and outpatient acute detox treatment.
Within the first year of operation, the BH-Link has proven itself to be an essential community resource and ED alternative.

Most client engagement has occurred through marketing and outreach efforts made by program coordinators and state funded liaisons. These ongoing engagement efforts have led to an increase in community awareness of the services provided by the BH-Link.

STORY

Danielle is a full-time accountant in Providence, works a part-time bookkeeping job, and is a wife and mother of two. This past June she found herself in the process of moving into a new house, all while her professional responsibilities continued to escalate with the month’s end approaching. Danielle later expressed to us, “The amount of pressure all these parts of my life put on me [that] day sent me spiraling, with thoughts so dark I was no longer sure I could trust [they were] ‘just thoughts’.” Danielle described feeling out of control, frightened of her own thoughts, and angry at herself for thinking of leaving her children without a mother.

Danielle’s husband found the BH-Link phone number, spoke with program staff, and brought her to the unit the next morning. By her account, she spent 4 hours on the unit, and in that time was seen by both a nurse and clinician who were warm, thorough, and made her feel at ease. The staff of BH-Link helped Danielle to realize that she had been stretching herself thin and that she needed to invest more time into her own self-care. She left BH-Link with an outpatient referral, the plan to take time off work, visit her previous therapist and prescribing doctor, and to start on a medication that would assist her in the process of recovery. She left our program hopeful that what she was experiencing wouldn’t last forever and that she could feel in control again.

QUOTE

“With my time at BH-Link, I am coming around. The reminders and support I received there, while at my lowest of lows, have given me my life back.” —Danielle

Acute Stabilization Unit

MANAGER
Scott Bjurman, MSW, LCSW, QMHP—Program Manager

The Acute Stabilization Unit assists individuals from all cultures and backgrounds who are experiencing a mental health and or substance use crisis. This program strives to provide a level of care that continually exceeds clients’ expectations while on the unit as well as standards set by best practices. Clients admitted to the unit can expect to be met with kindness and compassion from knowledgeable staff whose training emphasizes Trauma Informed Care.

Services provided by the ASU include respite, 24/7 access to RN support, case management, and medical prescriber coordination. In addition, guests are exposed to a client-centered and strengths-based treatment curriculum, aimed at enhancing their sense of self-worth, empowerment, and overall
resilience. Examples of group topics and activities include mindfulness and meditation, Tai Chi, coping skill development, relapse prevention planning, and strengthening insight. Guests of the ASU often find their way to the program as a result of a cycle of negative coping strategies that have been created and exacerbated by environmental stressors. The ASU applies a holistic approach to care that helps those in treatment to transform this cycle into one of recovery and growth, reinforced by clinical services and social supports.

OUTCOMES & ENGAGEMENT

- Admitted 957 individuals

Over the past year, the ASU has worked diligently to foster and strengthen relationships with other treatment providers. These providers include the BH-Link, The Warm Shelter, Crossroads, Road to Recovery, MAP, Sojourner House, local hospitals and mental health centers and many more residential facilities statewide. Strengthening these connections has provided our clients a more comprehensive and uninterrupted continuum of care.

Our guests are engaged in treatment from the moment they walk through the doors of the ASU. The atmosphere of the program is meant to parallel our philosophies of care, which emphasize treatment that is motivated and guided by the desired outcomes of the guests. Those that we serve are continually reminded that lasting change and effective treatment starts with their investment. They are recognized as the most important member of the treatment team, as without their participation, progress can’t occur. Guests of the ASU understand that they are being offered a level of care that is considerably less restrictive than its inpatient counterparts. For these reasons, clients are more likely to be active participants in the services provided by our team.

STORY

Georgia is a 21-year-old female, who came to the ASU by way of a referral from BH-Link. Georgia had been suffering from increased depression and anxiety related to family and finances. She was advised by her academic professors to seek help and mental health stabilization and was admitted through a joint effort consisting of her academic professors, the BH-Link, and BHDDH. Georgia was diagnosed with PTSD (extensive trauma history), OCD, and Autistic Spectrum Disorder. After completing BH-Link triage she was admitted to the Acute Stabilization Unit. While admitted to the ASU, family meetings revealed that client was being financially exploited by her father, who at the time was her rep-payee. ASU staff coordinated with the BHDDH to assist Georgia in gaining financial independence.

Additional treatment team efforts focused on medication stabilization, exploring alternative living situations, providing the client with the necessary tools to navigate through crisis situations. As a result, Georgia was able to secure a bed at the Woonsocket shelter until her dorm was available in the fall. This is just one example of the many ways in which the ASU serves as a vital first step in the healing process of so many of its guests.
QUOTES

“[My favorite part of the ASU was] the compassion and understanding of the staff; especially Scott, Diego, Seth and Emily. They helped me out, as well as the rest of our crew, non-stop. They were amazing.”—Anonymous from Client Satisfaction Survey

Community Incident Response, Consultation & Support Services

MANAGER
Becky Chartier, CCSP, BA, LCDP, RCS—Program Coordinator

This Employee Assistance Program (EAP) is tailored to support police, fire, and EMS workers. The program assists employees with both personal and professional issues that can impact job performance, health, and wellbeing. Program staff specialize in providing counseling, training, and crisis response services to contracted departments, helping employees to better understand the impacts of environmental and interpersonal stressors and develop strategies to increase emotional and psychological resilience.

In addition, EAP clinicians provide support services to community members who have experienced traumatic events, including police and other first responders who work these critical incidents.

OUTCOMES & ENGAGEMENT

In the past year, the CIRCSS program placed a strong emphasis on employee engagement and access through the development of Peer Support Networks. At the core of these networks are the Peer Responders of the program. In this service model, first responders nominate peers in their department, who become the primary connection for personnel in need of EAP support services. The availability of these Peer Supports offers employees the comfort of knowing that they can reach out to someone who is respected by their peers, who understands their circumstances, and who has been trained to connect them with the right resources/professionals. This model of outreach is directed by the client and has instilled a sense of trust and comradery in the referral process.

In addition, Acute Services EAP service agreements have incorporated Crisis Responder Trainings for police and other first responder departments. These trainings prepare first responders for on-the-scene identification and intervention of mental health crises. The demand for this resource has continued to grow, as Crisis Responder Trainings have led to safer street encounters and an overall decrease in restraints and use of force.

- 12 open EAP contracts with Rhode Island police departments and 2 town contracts.
- 150 hours of individual counseling provided to police and their family members.
- 75 hours of training to police departments, including peer support.
- 17 debriefings related to clinical incidents.
- 25 hours of coordination with service recipient administration for the purpose of customizing services to meet the needs of each department.
Rise to Recovery

Partial Hospitalization & Intensive Outpatient Programs

MANAGER
Francis Spicola, MA, LCDP—Program Manager

Depending on clients’ needs, the Partial Hospitalization Program (PHP) provides intensive treatment for five days a week/five hours a day; or the Intensive Outpatient Program (IOP), which is intensive treatment three days a week/three hours a day. These programs are for people eighteen years or older, suffering with substance use and/or related mental health (MH) disorders. Individuals are post medical detox requirements and must be psychiatrically stable and able to participate in the program activities, a mixture of psycho-education, group and individual therapy, and expressive art therapy. 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

- 291 clients served, a 28% increase from previous Fiscal Year
- 296 Assessments, a 37% increase from previous Fiscal Year

While much of the program description speaks to factors that impact client engagement, the following areas were addressed this past year to positively influence program participation for clients at the PHP/IOP program.

Transportation — Clients’ ability to attend the program, due to a lack of transportation, has historically been one of the most substantial barriers to participation in treatment. For this reason, each of our clinicians have been cleared to transport clients to and from the program (and can even provide other case management services). In addition, we’ve helped clients to acquire long-term and temporary bus passes.

Group Curriculum — Since 2017, the PHP/IOP program has doubled the number of group topics made available to its clients. These recent changes include a new meditation group that incorporates both eastern and western practices, a journaling group that offers clients the opportunity to share and provide feedback, and an expansion of other group modalities (including Psychoeducation and Expressive Arts). Previously implemented groups, including mindfulness groups (conducted by the team Psychiatrist) and field trips to 12-step groups and recovery drop-in centers, continue to play an important part in the core curriculum of the program. While the PHP/IOP program recognizes this expansion as a significant achievement, we are constantly researching new group modalities and evidence-based practices to add to our toolbox of available treatment options. In addition, the program maintains an updated message board with educational groups and sober activities in the community.
STORY

Edward was diagnosed with Bi-Polar Disorder at an early age after beginning to display difficulty sleeping, expression of euphoric and grandiose ideas, and high-risk behaviors. Despite having the support of his family, he resorted to self-medication with cannabis, alcohol, cocaine, and eventually heroin. Edward found himself caught in a cycle of transition between incarceration, homelessness, temporary living situations, and residential treatment. Despite sincere attempts on his part to engage in a variety of treatment services, he could not maintain a healthy and ongoing recovery for more than three months at a time.

After being released from a three-year prison sentence, Edward relapsed once again. He found himself on the familiar path of detox, residential treatment, and sober housing; but, for Edward, this time was different. This time, he chose to continue with treatment, maintaining his living arrangement with sober housing and involvement with his 12-step program. Two days after being discharged from a residential program, Edward was accepted to CCA’s IOP program. Consistent attendance and participation resulted in an improvement in Edward’s quality of life. He began to eat and sleep better, rebuild relationships with his family members, improve his financial independence, and gradually replace old destructive behaviors with healthy routines and coping strategies. Throughout his treatment in our program, Edward’s substance use and mental health issues were treated in much the same way any medical issue would be treated. We worked with him through periods of relapse and increased support when needed. Edward had the strength to find his way through our doors, and we offered him the tools and support to stay the path. —As told by Francis Spicola, Program Manager

QUOTES

“When I told them I never thought I could stop using drugs or even drinking, they didn’t say ‘I could do it,’ like all the others. They said if I wanted to make changes, they would help me. They said they would help me even if I wasn’t sure I wanted to quit.”

“I’ve been to so many places and this was the first place that didn’t throw you out of the program if you relapsed. It was just the opposite. They offered more help.”

“My first day (of treatment), I was nervous and really just scared; but the lady at the front was so nice to me and even let me use her pen to sign the paperwork. She made me feel like a person, and it just made everything a little better. I’m very grateful for the program, and I thank you all.

Residential Substance Use Treatment Programs—Wilson House & Jellison House

MANAGER

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

Wilson and Jellison House provide specialized treatment to men (over the age of 18) who are recovering from substance use/addiction. While services at this facility emphasize treatment of chemical dependency, our highly qualified staff, clinicians, and supervisors are all trained to provide
co-occurring mental health treatment and are licensed in the delivery of Trauma Informed Care. Each client works with clinical staff to develop a personalized treatment plan based on their individual needs. Recovery is an intensive process that includes a variety of therapeutic approaches and a diverse treatment curriculum focused on gaining the necessary tools for early sobriety.

Program staff connect clients with an array of community resources based on the needs of the client. Examples of these resources include primary care physicians, dental professionals, mental health providers, employment and housing assistance, and medication assisted therapies. Support staff promote health, safety, and consistency of care for residents who often have barriers preventing them from engaging in treatment at lower levels of care.

In working actively with our certified counselors to develop a personalized treatment plan, each resident is empowered to take part in a recovery process that is tailored to meet specific needs. All the while, clients are introduced to a community of staff and peers that instills a sense of acceptance, support, and responsibility. Residents are encouraged to identify and access available support systems to overcome crises and achieve long-term stability.

OUTCOMES & ENGAGEMENT

- 224 Clients served
- 74% of clients involved in 12-step support groups after program completion

In the past year, the Substance Abuse Residential program has emphasized coordination with other CCA programs and aftercare planning in order to strengthen each client’s continuum of care. Understanding the nature of risk and relapse has enabled program staff and supervisors to better plan and adjust treatment based on the needs of the client.

- Improved communications and procedures with BH-Link and the Acute Stabilization Unit (ASU) created a more seamless transition into residential treatment; and allowed clients of our residential programs to transition to and from the ASU when the need for a higher level of care was identified.

Wilson and Jellison continue to connect clients with resources and tools that have been shown to increase the odds of long-term success. Whether through a curriculum that helps to develop and reinforce life skills or guidance to set up a stable housing situation, preparing our clients for life after treatment starts well before their last days in the program.

The Residential Substance Abuse program strengthened its emphasis on aftercare by actively incorporating family involvement in the clients’ treatment plans, whenever appropriate. Doing so helped to address the need for effective supports upon program completion. Tied to that need is the importance of community-based resources, and the program has continued to make new and vital connections with outside referral sources. One great example is the employment support services provided by the Anchor Recovery Center. Connections like these play a pivotal role in the stability, self-worth, and resilience of our clients.
• The Substance Abuse Residential program provided multiple activities throughout the year, including Pawtucket Red Sox games, fishing trips to Newport, community fundraisers, AA/NA cookouts, recovery rallies, and beekeeping, a newly added activity at Rhode Island College with program clinician, Daniel Seliger.

• We continue to connect clients to 12-step recovery meetings in addition to physical recovery groups (ex. Public library, movies, weekly store trips, etc.) designed to facilitate community engagement and better understanding of a world outside of substance use.

• Twice, the program held Alumni Gatherings, where program graduates share their stories and engage with current residents. These Alumni reach out regularly with employment opportunities and sometimes “sponsor” a resident of the program. These aspects of community not only serve to normalize the experience of clients; but, help them to better envision a new life for themselves and to believe that their vision is achievable.

STORY

When Ian came to our program this past summer, he did so having experienced a previous admission and the regret of having relapsed due to alcohol consumption. However, with that experience came new resolve. During this recent admission, Ian participated actively in his treatment, working with his clinical team to develop a pattern of daily routines and a network of supports that would lead to lasting recovery. After completing the program for a second time, he took the tools and resources that he’d acquired at Jellison and created a life for himself that has both structure and purpose. Ian transitioned from our program to the Hope Recovery House in Cranston. Since then, he has remained heavily involved in 12-step work, established a viable sober support network, and is working full-time. Ian reports, “I completed a 30-hour recovery support specialist training. I want to, hopefully, become a substance abuse counselor one day.” He reports that he is now the manager of the recovery house at which he resides and is “really looking forward to the future.”

QUOTES

“Since becoming sober, when I talk to my mom and my sister, I feel like we’re best friends again!”

“The staff are great here. They help me out from day to day with life’s trials and tribulations. Without this place, I don’t think I would be alive today.”
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, LCDCP, 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

- The program had an increase in admissions (28%) this past year serving a total of 1084 clients.
  - 971 were enrolled in the Community Support Program
  - 799 were enrolled in Integrated Health Homes
  - 165 were enrolled in Assertive Community Treatment (ACT)

A significant increase in the number of the admissions from hospital discharges (33% in FY 2018 to 43% in FY 2019) meant an increase in the acuity of the client population, necessitating more intensive services at the front door and an increased need for ACT, a higher level of care. In consultation with the Department of Behavioral Health, Developmental Disabilities and Hospitals, the program designed a model to address both of these trends with an expansion of the ACT team and the restructuring of one Health Home specialized intake team.

The teams continue to accent on crisis management and preventing hospitalizations. With about a year of implementing a new HEDIS measure (Emergency Department visit follow-up within 7 and 30 days), the program is performing at a high level.

- 77% receiving follow-up care within 7 days; and 90% within 30 days; both of which are significantly higher than the national average of at best 50% at 7 days and 60% at 30 days.
- There was an increase in the number of clients discharged for completing treatment from 4% in FY18 to 10% this fiscal year
- The trend in psychiatric hospitalization have continuously dropped in the last three years from 20% in FY2016 to 10% this fiscal year.
- 4% of our clients experienced a repeat hospitalization.

The number of clients with co-occurring substance use issues continues to represent about 60% (565 clients) of the program’s population.
The Substance Use Specialists conducted 159 co-occurring assessments, providing a total of 2309 individual substance use services and 620 group sessions. This is a positive outcome given the difficulty engaging this co-occurring population.

The program put significant effort into staff development and training this year. As part of the State Innovation Model (SIM) grant, CCA participated in a taskforce at The Leadership Council in redesigning the Case Management training and developing a training outline focusing on competencies and skill development to better equip staff working with SPMI (severe and persistent mental illness) clients in the community. The result of the taskforce helped to enhance the existing CCA Case Management training program.

Program managers supported their staff in their education goals and training development.

9 staff are pursuing a Master's degrees in the field, 3 are completing their Bachelor's degree and 4 are working toward their LCDP.

Also through SIM collaboration, CCA contributed to the effort of expanding field placements out of the typical office-based locations into community-based programs. CCA worked in conjunction with Rhode Island College to provide this enhanced internship program for students placed at CCA. In total there were 12 interns from various health related and social service programs that rotated through the Community Support Program, and attended weekly seminars in conjunction with field placements. Students gained a better understanding of the community based programs offered.

**STORY**

I was meeting with Jeremy this morning. He was talking about his treatment and said "This place is great, it really helped me out a lot. It kept me alive—out of trouble and alive." So I asked if I could quote him for the report and he said of course. —Dawn Whitehead, speaking about Jeremy Kerrigan
When you speak with Conrad you are instantly aware of his sincerity and you feel empathy for him too. He’s had a difficult life that started out in unfavorable circumstances. He told me this right away. He comes from a family of ten siblings. When his parents were working his older brother took care of him and dropped him off the banister a few times. I was punished and had to go to bed early without supper. Conrad attributes the problems in his head to these moments in his childhood.

He says he started coming for mental health services because he has had sicknesses. He describes feelings of his head exploding... “popping!” My head felt like it was blowing up like a balloon.”

“I really appreciate CCA because they’ve helped me out. I felt like I was dying. I was seeing things and my sicknesses were really bothering me. I was angry.” Conrad has been coming to CCA for over 20 years.

When asked what has helped him the most, he says “The medication has helped me a lot.” He tells me how important it is to stay on schedule with his medications because he gets sick if he doesn’t. Conrad receives Community Support Services. Every two weeks, his case manager, Barbara Corsi, goes to his house or meets him for coffee. She brings him to appointments if he needs her to. Her visits help ensure that Conrad is on track, being social, going to work, maintaining his diabetic condition and is generally doing okay.

Conrad also appreciates the activities he attends with the Alive program, like going to the movies and bowling with the friends he’s made there. Barbara tells him, and he agrees, “You’ve got to get out and not be in the house too much.” “I’m very fortunate to have met nice people,” he says.

Barbara says that Conrad has a very understanding boss. He’s been working the same job for over 20 years. He delivers vegetables to local restaurants and stores three days a week. Conrad tells me it’s important to keep paying his bills. Barbara says he’s good at listening to any advice, and he jokingly mentions, “except about the taxes.” He’d rather pay his tax preparer than have them done for free and holds firm on that. Barbara shrugs. If that’s the thing...

“I’m really thankful for CCA. If I didn’t have my medication, my sickness would get worse and would get the best of me. It really helps me out a lot, honest to God. Without CCA, I would end up in the hospital.” During our interview, Conrad probably said it 25 times, “I really, really appreciate CCA.”

—Conrad is a client in the Community Support Program
As told by Colleen Joubert, Director of Communications & Development
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

Our mental health rehabilitative residences continue to be step down options for individuals with severe mental illnesses who had been placed long term at the state psychiatric hospital. The group home structure and treatment aims to transition these individuals into a supervised community setting. Five clients were admitted into group homes this year, four of which were referrals from the state hospital. The program engages clients in treatment, providing a safe and supportive environment to work on recovery goals.

- 46 clients lived in our residential homes
- All new admissions remained in the program without any further hospitalization or crisis care. In fact, one client was successfully transitioned to a community apartment in less than one year, much sooner than the average length of stay.

Residential clients and the staff who cook with and for them were introduced to the FDA "Choose My Plate" model of meal planning. Meals in all settings now include vegetables and whole grains as larger percentages of available meal choices, in hopes of decreasing cardiac and metabolic risk common to many psychotropic medications these individuals take. Nursing staff encouraging daily activity, integrate regular nutrition information with monitoring of biometric data, and provide care coordination to ensure preventive and specialty care. We hope to see gradual, lasting decreases in BMI with these healthy lifestyle changes. Nursing support for med adherence decreases missed medication doses and improves management of acute and chronic disease that otherwise increase risk of hospitalization.

- Six clients were hospitalized (either psychiatrically or medically) and 7 clients had hospital Emergency Department contacts during this period.
- There were 4 discharges; 3 that were successfully transferred to other levels of care and 1 discharge due to not engaging in the program and following program rules.
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

The Wellness and Recovery Center provides groups and services for clients enrolled in the Community Support Program. This year showed an increase in the number of referrals to groups since providing outreach to CSP staff explaining the different groups offered.

- 27 groups were offered (2 Substance Use, 12 Psychotherapy, and 13 Health and Wellness)
- 4968 group sessions were provided
- 177 clients attended at least one group
- As a result, there was a 5% increase in total group participation with over 100% increase in the number of the psychotherapy group attendance.
- The Wellness and Recovery Center has increased access to other program clients and developed a referral process for Outpatient Services clients.

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

With continued funding support from the Parent Support Network, the Alive program had a year of growth and increased engagement.

- Formerly open to just clients in the Community Support Program (CSP), this past year the program opened access to other CCA programs.

Our dedicated Peer Recovery Specialists from our Health Home teams encourage their clients to attend the Alive Program to increase opportunities to socialize with peers and become more active in their community. They also assist in facilitating the social groups and activities.
The program saw an increase in the number of engaged Alive members this past year in both on-site and community activities.

- 194 activities were held during the year with half provided in the community.
- 1843 attendance at all the activities, an increase of about 37% from last year.
- The average monthly member participation was 42 individuals, compared to last year’s average of 32 individuals—a 30% increase—with a high month of 61 compared to 54 the previous year.
- The members were engaged in the many more activities offered, with an average attendance jumping from 7 to 10 per activity. The largest increase was in the on-site attendance—about 63%.
- The program would have seen a larger increase with community activities; however, the van capacity limits the number of participants at each community event.
- Peer recovery specialists worked with 182 clients individually with a total of 1771 of face to face services.
- New Alive activities were well-received, with plans to repeat 7 new activities in future monthly calendars. Examples of these are “Paint and Percolate” and “Painting Kindness Rocks” (later placed in local parks by members).

Holiday events continue to be well attended as many of our members have limited family and social supports and find comfort in attending holidays with their friends.

- A total of 41 members attended annual Thanksgiving dinner and 47 celebrated together at a holiday party. A full hot meal was served during the Thanksgiving Dinner and lots of dessert and fruit options were offered at the annual Holiday Party. Each year, Alive members look forward to celebrating the holiday with friends and a visit from Santa Claus distributing one gift to each person. For some of our Alive members, this is the only gift they receive.
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

- There was a decrease in the # of total hospitalizations to 6 compared to the previous year at 11; representing only 5 clients needing that level of care.
- 2 clients were in need of more skilled nursing care and were transferred to a nursing home.

Evergreen staff incorporated more activities into the residents’ daily schedule to help them stay engaged and motivated. Residents participate in various activities such as Bingo, Karaoke, holiday parties and summer BBQ’s. This past fall, Evergreen hosted an intern from CCRI who assisted staff with engaging the residents and developing new activities to increase their socialization. At one point, a workshop was held on the topic of peer bullying, which also provided residents with skills on how to set limits and develop healthy boundaries.

Upgrades have had a positive effect on resident satisfaction, such as the various improvements to the first floor and living areas. Wooden wall paneling was removed and the walls were sanded down and re-painted. New furniture was donated to help furnish the living area, as well as resident bedrooms.

There was also an increased focus on providing Evergreen residents with additional health and medical services. Because, at times, it is difficult for residents to get to their doctor appointments without the assistance of their IHH/ACT case managers, the administrator coordinated with both a podiatrist and a phlebotomist to bring services into Evergreen on a regular basis. Additionally, the staff at Evergreen have provided residents with increased diabetes education and worked with them on healthy nutrition. Residents have the ability to request specific meals that are both healthy and part of their cultural traditions. All of these services have helped maintain the mental and physical stability of our clients and allow them to feel safe in a home-like environment.

QUOTE

When describing Evergreen, clients used words like, “more homey,” “feels like family,” and “quiet, peaceful.”
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

- Outpatient staff made creative use of technology to engage and support clients.
- Clients participated in group activities along with their peers in home-based services. Some of these groups raised funds to support future enrichment activities.
- We provided Outpatient Services at schools in Central Falls and Burrillville.
- Outpatient staff continue to utilize MIRAH, an assessment tool, to inform their work with clients.

STORY

LB is a young person who came to Children’s Outpatient Services at the young age of 14 after inpatient admissions to Bradley Hospital. At the time she was engaging in self injury, was socially isolated and not attending school on a regular basis. But with consistent support, therapy and medication management JB graduated from high school where she took an advanced placement course and engaged in extracurricular activities. She is now a Dean’s list student in college and working part time.

QUOTE

“Our Outpatient Services staff are dedicated, trauma informed, therapists who are passionate about helping children and youth manage behavior and emotions that are impacting their everyday life.”
—Outpatient Services Clinician
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

- Served 290 children
- The EOS team continues a collaborative relationship with Tides Family Services by providing clinical services, behavioral supports and medication management for client served by the preserving families network.
- We are serving more clients outside our traditional catchment area particularly in Central Falls and Pawtucket.
- Services have been provided to a number of Spanish-speaking families by our three bilingual/bicultural clinicians.
- EOS continues to effectively collaborate with school personnel in an effort to optimize clients functioning.
- Along with their colleagues in Children’s Outpatient Services, EOS staff participated in a variety of pro-social group activities.
- Staff continues to utilize the MIRAH measurement based assessment to inform their work with children and their families.

STORY

DP is a young boy who lives with his relative guardians in Woonsocket. He was placed with relatives due to a history of severe neglect. DP presents with the complex medical and psychiatric issues whose symptoms vary in severity and intensity as he grows.

His community-based clinician has effectively been able to support him and his family through these challenging times and has thus maintained the permanency that every child needs.

QUOTE

“I totally appreciate the support you provide for our students and their families. The staff is always responsive and easy to work with.” — A Woonsocket Service Worker
Healthy Transitions

MANAGERS
Tara McConkey, LICSW—Team Manager

The HT Team provides a comprehensive array of services to young people aged 16-25 with a serious mental health or co-occurring disorder. Services are delivered with consideration of the unique developmental needs of transition age youth. Emphasis is placed on supporting participants in continuing their education or obtaining employment.

OUTCOMES & ENGAGEMENT

Healthy Transitions served 94 individuals. Evaluation of participants at Community Care Alliance and Thrive Behavioral Health indicates the following from baseline to discharge:

- 43.8% increase in social connections
- 50% change in attending school or remaining employed.
- 81% change in using the emergency room in the last 30 days.

STORY

SA is a young woman who spent much of her adolescence in the care of the Department of Children Youth and Families. When she aged out of care she was experiencing symptoms of Post-Traumatic Stress Disorder, was engaging in significant substance use and did not have stable housing. With the ongoing support of the Healthy Transitions team she was able to stabilize those symptoms and discontinued her substance use, she is presently enrolled in Job Corps, has obtained her GED and is preparing for a career in the culinary field. Although she is currently in Exeter, she continues to receive services and support from the team.

QUOTE

“Consistency—being there all the time to help me with anything I need—the team is very inspirational. They can be themselves without putting up a front. They show me I am not alone, that everybody goes through things and nobody is perfect. They answer my phone calls in my most desperate moments. They help me to communicate better with my family by helping me understand how they think about things. They help me to see the true me.”

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. Families are often overwhelmed by chronic or acute stressors and are unsure how to proceed. 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, and help to understand risk and safety issues.

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.

**OUTCOMES & ENGAGEMENT**

- 344 Youth and their families were served
- DCYF reported that less than five percent of families who open with the FCCP subsequently open to DCYF within 6 months of closing to FCCP.
- Families receiving services through CCA have an average length of stay of 4 months. Approximately 72% of families achieve “some or most” of their goals at discharge. Many of the unmet goals are related to housing issues.
- Of the Families who opened to the FCCP last year, 29% reported not being in stable housing at intake. The FCCP helps families who are experiencing housing stress and homelessness to negotiate the necessary steps to obtain housing in a family or domestic violence shelter. We also assist them to take steps to apply for future housing opportunities through the Housing authorities, Section 8 and the Coordinated Entry Placement opportunities for the homeless.
- FCCP outreached to each community in the Northern Region, including each school; and were invited to several team meetings to present the program.
- In an effort for improved internal and external communications, supervisors regularly attended team meetings with Children’s Behavioral Health, Enhanced Outpatient Services, Community Support Program, The Woonsocket Family Shelter, Rhode Island Works, the Department of Health Family Visitation, Tides Family Services, and Parent Support Network.
- Families are able to reduce stress as a result of school advocacy. We provide planning to support parents so that they can attend to mental/behavioral health or household organizational needs. The FCCP is in contact with all school districts in the 11 towns in the Northern catchment area.
- The FCCP sponsored or co-sponsored:
  - A Pumpkin Event at Adams Farm in Cumberland in October.
  - Family Bowling activity at Woonsocket Bowl in April.
  - A Family Farm Day in Chepachet in June.
  - A Family Unity event at the Boys and Girls club in June.
  - A Community Block Party at the YMCA in June.
- 8 Spanish Support group meetings.
- Child abuse prevention month in April.
- A barbeque and baseball Game at McCoy stadium.
- The Levitt Amp Music Services held at River Island park in Woonsocket.

The FCCP enters data into the DCYF sponsored RIFIS Electronic Record. The FCCP implemented a new assessment (The CANs) during fiscal year 2019. The data from these assessments were not entered into RIFIS until 6/2019 and the data is not yet available to programs for analysis.

**STORY**

A young mother who experienced domestic violence left her boyfriend and experience homelessness with her 4-year-old son. The FCCP was able to support her as she stayed in a hotel utilizing emergency funds. She moved to the Woonsocket Family Shelter and once there was able to get her son into early Head Start and find a job. She is now feeling hopeful and is looking forward to being in a home again. The FCCP collaborated with Rhode Island Works staff and Shelter staff to provide care to this young family.

**QUOTE**

When speaking about the FCCP working with the family a mom said, “He knows my schedule. He knows how to reach me. He is like one of the family now.”—FCCP Case Manager

**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**

- 78 families were served
Our Program services families with children 0-17 who are involved in the Child Welfare system and in an out of home placement. We provide supervised visitation for bio-families, parenting skills, and intensive case management with a goal of re-unification and/or permanency for children. We use evidence based parenting curriculums with families.

- All families, that were in the program for more than 30 days, saw improvement in the areas of parental effectiveness, engagement in services, and family communication (per data collected for the FAST). FAST data indicates that families that participated in NRIVC services made improvements in all measurable categories, including housing stability, mental health, substance use, and decision-making skills.

### 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

- 94 families served.
- 72 families were maintained in the home, 4 removed and placed and DCYF care, 6 did not have their children in the home.
- 12 families were reunified. At the start of services these 12 families’ children were placed in DCYF care. By the end of services all 12 families were reunified.

IFP provides a Parent Support Group that usually meets quarterly. Activities such as jewelry making, movies, bowling, arts and crafts, etc. are enjoyed by IFP clients, and any parents in the community who are looking for positive connections with others. The group also helps parents build supports with other parents who have been through similar experiences with DCYF, or experience with abuse/neglect. Some parents who have met through the Parent Support Group have maintained supports with each other over time. IFP families attended a fall event with the FCCP team and enjoyed hay rides, a corn maze, arts and crafts and brought a pumpkin home. IFP also held a Farm Day for IFP families with a cook out, farm animals to pet and feed and arts and crafts.

### STORY

IFP functions as a continuum service so that families are able to maintain the same case manager for visitation services that are required due to a child being removed from the home. One mother was open to IFP when reunifying with her son. However, mom relapsed and her son was removed and placed in DCYF care. The IFP case manager remained with this family and provided visitation services to mom and her son. Visits first began at the Northern Rhode Island Visitation Center. As mother made progress, visits moved into mom’s home and went from supervised to modified to
unsupervised. Mom and son were reunified after a few months and mom was able to successfully maintain her child in her home. Throughout services, IFP case manager kept regular contact with the DCYF worker as well as substance use/clinical providers (through CCA) who were working with this family. IFP closed with this family successfully.

QUOTE

“I needed a hero, so I became one.” —IFP Mom

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 32 families. All 32 families saw their weekly visits with their babies increase by 100% (2-4 hours or more weekly) to increase attachment and bonding. 12 families successfully reunited within a 3-10-month period and received after-care services thru our Intensive Family Preservation Program.

Of the 32 families:

- 62% were first time parents
- 90% of the children were placed in out of home care at birth.
- 27 families were involved with other Community Care Alliance programs.
- 68% had parental substance use, and 69% of babies were substance exposed at birth.
- 100% had mental health issues which required clinical intervention.
- 50% of parents referred had a history of child welfare involvement when they were children.
- 100% of families referred were exposed to chronic trauma (i.e., poverty, domestic violence, community violence, etc.).
- Average age of children involved in NEC: 0-6 months
- 82% of children were placed at birth and became involved with NEC within 3 months or less.
- 70% of babies were eligible and received Early Intervention services.
- 50% were reunited within a one-year period.
- Shortest length of out of home placement — 2months
- Longest length of out of home placement — 16 months
- 1 open adoption
STORY

Katie and Brian are first time parents who both have some developmental and mental health needs. Their baby, Jesse, was placed with a paternal grandmother at birth by DCYF and the family became involved with our Nurturing Early Connections Program. They had supervised visits with their baby and learned about baby’s developmental milestones, importance of bonding and attachment and basic child care and parenting skills. Both mom and dad received mental health services thru CCA Adult Outpatient Program, basic needs with the CCA Family Support Center and became involved with CCA’s Healthy Families America Program. Dad found a part time job and mom began studying for her GED. With the support of all their providers and family, Jesse was returned home. The family has continued to receive weekly home visits from HFA and Intensive Family Preservation.

QUOTE

“Because of all your help, we got our baby back.” —NEC Parent

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 & ENGAGEMENT

- 93 children were placed in TFC

Treatment Foster Care offers many opportunities to have all of our families and children gather and participate in different activities like holiday parties, bowling, and summer barbeques. We also encourage our families to get together, especially when siblings are placed in different homes. We spend time getting to know our children—their wants, needs, likes and dislikes. Staff retreats help our team to engage with each other and learn each other’s strengths and skills.

STORY

We didn’t have a home that could keep a brother and sister, 5 and 6 years old, together, so placed each child in homes with foster parents who agreed to facilitate visits between the siblings. This was in addition to the court ordered visits with the parents. The children saw each other often on the weekends and attended each other’s school events. The children were reunified with their Dad and Stepmom, who they did not live with prior to the removal from their Mom. During the time that the children were in placement, they utilized the visitation center to have visits. There was a reunification plan in place and the children were placed with their Dad. Our Case Manager provided aftercare for a
period of 6 months to help the transition to living with Dad. The family was also a recipient of a holiday basket, and Dad went to Outpatient Counseling. The children have been home and they are doing well. —As told by Linda Harrod, Program Manager

QUOTE

“I don’t know where I would be without the support from my child’s foster parents as well as the staff at CCA.” —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

- We began this reporting period with 253 clients and had 216 referrals for a total of 463 children served. The program enrolled 150 new clients and the 66 children found not eligible were guided to other resources for family support services and/or developmental monitoring.
- 117 children were discharged with 60% of the children transitioned to pre-school special education services at age 3. Of the remaining children, 50% met their goals before age three.

During a recent survey of parents in our program, the following outcomes were noted:

- 94% reported feeling more confident about guiding their child’s development.
- 95% reported becoming more knowledgeable about next steps in their child’s education and satisfaction with the services received in EI.

We offer two weekly parent-child groups for families to experience their children succeeding in peer settings in preparation for pre-school. Families also enjoy an 8-week music story hour led by our music therapist and parent consultant in partnership with a local library. This integrated group is offered to typically developing peers at no cost and provides age-typical role models and the opportunity for all children to appreciate learning differences and have fun together.

STORY

Chloe was born with sensory neural challenges that resulted in limited vision and motor challenges. She was found eligible for EI services and she and her family receive parent coaching relative to development, vision and mobility services and speech and language therapies.
family wanted their daughter to participate with age peers as much as possible and our EI team consulted with the early care center where Chloe’s older siblings had attended when her parents returned to work. Since initial concern about a legally blind child in a busy toddler room, the guidance offered by the EI team along with the parental advocacy to include Chloe in daily activities, the partnership has flourished and she is thriving in this setting. Chloe’s mom reports that she was concerned that her daughter would not experience independence when she was diagnosed at birth with this challenging condition – she now has confidence that Chloe can and will succeed. —As told by Darlene Magaw, Program Director

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

In addition to the standard First Connections screening services, in May 2018, we added a specialized nurse-case manager component for serving the unique needs of families with children diagnosed with neonatal abstinence syndrome (NAS) due to exposure to opiates during pregnancy. This is offered in collaboration with Women & Infants Hospital Family Care Unit for babies that need intensive monitoring and supports - funding for this enhanced care coordination comes from BHDDH and RIDOH. Children diagnosed with NAS are automatically eligible for EI, so one of our First Connections nurses acts as a bridge from hospital to home, seeing the family during the hospital stay, participating in daily rounds and discharge planning and then assisting with transition to home and community services.

- Received 1561 referrals and completed at least one visit with 437 or 28 % of those referred.

Many of our referrals come from the birthing hospital so a family-centered approached is essential to meeting families where they are at.
Screened 98% of new moms for post-partum depression and completed developmental screenings on 91% of children over 1 month of age.

Referred 71 children to Early Intervention services.

207 referrals to connect families to a variety of community services including WIC, housing, basic needs, and mental health resources.

First Connections families are more likely to be connected to their medical home and First Connections moms are more likely to complete their postpartum OB/GYN visit.

We continue our outreach to the local birthing hospital, Precious Beginnings at Landmark. One of our providers visits moms at the hospital and schedules home visits in the moment, rather than waiting until the family is discharged and not reaching the family by phone. Because many more births happen at Women & Infants, this effort hasn’t impacted our overall capture rate. What this collaboration has achieved is a more enhanced relationship with the birthing unit medical staff and social workers. The goal is to build our word of mouth reputation with new moms who are served at Landmark. RIDOH has taken our lead and placed a community health worker at Women & Infants on a part-time basis in October.

QUOTE

“This is a fantastic service. Having the personal touch of someone coming to your home and guidance during those first several weeks is such a comfort. My nurse says there are no silly questions and I'm so grateful I can ask her anything.” —First Connections Mom

STORY

Stephanie is a first time mom who was referred to First Connections during her 2nd trimester of pregnancy. She had lots of questions about what to expect and accepted a referral to our longer term Healthy Families America Program. The two services provided complementary approaches to assist Stephanie through her pregnancy and birth plan. Stephanie birthed a healthy daughter and breastfed exclusively for 6 weeks before she returned to work. She took steps for preconception health and completed her postpartum check-up in a timely fashion. Our Healthy Families America program continued to home visit and Marie has had age appropriate developmental screenings at 3 month intervals throughout. —As told by Darlene Magaw, Program Director

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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 & ENGAGEMENT

- 95 families were served during this reporting period. Total home visits numbered 1,112. 45 % were 1st time parents.
- 92 % of our CCA HFA families completed well child check-ups according to the American Pediatric Association (APA) recommendations. This underscores our partnerships with family medical homes to promote immunizations and periodic screening for lead poisoning which continues to be a concern in our local communities due to older housing. This percentage compares favorably to the statewide average of 80%.

Since our program begins prenatally or early in the first weeks of a baby’s life, post-partum care for moms are a priority.

- 83% of mothers completed their post-partum visit. Comparing favorably to the rest of the state with 73% visits. We stress the importance of these visits in order to support mother’s well-being and insure pre-conception planning (i.e., birth control), a decision made between the new mother and her medical team.
- Developmental screening is important during the early years and the CCA HFA completed these with 81 % of children and their families compared to the state average of 75%. We utilize a standard screening tool and curriculum which emphasizes the parental role as their child’s first and best teacher.

Social connectedness is a hallmark of family well-being. Our creative staffers offer periodic gatherings for parents in order to reduce isolation, promote informal family supports and help parents enjoy their children’s early years. These gatherings included:

- Spring Brunch which provided parents an opportunity to join a musical story time and make musical instrument with their children. Every parent went home with one made and to be made musical instrument using recycled materials. Our curriculum, Growing Great Kids, uses the vehicle of making toys together to support parent-child relationships and joy in the parenting journey.
- Born to Breastfeed RWP Zoo event – this is a statewide effort sponsored by the RI Breastfeeding Coalition to bring families together during Breastfeeding Week. We purchase RWP Zoo passes for our families and attend with them. For several families this was the first time they had been to this zoo, and was their first outing as a family.
- Parental Stress Focus, a group to learn from our families how best to introduce and utilize the patient health questionnaire (PHQ-9), which is a recommended screening tool for depression and anxiety. We learned much about our parents’ experiences with being asked personal questions around mental health, and provided important feedback to other home visiting programs as part of a PQI effort supported by RIDOH.
A trip to Adams Farm to enjoy the outdoors, meet a goat, complete a corn maze and view a working farm. Families picked their own pumpkin, enjoyed cider and apples, and took pictures of all the fun!

- Thankful Dinner – our annual turkey dinner, family activities and hat/mitten distribution.
- Photos with Santa, a no-cost event including photos with Santa and another chance to choose hat & mittens made by a local craft group.

**QUOTES**

During our recent HFA accreditation site visit in October, our peer reviewers interviewed families. They shared a few comments:

"My home visitor “listens and keeps me & my family in mind.”"

"I don’t think my kids would be with me right now if it wasn’t for the help of my home visitor.”

"She helps me with everything I need. Since I started, I’ve found a job, a better apartment and been encouraged along the way."

"I have a stronger relationship with my second child because of what I’ve learned.”

"HFA isn’t a program, it’s a family.”

**School Services**

**MANAGER**
Charles Stebbins, MA, LMHC—Program Director

**Behavioral Intervention**

**MANAGER**
David Lamoureux—Coordinator of School Services

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**

- 200 students served

Behavior interventionist (BI) work in schools to support students who struggle with Social Emotional Learning (SEL) by developing relationships with these students and helping them build skills in managing their behaviors. BIs also play a huge role in role modeling to the school staff on how to de-escalate students when they are dysregulated. When parents communicate to school personnel that they need mental health services, BIs help connect them to CCA services.
Data is collected by the individual schools. The data typically indicates that having BIs in the school has lowered the number of students needing out of district placement and lowered the number of out of school suspensions.

QUOTE
“I would not have passed for the year, if it wasn’t for you” —Student

**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**

- 1869 active clients served (active at any time during this period)
- 904 admissions
- 887 closures
- 600 received psychiatric assessment/medication
- 82 qualified for financial support through the Victims of Crime Act (VOCA) grant
- 556 (30%) with PTSD
- 1045 (56%) with co-occurring mental health and substance use
- 186 individuals served with Opioid Use Disorder

Serving a diverse adult population, aged 18 through the elderly, to help with a wide array of mental health and addiction challenges, clients were assisted in achieving the following outcomes:

- Reunification with children involved in child welfare
- Restoration of licenses following DUI
- Remittance of symptoms of depression, anxiety, and trauma
- Improved relationships with family and friends
- Connection to higher level of care as needed: inpatient, intensive community-based programs, BH Link
- Connection to shelter and housing
- Support in finding and maintaining employment by addressing behaviors that interfere
Promotion of recovery from substances and other addictive behaviors
Use of measurement-based care, an evidence-based practice, to evaluate progress
Connection to and/or coordination with primary care

STORY

Michael was initially referred to treatment due to a first offense DUI. Michael was suffering from depression and anxiety and used marijuana and alcohol as coping mechanisms. DCYF was also involved in his life and he was ordered to co-occurring treatment. At first Michael was completely guarded, withdrawn, and felt hopeless regarding his situation. Michael had a difficult time stopping use and did not have many positive coping skills to help with triggers, urges, and cravings. After several months of engaging in therapy he has been able to utilize skills learned in session to decrease symptoms and understands how substances effect mood, decision making, and overall health. Michael has been working hard in his recovery and has been sober for 3 months. He has followed through with all requirements given by both DCYF and the DMV and is expected to reunify with his children in the next 2 weeks. Michael has asked to stay in treatment even after his case is closed with DCYF as he finds therapy helpful. When I asked Michael what he feels he has accomplished since being in treatment he states, “I have my kids and my wife. I’m happy and clean ya know; I was in a bad place before. This place has really helped me and my family.”

GOP TEAM 5 — INTEGRATED HEALTH HOME

MANAGER
Christine Rathbun, MSW, LICSW—Team Manager

Integrated Health Home on Team 5 accepts a vast array of clients who are working to manage their mental health, substance use, and/or physical health diagnoses. Our program strives to ensure that clients are living to their full potential with the upmost dignity and respect for themselves. 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.

In order to assist clients in meeting their goals, our team routinely assists with the following: coordination with the Department of Children, Youth and Families to work towards reunification, applying for housing and coordinating with landlords to ensure safe and healthy living arrangements; providing guidance to meet basic needs such as submitting applications for the Family Support Center and other local food banks; making referrals for therapy to the CCA Adult General Outpatient Department in efforts to increase clients’ coping skills; assisting in completion of job applications; referring clients to CCA’s Employment and Training Department; coordinating with medical specialist and providers to ensure clients are current with their medical needs; and providing support to clients who are working towards recovery from substances through referrals to CCA’s Rise to Recovery Programs and the Serenity Center.
OUTCOMES & ENGAGEMENT

- Served 255 clients.
- While no official data has been collected, Team 5 has seen several families reunify with their children, has assisted in clients obtaining safe and affordable housing, has provided recovery supports and referrals, has assisted in job applications resulting in client employment and has supported clients in increasing their overall independence. While we do not have any numerical data, we also strive to keep our clients out of the hospital, both medically and psychiatrically, by providing preventative care and crisis management.
- Team 5 creates a Health and Wellness board each month on the third floor of 245 Main Street providing useful information on topics that are important to our community that are related to health. Some of the topics have included: Mental Health Awareness, PTSD, Hepatitis, Opioid Misuse Prevention, Smoking Cessation, Cervical and Ovarian Cancer, Prostate Cancer.
- A lending library is available for clients to borrow and/or donate books, as well as a clothing donation area for adults and children.

QUOTE

“I feel safe coming here. I feel supported and I don’t feel like I’m ever rushed, people care here.”

Serenity Center

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

The peer-run Serenity Center offers support services in a safe, welcoming environment 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

Members welcomed in the New Year with a substance-free celebration. Black History Month was celebrated in February with a delicious meal. Throughout the year, members enjoyed “Baking with Mom,” Karaoke, a Chili Cook Off, a Gratitude Brunch, Easter Egg Coloring, a picnic in the park, and more. Recovery is about living a purposeful life and shattering the isolation of addiction by surrounding oneself with positive people.

- 25 events were offered
- 164 individuals were active participants
  - 117 returned
  - 41 new participants
- 116 naloxone kits distributed
- 180 individuals educated in harm reduction strategies
QUOTES

"This program is a gift from God," — a member who has been participating in Serenity activities for years and appreciates the opportunity to be around others in recovery.

"When I feel lonely and gloomy. When I am cold and hungry. When I just miss someone, friends, family. When I am bored...I just come to Serenity."

"Serenity has always been with me, assigned to me for the last two years. This place has become true shelter for me. Always fills me with something to my desert-like dry mind."

"The door is open to anybody, anytime. Wonderful, lovely, friendly staff are always ready to support the people who is in need. They are really with warm and good hearts, now I feel like they are my family including other people who come in the center. We respect each other with love like brother and sisters. And it is a really fun place too. Serenity gives away not just emotional supports and mentoring, they also provide many different real activities and events throughout the year to improve people’s quality of life. My life has truly improved. I love Serenity. Thank-you Serenity." — Kwang Baek

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 personal closet where clients can “shop” for necessities. Clients have access to a variety of resources.

OUTCOMES & ENGAGEMENT

- 107 total clients: 68 basic, 39 case management clients
- 62 households visited our pantry 755 times. These households consisted of 91 family members: 84 adults and 7 children.
- Agape distributed 12,696 pounds of food. Agape also provided meals to 96 clients. Agape was visited 1,075 times by 98 clients living with HIV throughout Rhode Island.
Being able to provide people living with HIV a safe, supportive place to come socialize and learn, eat a healthy meal and obtain groceries and personal items lessens the social isolation of the disease. For example, Agape has been working with a 52-year-old woman who has been HIV+ for over 18 years. She came to the program in April of 2014 looking for assistance with housing, mental health counseling, dental care, HIV case management, social, and emotional support. She participates in case management and is now living in her own 1-bedroom apartment, which she was able to get through Community Care Alliance’s housing program. She sees a psychiatrist and works with a nurse through CCA’s Intensive Outpatient Program, she gets dental care regularly through our collaborative work with Thundermist Health Center’s Dental program. She has successfully remained in Infectious Disease Care and Women’s Health with the assistance of her case manager has not missed an appointment! Last year she was diagnosed with breast cancer. Working closely with her case manager, she went through radiation and all the necessary medical treatment and is now in remission. When her cancer provider relocated to Southern RI, her case manager continued to bring her to her monitoring appointments. Even with all her medical appointments, she has found time to volunteer in the kitchen as a cook and makes the best fried chicken wings! She is a wonderful example of continuing to live a full, healthy life with all Agape and CCA has to offer!

STORY

“Lorna Cohen, my case manager at the time, was highly instrumental in helping me “get out of my own way” so to speak. She introduced me to Agape and all it has to offer a few years ago and my life has changed for the better. I started participating as a volunteer and worked my way up to Program Assistant. I feel like Agape has helped my life become fuller and my work is so rewarding.” — Agape Client

QUOTE

“Before becoming more engaged with Agape, I was alone and scared. Now, thanks to my case manager, Nicolas, I fully enjoy participating in all that Agape has to offer!” — Agape Client

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

- 29 residents lived in Agape Transitional Housing:
- 25 clients received case management
- 36 clients received counseling
- 21 clients received basic services
- 130 days was the average length of stay
- 6 clients were discharged from housing to a higher level of care
- 10 clients were discharged from transitional housing to other stable housing
- 24 clients with an undetectable viral load:

STORY

I would like to take this moment to whole-heartedly express my sincere gratitude to the staff of Agape. Your help has made the difference in building a foundation toward my new path of recovery and sobriety. Your continued encouragement and support has led me on the path of becoming a new person. Without your help, I would not be where I am today... Thank you Agape.

Through mindfulness, spirituality, wellness and other groups, your guidance helped me to understand and take full advantage of the programs offered by promoting participation and personal feedback. They have been paramount on my journey to recovery. The staffs’ kindness blew me away. Agape is a perfect example that recovery from substance abuse and alcohol can be achieved if one puts in the work necessary.

To the staff of Agape Providence, please know that every single one of you have made a lasting impression, and I am forever grateful to have met all of you at the beginning stages of my recovery. Without you, this letter would have had no cause to be written. Sincerely—Victor Williams, Agape Client.
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.

- 48 men were served in the program.
- 76% of participants had stable housing upon discharge. This included moving into their own apartments and moving in with family or friends.
- 62% of participants were employed at the time of discharge
- 19% of participants were disabled and received SSI or SSDI benefits

QUOTE

"After many years of drinking and being homeless, living in a tent and on the streets, I had given up all hope about ever getting sober or having a safe place to live. Someone directed me to Access Hope Program. I was referred to Butler Hospital for help. Upon my release I went to Men’s Roads to Recovery until I was able to receive a grant through 942-STOP for a Sober living home. I was able to get into Community Care Alliance Men’s Recovery Home at Birch St. This has been a blessing in disguise. Having a safe place to live with a very helpful staff and resources has given me a chance to change my life. I finally have HOPE to become a productive member of society again. Thank you everyone. I have been blessed.” —Mr. John Paul N., Recovery House resident
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 support, employment and training, housing search assistance, CED 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 151 people comprised of single women and families. Over 40% were children.
- 86% of those exiting the shelter moved to permanent housing options.
- 49% of residents increased either their earned income or total income during their stay at the shelter.

### 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.

- 107 people were served through this program comprised of 42 adults and 65 children.
- 56% of participants successfully graduated the program and were able to either maintain their apartments or transfer into other subsidized housing opportunities.
- 20% of participants increased their income during their involvement in the program.

**STORY**

"On Halloween night in 2018, we came home to find our home ablaze. The fire burned through our home destroying everything in its path. With nowhere to go and only the clothes on our back we had to go to a hotel. Living this way took a huge toll on our savings. The week before Christmas, as we used the last of our savings, we got the call that CCA had gotten our family a spot at the local shelter on Sayles St. That was probably the best gift anyone could have given us. From there, CCA helped our family in more ways than we could have ever imagined. The feeling of safety and security for our family alone was monumental. We could actually take a breath. It felt like there was hope for the first time in a long time. It was arranged that our daughter could remain at her school and that was huge for her. Having a roof over our head gave us the freedom to work with the
amazing staff at the shelter and at CCA. Everyone worked together and only 8 months later we were accepted into the Rapid Rehousing program where we were able to move into our own place. This journey was stressful at times but without the help that we received from CCA, who knows where we would be. We will be forever grateful for everything that they did and continue to do for us today.”—Christopher, Crystal and daughter, Alexis previously participated in the Woonsocket Shelter and Rapid Re-Housing Programs

**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

**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 basic skills and Pre-GED classes for lower literacy students.
OUTCOMES & ENGAGEMENT

Many Project LEARN students engage with other programs offered by Community Care Alliance. Students may be enrolled in The Harbour Youth Center, RI Works Partnership, and PAID; or referred by a department other than Employment & Training. 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 and help them remove barriers to employment and become self-sufficient.

- Served 175 students
- 91 students participated in Project LEARN’s adult basic education (ABE) class
- 86 students participated in Project LEARN’s English as a Second Language (ESL) class
- 65 students were North Star Digital Literacy certified
- 30 students gained employment
- 118 students retained employment
- 5 obtained their GED
- 14 students were dually enrolled in Project LEARN and an occupational skills training program.

Students often begin with low reading and math grade levels, and lack self-esteem and confidence. When measurable skills improvements are made within the classroom, students gain self-esteem and confidence. Empowering our students through a contextualized curriculum and integrated resources helps keep students motivated.

QUOTES

“Studying in the ESL class at CCA has helped me with a lot of skills, such as conversational English, grammar, reading comprehension and writing. These skills are necessary for me to communicate with native English speakers.

Among the skills that I’m learning, I really enjoy writing because it helps me improve my critical thinking. It also shows me how to translate my ideas into an essay. I could study both reading and listening skills at home. However, I’ve found that writing skills are quite difficult to learn by myself. While studying at Project LEARN, my teacher, Lucas, has shown me how to write a paragraph and how to structure it. He has corrected my grammar and wording errors a lot. This has been very helpful.

I have taken some ESL classes before. Among all the classes, I really enjoy studying at Project LEARN. The other ESL centers have focused more on basic communication and are quite relaxing. Those teachers taught me basic conversation, which I could use daily. I am quite confident with that level of English already, so I was looking for an ESL class that could teach me more academic English.

At Project LEARN, Lucas has taught me more advanced reading and writing skills. I believe these skills will help me a lot when I study at CCRI.”
In the spring, I want to study at CCRI. Before that, I have to take the Accuplacer test including Reading, Writing and Math. At the same time, I will try to take the IELTS test in February. I have to learn English as much as I can.”—Kieu Nguyen – Project LEARN – ESL 3

Project Opportunity

Project Opportunity is funded through the Rhode Island Department of Education and is for students that receive cash assistance through the Department of Human Services RI Works program. Project Opportunity is part of Project LEARN, an adult education 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 basic skills and Pre-GED classes for lower literacy students.

Outcomes & Engagement

❖ 33 students served

As with Project LEARN, Project Opportunity students have access to the many programs offered by Community Care Alliance. For example, students may enroll at The Harbour youth center, RI Works Partnership program for those with split referrals, the PAID program, financial literacy, essential skills and job readiness workshops or other agency programs. Having so many programs available helps remove barriers to employment and improves self-sufficiency.

When measurable skill gains are made within the classroom, we see clients’ self-esteem and confidence improve so students can make the most of their educational experience. Empowering our students through a contextualized curriculum and integrating resources helps keep students motivated.

QUOTE

“I’ve been doing Lucas’s [job readiness] workshop for about 6 months now. It’s not full time, but what I have learned here has been amazing. I couldn’t even use a computer when I first walked into this room. And today I can write up business contracts. I can make projects on the computer. I didn’t know anything about it. I can actually be a secretary. At this moment, I could still do secretarial work, but I’m going for more than that. I’m still studying. I keep coming. It’s not like I’m here 40 hours a week. I’m here 2 hours a week and I’ve learned so much in that time. These classes have been awesome for me.”—Carey, Project Opportunity 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 Community Action Program agencies. The lead CAP agency is Comprehensive Community Action Program (CCAP). There are four components to this partnership that help clients become self-sufficient.

### SUPPORT SERVICES

This component 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.

### OUTCOMES & ENGAGEMENT

- 246 clients served with case management and resources to reduce barriers.

### QUOTE

"CCA has helped my obtain my GED and has helped me with my mental health issues. I have also received my digital literacy certificate from the computer class. I have come so far from where I was. A lot of it had to do with the services from CCA." —Stephanie Mello, RI Works client

### TEEN AND FAMILY DEVELOPMENT

Teen and Family Development (TFD) case managers assess and assist pregnant and parenting teens under the age of 20 who receive state benefits (cash and medical), and have barriers to education and employment such as transportation, childcare, housing, basic needs, physical health, mental health, financial literacy, and coordination of referrals. Case managers also track attendance in high school and GED programs and educate teens about sexual health and pregnancy prevention through one-on-one conversation and/or workshops. Clients are encouraged to participate in other CCA programs like Pathways to Adulting, Independence and Dignity (PAID) program, adult basic education programs, financial literacy, and summer employment through our Youth Center.

### OUTCOMES & ENGAGEMENT

- Served 33 clients, 13 on cash assistance and 20 receiving medical benefits only
- Case managers in the TFD program continuously promote sexual health education and pregnancy prevention. During that time there were no repeat pregnancies.
- Two TFD clients obtained their High School Diploma, one of whom enrolled in a post-secondary educational summer program.
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

- 77 Clients were served with referrals to vocational training and job readiness activities.

Money Sense

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

Funded by United Way, The Money Sense Program serves a wide array of low income, unemployed and underemployed individuals that include disconnected youth over age 16 engaged in our Project Learn classes and The Harbour Youth Center; homeless households living temporarily in CCA’s shelter or supportive housing and recovery housing; persons with persistent mental illness serviced by our Health Home Teams; families in crisis; and participants in CCA’s workforce development and adult education programs.

Additionally, Money Sense empowers agency case managers with financial tools to educate and guide their clients toward paying off lenders, improving credit scores, increasing net worth, opening and maintaining a bank account, and establish financial goals and budgets. Workshops are also offered to the general public at local libraries, schools and businesses.

OUTCOMES AND ENGAGEMENT

- Served 617 individuals and 25 Case Managers.
- 26 received intensive financial coaching.
- 73 increased their net worth.
- 55 increased their credit score, 7 paid off lenders, 5 opened and maintained a checking account.
- 87 clients created a budget and followed it for 6 months, and 13 clients decreased their debt.
- The program coordinator scheduled financial literacy training during various agency team meetings and as independent training workshops available to all case managers.
- We increased our outreach to VITA program participants, offering an array of tools and workshops, as well as individual counseling to all participants; and Money Sense Workshops and intensive individual counseling are provided to CCA’s Shelter residents to support their transition toward permanent housing solutions.
During the year, three varying Teen Money Sense Programs are presented to area youth. The first is offered to seniors at Woonsocket High School who take the class for full math credit as part of a credit recovery program. With this group, students are required to prove their ability to perform math-specific functions such as calculating compound interest on loans and savings, determining debt-to-credit ratios, understanding the true cost of buying a car and recognizing the pros and cons of using credit cards. A second group, known as the PM School, receive elective credit. While the intent of the class is less math-intensive, it too focuses on the importance of weighing alternatives when making financial decisions. A third group of high school students at an area after-school program, Riverzedge Arts Project, focuses on financial goal-setting, understanding net pay calculations and paying for higher education.

Through workshops and individualized financial coaching sessions, clients are more aware of their daily decisions and habits that have put them in their current situation. Clients look to change old ways and habits to be able to provide for a more financially secure life. Our clients maintain budgets, review their credit and remove themselves from predatory lending practices, as well as how to maintain a healthy banking relationship and how access online and mobile banking.

Ongoing financial coaching appears to be a must for this population as financial habits take time to change even when individuals are willing and their efforts are supported via education and coaching. Lasting change of long-held financial beliefs and habits often requires having considerable income to help make those changes (i.e., paying down/paying off debt and creating an emergency fund) which is often lacking in the population we serve. We continue to strive to provide a safety net of services within the agency so that times of trouble don’t result in financial devastation. Financial literacy and coaching are considered part of our safety net.

STORY

One Money Sense client who had reached a savings goal, continued budgeting and was able to save $800 to buy a good, used car at a resource she learned about at a one of our workshops. As part of her plan she saved enough money to register and insure the car. Now she is saving to get her new car inspected.

Another client, who was residing at our Shelter with her family, attended several workshop series and completed course requirements —expense tracking and creating a spending plan. At the end of her final round of workshops when she earned her certificate, she recalled a phrase we coined in the first workshop. That is, when it comes to money and budgeting, ‘there is no extra’.

The class observed that for many people gathered at that table ‘on paper’ they had a surplus or at the end of a week had ‘extra’ money in their pocket. By tracking expenses and realistic budgeting this client came to see ‘extra’ money as an opportunity to save. She said that ‘extra’ money was no longer for eating out, but would go to cover end-of-month shortfalls in her food budget, next week’s emergency, a future security deposit, or furnishings for their eventual, new apartment.
One high school senior who participated in the for-credit course at the high school, reported having been spared a bad car-buying decision. Someone was advising him to finance a new car, which was possible with his 30-hour per week job. After introducing him to online calculator tools and exploring financing rates, he realized how much he would have paid in interest. He realized that as an 18-year old with no established credit history he would have to pay a higher interest rate than a person with established, excellent credit scores. He decided that he would continue to save his money and eventually buy a used vehicle. He was thrilled that he avoided a potentially costly mistake.

After tracking expenses, other high school learners realized how much they spent on eating out, realizing that even small, fast food purchases add up. Others were amazed at the accumulated costs of buying clothes, music, phones, electronics and entertainment in general. Two learners understood that the cost of these wants were equal to that of a monthly car payment. —As told by Donna Andreozzi, Money Sense Coordinator.

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.

- Over 520 youth walked through our doors at some point in the year to utilize youth center services.
- We have assisted in the employment or internship opportunities for at least 170 young people this year, and provided career engagement opportunities for 900 high school students.
- 24 young adults successfully completed the PAID program with 80% finding employment in the past year and 11% pursuing post-secondary or industry training.
- 120 high school aged youth participated in the summer jobs program and worked in industries such as education, computer coding, maintenance, graphic design, and web design.
- 7 youth participated in our boat building class in conjunction with the Hereshoff Museum and The RI Marine Trades Association.
- 6 youth participated in the Entrepreneurial Mentoring Program with CVS employees
45 youth participated in our Wednesday night work readiness trainings.

Services range from a safe space for high school aged youth to comprehensive work-based learning and workforce development training for individuals—up to the age of 29. When asked what we do, we usually say we are a crisis center for youth, ages 14-24, that also offers trainings, supports and internships that assist individuals in finding employment and self-sufficiency.

Client engagement programs include outreach in the local schools, community partners, social media, etc. We also held the first US Census employment event to help clients and their families apply to be 2020 Census takers for the community.

QUOTES

"When I walk into the space, I am always greeted with kindness. No matter what is going on, the staff always have time to listen to me or help me with something. It’s like a second home!" —Juan, age 19

"Our young folks walk into the center with a myriad of issues and needs, so the staff is adept at knowing the multitude of resources at CCA and in the community to best serve our clients’ needs. We strive to be the place that youth and young adults can go if they need support or guidance. We may not have the answers but we will work to find them! More than anything, we want to make our space a safe, nurturing environment for anyone that walks through our doors.” —Stump Evans, Program Manager

Basic Needs

The Family Support Center

MANAGER
Darlene Magaw, MS—Family Support Director
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.

When a customer visits with a Family Advocate in FSC, the unique needs and priorities of each household are heard and assessed. We can’t solve all concerns although we can listen and guide a person to needed services that are related to their well-being such as behavioral health, employment assistance, job coaching, and specialty services like applying for health insurance, and developmental screening for infants and toddlers. Our Family Advocates regularly provide guided referrals to other services within our agency array of supports as well as other community resources as identified and agreed to by our customers. 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

- Due to the addition of LIHEAP, our Family Support Center provided services to 5,256 households which represents 11,552 persons.
- FSC expanded during this reporting period to include Low-Income Home Energy Assistance Program (LIHEAP) to offer Woonsocket & North Smithfield residents the opportunity to receive crisis and non-crisis grants to pay for heating bills, including oil, gas and electric. This grant is applied directly to the heating bill or, in the case for oil, authorizes a delivery to ease the utility burden for low-income households.
- A RI Foundation/RICAA grant provided rental assistance to 19 families and partnerships with United Way Good Neighbor Energy Fund served 34 households with utility assistance for those families who are just above the income limits for LIHEAP.
- FSC distributed 3369 food vouchers to local food pantries and 970 clothing vouchers to a local clothing ministry, Coat of Many Colors, operated by St. James Episcopal Church.
- The FSC continues its partnership with SNAP Outreach and National Grid Low-Income Assistance Representatives to offer monthly clinics for additional help with applying for SNAP benefits, utility arrearage payment plans and other related guidance.

QUOTE

“It’s great when families can have hope for the future and taking time to sort out all their concerns during a crisis. It says 'we care about you.'” —FSC Family Advocate

STORY

Jeziah is a mom of two children, ages 4 and 8, who came to our Family Support Center for help with her heating bill and food. Her children’s father had recently joined the military and finances were tight. We learned that she has strong natural supports in the community although they were unable to help with this utility concern. Our Family Advocate determined that the family was pending shutoff so was able to negotiate an affordable repayment plan with help from a local church utility fund. She also helped Jeziah enroll her 4-year-old in a local Head Start Program which allowed mom the opportunity to begin her job search with our EMTR Job Coach. This family’s income has increased due to mom’s working part-time while her children are in school and they have been able to keep current with their utility bills.