

Athens-Hocking-Vinton 317 Board

FY 2011 Year-End Outcomes Reports

Tri-County Mental Health & Counseling Services

Edna Brooks Foundation (My Sister's Place)

The Gathering Place

Athens Photographic Project

NAMI/Athens

Athens County Family & Children First Council

Hocking County Family & Children First Council

Health Recovery Services

Scenic Hills Senior Center (Hocking County)

Vinton County Senior Citizens

Health Recovery Services-Treatment & Prevention

Health Recovery Services-Community Awareness

George E. Hill Center for Counseling & Research, OU

John W. Clem Recovery House

Southeast Ohio Regional Jail

Tri-County Mental Health & Counseling Services, Inc. -- 24 Hour Crisis Services

NOM: Increased Safety and Increased Functioning

Disposition of Those Requiring Immediate Intervention

	Year	Contact Crisis Line	Required Immediate Intervention	Psychiatric Hospitalization	Percent	Crisis Residential	Percent	Community Safety Plan	Percent
<i>Historical</i>	FY 08	N/A	2819	237	8%	375	13%	2207	78%
	FY 09	6182	2554	277	11%	474	19%	1803	71%
	FY 10	5905	2219	295	13%	404	18%	1520	68%
<i>Current Fiscal Year</i>	Projections	6000	2600	260	10%	400	15%	1940	75%
	Mid Year	3154	1005	121	12%	197	20%	687	68%
	Final	5982	2053	277	13%	430	21%	1346	66%

Explanatory Notes on Data, if needed:

Target Population & Brief Program Description: Adults who present in crisis at risk of potential harm to self or others and who may be in need of psychiatric hospitalization. Services are available 24 hours per day, 365 days per year by contacting agency clinics or the Crisis Line; prescreens are done by qualified licensed staff, with back-up consultation available; prescreeners are trained to assure that consumers are referred to least restrictive setting needed to assure safety; crisis stabilization unit an important resource; working agreements with local hospitals to provide medical clearance; prescreeners try to respond within 2 hours of referral (or of medical clearance).

Brief Description of other knowledge, skills, behavior change that participants typically achieve in this program: Participants learn about the options available to them in psychiatric crisis, and how to access them safely. Those not admitted to ABH learn to develop safety plans for themselves. Participants, families/significant others/friends learn about resources available in the community.

Board Outcomes FY11 Crisis Prescreen Response Time

Measure: Time taken to start a prescreen from the time the request is made by law enforcement and ER personnel (after medical clearance, when needed). Request time is taken from Crisis Line logs, and start time is taken from CIT progress notes.

Goal: To respond to 90% of requests within two hours.

Data for first half FY11

Site	# of prescreens	Av. Response time	Comments
Obleness Hospital	189	36 minutes	
Hocking Valley Hospital	28	65 minutes	
Doctors Hospital	9	64 minutes	
Athens Sheriff	9	33 minutes	
Hocking Sheriff	3	15 minutes	
Vinton Sheriff	5	54 minutes	
Athens Police	6	42 minutes	
Nelsonville Police	0	0	
Jail	43	85 minutes	
Other	26	16 minutes	Clinic, REACH, Schools
Totals	318	44 minutes	93% were within the 2 hour target.

Data for second half FY11

Site	# of prescreens	Av. Response time	Comments
Obleness Hospital	232	42 minutes	
Hocking Valley Hospital	45	63 minutes	
Doctors Hospital	20	55 minutes	
Athens Sheriff	11	45 minutes	
Hocking Sheriff	4	111 minutes	
Vinton Sheriff	2	93 minutes	
Athens Police	2	75 minutes	
Nelsonville Police	0	0	
Jail	49	130 minutes	
Other	38	31 minutes	Clinic, REACH, Schools
Totals	403	47 minutes	89% were within the 2 hour target.

Data for FY11 – full year

Site	# of prescreens	Av. Response time	Comments
Obleness Hospital	421	27 minutes	
Hocking Valley Hospital	73	64 minutes	
Doctors Hospital	29	58 minutes	
Athens Sheriff	20	39 minutes	
Hocking Sheriff	7	70 minutes	
Vinton Sheriff	7	65 minutes	
Athens Police	8	50 minutes	
Nelsonville Police	0	0	
Jail	92	109 minutes	
Other	64	25 minutes	Clinic, REACH, Schools
Totals	721	44 minutes	91% were within the 2 hour target.

Narrative: The data from this year are consistent with that from the prior two years. Crisis line staffing patterns are also consistent (one prescreener for three counties). For the most part, we are able to arrive at prescreen destinations and begin the process within two hours (our target). Exceptions occur when more than one prescreen has been requested within the three county area at one time (and sometimes there may be three or four waiting). Longest wait times are at the Southeast Ohio Regional Jail, but jail personnel are aware that when there is more than one prescreen, they are last on the list since the residents are confined in a safe area already. If there is a particularly emergent situation, jail staff know to inform the crisis line.

Tri-County Mental Health & Counseling Services, Inc. -- ABH AfterCare Support

NOM: Increased Safety and Increased Functioning

	Year	Discharges	Attended appt. at TCMHCS	<u>Achieved target: 90 % of AHV residents discharged from ABH and attending initial appt. w/ TCMHC will continue in services</u>	Success Ratio	Post Discharge target: 90% of AHV residents d/c from ABH will remain stable and not be readmitted to ABH for at least 30 days post discharge.	Success Ratio
<i>Historical</i>	FY 08	N/A	N/A	N/A	N/A	N/A	N/A
	FY 09	N/A	N/A	N/A	N/A	N/A	N/A
	FY 10	187	118	113	96%	156	83%
<i>Current Fiscal Year</i>	Projections	240	168	151	90%	216	90%
	Mid Year	116	75 (65%)	71	95%	8 people out of 111 discharged 7-12/2010 were readmitted - 93%	93%
	Final	294	203 (69%)	189	93%	21 out of 239 d/cd readmitted (91%)	91%

Explanatory notes: FY10 data is baseline, based on 9 months of data. Data tell us that 63% of ABH discharges schedule & show up for follow-up with Tri-County. Therefore, FY11 projections reflect an attempt to improve on this. For FY11, we will project that 70% of AHV residents discharged from ABH will attend an initial appointment with TCMHC, that 90% of those will continue with services. Discharges are only AHV residents; out-of-state excluded.

Target Population & Brief Program Description: Adults with serious and persistent mental illness. Target is to provide follow-up services within 14 days of discharge and to engage clients in treatment as assessed and needed. Services may include a mix, based upon individualized needs.

Brief Description of other knowledge, skills, behavior change that participants typically achieve in this program: Participants need to be aware of post ABH treatment options, and need to know their risks for psychiatric deterioration and re-hospitalization if treatment is not pursued and continued. Participants need to be able to form treatment relationships with a provider who can address the cluster of needs to be addressed for recovery.

Tri-County Mental Health & Counseling Services, Inc. -- Crisis Residential

NOM: Increased Safety and Increased Functioning

	Year	Already Enrolled at Start of FY	New Referrals this Year	Engaged and Completed Program	<u>Achieved Target:</u> Customer has psychiatric symptoms stabilized and has at least two of the following: accepted referral to outside support, engaged in TCMHCS treatment, has safe housing	<u>Post Discharge Target</u>	Success Ratio
Historical	FY 08	N/A	N/A	381	350	N/A	92%
	FY 09	N/A	450	450	403	N/A	90%
	FY 10	N/A	338	338	321	N/A	95%
Current Fiscal Year	Projections	N/A	450	450	405	N/A	90%
	Mid Year		203	197	191		97%
	Final		437	430	413		96%

Explanatory Notes on Data, if needed:

Target Population & Brief Program Description: Adults in psychiatric crisis at risk of psychiatric hospitalization and adults "stepping down" from psychiatric hospitalization who are not yet capable of independent living; most will have a serious mental illness such as schizophrenia, major depression or bi-polar disorder. Safe, protective environment available 24/7, 365 days/year; Client-centered treatment planning, structured environment, opportunity for medication adjustment and monitoring by staff, linkage to treatment and other community services.

Brief Description of other knowledge, skills, behavior change that participants typically achieve in this program: Symptoms are decreased, risk of harm to self/others is decreased, linkage to community services.

Tri-County Mental Health & Counseling Services, Inc. -- Non-Medicaid Outpatient Services

NOM: Increased Safety and Increased Functioning

	Year	Already Enrolled at Start of FY	New Referrals this Year	Engaged	<u>Achieved Target:</u> Non-Medicaid customers continue with services	Post Discharge Target	Success Ratio
<i>Historical</i>	FY 08	N/A	N/A	N/A	N/A	N/A	N/A
	FY 09	N/A	N/A	N/A	N/A	N/A	N/A
	FY 10	95	373	468	253	N/A	54%
<i>Current Fiscal Year</i>	Projections	253	117	370	250	N/A	68%
	Mid Year	253	157	410	271	N/A	66%
	Final	253	352	605	296		49%

Explanatory notes: Of the 157 new subsidized referrals in the first half of FY11, 139 were crisis only, with only 18 new clients being admitted for ongoing services. Referral sources were: 12 ABH, 1 Family Health Care, 1 Job and Family Services and 4 "other".

Target population and Brief Program Description: Target population: primarily adults with serious and persistent mental illness who do not yet have Medicaid or who have a Medicaid spend-down; severely mentally ill adults with Medicare only who are in need of CPST services; children who do not have Medicaid (very few). Outpatient services are individualized based upon assessed need and may include psychiatric treatment, counseling and CPST (aka case management). The only new admissions accepted who access Board monies are ABH discharges and referrals from Family Health Care. Severely Mentally ill individuals who are already in service and using the sliding scale are still permitted to access Board monies. Other individuals without an ability to pay may be seen for crisis services only.

Brief description of knowledge, skills, etc which participants get as a result of this program. The use of Board monies for SMI individuals who have no pay source allows them to access mental health treatment. Without such treatment, their quality of life would decline, and some would be a risk for harm to self or others, and psychiatric hospitalization. Individuals become educated about their mental illness and about ways to minimize symptoms and to maximize recovery.

Tri-County Mental Health & Counseling Services, Inc. -- Payeeship

NOM: Increased Safety and Increased Functioning

	Year	Already Enrolled at Start of FY	New Referrals this Year	Engaged	<u>Achieved Target:</u> Customer maintains financial stability or leaves the program for a positive reason	Post Discharge Target	Success Ratio
Historical	FY 08	N/A	N/A	N/A	N/A	N/A	N/A
	FY 09	N/A	N/A	61	7	N/A	11%
	FY 10	55	9	64	64	N/A	100%
Current Fiscal Year	Projections			65	65	N/A	100%
	Mid Year	50	5	55	55 +6 graduated		#VALUE!
	Final	50	7	62	55 + 7 graduated		100%

Explanatory Notes on Data, if needed:

Target Population & Brief Program Description: Severely disabled adult clients at TCMHCS. This is a voluntary program; client and case manager meet with payee representative and plan a budget; payee writes checks for bills and provides the client with spending stipend; frequency that checks are written for spending depend on the capacity of the client to manage pocket money; case manager also helps with on-going budgeting; each client has a separate banking account which is audited through Social Security Administration on a yearly basis.

Brief Description of other knowledge, skills, behavior change that participants typically achieve in this program: clients are able to maintain basic necessities such as housing, food, utilities and clothing; clients learn budgeting and bill paying skills so they can graduate from the program.

Tri-County Mental Health & Counseling Services, Inc. -- Housing Loans

NOM: Housing Stability

	Year	Already have a loan at start of FY	Participant Approved for a loan	<u>Achieved target:</u> Participants making payments on loan	Success Ratio	<u>Super target:</u> Participant pays off loan in full	Success Ratio
Historical	FY 09	N/A	N/A	N/A	N/A	N/A	N/A
	FY 10	42	37	64	81%	15	23%
Current Fiscal Year	Projections	N/A	N/A		#VALUE!		#DIV/0!
	Mid Year	64	34	36	37%	8	22%
	Final	64	64	72	56%	30	42%

Explanatory notes:

Target Population & Brief Program Description: Loan program is available to TCMHCS clients. Small client loans (zero interest) are available to persons who need a loan in order to obtain or maintain housing. Must demonstrate that need will resolve the housing issue and that loan request is reasonable and budget will support re-payment. Clients with less than \$115/month in income are given grants.

Brief Description of other knowledge, skills, behavior change that participants typically achieve in this program: Participants learn to budget; learn fiscal responsibility. Participants who successfully pay off loans are eligible to apply again in the future. Credit letter of successful re-payment is issued which can be used to show good credit.

Edna Brooks Foundation: My Sister's Place

NOM: Increased Safety and Increased Functioning

	Year	Already Enrolled at Start of FY	New Referrals this Year	Engaged and Completed Program	<u>Achieved Target:</u> Client enacts safety measures specific to her situation	Post Discharge Target	Success Ratio
<i>Historical</i>	FY 08	N/A	193	182	171	N/A	94%
	FY 09	N/A	263	255	186	N/A	73%
	FY 10	27	243	243	184	N/A	76%
<i>Current Fiscal Year</i>	Projections	40	205	245	190	N/A	78%
	Mid Year	39	73	112	112		100%
	Final	79	143	221	221		100%

Explanatory Notes on Data, if needed: *Target changed from FY 08 to FY 09

Target Population & Brief Program Description: Female victims of interpersonal violence and their children. 24/7 crisis, shelter and outreach services delivered in a framework that puts safety of the client and staff at its core. MSP staff empower victims to make their own decisions and to provide the individualized support as clients take the necessary steps to achieve self determination and become survivors.

Brief Description of other knowledge, skills, behavior change that participants typically achieve in this program: Clients are empowered to make their own decisions in all aspects of daily living, including parenting skills, employment, additional educational opportunities, nutritional options, and establishing social support networks.

Edna Brooks Foundation: Domestic Violence Intervention Program

NOM: Decreased Criminal Justice Involvement

	Year	Already Enrolled at Start of FY	New Referrals this Year	Engaged and Completed Program	<u>Achieved Target:</u> Attendees who complete program will show an increased awareness of non-controlling & non-violent ways of relating to women as evidenced by pre and post scores	Post Discharge Target	Success Ratio
<i>Historical</i>	FY 08	N/A	41	39	N/A	N/A	N/A
	FY 09	N/A	56	12	9	N/A	75%
	FY 10	30	44	53	49	N/A	92%
<i>Current Fiscal Year</i>	Projections	21	40	40	39	N/A	98%
	Mid Year	21	12	7	7		100%
	Final	28	24	26	26		100%

Explanatory Notes on Data, if needed: *Target changed from FY 09 to FY 10

Target Population & Brief Program Description: Court-mandated perpetrators of violent crimes committed by males against women and their children. All DVIP clients complete a minimum of 24, two-hour group counseling sessions after completing two individual face-to-face sessions with a group facilitator who determines their appropriateness for group membership. Battering behavior is extremely manipulative and is often not recognized when taken out of the context of batterer treatment. DVIP Clinical Supervisors and Group Facilitators must be highly trained to recognize and confront this behavior.

Brief Description of other knowledge, skills, behavior change that participants typically achieve in this program: Participants increase their knowledge of inappropriate behaviors and learn non-violent ways of communicating with their intimate partner. Each participant develops their individualized "safety plan" to prevent further acts of violence.

Athens Mental Health, Inc. The Gathering Place, Home Away From Home, Friendship House

NOM: Increase Social Supports/Social Connectedness, Increased Employment, Increased Housing Stability

Programs: Information and Assistance, Employment, Education, Health & Wellness, Housing Assistance

Targets	FY 09	FY 10	FY 11 Projections	FY 11 Mid Year	FY 11 Final
Participants seek out information and assistance in order to access community resources or to solve a problem	223	143	150	60	178
Members are gainfully employed or pursuing education	83	30	50	15	33
Participants find meaningful activity through volunteering at TGP or in the community	61	52	50	20	31
Participants increase access to healthy foods and nutrition services	273	130	150	58	165
Participants gain information or access to housing resources	88	49	50	22	54
Members maintain personal empowerment and makes decisions based upon ODMH's Emerging Best Practices in Mental Health Recovery Model	40	37	40	17	79
Member maintains a high level of social connectedness based upon ODMH's Emerging Best Practices in Mental Health Recovery Model	28	32	30	20	44

Explanatory Notes on Data, if needed: The numbers for personal empowerment and social connectedness reflect consumers who have met that target in this reporting period and consumers who have maintained the target since the last reporting period. Athens Mental Health, Inc operates programs in Hocking and Vinton Counties (Home Away From Home and The Friendship House). Due to several circumstances, programming in Vinton Co. has been suspended. Hocking Counties final numbers are (in Target order) 75, 2, 40, 80, 18, 30,

Target Population & Brief Program Description: Athens Mental Health, Inc. “The Gathering Place” (TGP) is a community drop-in center for adults coping with mental illness, providing food relief, peer support, mental health education, and linkage services. The program focuses on reengaging mental health consumers into community life. TGP has been an integral part of providing a sense of place for this population for 35 years. During the 1970’s, deinstitutionalization brought clients out of the hospitals with few social networks to catch them. Originally started as a gathering spot to find refuge after people had been released from the psychiatric hospital, TGP has become a foundation of support in the community. Currently, the organization serves as a bridge to the community for over 120 individuals. We have no fee for service, providing a vital safety net for those individuals who fall through the cracks of the mental health system. Services are designed to enrich and empower each individual so that (s)he can create a meaningful and joyful life in spite of a mental illness and its accompanying affects.

Brief Description of other knowledge, skills, behavior change that participants typically achieve in this program: The changes that our consumers experience related to personal empowerment and social connectedness include, but are not limited to : awareness of need for personal empowerment, making healthy decisions, seeking information and assistance from staff and peers, awareness of accomplishments, develops sense of personal identity, defines goals, participates in activities of TGP, finds meaningful activity, looks for information related to recovery, makes face-to-face contact with peers, develops meaningful supportive personal relationships, becomes aware of methods for behavior modification, opportunities for community involvement and support networks, begins to give support to others, uses peer support and community resources, seeks out new growth opportunities, serves as a role model for other consumers, advocates for self and others, and develops new social opportunities that support recovery.

Athens Photographic Project

NOM: Increased Social Support/Social Connectedness

	Year	Already Enrolled at Start of FY	New Referrals this Year	Engaged and Completed Program	Achieved Target: Participants actively participate in 10-week class by attending two 2-hour classes per week, contribute to class activities, independently complete photo assignments, participate in group exhibition and attend opening session	Post Discharge Target: N/A	Success Ratio
<i>Historical</i>	FY 08	0	21	21	18	N/A	86%
	FY 09	0	51	51	43	N/A	84%
	FY 10	0	63	52	49	N/A	94%
<i>Current Fiscal Year</i>	Projections	0	26	24	20	N/A	83%
	Mid Year	0	28	24	19		79%
	Final	0	28	26	22		85%

Explanatory Notes on Data, if needed: Change in target from FY 08 to FY 09; Target meets ODMH Recovery Model areas of eliminating stigma & increasing confidence, community involvement, peer support, pride and purpose.

Target Population & Brief Program Description: APP promotes mental health recovery and community integration through photography classes and exhibitions to adults living with mental illness. APP offers an in-depth model of supportive arts learning and community participation. Classes are held at the Dairy Barn Arts Center and bring together SMD clients, professional photographers and OU photography students for 30-weeks per year. Each week participants engage in 4hrs of art classes and 5+hrs of photographing outside of class. APP's program concludes with a juried group exhibition of participant photographs at the Dairy Barn on display to the community. APP work is shown in statewide and at APP's member-run photo gallery located at the Market on State.

Brief Description of other knowledge, skills, behavior change that participants typically achieve in this program: APP evaluates the success of its program on several outcomes including: 1. Artistic skill building 2. Postive group participation 3. Students ability to complete weekly photography assignments independently at home and in the community 4. Elimination of stigma through student participation in public photo exhibitions 5. Increase in participant feelings of self-worth, confidence, and friendship. 6. Increase in meaningful activity and contribution to the community.

NAMI Athens Chapter

NOM: Increase Social Supports/Social Connectedness and Stigma Reduction

Programs: Support & Education Groups, Community Education, CIT, Cemetery Restoration

Targets	FY 09	FY 10	FY 11 Projections	FY 11 Final
Family to Family: Families increase understanding of mental illness and learn new skills	18 [FY 08: 33]	13	18	26
Hand to Hand: Families increase understanding of youth mental illness and learn new skills	11	7	8	10
Peer to Peer: Participants increase recovery skills	7	12	16	11
Bi-Annual Conference: Increase understanding of mental illness and decrease stigma	150	N/A	N/A	N/A
Support Group: Increase support for family members who have a loved one with mental illness	100 <i>*estimate</i>	134 est.	100 estimate	142est.
CIT: Increase officer understanding of mental illness, increase de-escalation skills and decrease stigma	33	25	23	23
Ridges Cemetery Project: Maintain and improve cemeteries to increase respect and decrease stigma	\$9496.04 <i>*invested</i>	\$12,939.06 invested	\$5,000.00 est.	\$2,848.72 invested
WOUB: Increase understanding of mental illness and decrease stigma	15 <i>*programs</i>	17 programs	15 Programs	20 Programs
Newsletter: Produce 5-6 editions of newsletter/year	Mailed to 485 people; 25 new	523 mailed; 39 new	525+	538 mailed, 15 new
Membership: Maintain and Increase membership	84 members (71 returning and 13 new)	106 members (61 returning; 45 new)	115 Members	89 members (32 returning; 22 new)

Explanatory Notes on Data, if needed: The Hand to Hand class has now become NAMI Basics.

Athens County Family and Children First Council: High Risk Youth

NOM: Improved Functioning

	Year	Already Enrolled at Start of FY	New Referrals this Year	Engaged	<u>Achieved Target:</u> Child will not access out of home placement (other than for brief respite care)	Above & Beyond Target: Child maintains stability (home, school, social) for a sustained period of time and completes program or moved to less intensive level	Success Ratio
<i>Historical</i>	FY 08	N/A	N/A	N/A	N/A	N/A	N/A
	FY 09	N/A	13	12	9	N/A	75%
	FY 10	N/A	10	7	7	N/A	100%
<i>Current Fiscal Year</i>	Projections	0	15	13	10	N/A	77%
	Mid Year	9	10	19	14	N/A	74%
	Final	19	6	23	18	N/A	78%

Target Population & Brief Program Description: Children who meet mental health diagnosis or behavioral health care concerns and who are at high risk of out-of-home placement. This outcome tracks a group of high risk youth who are monitored through the FCFC Service Coordination system; the typical youth remains active for 10-12 months; it is the goal of intersystems to provide collaboration for as long as needed and to provide the best local services in order for youth to remain in the community and in their own home. Program strives to access and coordinate services, accurately identify the critical problems that are interfering with a child's success, advocate for children and provide

Brief Description of other knowledge, skills, behavior change that participants typically achieve in this program: Families engage with treatment team and the key issues are identified.There is a distinct difference in attitude with the new families who enter Service Coordination Mechanism and the current families, providing us some evidence that “engagement” within family systems works. 100% of the new families that requested SCM from the FCFC exhibited behaviors that included hostility, resentment, or confusion. These feelings were largely targeted towards professionals (school, mental health staff, children services caseworkers). Family Teams, with their focus on what the parent wants and what the child needs, changed the attitude of 80% of the new families within 3 months of beginning Family Teams. The parents engaged in problem-solving activities as one typical skill, and are learning behavior management techniques unique to the child with emotional /behaviors problems as another skill. The Family Teams also take a holistic approach integrating the components of health, child development & mental health, family systems, and trauma to piece together a treatment plan that works.

Hocking County Family and Children First Council: Pooled Funding

NOM: Improved Functioning

	Year	Already Enrolled at Start of FY	New Referrals this Year	Engaged and Completed Program	<u>Achieved Target:</u> Child maintains stability as evidenced by diversion from residential placement or if already in a residential placement the child improves	Post Discharge Target: N/A	Success Ratio
<i>Historical</i>	FY 08	N/A	N/A	N/A	N/A	N/A	N/A
	FY 09	N/A	39	39	38	N/A	97%
	FY 10	N/A	19	19	18	N/A	95%
<i>Current Fiscal Year</i>	Projections	0	20	60	42	N/A	70%
	Mid Year	50	8	58	56		97%
	Final	50	27	82	80		98%

Explanatory Notes on Data, if needed: I added the words "or if already in a residential placement the child improves" to the achieved target

Target Population & Brief Program Description: High risk children with multiple needs from Hocking County approved by both Intersystem group and FCFC Council currently in residential placement or therapeutic foster care or children with mental health diagnoses who may be in danger of placement outside their homes. Family team meetings which divert many children from placement in residential services and/or therapeutic foster care; can enter into the system at any age and most, if not all, stay in care until they age out of the system at age 18 or 22.

Brief Description of other knowledge, skills, behavior change that participants typically achieve in this program: Participants which include the identified youth and their family, learn how to best deal with their particular issues and these are all individualized to each child/family. They also learn about and how to utilize various support systems, and how to help their child reach their own potential. For every child/family it is different based upon their needs and the family's desired outcomes. Parents/custodians are encouraged to be the leader at their Family Team Meetings and so through this process the parents/custodians learn how to advocate for their child's needs.

Health Recovery Services: Hocking Mental Health

NOM: Increased Functioning

	Year	Already Enrolled at Start of FY	New Referrals this Year	Engaged and Completing Program	<u>Achieved Target:</u> Customer meets criteria for successful discharge	<u>Post Discharge Target:</u>	Success Ratio
<i>Historical</i>	FY 08	N/A	128	76	51	N/A	67%
	FY 09	N/A	149	125	59	N/A	47%
	FY 10	221	160	144	27	N/A	19%
<i>Current Fiscal Year</i>	Projection	267	110	100	50	N/A	50%
	Mid Year		67	56	32	N/A	57%
	Final		165	139	87	N/A	64%

Explanatory Notes on Data, if needed: 269 will be carried over to FY 2012.

Target Population & Brief Program Description: Adolescents typically between ages of 4 and 18 with demonstrated difficulty in social and/or school functioning. Counseling, case management, family counseling and court diversion services offered. Treatment is typically no less than six months, but on average about 12-18 months.

Brief Description of other knowledge, skills, behavior change that participants typically achieve in this program: We are serving children and their families who enter with poor communication, high stress, loss and trauma issues, and a variety of presenting factors depending on the circumstance. Often, issues have been presenting for some time prior to readiness to engage in treatment. The degree of typical achievement is great with improved emotional and behavioral functioning both reported by the child, parent, and worker with use of Ohio Scales for outcome measurement. Some children improve their academic functioning, social skills, and communication skills. Families who participate in treatment often report reduced arguments, improved communication, less stress, and healthy activities with their family members due to issues being addressed within a supportive, outpatient treatment environment. We encourage children and families to use community resources and support systems while in outpatient treatment. Many who complete treatment are able to expand confidence. This assists with continued progress beyond treatment.

Health Recovery Services: EAGER - Elementary Activities for Growth and Encouragement of Responsibility

NOM: TBD

	Year	Already Enrolled at Start of FY	New Referrals this Year	Engaged and Completed Program	Achieved Target: Youth score higher on post test indicating greater understanding of program ideals	Post Discharge Target: N/A	Success Ratio
<i>Historical</i>	FY 08	N/A	N/A	N/A	N/A	N/A	N/A
	FY 09	N/A	N/A	N/A	N/A	N/A	N/A
	FY 10	N/A	N/A	N/A	N/A	N/A	N/A
<i>Current Fiscal Year</i>	Projections	0	470	470	0	N/A	0%
	Mid Year		159	79	37	N/A	47%
	Final		285	148	67	N/A	45%

Explanatory Notes on Data, if needed: Explanation: Achieved Target includes both higher scores on post test and no change in post test scores (if scores were already at or above an 85% level of understanding). At this time, we only have approximately 2/3 of the scores (a total of 53 of the 79 who have completed the program); so actually, 37 / 53 have demonstrated increased understanding (70%).

Target Population & Brief Program Description: Children grades kindergarten through fourth and their families living in Hocking County. The focus of the EAGER Program centers on the referred “at risk” youngsters being approximately 10% of the total school enrollment. The students identified “at risk” are those youth with characteristics correlated with behaviors that may ultimately result in acts of unruliness and delinquency.

Brief Description of other knowledge, skills, behavior change that participants typically achieve in this program:

EAGER is a uniquely innovative, school-based prevention program designed to enhance self-esteem, promote sound decision-making, and develop awareness of values for growth and responsibility among elementary school students. The Positive Action Program has been implemented into the EAGER program to help achieve these goals.

Scenic Hills Senior Center: Homemaker Program

NOM: Increase Social Supports/Social Connectedness and Increased Housing Stability

Targets	FY 09	FY 10	FY 11 Projections	FY 11 Final
Participant receives services and continues to live at home	4	4	4	4

Explanatory Notes on Data, if needed:

Target Population & Brief Program Description: Persons age 60 and older in Hocking County with focus on those age 75+ and who meet one or more of the following: homebound, female, living alone with little or no support network, low-income, frail, disabled, lonely and depressed. Homemaker services allow elderly to remain in their home; once on the program, most customers continue until health conditions necessitate another environment; trusted source for providing homemaker services.

Brief Description of other knowledge, skills, behavior change that participants typically achieve in this program: The clients we serve in this program are Dx. with depression and/ or mental diseases of some kind. We work with them to show them how to keep their home clean and safe, we can also make sure they get their groceries and prescriptions each month.

Complete the following narrative. Do not exceed one page.

Year End Narrative: Briefly describe achievements, challenges and program improvements. Address any discrepancies between projections and actuals. Include narrative that demonstrates the value of your program beyond the outcome numbers listed above--leveraging other resources, satisfaction surveys, staff retention/training, efficiencies and cost savings, positive effect your program has on other systems or the community, etc.

Health Recovery Services: Athens Outpatient (AOP)

NOM: Abstinence from Drug/Alcohol Use

	Year	Already Enrolled at Start of FY	New Referrals this Year	Engaged and Completing Program	Achieved Target: Customer satisfies criteria for successful discharge	Post Discharge Target: Customers who are successfully discharged and who are available for follow up report maintaining sobriety 30 days post-discharge	Success Ratio
<i>Historical</i>	FY 08	N/A	213	339	218	43	64%
	FY 09	N/A	273	198	125	101	63%
	FY 10	126	337	265	82	41	31%
<i>Current Fiscal Year</i>	Projections	216	250	164	108	50	66%
	Mid Year		402	189	73	26	39%
	Final		762	364	173	63	38%

Explanatory Notes on Data, if needed: *National Benchmarks: 47% completed treatment according to the Office of Applied Studies, SAMHSA, Treatment Episode Data Set (TEDS); 129 people will be carried over into FY 2012

Target Population & Brief Program Description: Adults, typically court-ordered. Treatment typically lasts 3-12 months, based upon individual need. Customers receive assessment services, group and individual counseling, case management, intensive out-patient and aftercare planning and relapse prevention. Some customers continue with aftercare and relapse prevention beyond the estimated 12 months, as a maintenance tool.

Brief Description of other knowledge, skills, behavior change that participants typically achieve in this program:1)

Personal knowledge and development of understanding related to how their abuse / dependency on substances is affecting their lives and how substances, in general, interact with emotional and physical complications, legal and family/communication problems, etc. Throughout individual and group treatment, consumers develop knowledge, skills, and behavior changes which transform their daily lives, change how they approach the community and their family, and help them to identify how to handle their specific emotional or physical stressors. In order to be discharged successfully, there is an active and working relapse prevention plan and review during individual and group treatment of progress with random drug screens. Often, consumers experience relapse more than once during treatment and learn how to handle the stressors which are identified as relapse triggers. Individuals receive treatment according to their own dynamics and attributes and mostly show increased strength, knowledge, ability to handle situations surrounding usage and preventing relapse and become engaged with a support system through family and or community support groups. Consumers know that they can return to treatment for assistance at any time.

Health Recovery Services: Hocking Outpatient

NOM: Abstinence from Drug/Alcohol Use

	Year	Already Enrolled at Start of FY	New Referrals this Year	Engaged and Completing Program	<u>Achieved Target:</u> Customer satisfies criteria for successful discharge	<u>Post Discharge Target:</u> Customers who are successfully discharged and who are available for follow up report maintaining sobriety 30 days post-discharge	Success Ratio
<i>Historical</i>	FY 08	N/A	368	234	202	37	86%
	FY 09	N/A	208	172	157	55	91%
	FY 10	79	163	118	56	36	47%
<i>Current Fiscal Year</i>	Projections	81	150	112	80	45	71%
	Mid Year		141	88	29	5	33%
	Final		305	195	85	16	41%

Explanatory Notes on Data, if needed: *National Benchmarks: 47% completed treatment according to the Office of Applied Studies, SAMHSA, Treatment Episode Data Set (TEDS); 68 will be carried over into FY 2012

Target Population & Brief Program Description: Adults, typically court-ordered. Treatment typically lasts 3-12 months, based upon individual need. Customers receive assessment services, group and individual counseling, case management, intensive out-patient and aftercare planning and relapse prevention. Some customers continue with aftercare and relapse prevention beyond the estimated 12 months as a maintenance tool.

Brief Description of other knowledge, skills, behavior change that participants typically achieve in this program: Personal knowledge and development of understanding related to how their abuse / dependency on substances is affecting their lives and how substances, in general, interact with emotional and physical complications, legal and family/communication problems, etc. Throughout individual and group treatment, consumers develop knowledge, skills, and behavior changes which transform their daily lives, change how they approach the community and their family, and help them to identify how to handle their specific emotional or physical stressors. In order to be discharged successfully, there is an active and working relapse prevention plan and review during individual and group treatment of progress with random drug screens. Often, consumers experience relapse more than once during treatment and learn how to handle the stressors which are identified as relapse triggers. Individuals receive treatment according to their own dynamics and attributes and mostly show increased strength, knowledge, ability to handle situations surrounding usage and preventing relapse and become engaged with a support system through family and or community support groups. Consumers know that they can return to treatment for assistance at any time.

Health Recovery Services: Vinton Outpatient

NOM: Abstinence from Drug/Alcohol Use

	Year	Already Enrolled at Start of FY	New Referrals this Year	Engaged and Completing Program	Achieved Target: Customer satisfies criteria for successful discharge	Post Discharge Target: Customers who are successfully discharged and who are available for follow up report maintaining sobriety 30 days post-discharge	Success Ratio
<i>Historical</i>	FY 08	N/A	102	62	42	11	68%
	FY 09	N/A	87	61	51	14	84%
	FY 10	38	85	70	40	15	57%
<i>Current Fiscal Year</i>	Projections	77	85	70	40	15	57%
	Mid Year		59	41	32	18	78%
	Final		111	88	50	33	45%

Explanatory Notes on Data, if needed: *National Benchmarks: 47% completed treatment according to the Office of Applied Studies, SAMHSA, Treatment Episode Data Set (TEDS); 55 will be carried over into FY 2012

Target Population & Brief Program Description: Adults, typically court-ordered. Treatment typically lasts 3-12 months, based upon individual need. Customers receive assessment services, group and individual counseling, case management, intensive out-patient and aftercare planning and relapse prevention. Some customers continue with aftercare and relapse prevention beyond the estimated 12 months as a maintenance tool.

Brief Description of other knowledge, skills, behavior change that participants typically achieve in this program: Personal knowledge and development of understanding related to how their abuse / dependency on substances is affecting their lives and how substances, in general, interact with emotional and physical complications, legal and family/communication problems, etc. Throughout individual and group treatment, consumers develop knowledge, skills, and behavior changes which transform their daily lives, change how they approach the community and their family, and help them to identify how to handle their specific emotional or physical stressors. In order to be discharged successfully, there is an active and working relapse prevention plan and review during individual and group treatment of progress with random drug screens. Often, consumers experience relapse more than once during treatment and learn how to handle the stressors which are identified as relapse triggers. Individuals receive treatment according to their own dynamics and attributes and mostly show increased strength, knowledge, ability to handle situations surrounding usage and preventing relapse and become engaged with a support system through family and or community support groups. Consumers know that they can return to treatment for assistance at any time.

Health Recovery Services: Albany Alternative Education Program

NOM: Abstinence from Drug/Alcohol Use & Increased Functioning

	Year	Already Enrolled at Start of FY	New Referrals this Year	Engaged and Completing Program	<u>Achieved Target:</u> Customer satisfies criteria for successful discharge--return to home school, return to Bassett House, continue at Alternative School or graduate from high school	<u>Post Discharge Target:</u>	Success Ratio
<i>Historical</i>	FY 08	N/A	65	54	55	N/A	102%
	FY 09	N/A	96	77	59	N/A	77%
	FY 10	39	46	48	24	N/A	50%
<i>Current Fiscal Year</i>	Projections	49	70	60	50	N/A	83%
	Mid Year		27	9	15	N/A	167%
	Final		53	31	40	N/A	N/A

Target Population & Brief Program Description: Adolescents and their families are engaged in services for 2-6 months (shorter or longer) based on individual needs. They receive assessment, group / individual counseling, case management, education services and aftercare/discharge planning.

Brief Description of other knowledge, skills, behavior change that participants typically achieve in this program: Consumers receive individualized treatment/services based on their specific needs. While consumers suffer from a number of disorders (i.e. Substance Use Disorders, Anxiety, Depression/Mood Disorders, ADHD, and Oppositional Defiant Disorder), all need assistance with understanding their disorder and learning ways to manage symptoms. Consumers receiving treatment for Substance Use Disorders learn about the nature of their disease, ways to control cravings and manage relapse triggers and improve coping skills for overall life management and sobriety maintenance. Consumers receiving treatment for mental health disorders learn about their particular disorder and about resources and coping skills for symptom management and improvement in daily functioning. Consumers who have actively participated in their treatment show greater ability to self-soothe, manage anger, interact appropriately with peers/others, make appropriate decisions, and increase their overall academic performance.

Health Recovery Services: Bassett House (AHV Only)

NOM: Abstinence from Drug/Alcohol Use

	Year	Already Enrolled at Start of FY	New Referrals this Year	Engaged and Completing Program	<u>Achieved Target:</u> Customer assists with development of and commits to aftercare program	<u>Post Discharge Target:</u> Customers who are successfully discharged and who are available for follow up report maintaining sobriety 30 days post-discharge	Success Ratio
<i>Historical</i>	FY 08	N/A	50	47	32	18	68%
	FY 09	N/A	25	28	27	17	96%
	FY 10	1	22	16	14	9	88%
<i>Current Fiscal Year</i>	Projections		36	28	24	20	86%
	Mid Year	4	10	9	9	5	100%
	Final		32	19	19	13	83%

Explanatory Notes on Data, if needed: *In FY 08, HRS reported on all Customers and in FY 09 we asked for data only on AHV customers; 7 will be carried over into FY 2012

Target Population & Brief Program Description: Juveniles between the ages of 13 & 18, heavily involved in substance use and/or abuse and may have co-occurring mental health disorders. Residential treatment program based on bio-psychosocial model of addiction therapy that provides integrated care from residential treatment to community based services. Close collaboration with referral source; strong encouragement in 12 step programs; aftercare plan designed with client, parent and referral agent.

Brief Description of other knowledge, skills, behavior change that participants typically achieve in this program: Youth in the Bassett House Program address their substance abuse and co-occurring mental health issues through group, individual and family counseling. Issues addressed include but are not limited to: understanding the addiction process, cravings, relapse triggers, resistance techniques and refusal skills. In addition, they address life skills issues, anger management issues, educational issues, and legal issues. Family issues are addressed through family counseling and the Creating Lasting Family Connections (CLFC) program. The youth are taught non-using recreational skills and are provided community interactions through the Adolescent Community Reinforcement Approach (A-CRA) to assist them in identifying and utilizing community resources to aid in their recovery.

Health Recovery Services: Rural Women's Recovery Program

NOM: Abstinence from Drug/Alcohol Use

	Year	Already Enrolled at Start of FY	New Referrals this Year	Engaged and Completing Program	Achieved Target: Customer commits to aftercare program, develops relapse prevention plan and meets criteria for successful discharge	Post Discharge Target: Customers who complete program successfully will report attendance at community-based groups at least weekly for 60 days post discharge	Success Ratio
<i>Historical</i>	FY 08	N/A	16	12	11	8	92%
	FY 09	N/A	29	22	12	11	55%
	FY 10	8	29	16	13	9	81%
<i>Current Fiscal Year</i>	Projections	12	27	17	8	7	47%
	Mid Year		44	25	5	5	20%
	Final		66	39	9	8	18%

Explanatory Notes on Data, if needed: 2 will be carried over to FY 2012

Target Population & Brief Program Description: Women ages 18-45, usually in mid-30s with 2 or more dependent children; majority have past trauma; majority court ordered. This is a 24 hour/7 day a week program where most groups and clinical interventions occur on a daily basis. Program designed to empower women to complete its requirements generally between 60-90 days. Welcoming and comfortable facility with properly trained female personnel to deliver gender-specific services.

Brief Description of other knowledge, skills, behavior change that participants typically achieve in this program:

Consumers gain knowledge about the process of addiction and recovery from addiction to ATOD, learn skills to refuse drugs/alcohol and to manage mental health symptoms and behaviors. They also gain an understanding of the effects of ATOD use on their body and how their lives have been changed because of their addiction. The program incorporates a life skills curriculum to help women transition to their post treatment environment successfully and provides linkages to the next stage in their treatment continuum.

Health Recovery Services: Suboxone Program

NOM: Abstinence from Drug/Alcohol Use

	Year	Already Enrolled at Start of FY	New Referrals this Year	Engaged and Completing Program	Achieved Target:	Post Discharge Target:	Success Ratio
					Customer completing MAT and continued maintenance with the use of Suboxone (12+ months) or abstinent without use of Suboxone	N/A	
<i>Historical</i>	FY 08	N/A	N/A	N/A	N/A	N/A	N/A
	FY 09	N/A	N/A	N/A	N/A	N/A	N/A
	FY 10	N/A	N/A	N/A	N/A	N/A	N/A
<i>Current Fiscal Year</i>	Projection		50	20	15	N/A	75%
	Mid Year		60	11	0	N/A	0%
	Final		92	38	12	N/A	100%

Explanatory Notes on Data, if needed: *Engaged and Completing Program

This number may reflect clients that have received some “strikes” or set-backs in the program. However, as of 12/31/10 these clients were compliant with treatment and counseling. 26 will be carried over into FY 2012

Target Population & Brief Program Description: The customers of this program are strictly opioid addicts that have contacted the program for treatment. They can be self-referred, court ordered or ‘other’ referred. They must complete the assessment process and meet the need criteria for Suboxone treatment. They must present with a primary diagnosis of 304.00—Opioid Dependence. They must also agree to the strict rules of the program, including compliance with outpatient treatment services and submission to random drug screens. Currently, there is one physician (Dr. Cordingley), assisted by 2-3 nurses implementing the program in the Athens area. Future plans are to recruit another physician to expand services to consumers. Participants in the Suboxone program are required to participate in Outpatient services as well (individual and/or group counseling, random drug screens, etc.).

Brief Description of other knowledge, skills, behavior change that participants typically achieve in this program: Most clients gain understanding of the ramifications of continued opioid use, as well as, the need to be drug free to fully participate in society and their personal families. They often gain a better understanding of when to legitimately seek medical care. Many clients have improved skills in dealing with opioid dependence and increased life skills related to education and gainful employment. Behavior change most often includes clean urine drug screens for substances other than Suboxone. We may also see changes with regard to employment and school attendance, as well as, improved family relationships.

Health Recovery Services: Detox

NOM: Abstinence from Drug/Alcohol Use

	Year	Already Enrolled at Start of FY	New Referrals this Year	Engaged and Completed Program	<u>Achieved Target:</u> Following discharge from detox, customer returns to HRS to participate in additional treatment	<u>Post Discharge Target:</u> N/A	Success Ratio
<i>Historical</i>	FY 08	N/A	N/A	N/A	N/A	N/A	N/A
	FY 09	N/A	N/A	N/A	N/A	N/A	N/A
	FY 10	N/A	N/A	N/A	N/A	N/A	N/A
<i>Current Fiscal Year</i>	Projections	0	20	14	7	N/A	50%
	Mid Year		14	13	4	N/A	31%
	Final		18	15	5	N/A	33%

Explanatory Notes on Data, if needed: Detox consumers are sent to Parkside Hospital in Columbus, OH.

Target Population & Brief Program Description: The target population for this program are consumers who have severe addiction and who would benefit from an in-patient detoxification program. Consumers come to and HRS Outpatient office and complete a brief assessment in order to obtain a referral to Parkside (if they meet the pre-determined criteria for the detoxification program). Once referred, HRS can assist with transportation to Parkside. Prior to completion of the program at Parkside, consumers are scheduled for an appointment with HRS to attempt to re-engage them in outpatient treatment or determine if they need residential treatment. This "continuity of care" approach gives the consumer the opportunity to develop a support system and obtain skills needed for sobriety.

Brief Description of other knowledge, skills, behavior change that participants typically achieve in this program:

Successful consumers realize that they have a problem with addiction and have the motivation to make changes in their lives. Ideally, consumers return for outpatient counseling (both individual and group) after finishing the detox program. Once consumers are "clean," they have the ability for better decision making. Consumers that take advantage of the "continuity of care" offered by HRS and Parkside have a better chance at maintaining sobriety and obtaining gainful employment.

Health Recovery Services: Community Awareness

Goal: 2000 of the 2500 customers served by the Community Awareness programs in SFY 2011 will demonstrate, either verbally or through pre and post testing, an increase in their perception of the harm associated with ATOD use.

	Year	Projected to be served	Actual served	Direct Service - <i>Implementations that directly serve the customer and allow for two-way interaction at that instance.</i>	Indirect Service - <i>Implementations that indirectly serve the customer and are typically one-way communication and do not allow for interaction.</i>
<i>Historical</i>	FY 08				
	FY 09	700	6000		
	FY 10	2250	5399		
<i>Current Fiscal Year</i>	Projections	2500		2500	0
	Mid Year		3313	2594	719
	Final		4964	3848	1116

Explanatory Notes on Data, if needed:

Target Population & Brief Program Description:

Target Population

Customers are youth, adults and senior citizens residing in Athens, Hocking and Vinton Counties.

Brief Description of other knowledge, skills, behavior change that participants typically achieve in this program: Due to the brief nature of these programs, outcomes assessment is relatively simple, consisting of either pre and post testing or verbal interview to determine any increase in the perception of harm from alcohol tobacco and other drug use.

Health Recovery Services: At Risk Residential Program

Goal: During SFY '11, 65 of the 100 customers served by the At-Risk Residential Programs will demonstrate an increased perception of harm of using ATOD as determined by pre and post testing and attitudinal surveys.

	Year	Projected to be served	Actual served	Direct Service - <i>Implementations that directly serve the customer and allow for two-way interaction at that instance.</i>	Indirect Service - <i>Implementations that indirectly serve the customer and are typically one-way communication and do not allow for interaction.</i>
<i>Historical</i>	FY 08				
	FY 09	50	22	22	0
	FY 10	50	56	56	0
<i>Current Fiscal Year</i>	Projections	100		100	0
	Mid Year		262	262	0
	Final		885	885	

Explanatory Notes on Data, if needed:

Target Population & Brief Program Description:

Target Population

- Ages 12-18 (grade 6-12)

Brief Description of other knowledge, skills, behavior change that participants typically achieve in this program: In addition to reporting an increased perception of harm from the use of alcohol, tobacco and other drugs, program participants demonstrated increased pro-social and communication skills from being exposed to non-clinical intervention modalities. Several of them expressed an interest in being involved in prevention programs in their schools upon release. They also reported that they immensely enjoyed the prevention presentations because of their fun, interactive nature. This kept them engaged and highly motivated to participate.

Health Recovery Services: Positive Associations and Life Skills (PALS)

Goal: During SFY '11, 20 of the 30 customers served by the PALS program will learn and demonstrate personal self-management skills that will enable them to make healthy life choices including abstinence from alcohol, tobacco and other drugs during their participation in the PALS

	Year	Projected to be served	Actual served	Direct Service - <i>Implementations that directly serve the customer and allow for two-way interaction at that instance.</i>	Indirect Service - <i>Implementations that indirectly serve the customer and are typically one-way communication and do not allow for interaction.</i>
<i>Historical</i>	FY 08	N/A			
	FY 09	N/A			
	FY 10	30	14	14	0
<i>Current Fiscal Year</i>	Projections	30		30	0
	Mid Year		3	3	0
	Final		4	4	

Explanatory Notes on Data, if needed:

Target Population & Brief Program Description: Despite repeated efforts by the implementers to arrange referrals with the Athens County Juvenile Court and Children's Services early in SFY 11, only 4 had been generated by the end of the first quarter. Staffing changes at that time resulted in reduced resources, so the decision was made to focus on our other programs, which have correspondingly higher numbers as a result

Brief Description of other knowledge, skills, behavior change that participants typically achieve in this program: See above

Health Recovery Services: Safe Dates

Goal: During SFY '11, 250 of 300 customers participating in Safe Dates will demonstrate gaining the skills to develop healthy dating relationships, including positive communication, anger management, and conflict resolution.

	Year	Projected to be served	Actual served	Direct Service - <i>Implementations that directly serve the customer and allow for two-way interaction at that instance.</i>	Indirect Service - <i>Implementations that indirectly serve the customer and are typically one-way communication and do not allow for interaction.</i>
<i>Historical</i>	FY 08	N/A			
	FY 09	N/A			
	FY 10	N/A			
<i>Current Fiscal Year</i>	Projections	300		300	0
	Mid Year		1043	1043	0
	Final		3927	3927	

Explanatory Notes on Data, if needed:

Target Population & Brief Program Description:

Target Population for Safe Dates

*Students in grades 7-12

Brief Description of other knowledge, skills, behavior change that participants typically achieve in this program:

Customers complete a Pre and Post Program survey to determine their baseline knowledge and perceived level of safety from dating violence, which is used to document knowledge, attitude and behavioral changes resulting from the Safe Dates program. Students reported the following outcomes:

- less acceptance of dating violence
- stronger communication and anger management skills

George E. Hill Center for Counseling & Research, Ohio University Medical Associates

NOM: Abstinence from Drug/Alcohol Use

	Year	Already Enrolled at Start of FY	New Referrals this Year	Engaged and Completed Program	<u>Achieved Target:</u> Customer has met the criteria for Relapse Prevention Group; completes 10 group sessions or participates in individual counseling	<u>Post Discharge Target:</u> Upon completion of all group or individual sessions, client agrees to participate in a 10-week relapse prevention group	Success Ratio
<i>Historical</i>	FY 08	N/A	N/A	N/A	N/A	N/A	
	FY 09	0	157	87	42	42	48%
	FY 10	0	151	148	98	63	66%
<i>Current Fiscal Year</i>	Projections	0	150	120	100	25	83%
	Mid Year	0	76	58	34	20	59%
	Final		150	107	65	53	61%

Explanatory Notes on Data, if needed: Slight change in target from FY 09 to FY 10; Target is based upon Center for Substance Abuse Treatment (CSAT) Treatment Improvement Protocols (TIP 41)

Target Population & Brief Program Description: Patients of two physicians who are being treated for opioid addiction with buprenorphine at University Medical Associates (UMA); many patients lack transportation, supportive home environment, social supports and employment. Patients are screened for motivation to participate actively in recovery program; those accepted participate in weekly group or individual sessions for ten weeks; relapse prevention group optional for an additional ten weeks.

Brief Description of other knowledge, skills, behavior change that participants typically achieve in this program: Clients are expected to participate in educational and therapeutic activities in group or individual counseling. Counselors target strategies for relapse prevention in group, but also work to foster the development of interpersonal skills in order to facilitate clients being able to acquire and maintain healthy social support systems. On open-ended feedback questionnaires, clients have noted that they see differences in their personal relationships, in their work ethic, and in their ability to set goals after completing the program.

John W. Clem Recovery House

NOM: Abstinence from Drug/Alcohol Use

	Year	Already Enrolled at Start of FY	New Referrals this Year	Engaged and Completed Program	<u>Achieved Target:</u> Participant completes 90 days of recovery graduating from JWCRH	Post Discharge Target: Participants attend an alumni dinner showing evidence of longer term recovery	Success Ratio
<i>Historical</i>	FY 08	N/A	N/A	N/A	N/A	N/A	N/A
	FY 09	N/A	N/A	N/A	N/A	N/A	N/A
	FY 10	N/A	42	10	10	N/A	100%
<i>Current Fiscal Year</i>	Projections		42	42	8	8	19%
	Mid Year		22	4	4	4	100%
	Final		52	9	9	N/A (1x/yr)	100%

Explanatory Notes on Data, if needed:

Target Population & Brief Program Description: Male alcoholics and drug addicts age 18 and older; have been addicted for 10-30 years and may never have been in recovery; frequently court-ordered; often unemployed; frequently divorced or unmarried but with dependent children; contract with Veterans Administration to serve Veterans. Safe and drug free environment with 24/7 services; 12 Step Philosophy with meetings conducted daily; zero tolerance of alcohol and drug use or possession; active support from recovery community; Length of stay designed to be 3-6 months with average length of stay 3 months;

Brief Description of other knowledge, skills, behavior change that participants typically achieve in this program: Improved self awareness; enhanced anger management skills; introduction to the value of counseling.

Southeast Ohio Regional Jail

NOM: Abstinence from Drug/Alcohol Use and Decreased Criminal Justice Involvement

	Year	Already Enrolled at Start of FY	New Referrals this Year	Engaged and Completed Program	<u>Achieved Target:</u> Customer graduates from the program- has knowledge of addiction process, lifestyle changes to support drug free living, relapse process & benefits of 12 step programs	Post Discharge Target: Graduates will not return within 6 months post-release from SEORJ	Success Ratio
<i>Historical</i>	FY 08	N/A	161	84	19	N/A	23%
	FY 09	N/A	299	209	44	N/A	21%
	FY 10	52	275	167	50	34	30%
<i>Current Fiscal Year</i>	Projections	14	200	150	50	35	33%
	Mid Year	26	138	152	29	20	19%
	Final	18	140	310	50	35	16%

Explanatory Notes on Data, if needed:

Target Population & Brief Program Description: The drug and alcohol intervention program is designed to help inmates at the Southeastern Ohio Regional Jail who have been incarcerated due to their continued use of drugs/alcohol. The goal of the program is to reduce the recidivism rate among these inmates. This program addresses four areas of concern: the addiction process, lifestyle changes, relapse processes and drug free support systems. The first six months of this year, July 2010 through December 2010, 152 inmates, 78 female and 74 male, were involved in the program.

Brief Description of other knowledge, skills, behavior change that participants typically achieve in this program: The number one issue for all inmates who choose to live drug free is developing a drug free/sober support system. Inmates learn to say “no” to drug using peers, to be more assertive about their recovery and to stop seeing themselves as a victim while taking responsibility for their behavior.