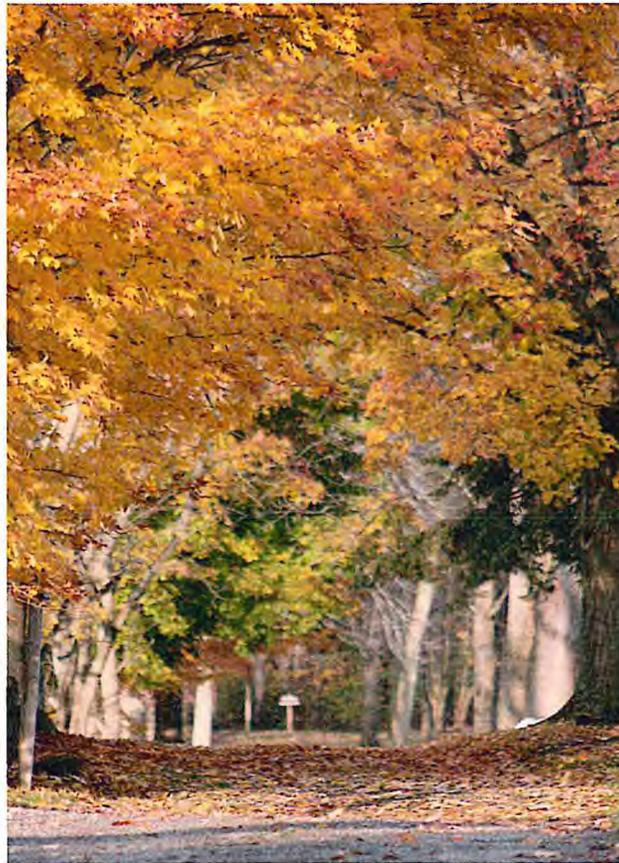


HOPEWELL

a therapeutic farm community

HOPEWELL 2015 OUTCOMES REPORT



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HOPEWELL 2015 OUTCOMES REPORT

Outcomes Research Program

In 2006, with support from The Margaret Clark Morgan Foundation and in consultation with Hiram College faculty, Hopewell began a systematic data collection program of outcomes research to guide its efforts to help the seriously mentally ill. As part of this program, Hopewell tracks attendance and participation of each Resident on a daily basis and collects periodic systematic measurements of each Resident's progress. The data recorded include participation in work crews, therapeutic clinical groups, social activities, and exercise and community meetings.

When Residents are admitted to Hopewell, a baseline of information is collected for assessing outcomes, including Global Assessment of Functioning (GAF)* scores, Individual Service Plan goals, Diagnostic Assessment information, medications, living situation, gender and diagnosis. Every three months, Residents are administered Hopewell Satisfaction Surveys, Brief Psychiatric Rating Scales (BPRS), Camberwell Assessment of Needs (CAN), Quality of Life Assessment and Hopewell Outcomes Worksheets (HOW). The GAF is completed at admission, periodically throughout the resident's stay, and at discharge.

GAF is a measure of the individual's overall level of functioning. Ranging from 1 (lowest level of functioning) to 100 (highest level), it measures psychological, social and occupational functioning. It is widely used in studies of treatment effectiveness. The Brief Psychiatric Rating Scale (BPRS) assesses psychopathology on the basis of a small number of items, usually 16 to 24, encompassing psychosis, depression and anxiety symptoms. Camberwell Assessment of Needs (CAN) measures the needs of individuals with severe mental illness. It covers domains including self-care, daytime activities, physical health, psychotic symptoms, information about condition and treatment, psychological distress, safety to self and others, intimate relationships, money, sexual expression, socialization and basic education. The CAN has two versions, one for the Resident's self report and the other for staff observations. The Hopewell Outcome Worksheet (HOW) is an instrument to evaluate how Residents are coping with their mental illness and how helpful the Hopewell program is for those Residents. The instrument is divided into sections and includes the conditions that brought the Residents to Hopewell, what they think of themselves, and their concerns about how they influence others, future situations and goals and what they thought about the experiences they have had while at Hopewell.



*Although GAF is no longer recognized in the most recent Diagnostic and Statistical Manual of Mental Disorders (DSM-V) published on May 18, 2013, Hopewell has found and continues to find it to be invaluable in tracking Residents' progress over time.

Although each Resident's situation differs, common areas of need upon admission to Hopewell include: understanding and acceptance of their own mental illness; help in developing socially acceptable behavior; support in attending to activities of daily living, including hygiene, interpersonal skills, improving family relationships, emotional regulation, education and vocational goals/needs; experience in participation in the community, peer interactions, creative expression and self-care; and management of psychiatric symptoms and impairment .

Length of Stay and Phase System

Evaluating the appropriate length of stay, in close consultation with the Resident and his/her family, is one of the primary ongoing tasks of the Hopewell staff. Length of stay averages: Asperger's, 18 months; Mood disorders, 6-9 months; Schizophrenia/schizoaffective disorders, 20 months. Length of stay is sometimes short of optimal because of individual circumstances. Our overall average length of stay is 6-9 months.

Hopewell's system for encouraging and rewarding socially positive behaviors is a 4-phase system where new admits start at the Entry Phase, the most restricted in terms of privileges. Starting at the Entry Phase allows the newly admitted to be safe in the community while the staff and other Residents get to know them. Residents earn the right to move into other phases by higher levels of attendance and participation in community activities, and attention to activities of daily living, such as eating, bathing, dressing, toileting, transferring (walking) and continence. Utilization of basic social values and modeling of behaviors for other Residents are needed to move from Entry Phase to Phase 1, 2, 3 and eventually Transitional Phase.

Motivating Aspects of Hopewell's Program

The primary motivating factors for Residents at Hopewell are the experience of success, self-worth and self-control in a social environment where all these factors are socially respected and publicly recognized. The phase system and programming at Hopewell provide Residents with regular opportunities to engage in these experiences.



Mental Health Outcomes Management/Data

As previously noted, outcomes data are routinely reviewed with the Residents, and their feedback is encouraged concerning improvements in programming. As a result of such feedback, we have implemented a number of suggested changes including the addition of therapeutic groups, changes to the program schedule, posting of menus in the cottages and meal and snack choices.

Outcomes data are shared with Clinical Staff to apprise them of progress that Residents are making and where additional assistance is needed. As noted, outcomes information is regularly shared with individual Residents to assist them in tracking their own progress and goal achievements.

Preliminary Study Implications

The preliminary results indicate that measureable improvements are being experienced by most of the Residents at Hopewell. The observed improvements include a general reduction in negative psychiatric symptoms, an improvement in overall social functioning and a greater readiness for community reintegration. Specific examples of these improvements include successful integration of Residents into their homes and families while securing employment, advancing their education and building new social relationships.

With a foundation in nature, the therapeutic farm setting offers a safe, tranquil and work-based environment. Hopewell is able to successfully incorporate concepts of the *mind-body-spirit* philosophy found in early “moral-based treatment” to provide a modern recovery-based healing model. In conjunction with effective medication, this research supports the conviction that Hopewell and similar therapeutic communities can, in fact, effectively generate measureable and positive recovery results for individuals experiencing serious mental illnesses.

Hopewell Therapeutic Community -Goals for 2016 – new instruments and focus

In the new year of 2016 Hopewell has added instruments and scales to focus on different diagnoses in order to assist clinicians in their therapeutic role and to better evaluate programming needs. Clinicians have started to administer specific instruments for specific diagnoses including: Young Mania Rating Scale, Hamilton Anxiety Rating Scale, Montgomery and Asberg Depression Rating Scale, Trauma Symptom Checklist – 40, and Life Stressor Checklist revised. Other instruments will be explored and implemented as needed.

Lyman House – Hopewell’s Adult Family Home

Lyman House, located approximately two miles from the farm, is licensed by the Ohio Department of Mental Health and Addiction Services (ODMHAS) as an Adult Family Home. As such, Hopewell may provide accommodations, supervision and personal care for residents at Lyman House. When residents transition from the farm to Lyman House, their clinicians continue to see them through their participation in Club Hope, Hopewell’s daily activities program. While Club Hope is voluntary, all residents who have entered Lyman House have chosen to participate in Club Hope. Outcome measures are collected from the residents at Lyman House and include the Lyman House Outcomes Survey, Hopewell Life Balance Wheel, Katz Index of Independence in Activities of Daily Living (ADL) and The Lawton Instrumental Activities of Daily Living Scale (IADL).

Summary/Findings

The data collected to date document the treatment benefits of Hopewell. Ongoing studies and data collection will continue to explore and refine these impressions, which in turn will drive future modifications to our treatment model. Our conclusion at this point is that, factoring in costs and other issues, Hopewell offers a financially advantageous and powerful alternative for delivering highly effective treatment to those with serious mental illness, and that persons with serious mental illness can optimistically and realistically, with help, look forward to self-satisfying and socially effective lives.

Research Projects – Case Western – Dr. Sana Loue – Summary and Updates

Hopewell is moving forward with an ambitious research agenda. Three research projects that focus on program evaluation, sandplay therapy, and longer-term outcomes are currently underway and a fourth one involving collaboration with CooperRuis and Rose Hill is in development and on schedule to begin in Summer 2016.

Program Evaluation to Enhance Coping and Managing Symptoms of Mental Illness

This research involves the conduct of face-to-face or phone interviews with Hopewell's past and long-term residents to identify the strategies that they are using to cope with and manage their illness symptoms and the strategies that they are utilizing to further their recovery and to learn from them what worked and didn't work for them at Hopewell. Originally designed as a 2-year study, the study has been extended due to difficulties associated with locating past Hopewell residents.

The research will (1) identify past and current strategies used by past and current Hopewell residents to cope with the symptoms of their mental illness; (2) identify and assess the extent to which religious/spiritual beliefs or practices may promote or impede the adoption of healthy behaviors and/or adherence to prescribed regimens; (3) ascertain residents' definition of successful recovery and the relationship between their coping strategies and self-reported achievement of recovery; and (4) identify domains for which the addition of new or augmentation of existing programs at Hopewell that may be helpful to residents in their efforts to cope with and recover from their mental illness. To date, a total of 19 interviews, each approximately 60-90 minutes in length, have been completed.

Many of the interviews suggest that individuals found their experience at Hopewell critical to their ability to move forward. One past resident said, *"I am glad that I went there. I was detoxing there, I was not alright in my head, I was foggy. I needed to be around people."* Another person said, *"It [Hopewell] helped me find different coping skills like positive self-talk, and distractions to get through."* A third person said, *"It [Hopewell] gave me a sense of community."*

Assessment of Acceptability, Feasibility, and Clinical Benefit of Sandplay Therapy

This project (1) assesses the acceptability and likely extent of utilization by Hopewell residents of sandplay therapy as an adjunctive therapy and (2) assesses on a preliminary basis the clinical benefit to Hopewell residents of sandplay therapy. A secondary aim is the evaluation of participant progress during the course of the sandplay. The research involves the following components: (1) a short meeting with Hopewell residents to explain what sandplay therapy is, to answer any questions, and to ascertain initial interest in participation/utilization; (2) the provision of a basic training session in sandplay therapy to interested staff; and (3) the provision of sandplay therapy to interested clients over the course of a 9-month period. Sandplay sessions will be offered to clients for a maximum of 18 sessions; each session is 45-60 minutes in length.

To date, a total of 10 Hopewell residents have participated. Four individuals have been participating in sandplay consistently, one discontinued sandplay, and 5 participated consistently until their departure from Hopewell. All of the residents who have participated have said that they have found it helpful. Some of the individuals participating in sandplay have said that it helps them to feel calmer, that it helps to quiet the voices in their head, and that it helps them understand better what they are feeling and to see the bigger picture.

FUTURES: Follow Up To Understand Resident EvaluationS

This project will

1. determine the extent to which clients' mental health functioning changes from the time of their admission to Hopewell through discharge and one-year post-discharge;
2. identify factors that promote or impede clients' recovery from mental illness following their discharge from Hopewell;
3. identify Hopewell programs and program components that, based on client self-report, were most critical to the improvement of their mental health functioning

The study will gather data from discharged Hopewell residents through interviews conducted from the time of their admission in 2015 through a one-year period following their discharge from Hopewell in a series of four interviews. We have begun conducting interviews with residents newly admitted to Hopewell in 2016 and, to date, have conducted interviews with four new residents.

ARCH: Assessing Recovery through Community Healing

This research study is a collaborative undertaking between Hopewell, CooperRiis, and Rose Hill. We are very excited about this study because the combined database from the three communities will be, to the best of our knowledge, the largest database in the United States to assess outcomes of care at healing communities for mental illness. We anticipate that our analyses will provide answers to important research questions, such as the following:

- What percentage of residents/clients demonstrates improvement in functioning after y months (as measured by ...)?
- What percentage of residents/clients have improved physical health after y months/on discharge (as measured by ...)?
- What percentage of residents/clients have achieved $y\%$ of their goals at discharge?
- What percentage of residents/clients goes to more independent living at discharge?
- What percentage of residents/clients indicates that they will continue with their medications?

Assuming that the analyses show positive results, we would be able to conclude and state that these data indicate that integrated residential communities are effective in helping $x\%$ of clients achieve recovery from admission to discharge. The factors x , y , and z are predictive of recovery.

Additionally, the results of this study may support member organizations' efforts to develop the resources that are necessary to support future research studies, grant proposals, and publications.

We are currently in the process of setting the foundation for this study. All data analysis will be overseen by a Data Steering Committee, comprised of two representatives from each of the three participating healing communities. Hopewell has appointed Mark Teague and Candace Carlton to serve in this capacity. Their participation will provide the project with guidance from both clinical and board perspectives. It is anticipated that we will actually begin receiving the data to establish the database sometime during summer 2016 and anticipate that the study will require two years to complete.



Data Summaries

The study data has been collected across June 2006 to December 2015 and is ongoing.

Graph I. The graph shows the frequency of primary diagnoses for the Residents in the study and shows that Bipolar Disorder and Schizophrenia have the majority percentages of primary diagnoses for Residents. These results are compiled by information from Resident's diagnostic assessments.

Graph II. The graph examines the length of stay at Hopewell for Residents in our study.

Graph III. Age spread was done in groupings with 21-30 year grouping having the most Residents. The grouping of 61-70 and 70+ had the least amount of Residents in them. These results were obtained from information collected from Residents on Diagnostic Assessments.

Graph IV. The study data has been collected across June 2006 to December 2015. These results were obtained from information collected from Residents on Diagnostic Assessments.

Graph V. This graph shows GAF averages at admission and at discharge per diagnosis.

Graph VI. The graph shows admission and discharge GAF averages for females at Hopewell from June 2006 to December 2015.

Graph VII. The graph shows admission and discharge GAF averages for males at Hopewell from June 2006 to December 2015.

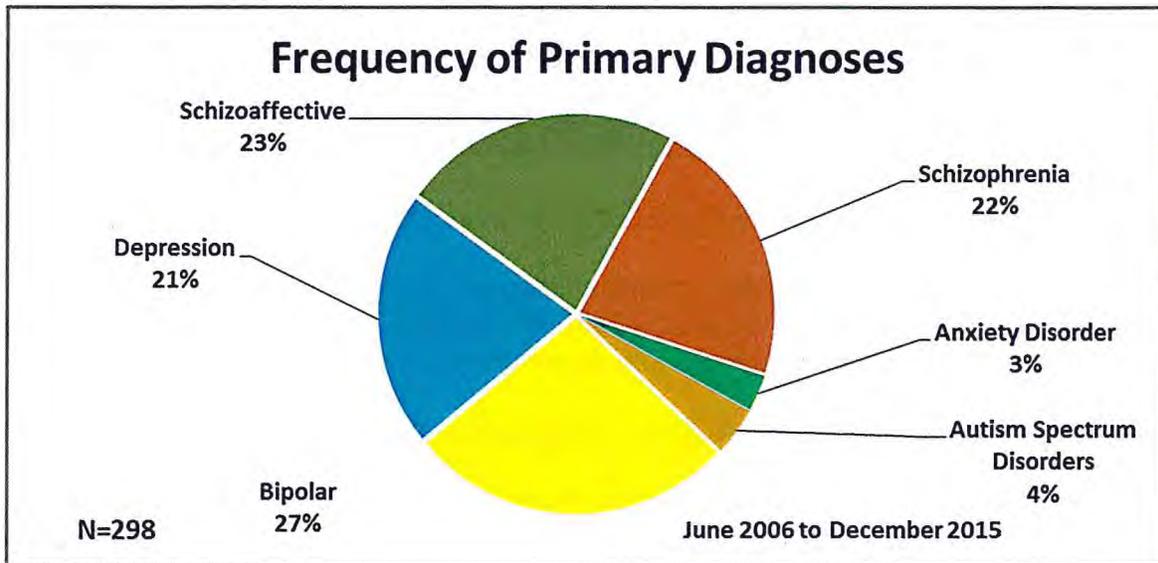
Graph VIII. BPRS (Brief Psychiatric Rating Scale) is a standardized test that measures 24 different areas of concern. This instrument is administered at admission, every three months during the stay at Hopewell and upon discharge. The average difference in BPRS Scores is computed by taking the Discharge BPRS Total Score or current BPRS Total Score and subtracting by the Admissions BPRS Total Score and then averaging them by diagnosis. The measured differences for each diagnosis collectively are all in positive ranges.

Graph IX. This graph represents the Residents who were discharged from June 2006 through December 2015. The graph examines where Residents live after they have left Hopewell. There are six categories that describe the living situations for post-discharges.

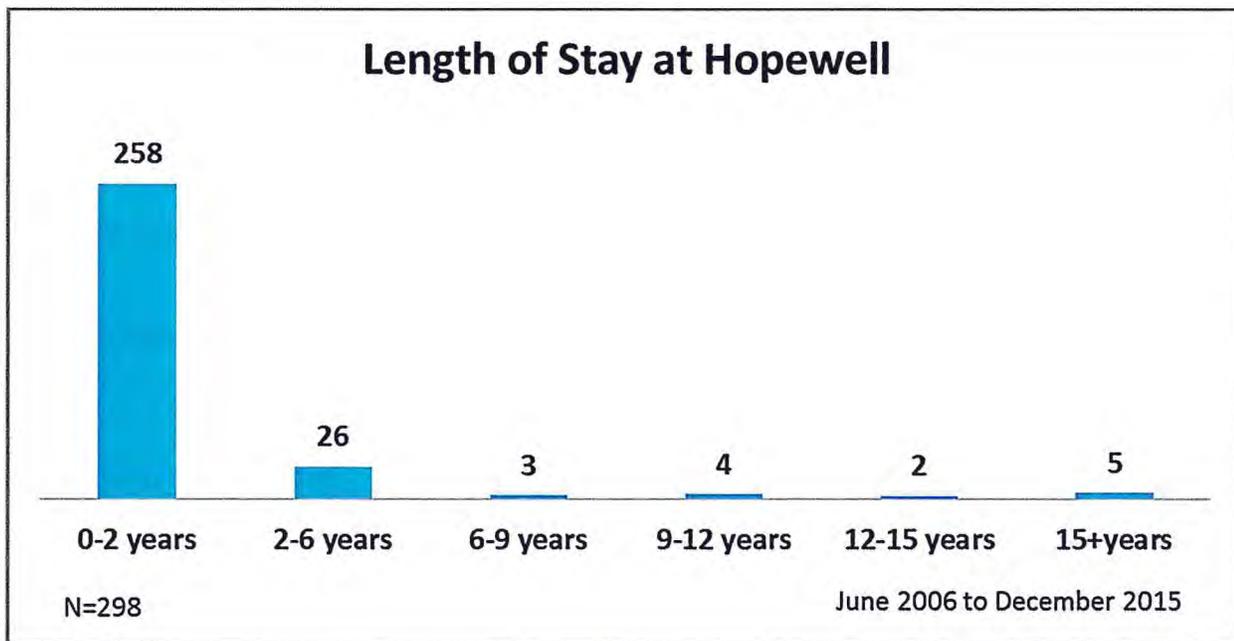
Graph X. Hopewell offers assistance to residents who are interested in furthering their education by giving them opportunities to receive their high school diploma through our education program.

Graph XI. Hopewell administers the Hopewell Satisfaction Survey every 3 months. This graph shows the overall rates of Satisfaction with Hopewell programming and services for 2015.

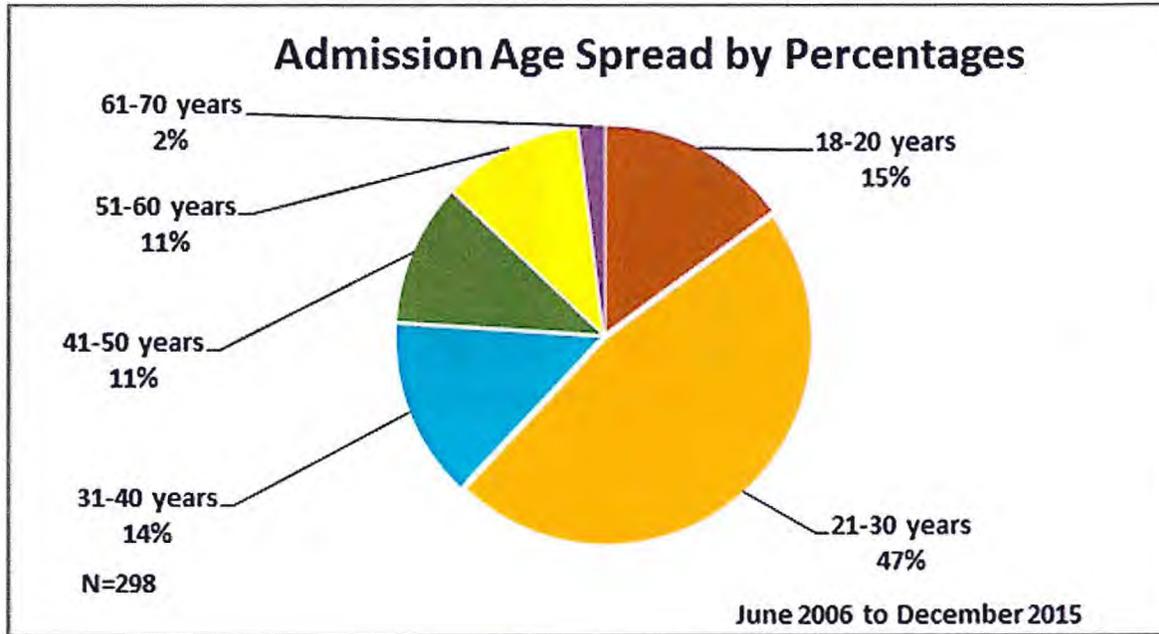
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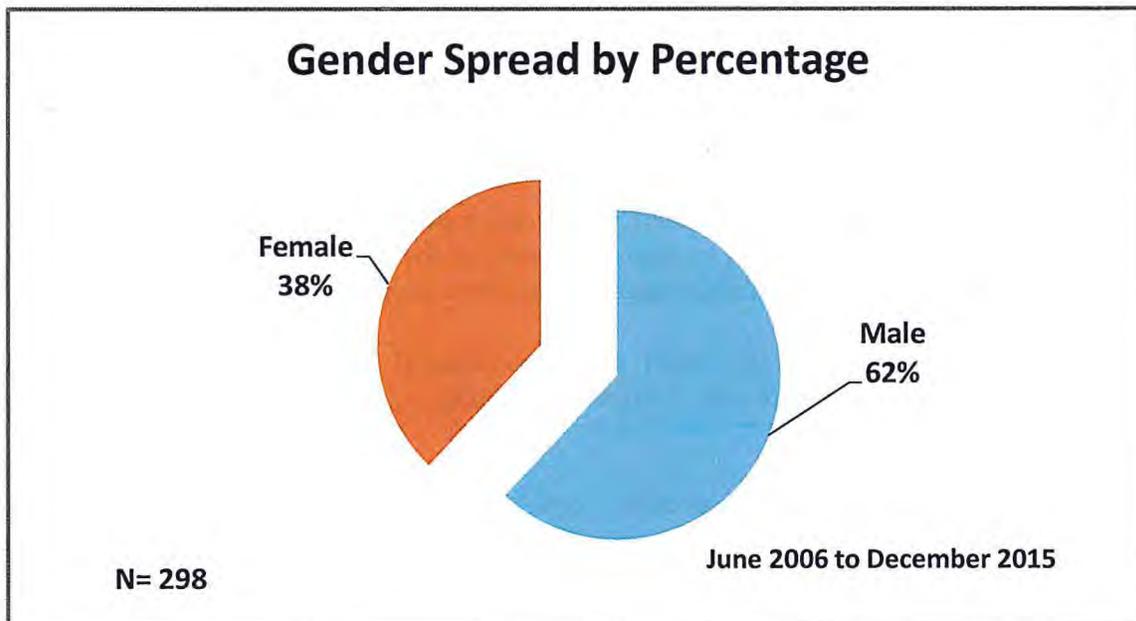
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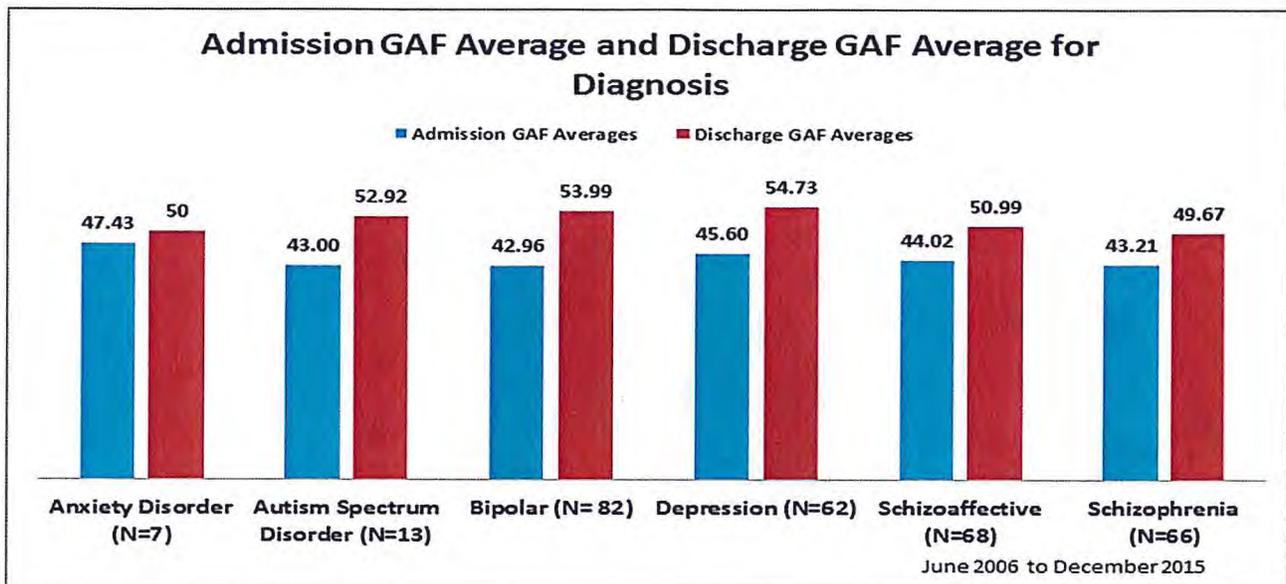
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Graph IV. Gender Spread by percentages. These results were obtained from information collected from Residents on their diagnostic assessments.



Graph V. This graph shows GAF averages at admission and at discharge per diagnosis.



Key: Global Assessment of Functioning Scale

91 - 100 No symptoms. Superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his or her many positive qualities.

81 - 90 Absent or minimal symptoms (e.g., mild anxiety before an exam), good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns (e.g., an occasional argument with family members).

71 - 80 If symptoms are present, they are transient and expectable reactions to psychosocial stressors (e.g., difficulty concentrating after family argument); no more than slight impairment in social, occupational or school functioning (e.g., temporarily falling behind in schoolwork).

61 - 70 Some mild symptoms (e.g., depressed mood and mild insomnia) *or* some difficulty in social, occupational or school functioning (e.g., occasional truancy or theft within the household), but generally functioning pretty well, has some meaningful interpersonal relationships.

51 - 60 Moderate symptoms (e.g., flat affect and circumstantial speech, occasional panic attacks) *or* moderate difficulty in social, occupational or school functioning (e.g., few friends, conflicts with peers or co-workers).

41 - 50 Serious symptoms (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting) *or* any serious impairment in social, occupational or school functioning (e.g., no friends, unable to keep a job, cannot work).

31 - 40 Some impairment in reality testing or communication (e.g., speech is at times illogical, obscure or irrelevant) *or* major impairment in several areas, such as work or school, family relations, judgment, thinking or mood (e.g., depressed adult avoids friends, neglects family and is unable to work; child frequently beats up younger children, is defiant at home and is failing at school).

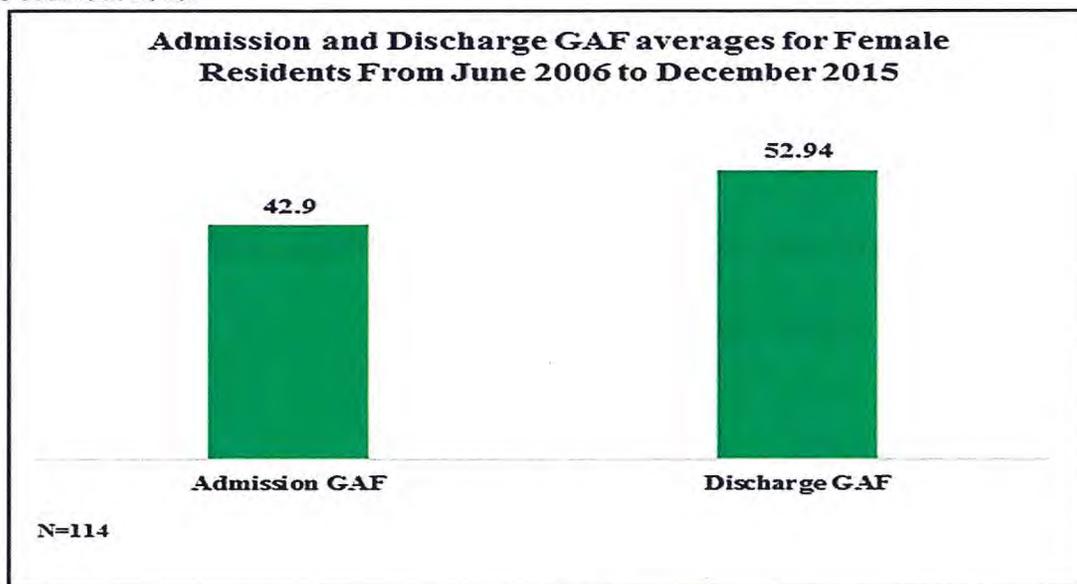
21 - 30 Behavior is considerably influenced by delusions or hallucinations *or* serious impairment in communication or judgment (e.g., sometimes incoherent, acts grossly inappropriately, suicidal preoccupation) *or* inability to function in almost all areas (e.g., stays in bed all day, no job, home or friends)

11 - 20 Some danger of hurting self or others (e.g., suicide attempts without clear expectation of death; frequently violent; manic excitement) *or* occasionally fails to maintain minimal personal hygiene (e.g., smears feces) *or* gross impairment in communication (e.g., largely incoherent or mute).

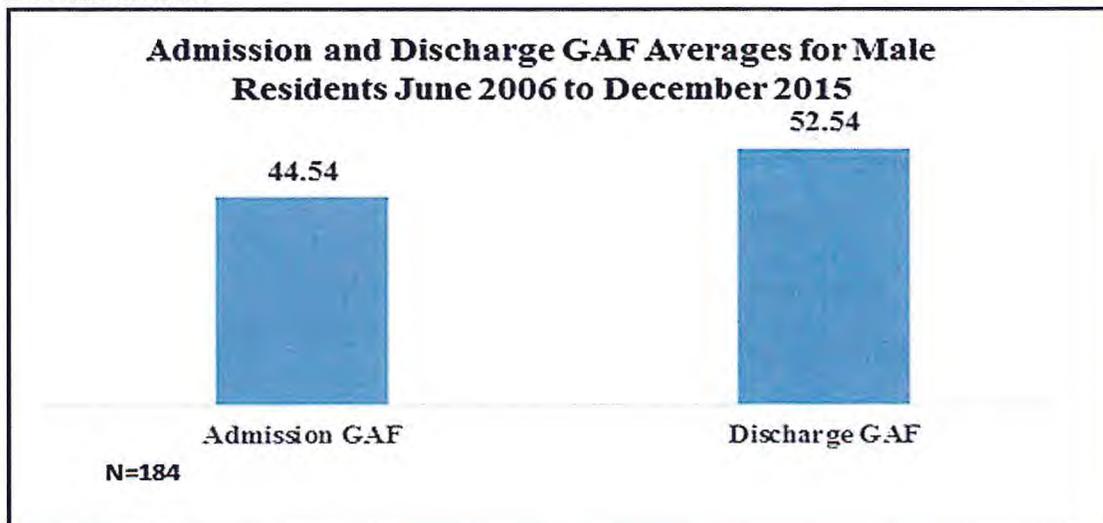
1 - 10 Persistent danger of severely hurting self or others (e.g., recurrent violence) *or* persistent inability to maintain minimal personal hygiene *or* serious suicidal act with clear expectation of death.

0 Inadequate information

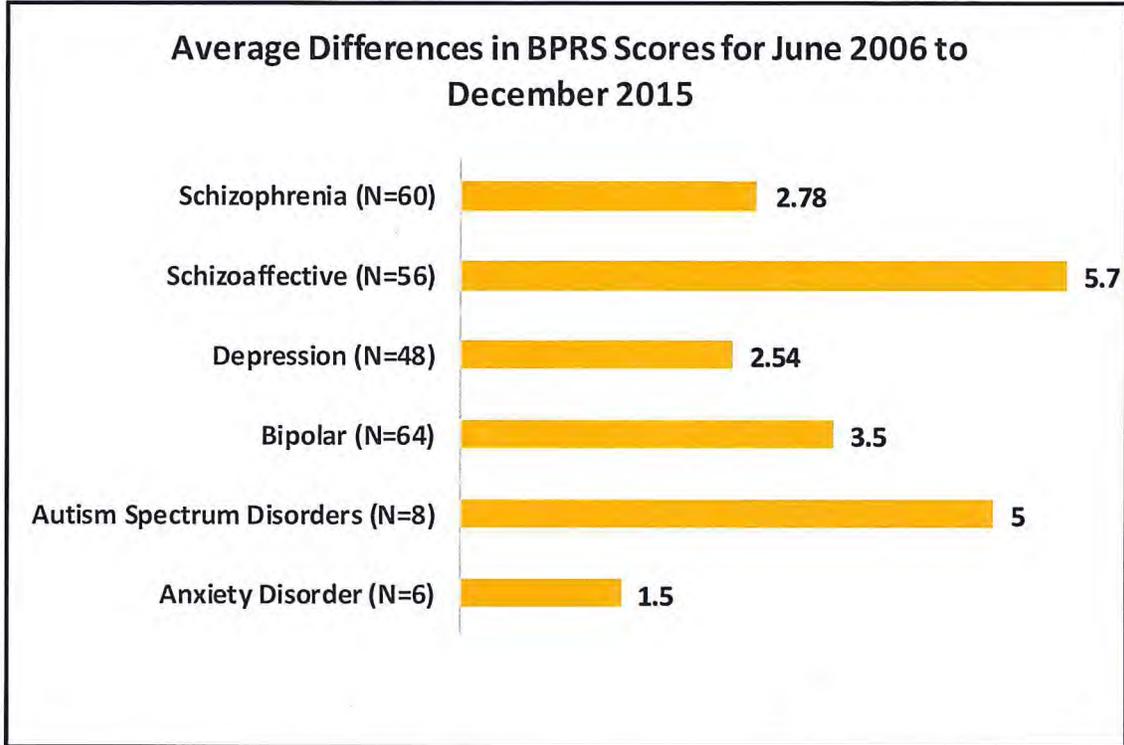
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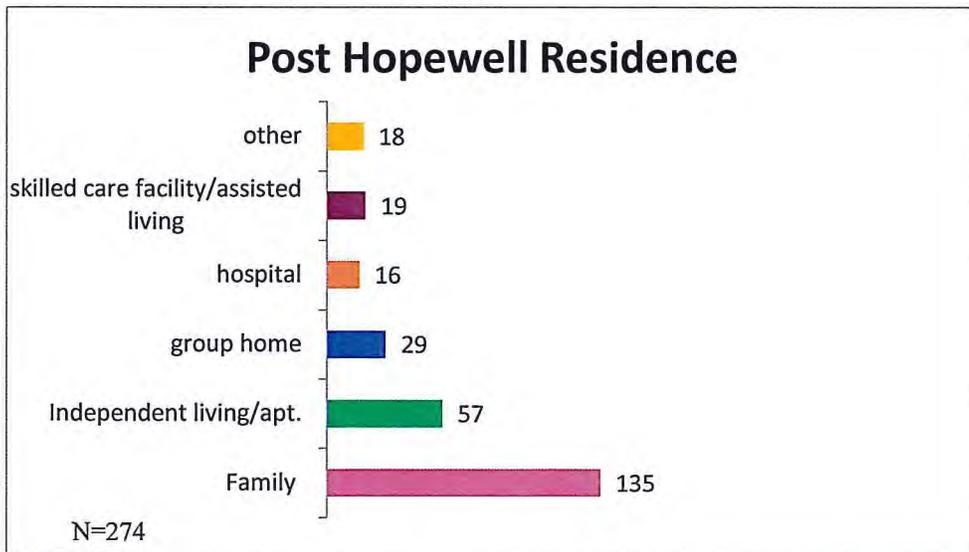
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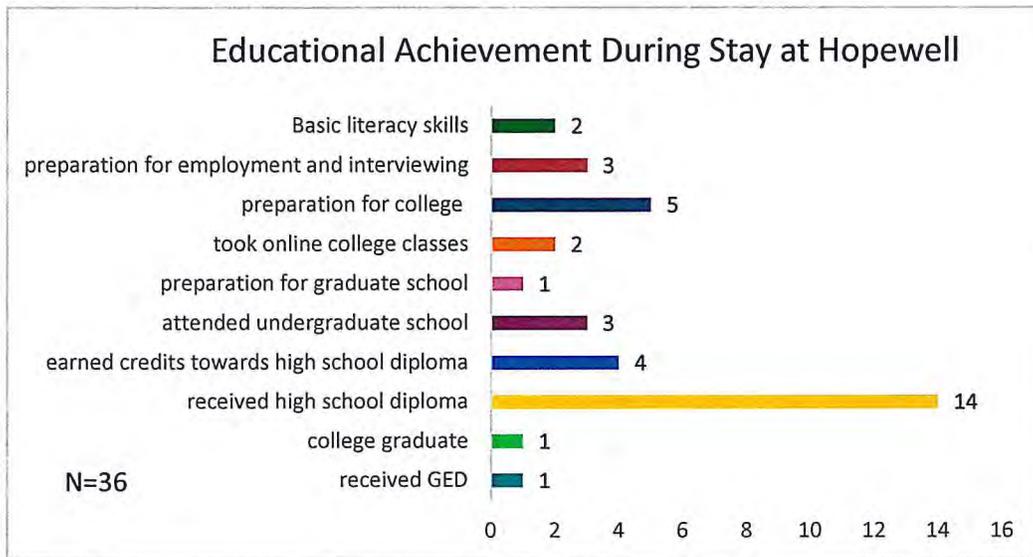
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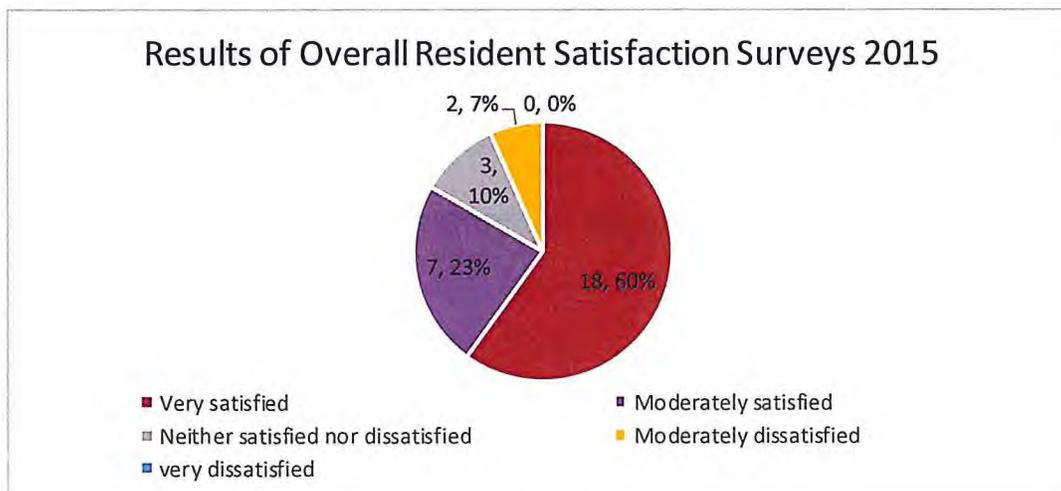
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Graph X. Hopewell offers assistance to residents who are interested in furthering their education by giving them opportunities to receive their high school diploma through our education program. The graph below shows that 14 Residents have received their high school diploma through Hopewell’s education program. One person received his GED with preparation assistance through the program. Four Residents who did not receive their high school diplomas did receive credits toward their diploma. Two Residents attended a local college in an undergraduate program and received assistance from staff. One resident graduated with an associate’s degree and is working toward a bachelor’s degree. One former Resident who went to graduate school began the preparation process with the assistance from staff at Hopewell.



Graph XI: The graph below represents the reported overall satisfaction from residents about their experiences at Hopewell in 2015. These results come from the Hopewell Resident Satisfaction Surveys that are administered every 3 months.





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