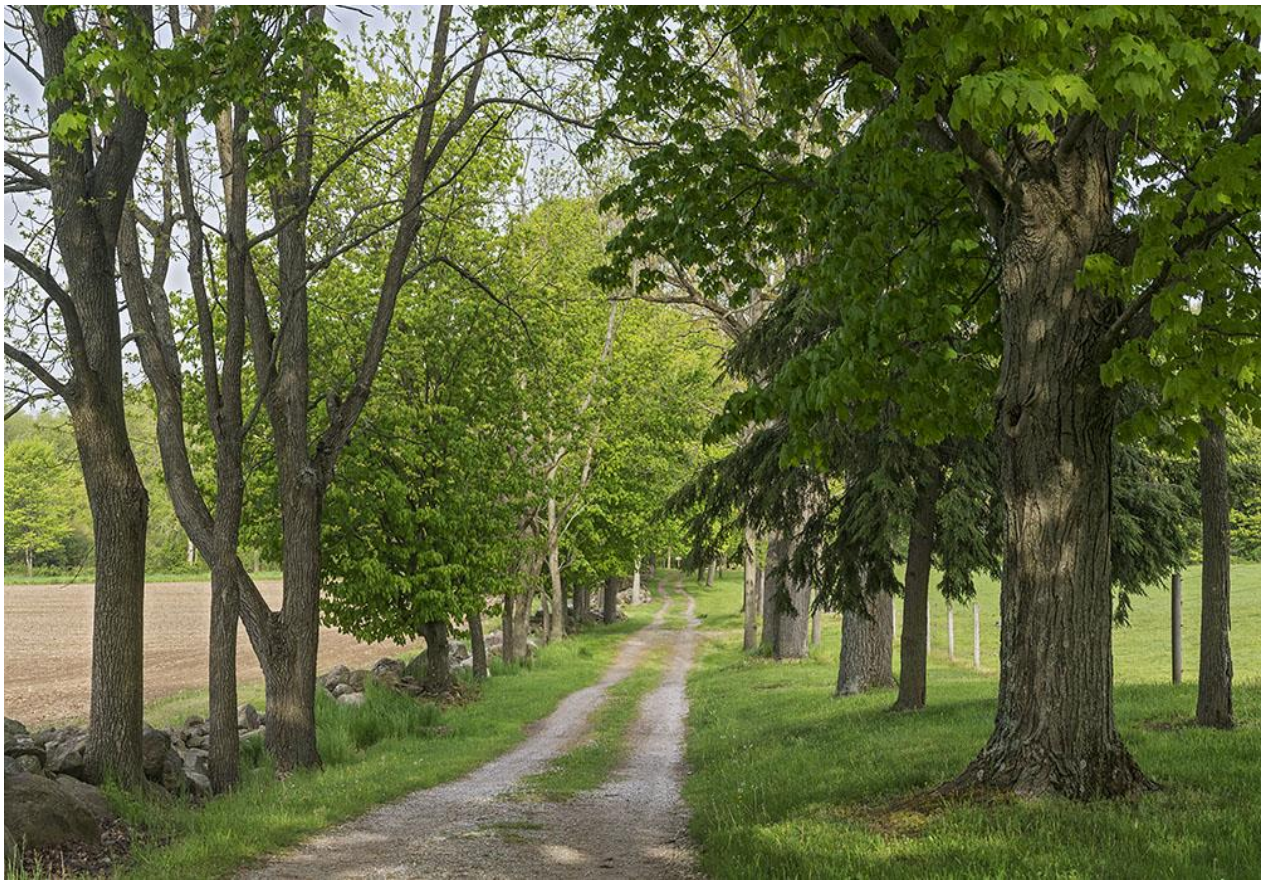
HOPEWELL

a therapeutic farm community

HOPEWELL 2014 OUTCOMES REPORT



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HOPEWELL 2014 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, 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, 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: Aspergers, 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 new admits 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, suggested changes have emerged 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 assist them in knowing the progress that Residents are making and where assistance is needed. As noted, outcomes information is regularly shared with individual Residents to assist them in tracking their own progress and goal achievements.

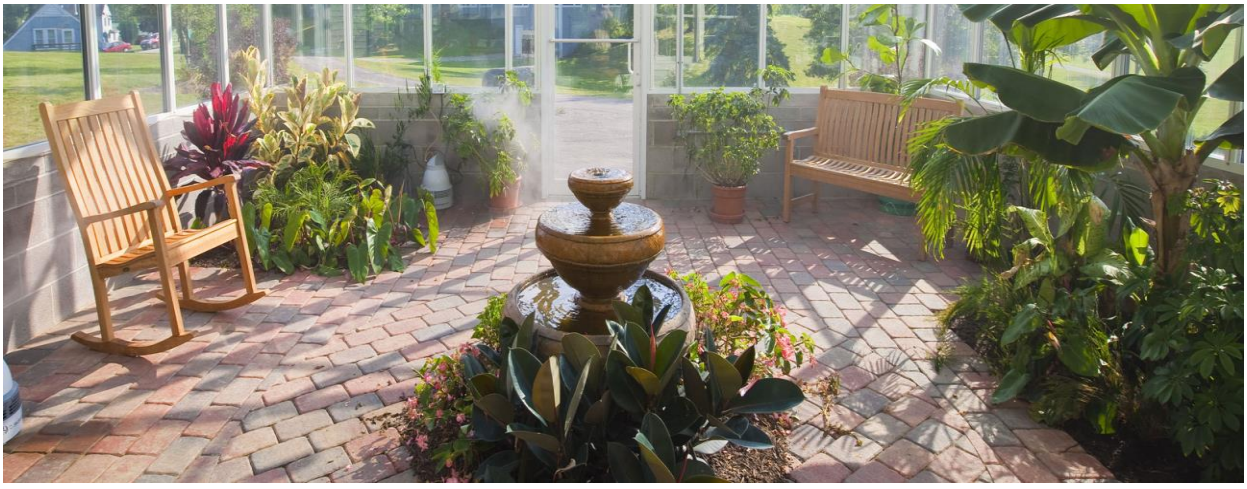
Preliminary Study Implications

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.

Summary/Findings

The data collected to date document benefits of treatment at 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.



Data Summaries

The study data has been collected across June 2006 to December 2014 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 2014. 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 2014.

Graph VII. The graph shows admission and discharge GAF averages for males at Hopewell from June 2006 to December 2014.

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.

Graph IX. This graph represents the Residents who were discharged from June 2006 through December 2014. 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.

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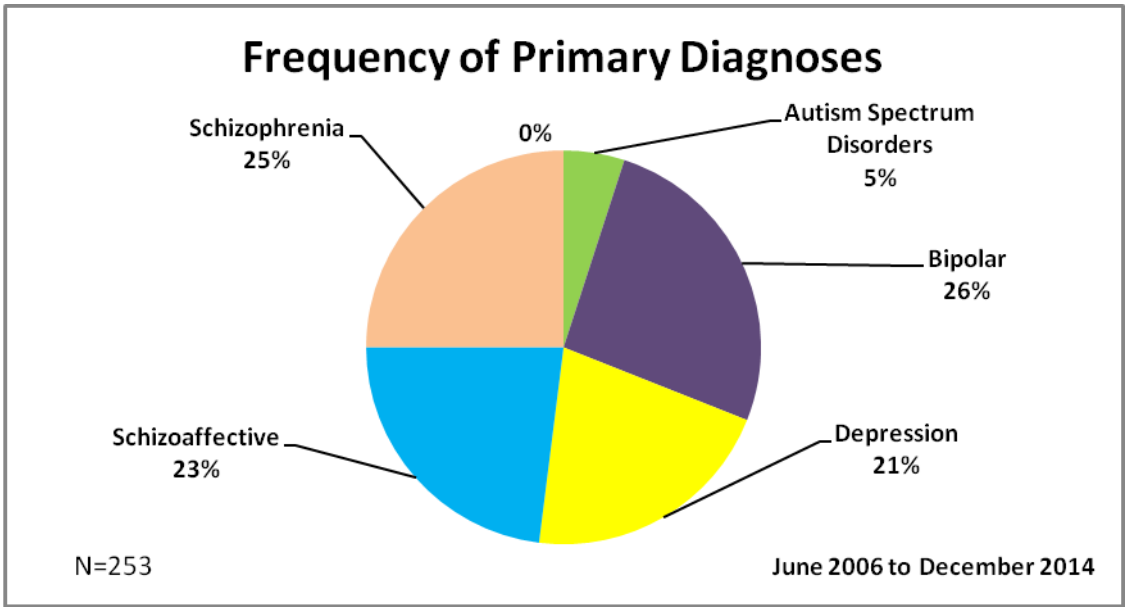

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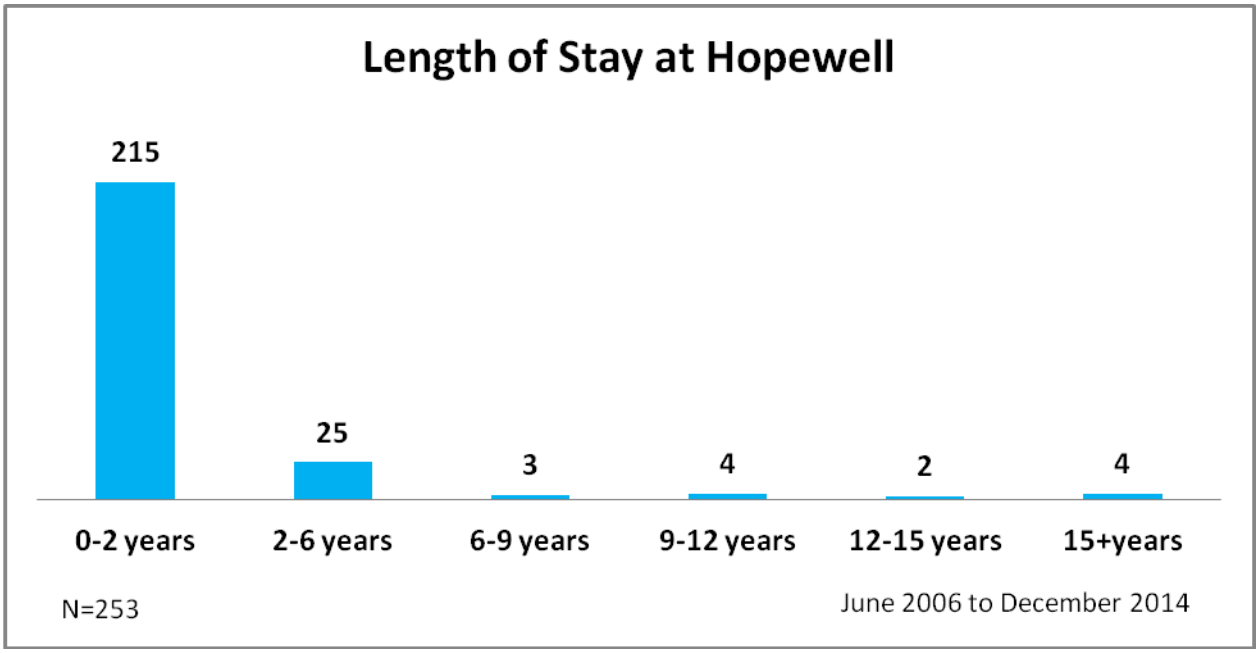

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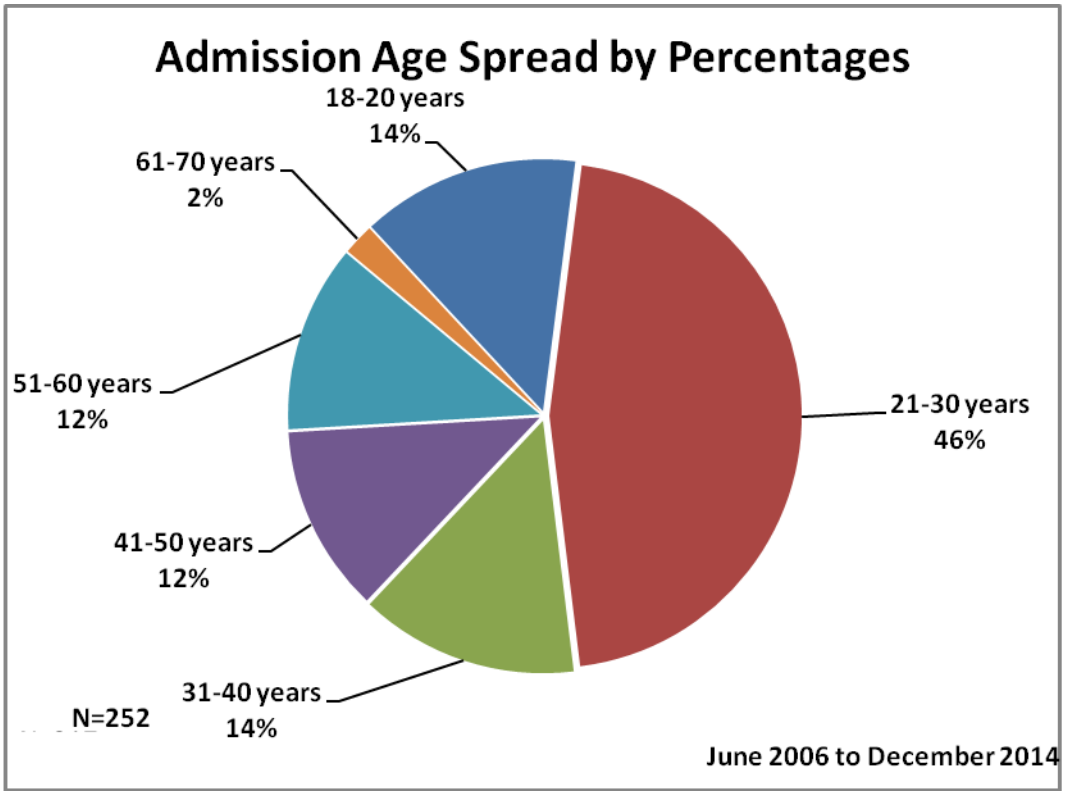
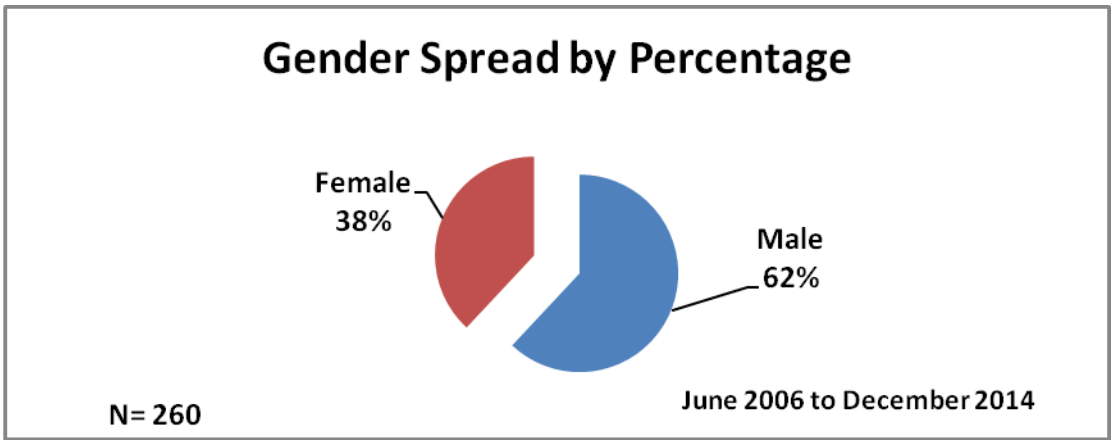


Graph IV. Gender Spread by percentages. These results were obtained from information collected from Residents on their diagnostic assessments.



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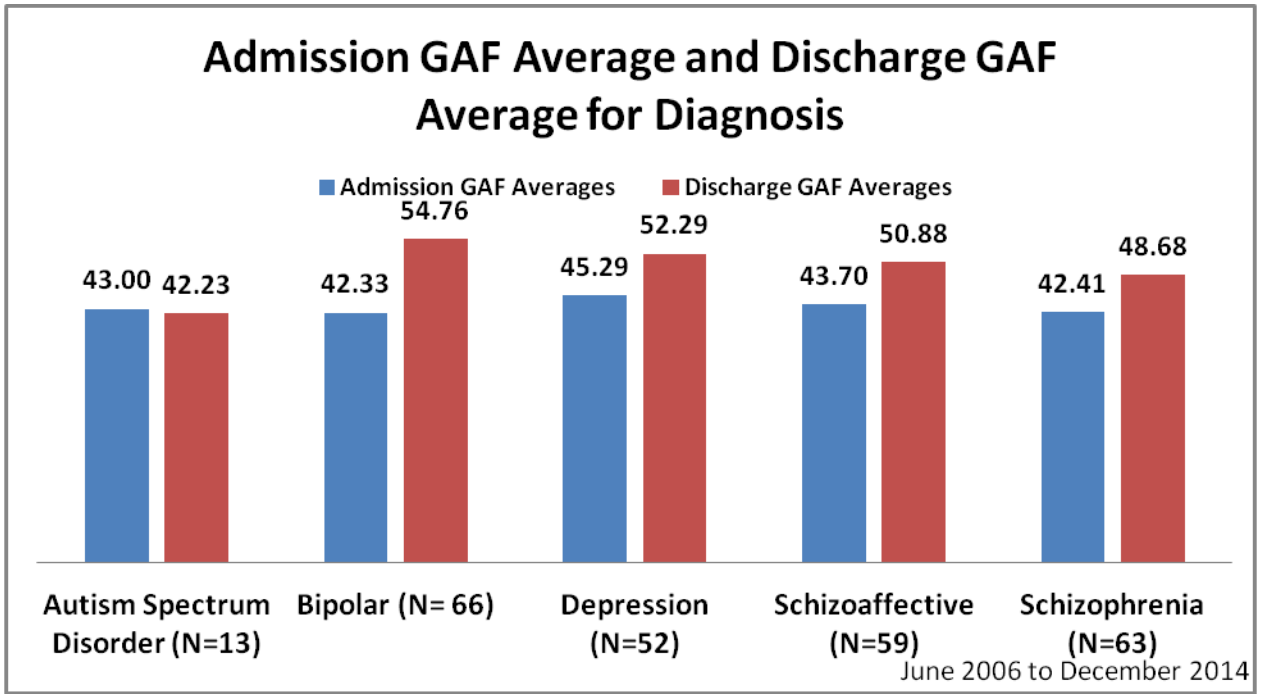


Key: Global Assessment of Functioning Scale

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).

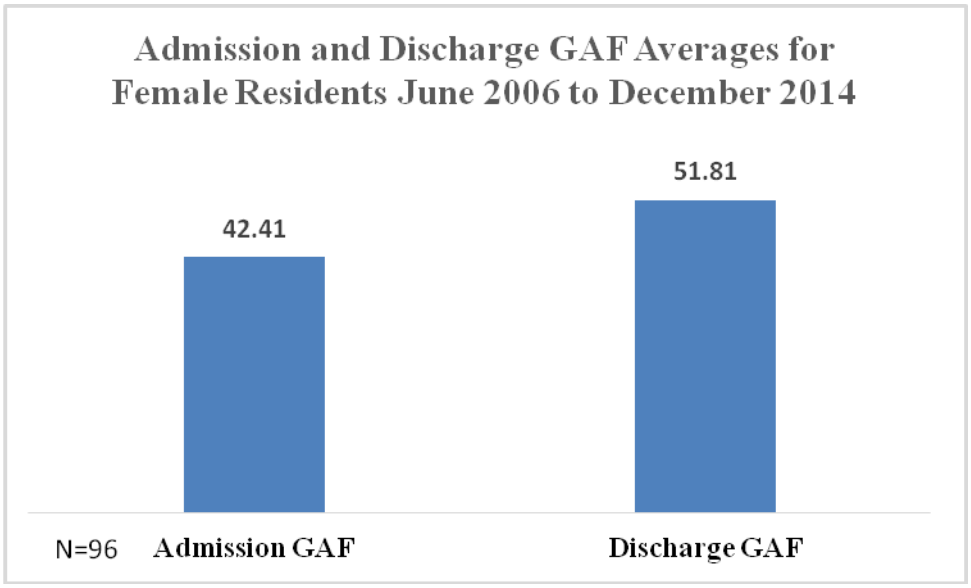
21 - 30 Behavior is considerably influenced by delusions or hallucinations *or* serious impairment in communication or judgment (e.g., sometimes incoherent, acts grossly inappropriately, suicidal preoccupation) *or* inability to function in almost all areas (e.g., stays in bed all day, no job, home or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

Graph VI. The graph below is admission and discharge GAF averages for females at Hopewell from June 2006 to December 2014.



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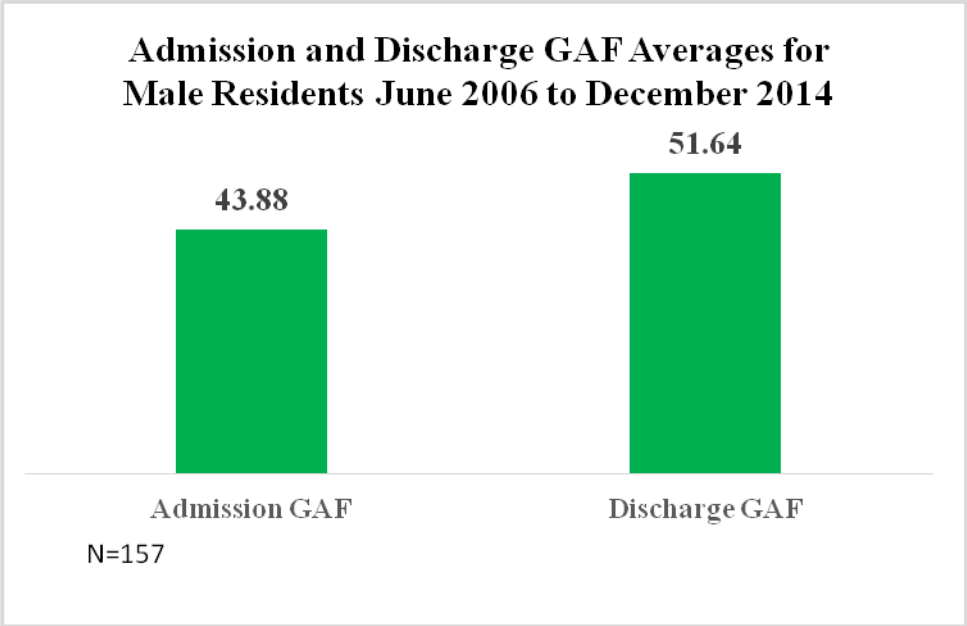

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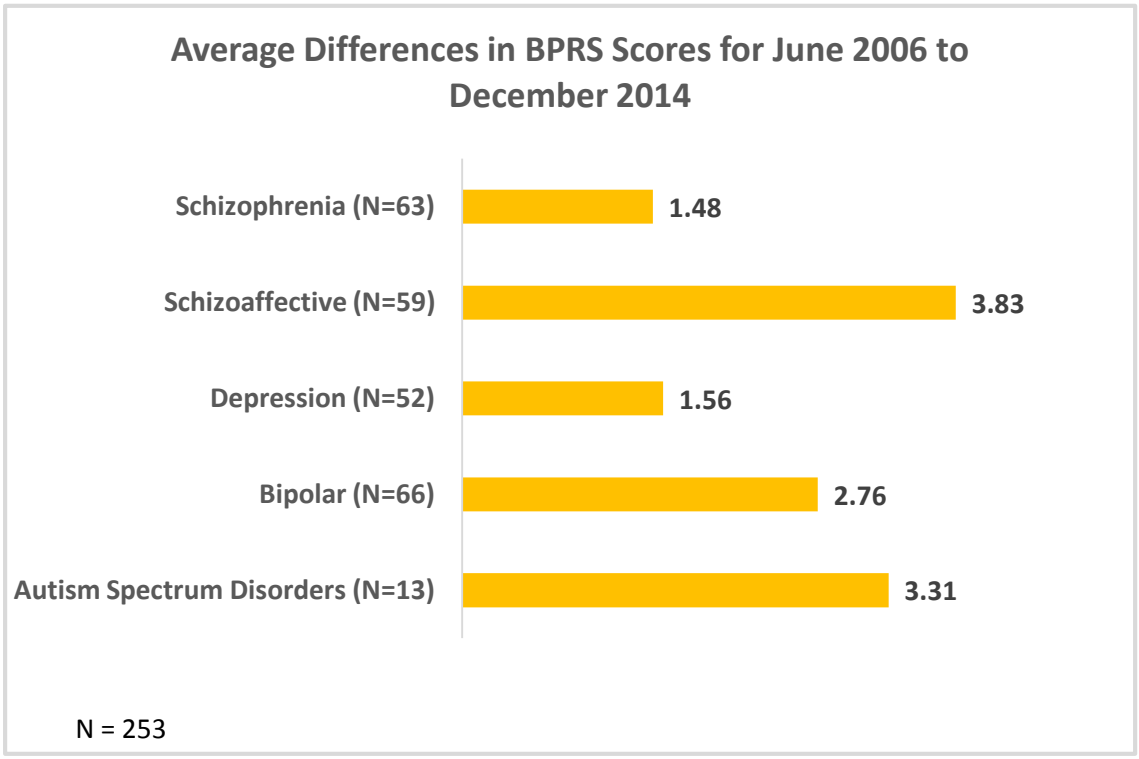

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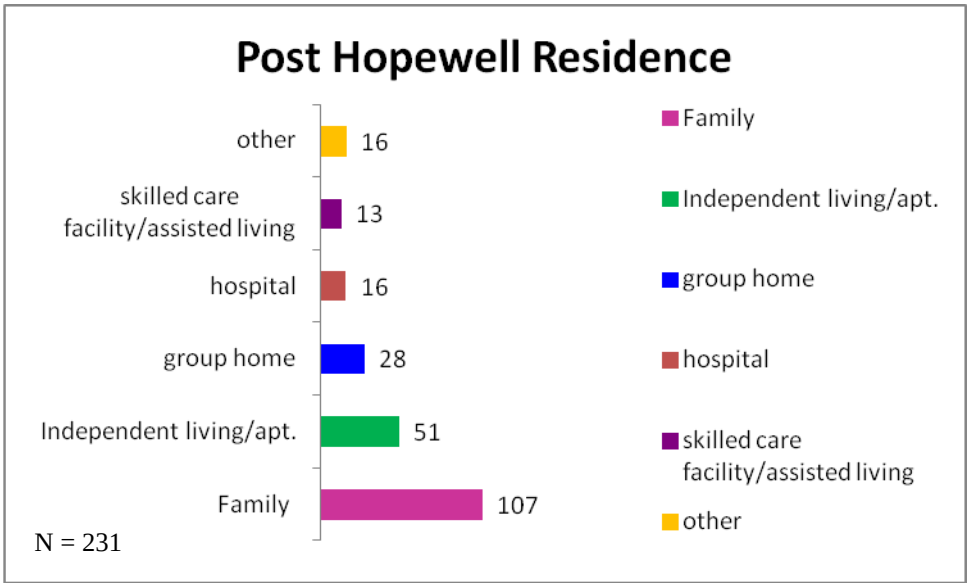
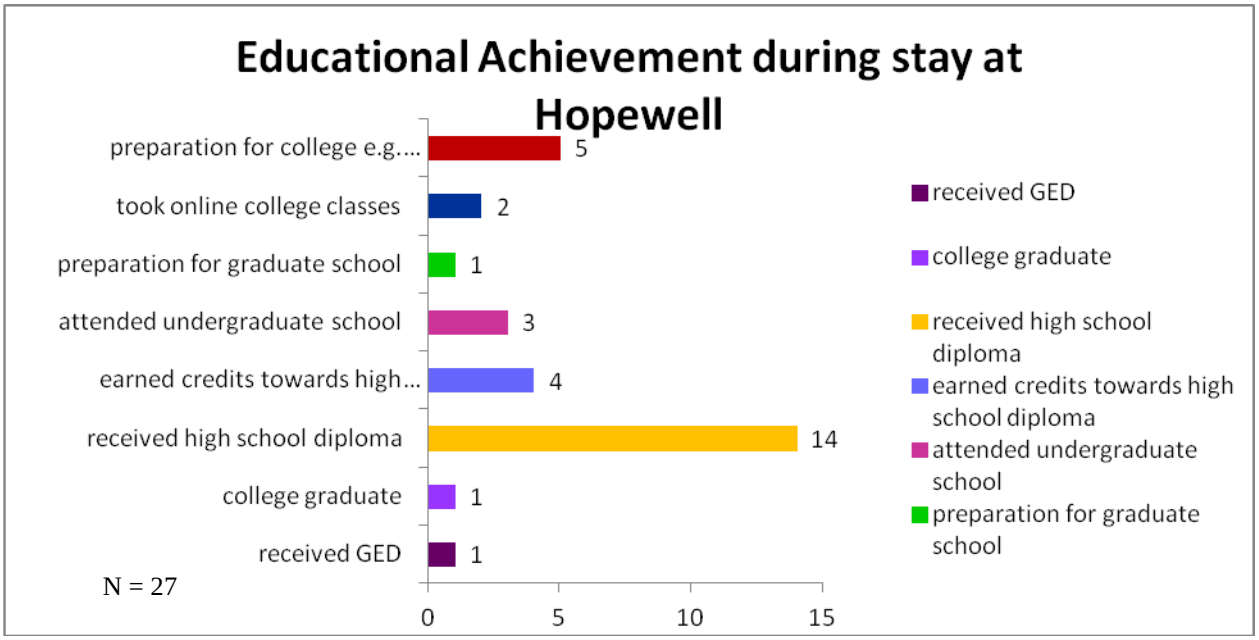
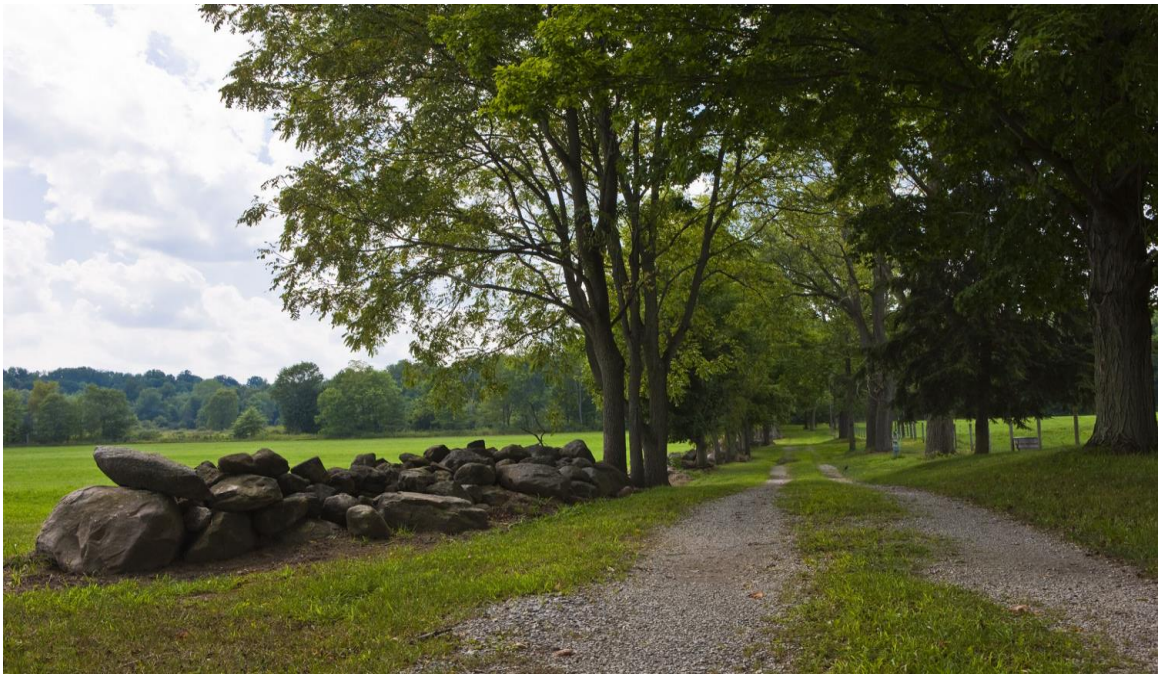


Graph X. Hopewell offers assistance to residents who are interested in furthering their education by giving them opportunities to receive their high school diploma through our education program. The graph below shows that 14 Residents have received their high school diploma through Hopewell's education 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.





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