NEW YORK STATE | Office of Mental Health

OMH News

January 2017

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Commissioner

Mobile INTEGRATION TEAMS:

Taking Mental Health Care into the Community

Research has indicated that the likelihood for recovery from mental illness is greater when clients are living in the community and have ready access to services.

OMH's Mobile Integration Teams (MIT) play an integral role in helping clients make the transition back into the community or avoid institutional care all together.

An important component of its Transformation Plan, OMH established its first MITs in Long Island, the North County, Rochester, the Southern Tier, and Western New York — areas in which community services were expanded to accommodate the reduction of beds at local psychiatric centers under the Transformation Plan.

OMH established additional teams last year at Bronx, Creedmoor, Elmira, Hutchings, Mohawk Valley, and South Beach psychiatric centers. Mobile teams are also being created by local governments and community organizations to complement the services provided by OMH's teams, address the needs of specific populations, or serve particular geographic areas.

Basic Principles

MITs are multidisciplinary and can include peers, registered nurses, social workers, mental health therapy aides, and other direct-care staff. Team members cover multiple counties in their regions, traveling thousands of miles each year.

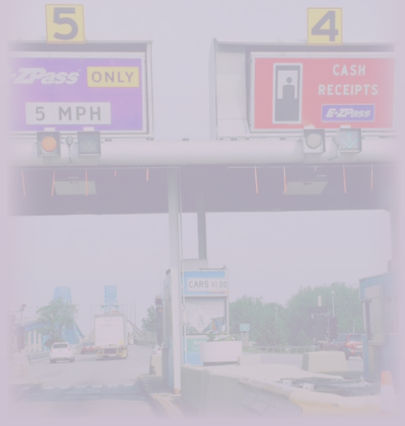
MITs work in client's homes or at community locations such as a provider's office, the county Department of Social Services, or even at a grocery store. Each team is structured differently, to meet the unique needs of its region, and can change as demands change.

Accordingly, services vary widely in frequency and duration based on each client needs, and are determined in collaboration with the area's existing facilities and providers. MITs frequently provide services during a client's transition from an institution to a supportive housing or Health Home program. Services most often focus on preventive care, therapy, medication management, and other wrap-around services to help support clients in their community.

"Every MIT works on the same three basic principles: Individuals do recover, individuals and families are resilient, and there is hope for the future," said Salvatore Cerniglia LMHC, CRC, MBA; Mobile Integration Team Statewide Program Lead. "Their focus is on bringing care **to** the client."

MITs are proving valuable in removing patients' barriers to care, eliminating fragmentation of care, reducing costly admissions and re-admissions, and easing the frustration of clients and professionals. This edition of *OMH News* will introduce you to the members of some of our mobile teams and they'll share stories about some of their successes.

You can share your comments and stories by contacting us at: omhnews@omh.ny.gov.



Integration:
A Crucial Part of the Transformation Strategy

The initiative to develop mobile integration teams came from New York State's plan to expand the availability and accessibility of mental health services, using reinvestment funding to strengthen community-based services.

"Research had shown that, without such support and continuity, the mental health of transitional patients can decline," said Salvatore Cerniglia LMHC, CRC, MBA; Mobile Integration Team Statewide Program Lead. "As a result, patients often end up in hospital emergency rooms needlessly. Mobile Integration Teams are intended to address the need to take the focus of mental health care off of hospitals and make it more preventive."

For more information on OMH's mobile integration teams, visit: https://www.omh.ny.gov/omhweb/transformation/all-programs-list.html.

One of Several Innovations

Mobile mental health teams were one of several new community-based mental health services started by Governor Andrew M. Cuomo in September 2015, including home-like residential programs and early intervention services. OMH allocated $20 million to help make MIT programs available.

OMH's mobile integration teams serve nearly 5,000 New York residents to date, providing an array of services that include health assessment, psychiatric rehabilitation and recovery, peer support groups, skill building, crisis assessment and intervention, legal system collaboration, community support, and other support services.

In all, more than $59 million was dedicated during each of the past two state fiscal years to expand the availability and accessibility of mental health services. This included new crisis respite houses at Hutchings, Sagamore (Dix Hills), Elmira, and St. Lawrence psychiatric centers. Crisis respite houses are currently in operation at New York City Children's Center and also at Greater Binghamton Health Center.

Each crisis respite program has potential to serve 175 to 200 children and adolescents 10 to 17 per year. Each has six to eight beds, with the average length of stay being 10 days. These programs have helped families and caregivers by stabilizing crisis situations and offering "breathing space" for youth in crisis and their caregivers.

Strengthening Community Support

MITs are a crucial part of OMH's Transformation Plan, which focuses on strengthening community-based prevention, early identification and intervention, and evidence-based clinical services and recovery supports.

So far, these services have reached more than 5,000 New York State residents. The Transformation Plan continues to expand with new programs becoming operational each month. OMH issues monthly reports to keep the public informed on its progress.

"OMH's mobile teams are designed to provide care that centers on the individual," Cerniglia added, "ensuring they receive the right care, by the right provider, at the right place, in the right time."

Long Island:
Warm Hearts Solve a Case of Cold Feet

Mobile INTEGRATION TEAMS

The Pilgrim Psychiatric Center Community Transitional Support Team (CTS) began working with Lee Maluth in September 2015. CTS is one of seven teams created to provide wrap-around support to help people maintain – or in some cases start – a life they love in the community.

For the nine months prior to meeting the Support Team, Lee lived at Pilgrim's Crooked Hill State Operated Community Residence. This was a huge accomplishment in itself – after having experienced life in the mental health system's "revolving door" for the past 25 years.

"When Lee first arrived at the Crooked Hill Residence, he was quiet and shy, spending most of his time in solitary pursuits like doing puzzles and talking very little," said Nicole Signorelli, Residential Program Manager. "Gradually, he began to reach out to others, join in activities, and make attempts to be accepted, to belong, and to be part of what was happening there. He became good friends with a fellow resident and began to build his own support system – his family of choice."

Lee Maluth, in his new home!

A Daunting Concept at First

When the Support Team first spoke with Lee about considering moving from Crooked Hill to a supported apartment, he was hesitant, doubtful of his capabilities, and certain that he needed more staff involvement in his recovery.

"After so many years in and out of the hospital and state-operated community residences, the potential loss of his world was a daunting idea," said Linda Jennings-Lowe, Associate Director for Residential Services. "Like so many others, Lee found it difficult to make the shift from hospital-based to community-based care and to trust the safety nets that were there for him."

The team said that it was hardest for Lee to believe that he could take care of himself and have a life on his own, insisting he needed help doing many routine daily tasks that most folks take for granted. Shortly after the Support Team began working with Lee, he was accepted to the Federation of Organizations – a community-based agency that operates programs that encourage self-help and provide peer support for special populations, such as people recovering from mental illness, the homeless, low-income seniors and at-risk children. He was then referred to the Federation's Mobile Residential Support Team (MRS).

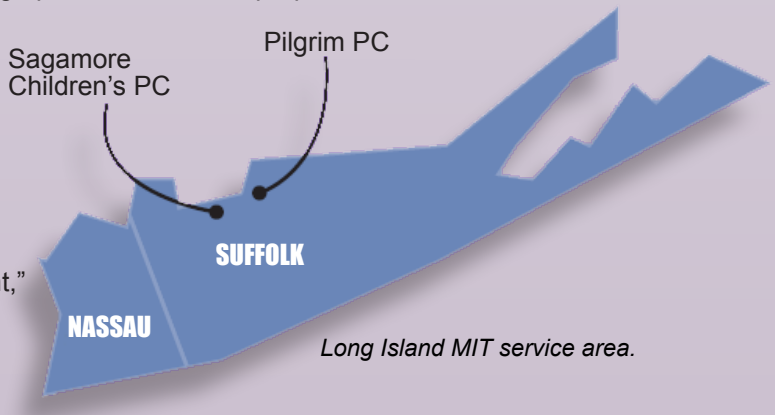
"Lee wasn't receptive to the idea of moving from a place where he felt safe and secure," said Matthew Hazinger, Mental Hygiene Therapy Aide. "He repeated that he wanted to wait a few more months." his transitional support team, residence staff and Federation staff continued to visit with Lee, address his concerns, and make him aware of the support he would have if he moved to a more independent living situation.

"It took some time, but Lee eventually began to trust that some of the people he felt safe with would stand by him and that he wouldn't be alone," Signorelli said. After a few weeks, Lee agreed to go on a five-day pre-placement visit to a Federation Enhanced Supported Housing apartment in Massapequa, with the man who had become his best friend at the Crooked Hill Residence.

Discovering His Independence

While on his pre-placement visit, Lee showed he could be independent in some of the areas he previously thought he needed help with. He was able to independently hold his own medications and take them properly and safely prepare simple meals, such as eggs, for his breakfast.

"After the visit. Lee said that he enjoyed his time at the apartment," Signorelli said. "Yet, despite all his success and experience with the supports he would receive, Lee remained doubtful."



Long Island MIT service area.

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Stephen Pazareckas, the Peer Specialist who plays a primary role on the CTS Team and worked very closely with Lee from the very beginning, explained why they had confidence in him, and reassured him that they would be there for him, even after relocating.

The turnaround happened when Lee's father came up from Florida for a visit. His father embraced the idea that his son could live in a supported apartment and said he was familiar with the new neighborhood. He asked if the discharge could take place in December, while he would be back on Long Island. This made Lee enthusiastic about the arrangement and he agreed to be discharged.

Moving Day!

That December, with his father's presence and blessing, Lee moved to his supported apartment. Since then, he has received ongoing medication-management skill training from the MRS staff nurse, is holding a full two-week supply of his medications, and successfully taking them as prescribed by his physicians.

Lee has been receiving psychiatric services from the Central Nassau Guidance (CNG) Roads to Recovery Personalized Recovery Oriented Services (PROS), and his medical services from South Ocean Care.

"When he first relocated, CTS and MRS helped Lee arrange Medicaid transportation through Logisticare – and now Lee is able to arrange his transportation for himself," Hazinger said. "He schedules and tracks all his own appointments. Within a few months Lee was able to go to the local Quest labs on his own for his monthly blood work."

With step-by-step guidance from CTS, Lee obtained his Supplemental Nutrition Assistance Program (SNAP) benefits, learned how to use food stamps to purchase groceries, and became comfortable doing this completely on his own. He learned to prepare several new recipes, properly store food and check for expiration dates, and maintain a neat and clean apartment. He also got a free cellphone from Assurance Wireless, which he uses to arrange his transportation, communicate with his health care providers, and talk with his father.

Lee parted ways with his transitional support team on October 14, 2016, but continues to attend psychiatric treatments and receive services from the Federation and its mobile support team.

Raising the Bar, One Success Story at a Time

"It's no wonder people are concerned, have questions, and are sometimes doubtful or just plain scared.

As psychiatric care and treatment makes the transition from a 20th century hospital-based culture to one based on wellness in our communities, the stakeholders at all points in the system – clients, their aging parents, siblings and extended family members, providers and advocates – wonder and worry about how anyone can make it in the 'real world' outside the hospital after recovering from mental illness.

Until recently it was hard for people to hope for full recovery from mental illness or even to dare to believe that recovery was possible. So, we indeed have raised the bar in the past five years.

Someday, we'll live in a world where the conversation will always start with the assumption that people with a mental illness can recover and live a life they love – a life based on talents, skills and interests, a life they choose, a life where anything is possible, in their community and just like anybody else.

How do we get there? One test of the system and one improvement at a time. One success story at a time.

Someday, and because of successes like these, the conversation will have been changed to such a degree that living a life you love after recovery from mental illness will be the expectation. Then the bar will be raised as high as the individual wants. This is a reality we shape and live into right now. Lee knows that now, and so do we."

Judy Pietropinto, PhD, Pilgrim Administration

Exploring the Community

Now Lee is exploring the resources available in his community and developing new interests. On the weekends, Lee enjoys walking with his friend to the local Public Library, which is located down the street from their apartment.

"Lee knows there are people in his life he can rely on and turn to," Hazinger said. "He knows he can make a life for himself in his community because he's doing it and enjoying it."

This past November, CTS drove Lee to Pilgrim's Peer-Run Conference, where a documentary video that he participated in was featured. In the video, Lee describes his recovery family as "supportive." After the conference and to celebrate Lee's successful transition to the community and share it with others, the Crooked Hill staff and CTS held a luncheon in his honor. Guests included old and new Pilgrim staff who assisted Lee in his recovery, former housemates, and new residents who had the opportunity to ask Lee about his transition to community life.

"It's OK to have cold feet when you are taking such a giant step," said Judy Pietropinto, PhD, Pilgrim administration, "especially when there are such warm hearts and capable hands to guide you."OMH

Southern Tier:
Providing for a Family in Need Over the Holidays

Mobile INTEGRATION TEAMS

This past month, members of the Southern Tier MIT proved their hearts are just as big as the sprawling, 15-county region they cover

When Elaine Ramsey, Children's MIT Psychologist for the Greater Binghamton Health Center (GBHC), sent out an e-mail one week before Christmas requesting help for a family in need of winter wear, furnace and window repairs — and most of all, presents for the children — her expectations were low.

GBHC staff, family, and friends had already supplied gifts and meals for 15 "Adopt a Families" in need.

"How could I possibly ask them for more?" Ramsey wondered.

Left to Right: From the Adolescent Day Treatment Program, Patricia LoVuolo, RN; and Sarah Bridgman, PhD, Chief of Psychology.

Left to Right: From the C&A MIT, Elaine Ramsey, Psychologist; Bob Nestoryak, RN; and Fikreta Toric, SWA.

At the minimum, Ramsey was hoping, that all four children in the newest family could receive a warm coat and gloves.

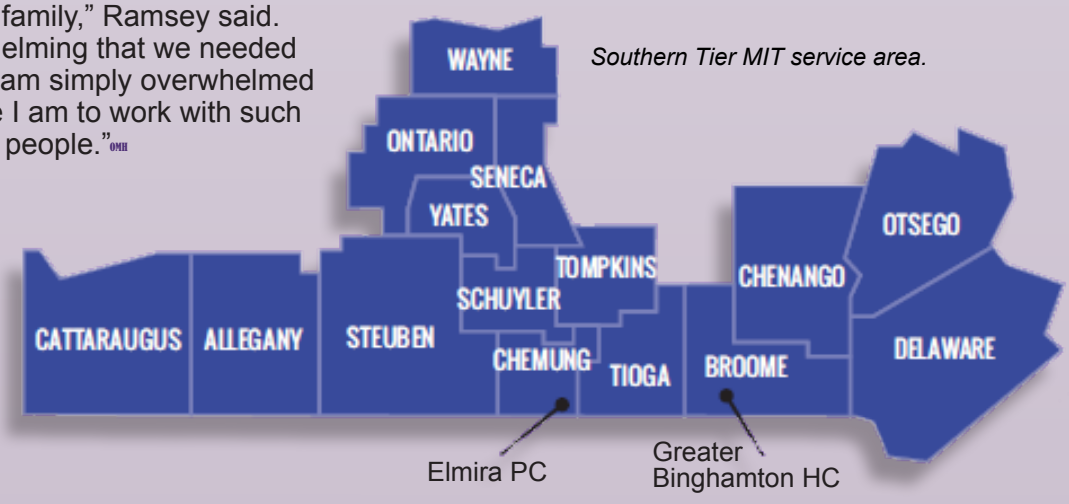
"But then the responses started to come in," Ramsey said. "And I realized my expectation were actually too **low!"**

Within five minutes of sending out an e-mail, team members found a donor for a beautiful new coat. Then came donations to make purchases for the children.

Soon, she received word that a chord of wood was being purchased for the family and that the wood supplier was donating another chord on his own.

Then she was given the name of an organization that could help the family obtain new windows and a furnace — free of charge. Hygiene products, food, games, art supplies, books and clothes also began rolling in.

"People gave their very best to this family," Ramsey said. "The response has been so overwhelming that we needed **two vans** to transport everything. I am simply overwhelmed with the realization of how fortunate I am to work with such generous, kind and compassionate people."OMH



Southern Tier MIT service area.

Western NY:
Empowering Clients and Their Families

Mobile INTEGRATION TEAMS

Community outreach has been a major focus of attention for the Western New York Children's MIT.

Up and running for more than a year, the team is made up of social workers, community mental health nurses, mental health therapy aides, peer specialists, and a recreational therapist. Members provide skill building, respite, peer support, family and caregiver support, transportation, access to community activities, and medication education and management. To date, all youth who have entered into the program have been safe and able to remain successful in the community.

In addition to their regular duties of providing services in 10 counties, team members have been active in the community, educating children and families and promoting mental health and wellness.

A Mental Health Awareness Fair at Windsor Village in Lockport this past summer was one of the many events they participated in. "Our purpose was to assist in raising awareness of mental health issues, connect with families and youth in the community and provide information about local, recovery oriented services and supports," said Lynda Trevean, MHTA.

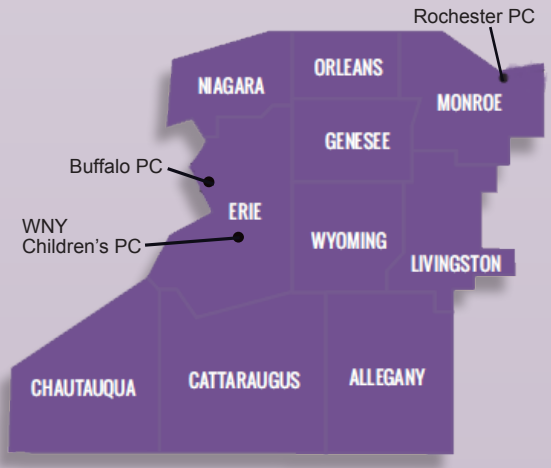
They shared information about services offered through the team and its Outpatient Clinic. "We engaged the youths and families in several activities that were designed to teach them about mental health awareness," she said. " We gave them various items to set up 'comfort boxes,' boxes filled with items that they can use to calm themselves or cheer themselves up – such as stress balls, therapeutic fidgets, kinetic sand, and Mandela coloring sheets. In turn, we asked for their ideas and suggestions on using the items."

Sponsoring Support Groups and Classes

The MIT has developed a female social empowerment/peer support group, intended to bring local teenage youth together on social outings in the community. Some of these outings have included bowling, visits to the art gallery, and miniature golf. They've also conducted creative arts and cooking skill classes at their Community Services location. "During these activities, young women were able to learn age-appropriate social skills; how to positively interact, communicate, and support each other; and to function as active members within the community," Trevean said.

Team members also joined with staff from the Outpatient Clinic at a Parent/Teacher Conference Night at the Buffalo Bilingual School-Public School 33, and at an outdoor summer fair at Buffalo's Canalside Park, to teach students about mindful learning activities based on the MindUP curriculum and the Common Sense Parenting program.

By the end of the team's second year in operation, it enrolled 433 youths and discharged 371. The team is fully staffed with 10 members and continues to develop partnerships with local providers within the counties it serves. OMH



WNY Children's MIT service area.

North Country:
Turning Lives Around

Mobile INTEGRATION TEAMS

Sometimes, persistence is the most important quality a team member can have. Two recent cases handled by the North Country MIT are evidence of that.

North Country MIT members (from left) Mike Smithers, Jill Carr, Rachael Stanton, and Kristin Leggo.

An Investment in Time

MIT members Mike Smithers and Jill Carr worked this past year with a client we'll call "Gordon," who moved back into the community after a long stay with St. Lawrence Psychiatric Center.

"Other agencies refused to work with Gordon due to his behavior and history with substance abuse," said MIT Treatment Team Leader Angela Burke. Gordon lived in a remote area, about 50 miles away from the nearest town. He had a history of not being compliant with medication and skipping outpatient mental health appointments. "His living conditions weren't the best, but he didn't want to change," Burke said, "These conditions were what he had always known and had grown comfortable with."

Despite some struggles and inappropriate behaviors, Mike and Jill didn't give up on Gordon. They continued to work with him and keep him in the community. They worked on getting Gordon to attend his appointments and take his medications. They helped him develop acceptable behaviors and socialization skills, and they helped him gain insight about his behaviors.

Their dedication and investment in time paid off. Gordon decided that living closer to a town would be better for him, so Mike and Jill are working with him at finding appropriate housing. "Gordon has turned the corner and says he wants to be more accepted in the community," Burke said. "He wants to have friends who aren't pushing to return to drugs or alcohol. As he says, he wants 'normal friendships' now and is working toward that."

Helping a Teen Discover Her Self-Worth

MIT members Rachael Stanton and Kristin Leggo started working last year with a client we'll call "Susan," a new student who moved into the area to live with a parent. "The parent, however, was an active alcoholic," Burke said. "This made Susan's home life difficult – which was reflected in her performance at school. She was stressed, and struggled academically and socially."

Susan was failing all of her classes and was determined to drop out as soon as she was old enough. She also got into arguments and fights with other students.

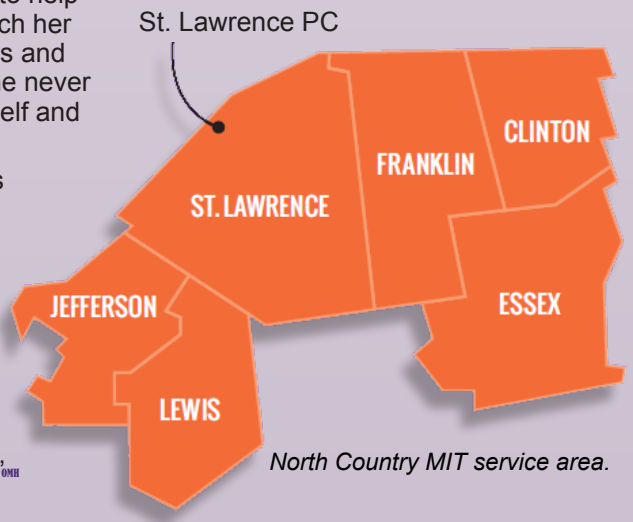
The MIT first helped Susan work on a safety plan to develop coping skills and identify the available supports in her environment. They helped Susan develop a plan to keep her safe when her father was drinking and being argumentative. They worked with school staff, calling several meetings to discuss academics and ways to support her. "Family involvement was crucial," Burke said. "Susan's father attended these meetings. He admitted he had a problem and was seeking help."

During the next several months, Rachel and Kristin kept meeting with Susan to help her recognize her strengths and interests, engaging Susan in activities to teach her about self-esteem and helping her learn to communicate her needs and wants and ask for help. "Even though Susan often found the process to be frustrating she never gave up," Burke said. "She started setting short- and long-term goals for herself and worked hard to get the passing grades she needed."

Rachel and Kristin even worked with school staff to find Susan a formal dress so she could attend the prom with her classmates.

Susan is now successfully studying at BOCES. "Her attendance, hard work and dedication has helped her reach her goal," Burke said. The MIT reviews Susan's safety plan each month to ensure she is aware of who she can reach out to for support.

Susan has become an active member of her community and school and continues to develop appropriate friendships with her peers. "She's become more open to helping others, and is seeking out students who need a friend," Burke said. "Susan is a caring young woman who has turned her life around."



North Country MIT service area.

Creedmoor:
Helping Partners Move Forward on Their Journeys to Recovery

Mobile INTEGRATION TEAMS

Since its inception in February 2015 as part of OMH's "second wave" of MITs, Creedmoor Psychiatric Center's (CPC) MIT has successfully discharged more than 200 clients from CPC Housing or directly from inpatient units.

Its multidisciplinary team, which includes peers, partners with people with mental illnesses and their families to keep them healthy while living in their communities.

One of their clients, whom we'll call "Mary," had been in the foster care system since she was a child, and had lived at several group homes and psychiatric hospitals. She had been transferred to CPC as a teenager from a facility for girls in another state.

Creedmoor Psychiatric Center's Mobile integration Team, (from left) Chao Chen, RN; Cindy Rodrigues, Peer Specialist; Leonie Collins, SW Asst. II; Keith Claudio, RPAII; Claudia O'Reagan-Williams, LMSW 2; Denise Goldberg, LMSW 2; Darius Clay RPAII; Julianna McGoey, Rec. Worker; Xindi Xu, SW Asst. II; and Marilyn Vallejo, RPM 4.

"I was abused both physically and emotionally by both strangers and family members," Mary said. "I was very rebellious and combative." Mary suffered from PTSD and personality disorder. At first, she had a very hard time adjusting to her new environment at CPC. She was placed on 1-to-1 observation status, as well as on the Secure Care Unit.

Staff from the Secure Care Team and Inpatient Ward were understanding and worked diligently with her. "The Dialectical Behavior Therapy program helped me tremendously," Mary said. "I was better able to understand my symptoms and manage my behavior." Eventually, Mary's overall behavior started to improve to the point she was granted privileges to go off the ward – first with staff, then independently.

Referral to the MIT Program

Once Mary was referred to the MIT program, staff members there provided her with a great deal of encouragement.

MIT staff are creative and take a hands-on approach to their roles. Team members are involved in advocating on behalf of consumers in applying for Social Security, citizenship and immigration, Medicaid, food stamps, and things like local community-based programs run by churches, food banks, day treatment programs, and social adult day programs.

"Our MIT staff is in constant verbal and written contact with all agencies involved in a consumer's treatment," said Marilyn Vallejo, LCSW, Office of Discharge Planning Coordinator at CPC and supervisor of the team.

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"They ensure all are aware of any issues that need to be addressed to support a continued stay in the community – such as ensuring that medication, psychiatric, and medical issues are covered. In the past, when consumers have run out of medications, our team has gone as far as contacting prescribing psychiatrists, filling the prescriptions, and delivering them to consumers' homes."

The discharge process started immediately. She attended MIT groups twice each week. "During these groups, we were encouraged to interact and participate fully," Mary said. Topics were always geared toward building community living skills. Role plays and sketches were some of the tools they used to demonstrate the skill building techniques.

"Facilitators were patient and allowed each of us to express ourselves in a timely manner, even though sometimes we would divert from the topic being discussed," she said. "I benefitted a great deal from a presentation about the use of K2 and the profound consequences. I was fully geared and prepared not to take part in any forms of illegal drugs upon my discharge."

Back to the Community

Mary was all at once anxious, excited, and impatient about the screening process. "My social worker, MIT worker, and other members of the treatment team encouraged me to be patient and try not to lose control of myself," she said. The screenings went well and she was accompanied by MIT members to visit the community residence supportive site where she would live next.

"I was very impressed with community residence," Mary said. "The transition went well and I was able to make friends and familiarize myself with my new environment." She also learned to how to choose her new friends wisely. Within a year, Mary was referred by her case manager to a more independent setting in the city. "This was also a very easy transition," she said.

Mary is now enrolled in the GED high school equivalency program and plans to attend a special program that will prepare her to become a Peer Specialist. In the meantime, she is interviewing for jobs at the area's different department stores and businesses. "I return often to CPC," she said, "as a guest speaker at MIT groups to provide them with a role model of a successful discharge."

"Our MIT staff has embraced the concept that all CPC patients have the potential to move on to community living with the right support and skills," Vallejo said. "We help them make the transition from CPC's supportive care environment to community supportive care, and help ensure that they have a long and successful stay in the community."

The Creedmoor MIT covers the borough of Queens.

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