Moving Forward with Community-Based Recovery: Five Years After The Mayview State Hospital Closure
Executive Summary

Introduction

The Mayview Regional Service Area Plan (MRSAP) project began in July 2005 with representatives of behavioral health authorities in Allegheny, Beaver, Greene, Lawrence and Washington counties working together to develop a plan for supporting people discharged from Mayview State Hospital (MSH) in their communities. The group eventually expanded to include representatives from other behavioral health organizations, people with mental illness, family members, and advocates.

In order to increase the likelihood of a successful transition from MSH to the community, Community Support Plans (CSP), which are person-centered and recovery-oriented, were completed with each person prior to discharge. The CSPs included consideration and recommendations for housing and mental health treatment, and served as a guide for the development of new and expanded community resources.

Following substantial progress achieved in developing new community resources and downsizing the hospital, MSH officially closed December 2008. This report provides an update about the people who were discharged, commonly held myths about outcomes for the people discharged and actual outcomes, financial implications of the closure, and continuing efforts needed in order to sustain the region in the absence of a state mental hospital.

The time frame for this report is January 1, 2009 to December 31, 2013. A total of 307 people were discharged from MSH between 2005 and 2008, however eight people have been excluded because they died prior to January 1, 2009. The following are some highlights from the report.

Demographics

- A majority of the people were white (59%), male (61%), between the ages of 45 and 64 (55%), and from Allegheny County (80%).
- The average length of stay at MSH was 5.1 years (range: 2 months to 44.5 years).

Service Use and Life in the Community

- More people were living independently in 2013 (36%) compared to 2009 (19%).
- People had access to a variety of community-based services. Over the five years following the hospital closure, a majority of people used Assertive Community Treatment teams (77%), outpatient mental health services (54%), crisis (40%), and case management/service coordination (35%) services.
- People were able to access more intensive services when needed. On average, over the five years following the hospital closure, 19% of people had an inpatient psychiatric hospital admissions. Extended acute care admissions occurred for 4% of people and residential treatment facility for adults services were utilized by 1.5% of people.
- Results from the Mayview Discharge Study showed that people’s psychiatric symptoms, social lives, and satisfaction with services improved. Overall, the study showed people were doing well in the community.

Myths Versus Realities Surrounding the Closure of MSH

- It was believed that the closure of MSH would result in homelessness, increased incarcerations, deaths as a result of suicide, and an increase in psychiatric admissions.
• In reality:
  o No one discharged experienced homelessness.
  o Eighteen people (7% of the cohort) had jail admissions.
  o The most common cause of death for the 48 people that have died was natural causes.
  o Inpatient admissions have steadily decreased.

Financial Implications

• Fifty-nine percent (or $37.4 million) of the MSH annual budget was transferred to the MRSAP Counties to support the development and expansion of services for people in the community. Reinvestment funds, in addition to other funding sources, were used for the initial development of services.
• The cost of supporting people in the community was 77% less than the cost of state hospitalization. The savings equates to approximately $254.2 million total or $889,000 per person, over five years.
• The cuts in mental health Base funding that occurred in FY 2012/2013 totaling over $6.8 million, resulted in reductions in staff positions and some programs.
• Approximately 1,278 people who may have been admitted to a state hospital were supported in the community.

Moving Forward without a State Mental Hospital

The Counties intend to focus on:
• Continuing to ensure services and supports are available to meet peoples’ needs.
• Finding ways to support people who find it challenging to live in the community with the use of predictive modeling.
• Working towards being a region where people truly believe people can and do recover from mental illness.
Based on the belief that recovery from mental illness is possible, representatives of behavioral health authorities in Allegheny, Beaver, Greene, Lawrence and Washington counties (the Counties) began working together in July 2005 to develop a plan for supporting people discharged from Mayview State Hospital (MSH) in their communities. The planning group eventually expanded to include representatives from MSH, the Pennsylvania Department of Human Services (DHS), community behavioral health providers, managed care organizations, people with mental illness, the psychiatric community, family members, and advocates. Allegheny HealthChoices, Inc (AHCI) was also contracted to coordinate and staff the project.

The effort became known as the Mayview Regional Service Area Plan (MRSAP) project. The goal was to develop: 1) an assessment and discharge planning process that was thorough, person-centered, individualized, and recovery-oriented and 2) a plan that would drive the development and/or expansion of community services and supports to foster recovery for people discharged from MSH and those who would otherwise use state hospital services.¹

In order to increase the likelihood of a successful transition from MSH to the community, Community Support Plans (CSP) were completed with people prior to discharge. The CSP consisted of three assessments (individual, family member, and clinical) that each focused on the individuals’ preferences, strengths, and desired supports. The CSPs included consideration and recommendations for housing and mental health treatment, as well as physical health care, substance use disorder services, desired social opportunities and supports, assistance with everyday living skills, and interest in employment. Additionally, all plans included crisis (management and intervention) plans. The idea was to give people a voice in what they believed would help them thrive in the community. CSPs also served as a guide for the development of new and expanded community resources.

When MSH officially closed December 2008, a total of 307 people were discharged. This report seeks to:

- Provide an update on the people discharged, including demographics, housing status, service use, and overall satisfaction.
- Address commonly held beliefs and/or assumptions about outcomes for people discharged from MSH.
- Discuss the financial implications of the MSH closure, as well as the effects of budget cuts in regards to serving people in the community.
- Highlight efforts needed in order to sustain the region in the absence of a state mental hospital.

The time frame for this report is January 1, 2009 to December 31, 2013. Since a multitude of services and programs will be referenced throughout this report, please refer to Appendix A, beginning on page 14, for a description of services and programs.

¹ For more information on the Mayview Regional Service Area Plan and process please refer to the full report at [http://www.mayview-sap.org/documents/AHCI_FullMRSAPwhitepaperFINAL.pdf](http://www.mayview-sap.org/documents/AHCI_FullMRSAPwhitepaperFINAL.pdf) or visit [http://www.mayview-sap.org](http://www.mayview-sap.org).
Between 2005 and 2008, a total of 307 people were discharged from Mayview State Hospital. Eight people are excluded because they died prior to January 1, 2009. For the remaining 299 people, the average length of stay was 5.1 years (range: 2 months to 44.5 years). A majority were white, male, between the ages of 45 and 64, and from Allegheny County (80%). See Figure 1 below.

**Figure 1. Demographics for former MSH residents (N=299) as of December 31, 2013**

- **Gender**: Male (61%), Female (39%)
- **Race**: White (59%), Black (39%), Other/Unknown (2%)
- **Age**: 21-44 (26%), 45-64 (55%), 65+ (19%)

**Life in the Community**

*More people lived independently in 2013 compared to 2009*

Determining where people were going to live after discharge from MSH was an important part of the MRSAP project. The process entailed efforts to accommodate people and their preferred housing choice, while also ensuring they had the amount of support they would need to live successfully in the community. Figure 2 compares where people lived on January 1, 2009 and on December 31, 2013, respectively, by housing category.

**Figure 2. Where people discharged from MSH lived in January 2009 and December 2013**

- January 1, 2009 (N=298):
  - Independent (16%)
  - Staff-Supervised (51%)
  - Institutional/Restrictive (33%)
- December 31, 2013 (N=257):
  - Independent (36%)
  - Staff-Supervised (40%)
  - Institutional/Restrictive (24%)

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1 Independent housing includes living independently or with family, permanent supportive housing (PSH), and supportive housing. Staff-supported/supervised housing includes community residential rehabilitation (CRR), domiciliary care, housing for people with intellectual disabilities, personal care homes (PCH) - including enhanced (EPCH) and comprehensive mental health (CMHPCH), and specialized supportive housing. Institutional/restrictive housing includes community inpatient, long-term structured residences (LTSR), jail, nursing homes, and state mental hospitals.
In 2009, one person was excluded because they moved out of the state. Of the remaining 298 people, a majority lived in a staff-supported (51%) or institutional/restrictive setting (33%). In 2013, 42 people were excluded: two people moved out of the state and 40 people died. Of the remaining 257 people, more people were living independently in 2013 (36%) compared to 2009 (16%).

Another important housing factor that impacts the recovery of an individual in the community is housing stability or changes in housing arrangements. Comparing where people lived on January 1, 2009 and December 31, 2013, of the 257 people in the cohort, 36% moved to a more independent setting and 11% moved to a less independent setting. Moving to a less independent setting, however, is not necessarily a negative outcome. This may indicate that an individual needs more assistance with daily living skills or treatment than was available in a more independent setting. Providing increased residential support can contribute to a decreased need for more intensive community-based services and improve functioning.

People are well-connected to community-based services.

In preparation for supporting people in the community, the Counties used CSPs as a guide for expanding/developing the following community-based services (services provided within the community and/or home setting) to address people’s needs:

- Case management/service coordination
- Assertive community treatment teams (ACT)\textsuperscript{ii}
- Crisis services (i.e. telephone, walk-in, mobile teams, and short-term residential crisis programs)
- Mobile medication services
- Mobile and outpatient mental health services
- Psychiatric and social rehabilitation services

CSPs were also used to assign everyone discharged from MSH to either an ACT team or a case manager/service coordinator, based on their level of need.

ACT is a person-centered and recovery-oriented evidence-based practice where a wide range of treatment and rehabilitation services are provided to individuals in their homes and communities by a team of transdisciplinary staff, rather than referring people to other services. Case management/service coordination services, on the other hand, are not as intensive and focus on helping people access the services they need from other providers. As a result, many people will use outpatient services in conjunction with case management/service coordination rather than with ACT.

From 2009 to 2013, a majority of people (77%) used ACT services. Over half of the people (54%) used outpatient mental health services. People also used crisis (40%), case management/service coordination (35%), housing support (28%), medication check (24%), and social rehabilitation (16%).

People have access to intensive mental health care when it is needed.

In order to support people in the community and prevent the need for state hospitalization, the Counties had to be able to provide options for people who may need short-term intensive services. Services that meet these needs include psychiatric inpatient hospitalizations (IPMH), extended acute care (EAC), and residential treatment facilities for adults (RTF-A).

\textsuperscript{ii}For the most recent update on Assertive Community Treatment (ACT) Teams in Allegheny County refer to the following link, \url{http://www.ahci.org/Documents/CTT/CTT%202013%20Report.pdf}.
Over the five years following hospital closure, 19% of people had an IPMH admission, EAC admissions occurred for 4% of people, and RTF-A services were utilized by 1.5% of people, on average.

Average length of stay (ALOS) for each of these services varied from year to year but has been decreasing for IPMH and RTF-A. Over the five years, the average ALOS was 34 days for IPMH, 106 days for EAC, and 84 days for RTF-A. Longer length of stays can be attributed to difficulties discharging to the next level of care. For example, there can be IPMH delays while awaiting an EAC bed or EAC delays while awaiting appropriate housing or step-down levels of care.

People are more satisfied living in the community than MSH.

The Mayview Discharge Studyiv, conducted by researchers from the University of Pittsburgh and the University of North Carolina, followed people discharged from MSH to learn about their experiences with the relocation process, how people adjusted to living in the community, and satisfaction with the services received. The study consisted of two phases; Phase 1 (years one and two post-discharge) and Phase 2 (years three and four post-discharge).

Data collection for both phases included visiting former MSH residents every three months to see how they were doing, as assessed by interviews and observations. Standardized assessments to measure psychiatric symptoms, social adjustment, quality of life, progress towards recovery, and perceptions of care were completed every six months. Fourteen people participated in Phase 1 only, 27 people participated in Phase 2 only, and 51 people participated in both phase 1 and 2.

Major findings from the study were as follows:

- People were mostly satisfied with the discharge process and reported that they liked and preferred living in the community rather than the state hospital.
- People’s social lives improved, though some people expressed that they would like to be involved in more activities.
- Psychiatric symptoms improved then somewhat worsened, with 50% of people meeting the criteria for remission of psychotic symptoms in Phase 1 compared to 37% in Phase 2. However, this was still an improvement from baseline or measures taken at six-months post-discharge.
- Quality of life and progress towards recovery remained stable but was higher than other populations for whom data has been published.
- Satisfaction with services and attitudes towards medications improved.

These findings highlight that, overall, people discharged from MSH are doing well in the community. Although the study has been completed, both community service providers and the Counties continue to monitor these people’s needs. Attention to improving services and getting people involved in more social connections/activities may prove to be beneficial for peoples’ recovery over time.

Myths vs. Realities Surrounding the Closure of MSH

While some people had been in MSH for a few months or less, others resided at MSH for years, even decades. Given this, uncertainty arose as to what would happen to people re-entering the community once MSH was permanently closed. It was believed that homelessness, deaths, incarcerations, and psychiatric inpatient admissions would increase for this population. It was also believed that without MSH beds, there would not

iv For more information about the Mayview Discharge Study refer to the following link, http://www.mayview-sap.org/documents/four%20year%20report%20mayview%20discharge%20study.pdf
be a place for people to go if longer term intensive treatment was needed. This section presents information to address each of these previously held assumptions, and shows that people are doing well in the community.

**Myth #1: People would not be able to maintain their housing, or sufficient housing would not be available, resulting in homelessness.**

No one discharged from MSH experienced homelessness.

To ensure that suitable housing was available for people upon discharge from MSH, the Counties used data from individual CSPs to invest/reinvest⁴ funds to develop new and/or expand existing housing options. Funds went towards:

- Permanent supportive housing (PSH)⁵
- Comprehensive mental health personal care homes (CMHPCH)
- Enhanced personal care homes (EPCH)
- Long-term structured residences (LTSR)
- Specialized supportive housing
- County-specific housing options

Additionally, ACT teams and case managers/service coordinators helped support people in maintaining their housing.

**Myth #2: People would be incarcerated because they would not receive necessary support/treatment in the community, resulting in criminal activity as a consequence of their mental illness.**

18 people had jail admissions.

Very few individuals that left MSH were incarcerated between January 1, 2009 and December 31, 2013 (Table 1). During this time period, 18 people (7% of the total cohort) accounted for 30 separate incidents. Nine people had multiple admissions. In December 2013, four people were reported as being incarcerated.

<table>
<thead>
<tr>
<th>Year</th>
<th>Allegheny*</th>
<th>Beaver</th>
<th>Lawrence</th>
<th>Washington</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>2010</td>
<td>5</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>7</td>
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<tr>
<td>2011</td>
<td>6</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>2012</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>2013</td>
<td>6</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>25</strong></td>
<td><strong>5</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>30</strong></td>
</tr>
</tbody>
</table>

*Note: 80% of the people discharged from MSH resided in Allegheny County.

④ Reinvestment funds are funds remaining after medical claims and other obligations are paid in the HealthChoices Medicaid Behavioral Health Managed Care Program. They are approved by OMHSAS for use in developing or expanding services and supports based on local needs.

⑤ For the most recent updates on the PSH program in Allegheny County please refer to the following link, [http://www.ahci.org/Documents/2013%20Supportive%20Housing%20JUNE%202014.pdf](http://www.ahci.org/Documents/2013%20Supportive%20Housing%20JUNE%202014.pdf).
Forensic services were developed/expanded in Allegheny, Beaver, and Washington counties to address the needs of people who may have an encounter with the criminal justice system. These services and programs throughout the region include:

- Training police officers to handle crises involving individuals with mental illness
- Jail diversion programs
- The use of a forensic assertive community treatment team (FACT)
- Facilitation and coordination of re-integration from jail back into the community
- Housing assistance for individuals released from jail
- Mental health courts that emphasize treatment to help people with mental illness successfully complete their probation

**Myth #3: Deaths due to suicide would increase because people would not receive the support/treatment they need in the community.**

For the 48 people that have died, the most common reason was natural causes.

Forty-eight (16%) of the 307 people that were discharged from MSH died prior to December 31, 2013 (Table 2). As shown in Table 3, suicide was the cause of death for one person. For a majority of the people (81%), the cause of death was natural causes (i.e., cancer, heart attack, medical complications, etc.). Age at death ranged from 30 to 88, with an average age at death of 63 years. Of note is that people with serious mental illness die, on average, 25 years earlier than the rest of the general population\(^\text{vii}\), which seems to hold true for this cohort. The life expectancy of the general population is 75 - 80 years of age.

<table>
<thead>
<tr>
<th>Year</th>
<th>#/% of people</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior to 2009</td>
<td>8 (17%)</td>
</tr>
<tr>
<td>2009</td>
<td>8 (17%)</td>
</tr>
<tr>
<td>2010</td>
<td>13 (27%)</td>
</tr>
<tr>
<td>2011</td>
<td>8 (17%)</td>
</tr>
<tr>
<td>2012</td>
<td>9 (19%)</td>
</tr>
<tr>
<td>2013</td>
<td>2 (4%)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>48 (100%)</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cause of Death</th>
<th>#/% of people</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accident</td>
<td>7 (15%)</td>
</tr>
<tr>
<td>Homicide</td>
<td>1 (2%)</td>
</tr>
<tr>
<td>Natural Causes</td>
<td>39 (81%)</td>
</tr>
<tr>
<td>Suicide</td>
<td>1 (2%)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>48 (100%)</strong></td>
</tr>
</tbody>
</table>

**Myth #4: Without state hospital beds, psychiatric inpatient admissions would increase.**

From 2009 to 2013, the number of people using intensive services has decreased.

In anticipation that some people would need short-term intensive services, extended acute care (EAC) and residential treatment for adults (RTF-A) services were added/expanded. These services are available for people discharged from MSH, as well as everyone else living in the five counties.

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\(^{\text{vii}}\)Parks, J. et al. (eds) *Morbidity and Mortality in People with Serious Mental Illnesses*, National Association of State Mental Health Program Directors (NASMHPD) Medical Directors Council, Alexandria, Va., (October 2006).
Service expansion included the opening of two hospital-based extended acute care (EAC) units. The first, with a 30 bed capacity, the Transitional Recovery Unit (TRU), opened prior to 2009. The second, with a 10 bed capacity, the Comprehensive Recovery Unit (CRU), opened in the second quarter of 2011. A community-based EAC was opened in 2009. Finally, the Residential Treatment Facility for Adults (RTF-A) in Allegheny County was expanded to a capacity of 16 beds and a regional RTF-A was in operation from September 2009 - July 2012.

Though the number of people who used intensive services fluctuated from year to year, fewer people used intensive services in 2013 compared to 2009. In 2009, 46 people used IPMH, nine people used EAC, and 11 people used RTF-A. In comparison, in 2013, 40 people used IPMH, six people used EAC, and only one person used RTF-A.

There was not a drastic rise in IPMH admissions as previously believed, in fact, IPMH admissions have steadily decreased over the years.

## Financial Implications Related to the Closure of MSH

### Transferring funds from MSH to the Counties

59% of the MSH annual budget was transferred to the Counties to support people in the community.

At the start of the MRSAP project, the MSH annual budget was $63 million, of which $37.4 million (59%) transferred to the Counties once MSH was officially closed; an average of $91,000 per person discharged. Determining how funds would be distributed among the Counties was based on a weighted average of each county’s average daily resident population in MSH and their total population in CY2004. Greene County did not have any residents in MSH, but the model redistributed funds to provide Green County with a portion of the revenue. Figure 3 presents how the $37.5 million was initially allocated between the Counties.

![Figure 3. Initial distribution of funds to the five counties after the official closure of MSH in December 2008](image)

While funds transferred from MSH are being used to support the people who left MSH in the community, as well as others who would have used state hospital services, it is important to note that reinvestment funds were also used to make initial investments in the development and expansion of services. Other funding sources currently used to support people in the community include Medicaid (HealthChoices), Medicare, county base dollars, intellectual disability waiver funds, private insurance, and personal sources of income.

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viii Reinvestment funds are funds remaining after medical claims and other obligations are paid in the HealthChoices Medicaid Behavioral Health Managed Care program. They are approved by OMHSAS for use in developing or expanding services and supports based on local needs.

ix HealthChoices is Pennsylvania’s mandatory managed care program for Medicaid recipients.
Community vs. State Hospital Costs

From 2009 to 2013, the cost of supporting people in the community was 77% less than it would have cost if they were in MSH.

Providing behavioral health services in the community has allowed for a more cost effective delivery of services than is possible in a state mental hospital. Figure 4 compares, by year, the average cost per person incurred by serving the people that left MSH in the community\(^x\) to what it would have cost if the same people were in a state mental hospital.\(^x\) Community-based treatment for the 286 people that used services totaled $74.5 million over five years, compared to $328.6 million if the same people were in a state mental hospital for five years. The savings equates to approximately $254.2 million total or $889,000 per person, over five years.

The actual SMH per diem rates, per year, used to calculate cost per person for SMH comparison were provided by the Bureau of Community and Hospital Operations within the Department of Human Services’ (DHS) Office of Mental Health and Substance Abuse Services (OMHSAS).

The impact of budget cuts

The cut in mental health base funding that occurred in FY 2012/2013 impacts the ability of the Counties to deliver quality, community-based services to everyone.

County base funds are used to provide support to people who are not eligible for HealthChoices, and to deliver services and supports not covered under Medical Assistance. In FY 2012/2013, county base funding was cut by about 10%. As a result, the new funding received to maintain community services through the closure was reduced across the five counties. The total reduction to Community/Hospital Integration Projects Program (CHIPP)\(^xii\) funding for the region was over $6.8 million, of which $3.75 million was from the closure of MSH.

These cuts impact the region’s ability to deliver ongoing quality community-based services to people in need of mental health treatment. The direct results of these cuts included:

- Reductions in nursing or other non-billable staff positions

\(^x\) Calculated from HealthChoices and Base claims data for Allegheny, Beaver, and Washington Counties. Lawrence County was not included because Base funded data was not available. However, the cost per person for the eight people discharge from MSH for Lawrence County, based on HealthChoices data, was $37,937 over five years ($303,493 in total).

\(^x\) The actual SMH per diem rates, per year, used to calculate cost per person for SMH comparison were provided by the Bureau of Community and Hospital Operations within the Department of Human Services’ (DHS) Office of Mental Health and Substance Abuse Services (OMHSAS).

\(^xii\) CHIPP provides funding for comprehensive community services to individuals who have been in the state hospital or are at risk of hospitalization. For more information please visit http://www.parecovery.org/services_communities.shtml
• Reductions in peer support services, administrative support and programs
• Reductions in access to ACT and service coordination supports
• Reductions in the number of people who relied only on base funding who could receive services

Managing the loss of these dollars has hindered development of services designed to address the evolving needs of individuals as their time in the community increases (i.e. special populations or people with medically complex behavioral and physical health needs). It also has limited enhancements to services that improve education and employment, potentially requiring people to remain in the treatment system who might otherwise be more self-sufficient.

**People who would have used state mental hospital services**

*From 2009 to 2013, approximately 1,278 people who may have been admitted to a state hospital were supported in the community.*

Without a state hospital in the region, the Counties estimate that they provided services to approximately 1,278 distinct individuals from 2009 to 2013 who potentially could have been admitted to a state mental hospital. Based upon criteria used in HealthChoices rate setting, a person is defined as being diverted from state hospitalization if they meet any of the following six criteria during a calendar year after having no services in the previous year:

1. Admitted to an Extended Acute Care (EAC)
2. Admitted to a Residential Treatment Facility for Adults (RTF-A)
3. Admitted to a Long Term Structured Residents (LTSR) under age 65
4. Has three or more inpatient psychiatric admissions OR 45 days or more of inpatient psychiatric services
5. Any history of state mental hospital use and an inpatient psychiatric admission
6. Assigned to an Assertive Community Treatment Team (ACT)

As these are people who were at an increased risk for a state hospital level of care but were supported in the community, this represents an additional cost savings. The cost of services provided to these individuals was $33.2 million from 2009 to 2013 (approximately $5,196 per person/per year), of which an estimated 13%, or $4.4 million, were paid by the Counties through county base funds.\(^\text{\textsuperscript{xiii}}\) The cuts to county base funds also impact the support that can be provided to this population.

**Moving Forward without a State Mental Hospital**

**The Pennsylvania Olmstead Plan**

Pennsylvania is supporting efforts to decrease institutionalization of adults who have a serious and persistent mental illness and to have people live in the least restrictive setting. Each county (or partnering counties) in Pennsylvania submits a plan outlining strategies to address the needs of the people in their area as they transition from institutions to the community. Current Olmstead planning efforts for the MSH region\(^\text{\textsuperscript{xiv}}\) focus on: 1) ensuring services and supports are available to meet people’s needs, 2) providing outreach and integration for people currently in large (>16 beds) Personal Care Homes (PCHs), and 3) reducing the number of beds at PCHs to fewer than 16, as large personal care homes may be considered institutional settings.

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\(^\text{\textsuperscript{xiii}}\) Calculated from HealthChoices and Base claims data for Allegheny, Beaver, and Washington Counties. Lawrence County was not included because Base funded data was not available. However, the cost per person for the eight people discharge from MSH for Lawrence County, based on HealthChoices data, was $37,937 over five years ($303,493 in total).

\(^\text{\textsuperscript{xiv}}\) For the 2012-2013 Olmstead Plan refer to the following link, [http://www.parecovery.org/documents/Olmstead_Plans/Mayview_Regional_Service_Area.pdf](http://www.parecovery.org/documents/Olmstead_Plans/Mayview_Regional_Service_Area.pdf).
**Predictive Modeling**

Though the current services and programs were developed/expanded based on CSPs, there are some people who find it challenging to live in the community (i.e. difficulty finding appropriate housing, short community tenure between inpatient stays, etc). This includes people who were discharged from MSH and those who have been diverted. These individuals use more intensive services more often and they may require services that do not yet exist. Even if the need for additional services is identified, funds may not be available to develop them. As such, the Counties are working on effective and efficient ways to provide services.

In an attempt to address this issue, the Counties have been collaborating to identify people who are in this category. As part of this effort, AHCI, in partnership with Community Care Behavioral Health, is developing a predictive model that calculates a persons’ level of risk. This model has potential to be used to develop clinical protocols that identify the most appropriate services and supports for individuals so as to provide optimal recovery and successful living in the community.

**Future State of the Region**

To date, and not without some challenges, the Counties have been successful in operating without a state mental hospital. The ongoing goal for the region is for all individuals to live in the least restrictive environment with the supports that they need. Regional work will continue to promote recovery and independence for people with complex mental health issues in an effort to create a region in which everyone believes that people can and do recover from mental illness.
Appendix A

Descriptions of Services and Programs

Assertive Community Treatment Team (ACT): An evidence-based practice. ACT 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, ACTs 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 ACT 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).

Case Management (called Service Coordination in Allegheny County): Services designed to ensure people with mental illness receive the continuous care and support they need. Caseload sizes are limited to ensure adequate attention to the person’s needs as they change. Emphasis is given to housing, food, treatment services, use of time, employment and education in order to lead a more stable and healthy life in the community.

Community Residential Rehabilitation (CRR): Designed to assist people with serious and persistent mental illness to live as independently as possible in a group home or apartment setting. While participating in mental health treatment, residents in CRRs are also given training and assistance to learn the necessary skills for independent living, including social and vocational skills.

Community Support Team (CST): The CST served as a resource to the MRSAP Counties and community providers by offering additional support to individuals as they transition from Mayview State Hospital. The team provided direct services to consumers and works to assist the community providers in implementing optimal supports for the consumers.

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.

Crisis Services: People experiencing crises call a toll-free number, and receive telephone counseling. When indicated, professional behavioral health counselors will provide mobile crisis services at the person’s home or in the community. Walk-in and overnight crisis services are also available. In Allegheny County, these services are available through the re:solve Crisis Network 24 hours a day. In Washington County, these services are available through Washington Communities MH/MR and Southwestern Pennsylvania Human 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.

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

Extended Acute Care (EAC): These programs offer diversionary and acute stabilization services in either a hospital or community setting. EAC provides a longer period of stabilization in a recovery-oriented environment that permits the individual to return to the community and avoid state hospitalization.

Forensic Assertive Community Treatment Team (FACT) - Beaver County: This service supports forensic and hospitalization diversions. This team serves individuals involved in the criminal justice system, whose primary needs are those pertaining to mental health or co-occurring mental health and substance use disorders. This team is similar to a traditional ACT in that it is a mobile outreach team that has the ability to provide the majority of mental health treatment, rehabilitation, service coordination, housing, vocational, and other general services typically provided by different components of the mental health system. This team also has the ability to complete COD assessments for the court.

Housing Support: Assistance provided to people to help maintain their tenancy and with integrating into their home community. Services include but are not limited to teaching skills necessary for independent living (for example, housekeeping, medication support, budgeting, grocery shopping, and laundry skills).
Inpatient Mental Health Services: Evaluation and treatment services provided in a licensed psychiatric unit of a community hospital or a community psychiatric hospital that is not part of a medical hospital. Services are provided to persons with acute illness where safety for self or others is an issue. Services are provided by psychiatrists, nurses and social services staff. Persons may be involuntarily committed for evaluation and treatment.

Long Term Structured Residence (LTSR): A highly structured 24-hour supervised therapeutic mental health residential treatment facility. They provide behavioral health treatment and specialized programming in a controlled environment with a high degree of supervision. LTSRs provide in-house therapeutic groups, activities and recreation.

Medication Checks: A service provided for consumers taking medication to treat their mental illnesses or substance abuse disorders. Medication levels are checked, side effects discussed, and adjustments to prescriptions are made as necessary.

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.

Mobile Mental Health Treatment (MMHT): A full range of outpatient therapy services for individuals who have encountered barriers to, or have been unsuccessful in receiving services in an outpatient clinic. Services are provided within the consumers’ place of residence or other appropriate community setting. The purpose is to provide therapeutic treatment to reduce the need for more intensive levels of service, including crisis intervention or inpatient hospitalization.

Outpatient Mental Health Services: Evaluation and treatment services provided to persons who may benefit from periodic visits that may include psychiatric and psychological evaluation, medication management, and individual or group therapy. Services are provided by licensed facilities under the supervision of a psychiatrist or by private credentialed practitioners.

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).

Quality Management and Clinical Consultation (QMCC) Team: The QMCC worked collaboratively with counties and providers to monitor the quality, effectiveness of service, the effective coordination of services, and development of staff expertise to meet the complex and changing clinical needs of consumers. The team worked to assist the community providers in implementing optimal supports through monitoring benchmarks of recovery, providing indirect support and education to community providers, and providing direct support when necessary/appropriate and in coordination with the counties.

Residential Treatment Facility for Adults (RTF-A): RTF-A 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 (also called 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.

Supportive housing: Programs that provide transitional or permanent housing along with needed supported services for individuals.
AHCI’s mission is to assure equitable access to quality, cost-effective behavioral health care that promotes positive clinical outcomes, recovery, and resiliency.

AHCI is a contract agency for the Allegheny County Department of Human Services’ Office of Behavioral Health.