Report on People Discharged from Mayview State Hospital for the Quality Improvement/Outcomes Committee and Steering Committee

Executive Summary

Mayview State Hospital closed on December 29, 2008. Over the last several years, the five counties in the Mayview service area[1], Mayview State Hospital, and the Department of Public Welfare (DPW) have developed a recovery-oriented community support planning (CSP) process for people being discharged. These efforts have been coordinated by Allegheny HealthChoices, Inc. (AHCI).

This report provides information on the people discharged with a CSP. Because the CSP process involved the hard work of many people and the development of new resources, we expect that people discharged:

- Have frequent contacts with their CTT or case managers/service coordinators.
- Have stable housing that offers the kind of support people need.
- Have the opportunity to change the services and supports they get in the community if their needs or preferences change.
- Remain safe in the community, with few hospitalizations or incarcerations (or other serious incidents).

While many people discharged have not yet spent very many months in the community, this report describes the group's demographics and preliminary data related to housing stability, use of services and supports, and time spent living in the community (rather than in a hospital or criminal justice facility). Key points from this report include the following:

The demographics of the people discharged with a community support plan:

- Of the 269 people discharged as part of the closure, more than half had two or more admissions to Mayview State Hospital (including their most recent stay)
- 25% are 55 years or older, 37% are between 45 and 55 years, 16% are between 35-45 years, and 22% are under 35 years

Housing arrangements at discharge:

- People were discharged to a variety of settings. The most common include: 26% to long-term structured residences (LTSRs), 22% to different types of personal care homes, and 19% to community residential rehabilitation (CRR) group homes or apartments.
- 19% of people who have been discharged at least three months have moved since their discharge. About two-thirds of these moves were to a less restrictive setting or setting with fewer supports.

Service use for people who have spent at least three months in the community:

- More people were recommended Community Treatment Team (CTT) services than case management/service coordination. As an evidence-based service, CTT is especially suited for people with significant hospitalization histories and complex needs.

[1] Allegheny, Beaver, Greene, Lawrence, and Washington Counties

- People with CTT services have had frequent contact with their CTT, where 26% of people had 6-7 average contacts per week, 33% had 4-5 average contacts per week, and 32% had 2-3 average contacts per week during their first three months in the community.
- People with case management/service coordination services have less frequent contact than those receiving CTT. During their first three months in the community, the majority of people with case management saw their case managers at least once per week on average (26%), 2-3 times per week on average (41%), or 4-5 times per week on average (14%).
- When considered in conjunction with the frequency of people living in 24-hour staffed residences, this preliminary data indicates that people are being seen frequently in the community.
- Use of other behavioral health services with the exception of outpatient mental health has been low. Given that CTT is a team-delivered comprehensive service, people with CTT should generally not need other behavioral health services.

Access to supports and activities for people who have spent at least three months in the community:

- Nearly 75% of people had contact with their peer mentor after discharge. Many peer mentors were involved during the CSP process.
- Only slightly more than 20% of people visited drop-in centers.
- About 80% had some type of contact or support from family, and slightly over 40% used spiritual supports.
- Very few people were either recommended or accessed vocational or educational activities during their first three months in the community.

Incarcerations and hospitalizations for people who have spent at least three months in the community:

- During their first three months in the community, 3% of people were incarcerated and 6% had some psychiatric hospital days.
- For those with more than three months in the community, 7% of people were incarcerated and 17% had some psychiatric hospital days.

Other early warning signs and critical incidents:

- Beginning in June 2008, AHCI developed an online database for reporting early warning signs and critical incidents.[2]
- When these instances are reported, the provider and county monitors discuss what follow-up is necessary to assist the individual in remaining safe in the community.
- While it is premature to identify trends, nearly a third of those discharged (29%) have had an early warning sign report, which indicates that providers are reporting incidents and counties are proactively working to address situations.

AHCI, in collaboration with the five counties and DPW, will continue to monitor and report on these domains to ensure that the goals of the closure continue to be met. This report, along with future reports, will help inform counties and DPW on the successes and challenges of the closure as well as provide context for any quality improvement activities.

[2] Before June 2008, providers were required to report these incidents to the counties, and the counties were required to follow-up but there was not a mechanism to easily count the number of events and look for trends.

Introduction

Mayview State Hospital closed on December 29, 2008. Over the last several years, the five counties in the Mayview service area[3], Mayview State Hospital, and the Department of Public Welfare (DPW) have developed a recovery-oriented community support planning (CSP) process for people being discharged. These efforts have been coordinated by Allegheny HealthChoices, Inc. (AHCI).

The goals of this CSP process were to:

- Develop a thorough discharge plan (CSP) for each person. Each CSP included recommendations for housing and mental health treatment. New housing programs were created when necessary. Frequent services were recommended to help support people as they moved back to the community.
- Address the whole person, not just housing and treatment. Based on individual needs, CSPs also recommended physical health care, substance abuse services, daily activities, and other supports.
- Involve each person being discharged in the planning process as much as they wanted. This meant asking about and addressing their preferences and needs. It also meant including family and peer mentors if the person wished.
- Involve community providers early to make sure people were connected to services like Community Treatment Teams (CTT) or case managers/service coordinators before discharge.

Because the CSP process involved the hard work of many people and the development of new resources, we expect that people discharged:

- Have frequent contacts with their CTT or case managers/service coordinators.
- Have stable housing that offers the kind of support people need.
- Have the opportunity to change the services and supports they get in the community if their needs or preferences change.
- Remain safe in the community, with few hospitalizations or incarcerations (or other serious incidents).

This report provides information on the people discharged with a CSP. AHCI used information from multiple data sources for this report. Using different kinds of data allows us to provide an overview of the services and supports *recommended* in the CSP and *received so far* in the community. We used:

- Data on the services and supports in the final CSPs. These are the recommendations for what the person should receive or have access to in the community.
- Data on the type of services and supports *actually* accessed each month, as reported by the County monitors to AHCI and DPW.
- Data on the amount of services billed by providers.
- Data on critical incidents.

Because the hospital recently closed and about one third of people were discharged as part of the closure between August and December 2008, it is too early to provide information on the services and supports *received so far* by everyone who participated in this process. This report serves as a first look, focusing most on *who was discharged* and *what happened* during the first three months after discharge.

[3] Allegheny, Beaver, Greene, Lawrence, and Washington Counties

We also do not include the perspective of the people discharged in this report (see Next Steps on page 19).

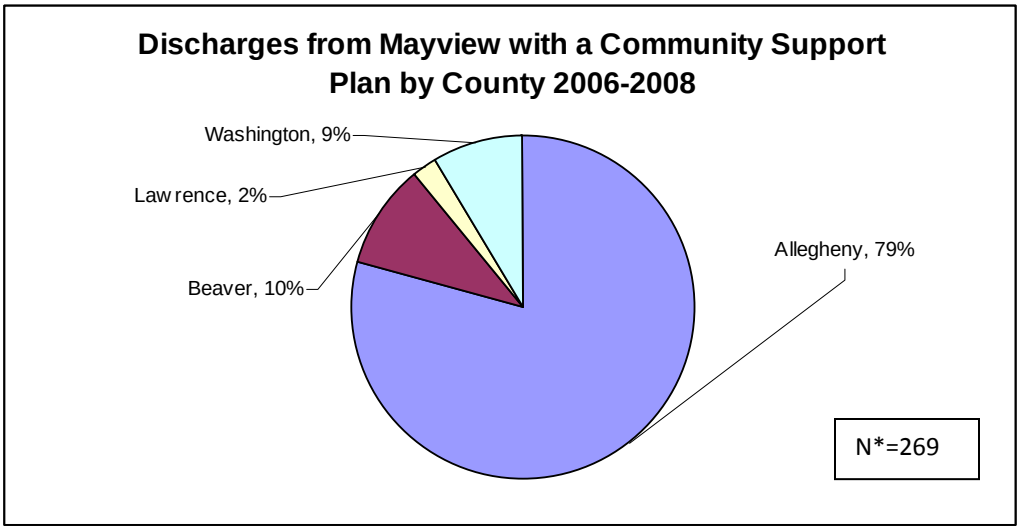
When reviewing the report, it is important to think about what the *overall* trends and patterns are in the data. Each county has staff that are checking in with each consumer and monitoring each service provider at least on a monthly basis. This helps to make sure that individual needs are being met and that any incidents, concerns, or changes in needs are being addressed.

This report covers:

Who has been discharged?

The following charts describe the people who have been discharged. Information in the charts includes peoples' county of residence, age, gender, race, and length of stay at Mayview State Hospital.

Chart 1



*N means the number of people included in the chart.

Chart 2

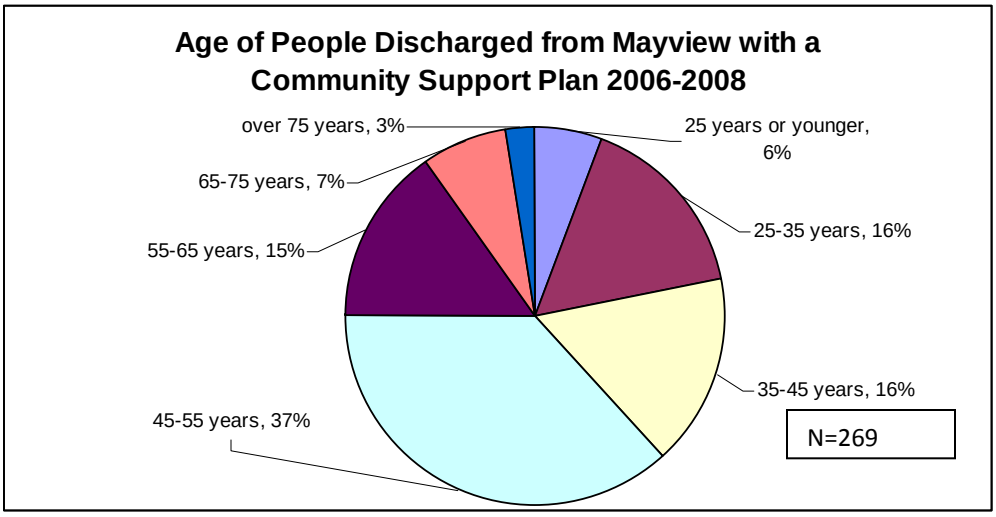


Chart 3

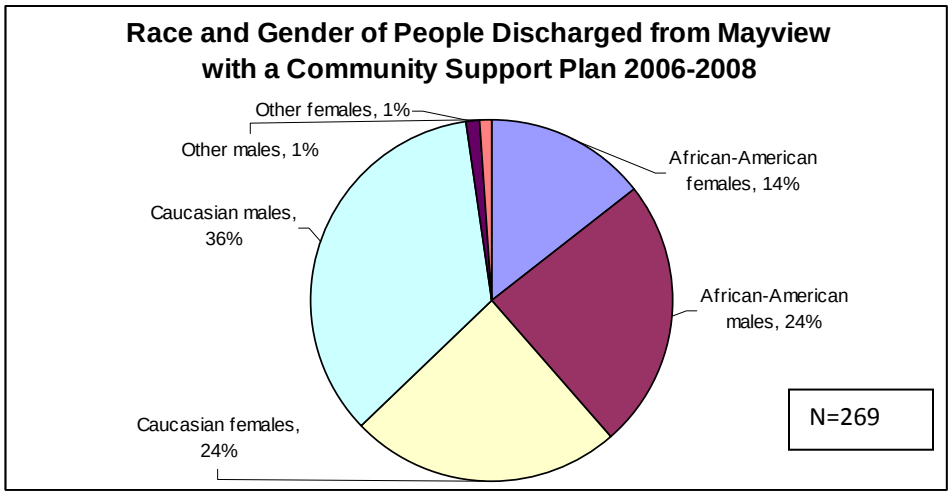


Chart 4

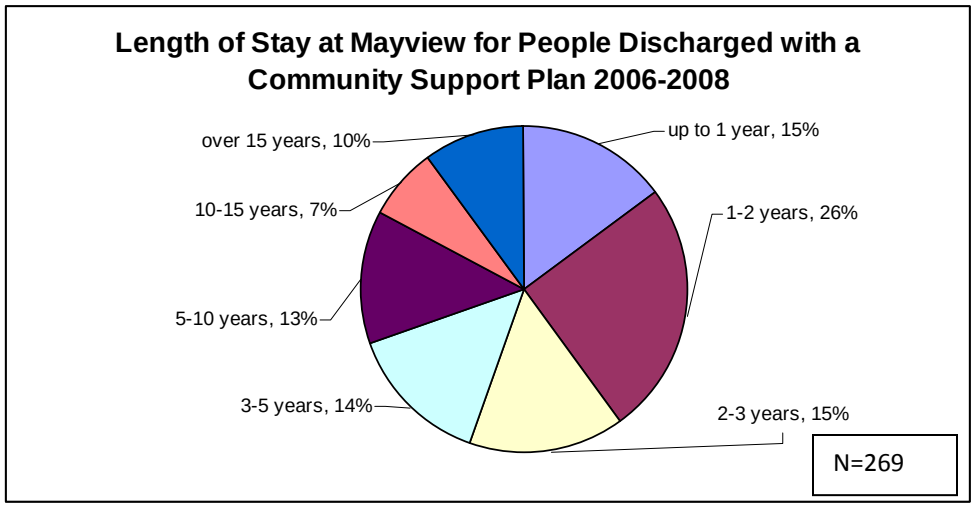


Chart 4 includes people's most recent stay at Mayview but many consumers have spent time in and out of the state hospital system through their adult lives:

- 65 people (24%) had one previous stay at Mayview
- 52 people (19%) had two to three previous stays at Mayview
- 28 people (10%) had four or more previous stays at Mayview
- 124 people (46%) did not have a previous stay at Mayview

The length of these past stays varied. For people with previous stays at Mayview, total amount of time in Mayview (excluding this most recent admission where a CSP was developed) was:

- Less than one year: 40 people (28%):
- One to three years: 59 people (41%):
- Three to five years: 22 people (15%):
- More than five years: 24 people (16%):

Housing at Discharge and Housing Change

The table below shows the housing arrangements that people went to when they were discharged from the hospital. The majority (80%) were discharged to a place that is staffed 24 hours a day. The counties have developed many new housing options, including expanding current housing programs, for people leaving Mayview. Definitions for the housing categories are in the glossary.

Table 1

Housing at Discharge for People with a CSP, 2006-2008		
Housing category	**Number of People**	**Percent of People**
Living arrangements without 24-hour residential staff		
Family	7	3%
Living independently	10	4%
Permanent supportive housing	6	2%
Supportive housing	19	7%
Living arrangements with 24-hour residential staff		
(Enhanced) personal care home (EPCH or PCH)	11	4%
Community Residential Rehabilitation (CRR)	51	19%
Comprehensive mental health personal care home (CMHPCH)	49	18%
Domiciliary Care	1	0%
Long-term structured residence (LTSR)	69	26%
Mental retardation (MR) housing	13	5%
Nursing home	12	4%
Specialized supportive housing	21	8%
Total	**269**	**100%**

Housing stability

About 19% of people (33 out of 170)[4] changed their housing arrangement between their discharge date and the most recent update from the county monitors.

- Of the 33 people who changed housing categories, 20 people (61%) moved from a setting that had more restrictions/built-in supports to a setting that is less restrictive/with fewer built-in supports (for example, LTSR to CRR).
- Of the 33 people who changed housing categories, 11 people (33%) were from a setting with fewer restrictions/built-in supports to a setting with more restrictions/built-in supports (for example, family setting to CRR).

[4] This includes only the 170 people with at least three months living in the community after discharge (discharged before 7/31/08). Note that people's discharge dates range from 2006 to 2008. Eleven people from Allegheny County who were either in the hospital or jail at the time the data was run were excluded because these living arrangements are considered temporary and their disposition at the time of the data was unknown (it could be either less or more restrictive or back to the same setting).

- Of the 33 people who changed housing categories, 2 people (6%) had a housing change that was neutral in terms of the type of setting (for example, from an independent setting to a setting with family).
- No one became homeless.

Moving from a less restrictive setting to a more restrictive setting is not necessarily a negative outcome. It may simply mean that an individual needed more assistance with daily living skills or treatment than expected during the CSP process. Also, as people spend more time in the community, their needs and preferences change.

Community Treatment Team (CTT) and Case Management/Service Coordination Use

During the CSP process, mental health services were discussed and recommended. Everyone discharged had either a Community Treatment Team (CTT) or a Case Manager/Service Coordinator. Please see the glossary for more information on these services. As of 12/29/2008[5]:

- 65% (174 people) were recommended CTT services
- 26% (70 people) were recommended some type of case management services, including a few with enhanced clinical case management teams

The next four tables (Tables 2 – 5) provide information on CTT and case management/service coordination services that people received, based on billed services, during their first three months in the community. When reviewing this data, it is important to note the limitations of the billing data available for this analysis:

- Paid services include claims filed to Community Care Behavioral Health and Value Behavioral Health for people who have HealthChoices insurance (Medicaid). Services paid by Allegheny County are also included. Services paid for by the suburban counties are not included as AHCI does not *yet* have access to that information.
- Some billing records may not yet have been submitted. Providers have 90 days to submit claims; because of the timing of this data, some individuals' billing records may not yet have been processed.
- Two CTTs were initially funded with HealthChoices reinvestment funds. These contacts were missing from the billing data. AHCI is working to correct this omission.
- Some individuals (about 16%) received both CTT and case management services. While generally people should receive one or the other, a number of individuals transitioned from case management to CTT after they were discharged. Average contact calculations for each service in these situations will be skewed.

The frequency of contact for CTT and case management services and comparisons to recommendations in the final CSPs will continue to be monitored as information is updated for a larger cohort and as data becomes more complete. In the meantime, this data provides an important overall view of service intensity provided by CTT and case management/service coordination.

[5] The counties had not yet completed the initial discharge report for 9% (25) of people discharged near the end of December 2008 so they are not included.

CTT Services Received During First Three Months after Discharge

Tables 2 and 3 provide information on paid CTT services for people discharged from Mayview before 7/31/08, for their first three months in the community. CTT services are expected to be intensive based on the needs of each person. See the glossary for more information on CTT.

Table 2

Frequency of Contact with CTT Months 1-3 after Discharge, in Comparison to Level of Supervision in Housing						
	NOT in 24 Hour Staffed Housing		IN 24 Hour Staffed Housing		Total	
	# of People	% of People with CTT	# of People	% of People with CTT	# of People	% of People with CTT
1 avg. contact per month	1	5%	4	6%	5	6%
2 avg. contacts per month	0	0%	0	0%	0	0%
1 avg. weekly contact	2	10%	1	1%	3	3%
2-3 avg. weekly contacts	3	14%	26	38%	29	32%
4-5 avg. weekly contacts	5	24%	25	36%	30	33%
6-7 avg. weekly contacts	10	48%	13	19%	23	26%
Total	21	100%	69	100%	90	100%

In Table 2, we see that:

- Most people are living in housing with 24 hour staff right after they are discharged (highlighted in gray: 69 out of 90 people, 77%). Fewer people are living in housing without 24-hour staff (highlighted in gray: 21 out of 90 people, 23%).
- Nearly all people living in 24 hour-staffed residences had multiple average contacts per week (highlighted in orange: 64 out of 69 people, 93%).
- People who were NOT discharged to 24-hour staffed residences had frequent contact, at least four times per week on average, with CTT (highlighted in green: 15 out of 21 people, 71%).
- Overall, only 5 out of 90 people (6%) had contact less than weekly (highlighted in pink).

Table 3 compares the frequency of CTT services *received* to the *recommended* frequency in the CSP. This does not reflect any changes made to the CSP recommendations after discharge.

Table 3

For people with CTT services in months 1-3 after discharge, what were the CSP recommendations for service intensity, and were they met? (N=67)				
Service Intensity Received	Recommended service intensity in CSP			
	2 - 3 Times/Week	4 - 6 Times/Week	Daily	Total
1 avg. contact per month	1%	1%	3%	6%
2 avg. contacts per month	0%	0%	0%	0%
1 avg. weekly contact	0%	0%	1%	1%
2-3 avg. weekly contacts	7%	1%	22%	31%
4-5 avg. weekly contacts	1%	4%	27%	33%
6-7 avg. weekly contacts	0%	0%	28%	28%
Total	7	5	55	67

Yellow = people who got less intensive services than recommended in their CSP
Blue = people who got the intensity (or more) of CTT services that was recommended in their CSP

Table 3 shows four main points:

- Most people (55 out of 67 people, 82%) were recommended daily contact with CTT in their CSP. A smaller number were recommended contact 4-6 times per week (5 people) or 2-3 times per week (7 people). See the total row in Table 3, shaded in gray.
- Of those where daily contact was recommended, 28% (19 of the 67 people with CTT) averaged 6-7 contacts per week; 27% averaged 4-5 contacts and 22% averaged 2-3 weekly contacts.
- However, people still had a lot of contact. Most were living in 24-hour staffed residences and saw CTT 2-5 times per week on average.
- Overall, 42% received *at least* the intensity recommended in their CSP (the sum of the blue numbers). 58% did not (the sum of the yellow numbers).

Note: Table 3 includes a smaller group of people than Table 2. Only people who were discharged after the closure announcement (August 2007) who received some CTT services are included. Before the closure announcement, the CSPs were not always specific about their recommendations for service intensity. So, it would not be accurate to include these people in the comparison.

Changes after three months

We also looked at service use beyond three months. Preliminary results suggest:

- After the first three months in the community, we did not see that service intensity for CTT dropped off.
- There were some changes at the individual level, both increases and decreases in average weekly contacts.

Case Management/Service Coordination Services Received During First Three Months after Discharge

Tables 4 and 5 provide information on paid case management/service coordination services for people discharged from Mayview before 7/31/08, for their first three months in the community. Case management services are expected to be as intensive as needed, based on the individual. Usually case management is less intensive than CTT (see the glossary).

Table 4

Frequency of Contact with Case Management/Service Coordination Months 1-3 after Discharge, Compared to Level of Supervision in Housing (N=58)						
	NOT in 24 Hour Staffed Housing		IN 24 Hour Staffed Housing		Total	
	# of People	% of People with Case Mgmt.	# of People	% of People with Case Mgmt.	# of People	% of People with Case Mgmt.
1 avg. contact per month	1	10%	5	10%	6	10%
2 avg. contacts per month	3	30%	2	4%	5	9%
1 avg. weekly contact	1	10%	14	29%	15	26%
2-3 avg. weekly contacts	3	30%	21	44%	24	41%
4-5 avg. weekly contacts	2	20%	6	13%	8	14%
6-7 avg. weekly contacts	0	0%	0	0%	0	0%
Total	10	100%	48	100%	58	100%

In Table 4, we see that:

- Most people are living in housing with 24 hour staff right after they are discharged (highlighted in gray: 48 out of 58 people, 83%). Fewer people are living in housing without 24-hour staff (highlighted in gray: 10 out of 58 people, 17%).
- Of the small number of people (10) who were NOT discharged to 24-hour staffed residences, their average weekly contacts with case management varied (highlighted in green).
- Nearly all people living in 24 hour-staffed residences had multiple contacts per week (highlighted in orange: 41 out of 48 people, 85%).
- Overall, most people had at least one contact per week on average (highlighted in pink: 47 out of 58 people, 81%).

We also looked at other comparisons with this data. We found that after the first three months in the community, the service intensity for case management does not seem to drop off. There were some changes at the individual level, both increases and decreases, in average contacts per week.

Table 5 compares the frequency of case management services *received* to the *recommended frequency* in the CSP. This does not reflect any changes made to the CSP recommendations after discharge.

Table 5

For people with case management/service coordination services in months 1-3 after discharge, what were the CSP recommendations for service intensity and were they met? (N=31)						
	Recommended service intensity in CSP					
	Semi-Monthly	Weekly	2 - 3 Times Per Week	4 - 6 Times Per Week	Daily	Total
1 avg. contact per month	0%	0%	0%	0%	16%	16%
2 avg. contacts per month	3%	0%	3%	0%	3%	10%
1 avg. weekly contact	0%	6%	3%	6%	6%	23%
2-3 avg. weekly contacts	3%	0%	13%	6%	13%	35%
4-5 avg. weekly contacts	0%	6%	6%	3%	0%	16%
6-7 avg. weekly contacts	0%	0%	0%	0%	0%	0%
Total	2	4	8	5	12	31

Yellow = people who got less intensive services than recommended in their CSP
Blue = people who got the intensity (or more) of CTT services that was recommended in their CSP

Table 5 shows three main points:

- Fewer people were recommended case management than CTT, and the recommended intensity was also less (see Total row, shaded in gray).
- Most people had one average contact per week (23%), 2-3 average contacts per week (35%), or 4-5 average contacts per week (16%) (shaded in pink).
- Overall, 42% received at least the case management intensity recommended in their CSP (the sum of the blue numbers). 58% did not (the sum of the yellow numbers).

Note: Table 5 includes a very small group of people. This makes it difficult to find trends. Only people who were discharged after the closure announcement (August 2007) who received some case management/service coordination services are included. Before the closure announcement, the CSPs were not always specific about their recommendations for service intensity. So it would not be accurate to include these people.

People with zero average contacts with CTT or case management

- 35 (21%) people out of those discharged before 7/31/08 had an average of zero contacts per week for either CTT or case management.
- Thirteen of these 35 people (8% of the total) are from Allegheny County. On further investigation, we found that all 13 did receive services either from an administrative case manager (two individuals in nursing homes, one involved with the mental retardation system) or from CTT (due to some billing reasons, their services did not appear in claims).
- Twenty-two of these 35 people (13% of the total) are from one of the suburban counties, where our data on service use is limited to people who have HealthChoices insurance. So, the fact that we have no services is probably a result of missing data because these 22 people were not eligible for HealthChoices insurance within three months after discharge.

Other Mental Health/Substance Abuse Services Used

While CTTs provide nearly all mental health and substance abuse services people are expected to need, people with case managers/service coordinators may also need to see a psychiatrist for psychiatric medications or need other services. Also, on rare occasions, people on CTT may need additional services, like drug and alcohol rehabilitation. Each CSP was individualized in the recommendations.

In people's first three months in the community, use of other behavioral health services was generally low.

- About 3% of people used a crisis service (note this doesn't include the crisis interventions done by CTT)
- About 17% of people used outpatient mental health services and 5% used partial mental health services
- Only 1% of people used either community-based or residential drug and alcohol services (note this doesn't include drug and alcohol services provided by CTT or community support groups like AA or NA).

People who do not receive CTT services generally will need to receive psychiatric services from either their residence (if living in an LTSR), or through partial or outpatient mental health services. A number of people without CTT services did receive outpatient mental health services, attend partial programs, and/or live in an LTSR. As some of the limitations to the data are addressed (see page 7), future analyses will examine whether people receive psychiatric services if they are not on a CTT.

Community Supports and Activities

During the CSP process, supports and activities are discussed and recommended. The three charts below show two kinds of information:

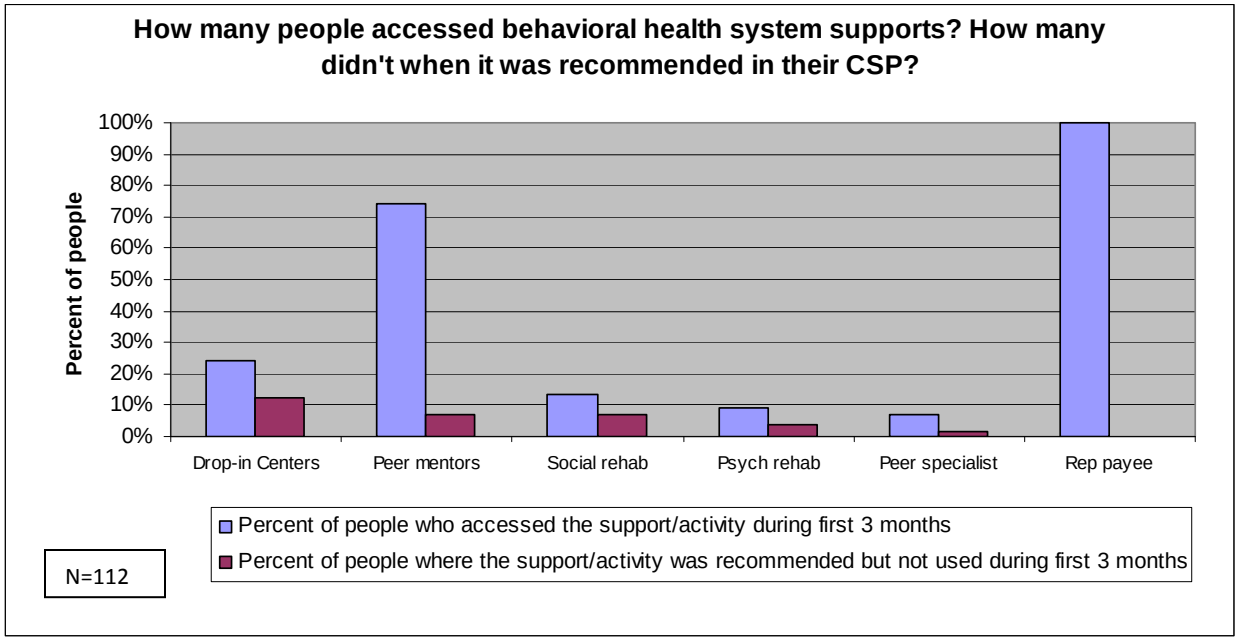
- The percent of people who actually used a support or participated in an activity during their first three months in the community (blue bars)
- The percent of people where the CSP recommended the support or activity but the person DID NOT access it during the first three months in the community (red bars)

The supports and activities are divided into three categories:

- Supports and rehabilitation activities through the service system (Chart 5)
- Community-based supports, those that anyone (not just consumers) have access to (Chart 6)
- Vocational/educational supports and activities (Chart 7)

Peer mentors were involved with many people during the CSP process. Chart 5 shows they continued some level of involvement after people were discharged, with more than 70% having some contact with their peer mentors during the first three months after discharge.

Chart 5



Note: Psych rehab includes Clubhouse, mobile psych rehab, and site-based psych rehab.

Chart 6

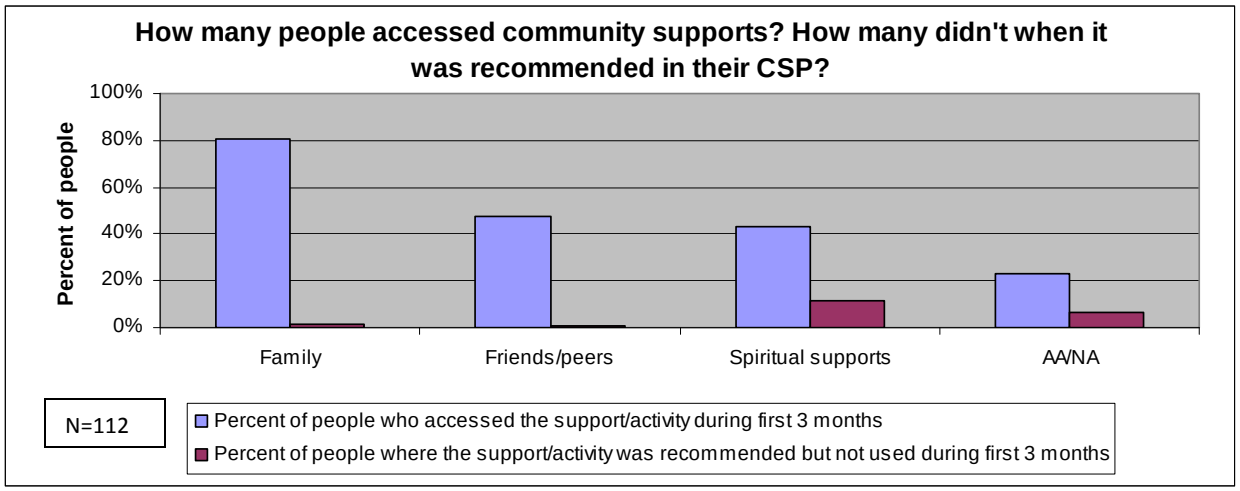
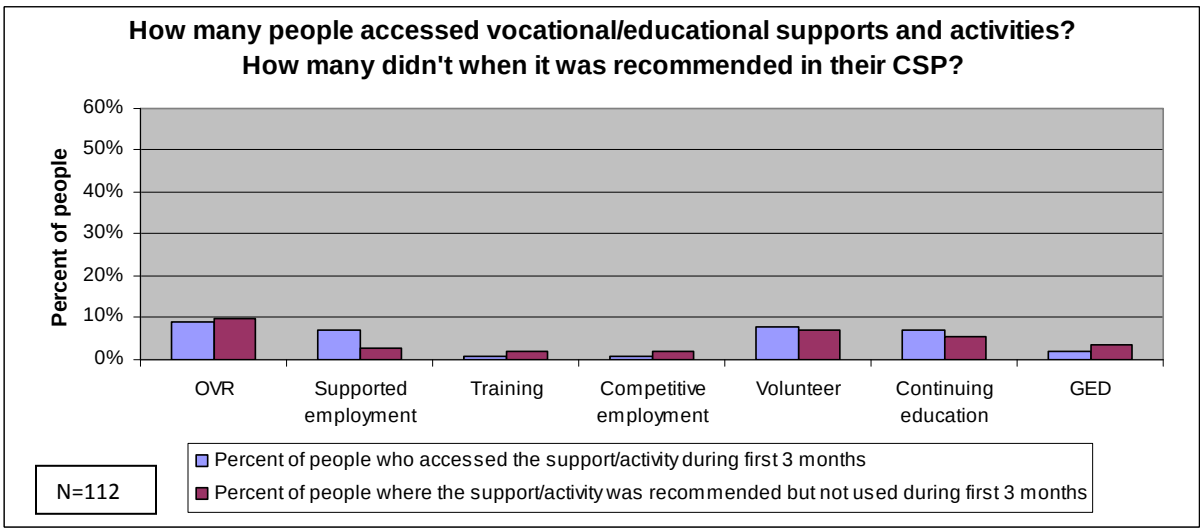


Chart 7



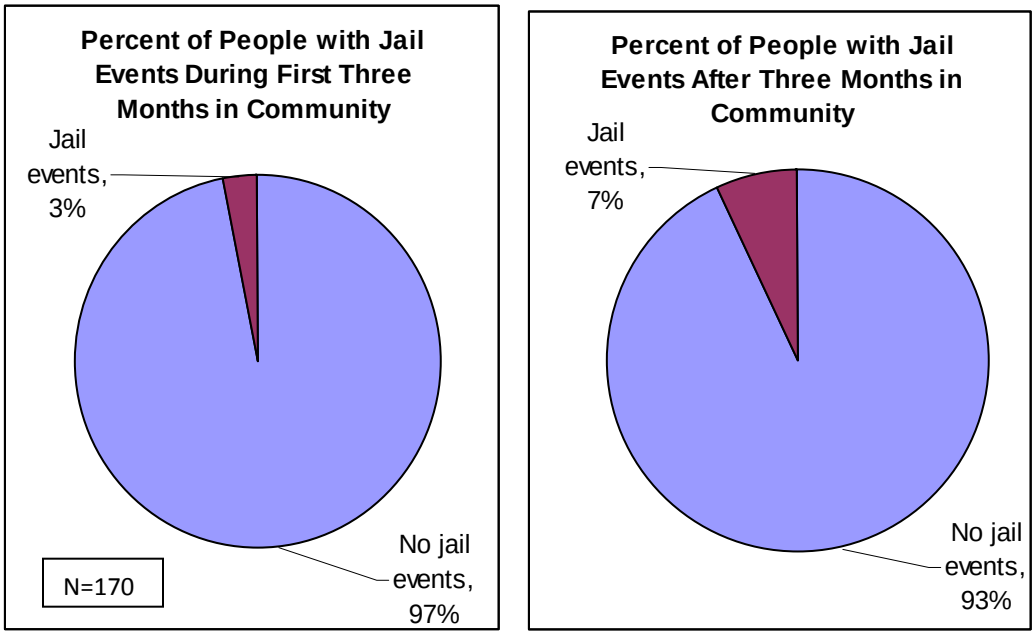
The above three charts show that:

- Peer mentors have been an important resource.
- Everyone receives a representative payee at discharge.
- Many people have some support/involvement with their families.
- There were low rates of recommendations for rehabilitation, education, and employment activities. Also, very few people accessed these opportunities during their first three months in the community.
- For the most part, people are accessing the supports that were recommended in the CSP process. A lot just weren't of interest and recommended to people during the CSP process.

Incarcerations

Based on reports from the county monitors, very few people have been incarcerated since their discharge into the community, including the first three months since their discharge as well as afterward. Note that people included below have spent varying amounts of time in the community (but at least three months). See Chart 8 below.

Chart 8

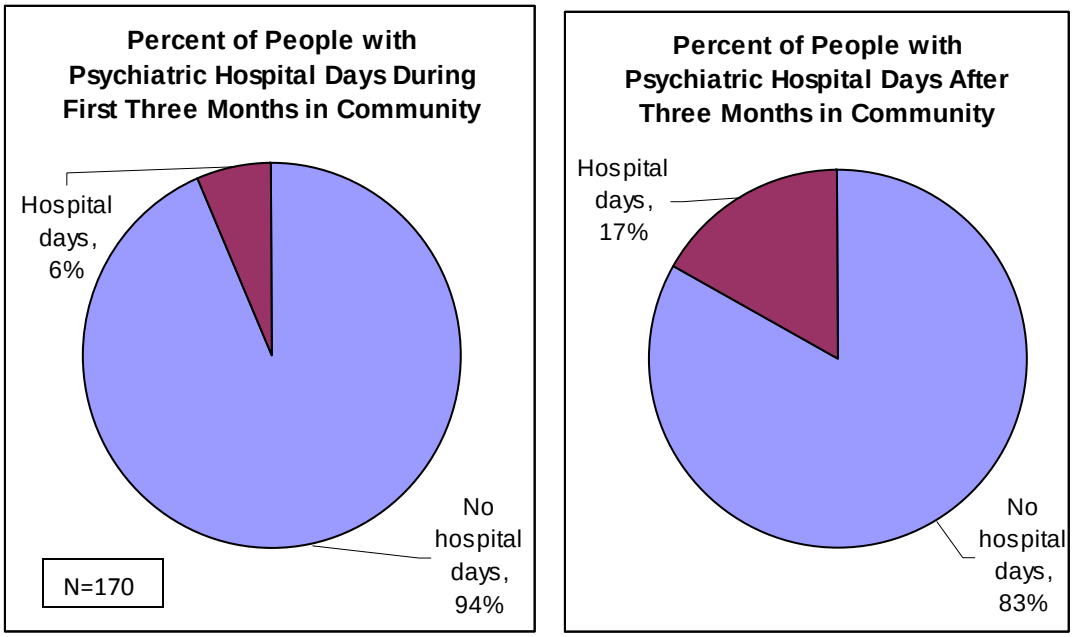


Of the people incarcerated, about half had one or two events. One person has had multiple incarcerations, and three people had longer term incarcerations.

Psychiatric Hospitalizations

Based on paid service records, very few people have been hospitalized during their first three months in the community. After their first three months, 17% had some hospital days. Note that people included below have spent varying amounts of time in the community (but at least three months). See Chart 9 below.

Chart 9



Most people are staying out of the hospital. The number of inpatient days has varied by the individual. Two people have received extended acute services and one person has been admitted to the Residential Treatment Facility for Adults (RTF-A) (not included in Chart 9).

When individuals have been admitted to a psychiatric hospital, the counties have convened treatment team meetings with the individual's community supports (including peer mentors), community treatment providers, residential providers, and the inpatient team to develop a discharge and support plan.

Early Warning Signs and Critical Incidents

Beginning in June 2008, AHCI developed an online database for reporting early warning signs and critical incidents. Before June 2008, providers were required to report these incidents to the counties, and the counties were required to follow-up but we didn't have a way to easily count the number of events and look for trends.

It is important to note that at this point, we can't yet evaluate whether these numbers are high or low. We will monitor for trends. It is positive that providers are reporting the incidents and the counties are following up. Incident reporting is a good way to identify people who are not engaged in their services.

Table 6[6]

Early Warning Signs Reported by Providers to Counties, June - December 2008 (N=269)			
Early Warning Type	**Number of events**	**Number of People with one or more events**	**Percent of people with one or more events**
Attempts At Elopement	1	1	0%
Atypical Behavior - Change From Baseline	66	42	16%
Property Destruction Complaints or Eviction	3	2	1%
E/R Visit - Behavioral/Physical Health	45	26	10%
Inability to Locate Consumer	10	4	1%
Indications For Increased Service/Supports	23	18	7%
Police Involvement	11	10	4%
Refusal to Take Medications Posing Risk	33	18	7%
Sleep Pattern Change From Baseline	4	3	1%
Unexcused Missed Appointments with Provider	15	7	3%
Total	211	77	29%

Table 6 shows that:

- Providers are observing people for small changes that may mean a person is struggling (for example, changing behavior, not sleeping well, or missing appointments).
- Providers are also reporting other concerning events, like ER visits, police involvement, or refusing to take medications.
- When these instances are reported, the provider and county monitors discuss what follow-up is necessary to assist the individual in remaining safe in the community. Providers may need to change their strategies to better engage the person in services.
- Overall, the percentage of people with each type of early warning sign is small. Overall, one third of people discharged have had at least one early warning sign reported.

[6] Tables 6 and 7 include all people discharged with a CSP (N=269). Because people just discharged have had very little time in the community for early warnings or critical incidents, the percent of people with incidents should be reviewed with caution. Also, because these tables include a different group of people and a different timeframe, hospitalizations and arrests can't be compared with pages 13 and 14.

Table 7

Critical Incidents Reported by Providers to Counties, June - December 2008 (N=269)			
Critical Incident Type	Number of events	**Number of People with one or more events**	Percent of people with one or more events
Arrest	6	6	2%
Attempted Suicide	2	2	1%
Involuntary Community Hospitalization	21	16	6%
Voluntary Community Hospitalization	17	12	4%
Housing Change	23	22	8%
Medical Hospitalization	35	29	11%
Medical Treatment Error	8	7	3%
Missing Person	4	3	1%
Other Incident - Serious Nature	28	22	8%
Serious Assault	1	1	0%
Total	145	78	29%

Note: The "Other" category includes a wide range of other incidents. Often these incidents involve disagreements voiced at an individual's residential program with other residents.

Table 7 shows the frequency of critical incidents:

- Medical hospitalizations are the most frequent event.
- Voluntary and involuntary psychiatric hospitalizations are the second most common types of events.
- With critical incidents, the counties follow up to make sure that providers are meeting expectations in the type and frequency of services provided.

Eight people involved in the CSPs have died; two while still in Mayview and six in the community. Seven of the deaths were due to natural causes and one was a suicide.

Next Steps

This report is the first in a series that will monitor services and supports people receive in the community after discharge. As people spend more time in the community, we will be able to include all people discharged with a CSP and look at their services over time. It will also be important to report on:

- How people discharged feel about their services and supports and overall quality of life
- The monitoring activities completed by the DPW's Quality Management and Clinical Consultation (QMCC) team
- The quality of services people receive
- Change over time in people's housing, involvement in their community, and supports

Glossary

Case management: Services designed to ensure people with mental illness receive the continuous care and support they need. Case managers help people to access mental health, substance abuse, housing, social and education services in order to lead a more stable and healthy life in the community. Case managers have a low consumer to staff ratio (usually fewer than 20 consumers to one staff).

Clubhouse: Clubhouses provide opportunities for people with mental illness to socialize, provide support to each other, develop relationships, and work. Members work together to manage the clubhouse operations.

Community residential rehab (CRR): A voluntary residential program in an apartment or group-home setting that provides housing, personal assistance, and psychosocial rehabilitation.

Community Support Plan (CSP): Each person discharged from Mayview as part of the closure develops a CSP. The treatment team, family (if the consumer chooses), community providers, county, advocates and peer mentors may all participate in the plan development.

Community Treatment Team (CTT): Also known as Assertive Community Treatment, CTT is a team-delivered service with extensive success in helping people with serious mental illness live in the community. While staffing patterns may vary from rural to urban areas, CTTs typically include a Team Leader, a Psychiatrist, Nurses, Mental Health Professionals, Drug and Alcohol Specialists, Peer Support Counselors and Vocational Specialists. The hours are flexible, services are provided in the community, and CTT handles after-hours emergencies. The teams provide a wide array of services, including psychiatric evaluations, mental health and drug and alcohol therapy, medication management, case management, peer support, assistance with housing, crisis and hospital diversion services, vocational assessments and supported employment, and assistance in managing personal finances. The staff to consumer ratio is low (10 consumers per staff).

Comprehensive mental health personal care home (CMHPCH): In addition to providing meal preparation and assistance with activities of daily living of enhanced personal care homes, CMHPCHs provide medication monitoring, activities, and have 24-hour staff including mental health professionals and registered nurses.

Consumer Action and Response Team (CART): CART is Allegheny County's Consumer and Family Satisfaction Team. People who work for CART are either consumers or family members. They do interviews with consumers and families in order to report on people's satisfaction with services and quality of life as well as their needs and preferences.

Consumer and Family Satisfaction Team (CFST): Each county in the Mayview service area has a CFST. People who work for CFSTs are either consumers or family members. They do interviews with consumers and families in order to report on people's satisfaction with services and quality of life as well as their needs and preferences.

Crisis Intervention Team (CIT): The CIT includes a specialized group of Pittsburgh Police officers who are trained to handle crises involving individuals with mental illness.

Department of Public Welfare (DPW): The state agency that oversees state mental hospitals and behavioral health treatment services.

Domiciliary care (Dom care): A private home which provides room, board and personal care for people who are mentally ill, mentally retarded, elderly, or physically disabled. Dom care homes usually accommodate three to four residents.

Drop-in center: A place for people with mental illness to go to build meaningful relationships, socialize, learn new skills, and participate in arts, music, and cultural and recreational activities.

Enhanced clinical case management (ECCM): ECCM is a team-delivered mental health treatment service available in Allegheny County. The team includes a clinical therapist, nurse, case manager, and peer specialist.

Enhanced personal care home (EPCH) A facility in which food, shelter and personal assistance or supervision are provided 24 hours a day. These facilities provide assistance or supervision in activities of daily living (ADLs), including dressing, bathing, diet or medication.

Long-term residences (also called specialized supportive housing): Allegheny County has developed several group homes for people who need extra support and supervision in specific areas (including medical needs or behaviors that require close supervision). These community-based homes have 24-hour staff.

Long term structured residence (LTSR): A highly structured 24-hour supervised therapeutic mental health residential facility. LTSRs provide intensive mental health services.

Mayview Regional Service Area Plan (MRSAP): Developed by Allegheny, Beaver, Greene, Lawrence and Washington counties, the goal of the service area plan is to provide excellent behavioral health care for the residents of the five counties. The planning process focuses on how best to support people discharged from Mayview in the community. The planning process also focuses on developing services and supports for people who would in the past have needed to go to Mayview.

Mobile medications: Mobile medication teams include three nurses and a peer specialist, with the consultation of a pharmacist. The teams focus on both providing medications and teaching people how to manage their own medications.

MRSAP Steering Committee: The Steering Committee guides the planning process for the five counties in the Mayview service area. The Steering Committee includes behavioral health professionals, staff from all five counties, administrators from Mayview State Hospital, consumers, advocates, and Pennsylvania Department of Public Welfare (DPW) representatives.

Office of vocational rehabilitation (OVR): Part of the state Department of Labor and Industry, OVR oversees rehabilitation services to promote the employment of people with mental illness and other disabilities.

Peer mentor: The Peer Support and Advocacy Network (PSAN) is operating a peer mentor program for people being discharged from Mayview. People with mental illness are trained to become mentors for people being discharged. Mentors support people through the CSP process and maintain their relationships with people in the community.

Peer specialist: Peer specialists are current or former consumers of behavioral health services who are trained to offer support and assistance in helping others in their recovery and community-integration process. Peer specialists provide mentoring and service coordination supports that allow individuals with serious mental illness to achieve personal wellness and cope with the stressors in their lives. Efforts to provide certification for peer specialists are occurring in Pennsylvania.

Peer Support and Advocacy Network (PSAN): PSAN is a consumer-operated agency. PSAN provides peer support activities at their drop-in centers. They also operate a warmline and a peer mentor program for people being discharged from Mayview.

Permanent supportive housing (PSH): PSH provides affordable housing linked to supportive services that are available, but not required. PSH is safe and secure, affordable to consumers, and permanent, as long as the consumer pays the rent and follows the rules of their lease. This program also includes a Housing Support Team that assists people in maintaining their tenancy and with integrating into their home community.

Psychiatric rehabilitation (also called psychosocial rehabilitation or psych rehab): Programs that help people with mental illness to re-discover skills and access resources needed to become successful and satisfied in the living, working, learning and social environments of their choice. Programs can be mobile (provided in the community) or site-based (provided at a provider's site).

Residential Treatment Facility for Adults (RTFA): RTFA programs provide highly structured residential mental health treatment services for individuals 18 years or older. They offer stabilization services and serve as an alternative to either state or community hospitalization.

Service coordination: Allegheny County calls case management services "service coordination." See case management definition for more information.

Social rehabilitation (social rehab): Social rehab programs help people with mental illness learn social skills and assists people in developing natural support systems in the community.

Specialized supportive housing (also called long-term residences): Allegheny County has developed several group homes for people who need extra support and supervision in specific areas (including medical needs or behaviors that require close supervision). These community-based homes have 24-hour staff.

Steering Committee: See MRSAP Steering Committee above.

Supportive housing: Programs that provide transitional or permanent housing along with needed supported services for individuals.

Warmline: The Warmline is a consumer-operated telephone service available for mental health consumers, or any other interested parties that are 18 and older, to call for support. The service provides supportive listening, problem solving, resource sharing, referral, and peer support.